

# **The Way We See It:**

**A Discussion Paper  
which examines  
Perspectives of Families and Clients  
within the  
Current Mental Health System in Manitoba**

November, 2006

## **Acknowledgements**

This discussion paper is respectfully submitted by the Ad-hoc Committee on Mental Health to the Provincial Council of Women of Manitoba, Inc.

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broadened our experience and understanding of the complex issues of mental health.

## **Introduction**

This discussion paper attempts to provide the background needed to discuss the issues and assess our interpretation of the failure to progress towards mental health renewal in Manitoba in spite of the assertion by the Manitoba Government and Manitoba Health that it is at the heart of all new activity in the mental health field.

We (the Ad Hoc Committee on Mental Health, Provincial Council of Women of Manitoba) are writing about the issues from the perspective of individuals and families suffering from mental illness and dealing with the mental health system. This is a limited perspective undertaken initially with the intention of playing a positive role in mental health renewal in Manitoba. We are trying to understand why the system has so alienated the families of those suffering from mental illness and why there is toleration for so many failures to serve adequately those who suffer from mental illness.

Our objective and our perspective lead us to conclude that we are faced with a massive systems problem. It is not unique to Manitoba, nor is it unique to mental health. However, our focus is mental health and the families and individuals in that system. Our analysis makes us realize the futility of making recommendations under the current system. Under this system the government may make a policy, and may appear to reflect new techniques and new thinking, but it has no authority to make its will effective. It has given away its authority to administer and has built no accountability into that delegated authority. At the same time it has legislated so much protection for actors within the system that the system serves itself and those working within it, not the public. There is no-one to regulate the regulators. There is privacy legislation, ostensibly to protect the public but which is used to protect the regulators. No-one, including the government, is accountable and a corporate loyalty and secrecy has been allowed to flourish at the cost of the mentally ill.

We are particularly indebted to the reports of judicial inquiries into the system. It gives us our only opportunity to understand what happens within that system.

It is our responsibility to inform ourselves and others about the issues in this paper. Recommendations from this ad hoc committee to the Provincial Council of Women of Manitoba for further action are on page 19.

## Section One: Background

There has been a fundamental shift in the theory of treatment of the mentally ill from the 1970's and continuing today. The shift and development are well articulated by the Provincial Inquiries into the deaths of Sharon Joyce Horn (Provincial Court Judge John H. Combs, June 8, 2006); and Ms Anna Maciocha (Provincial Court Judge A. Catherine Everett, March 6, 2006). Prior to the 1970's people who suffered from mental illness, particularly serious mental illness, were traditionally ostracized from society and institutionalized. In such mental hospital settings the patients were expected to line up for all activities. They would be awakened at the same time, line up for the bathroom and be handed their clothes for the day. They would line up for meals, all at the same time, and line up for medications. The wards were always locked. The mentally ill, even those living in the community, would be marginalized and stigmatized. This narrow approach to the treatment of the mentally ill has since been labeled the "treatment model".

In the late 1970's it began to be recognized that mental health patients could manage in the community and efforts were made to close the mental hospitals and treat people suffering from mental illness as much as possible in the community. Manitoba was one province among others that began studying and acting on moving patients into the community with the intention of developing services available to them in their own communities. Both the conservative and NDP governments accepted the philosophy and worked towards these goals. It is against this background that the Manitoba Government and its health ministry, now called Manitoba Health, developed the vision and policies, with special emphasis on re-training and re-integrating persons suffering from mental illness into the community, with hospital services available on a temporary basis to deal with crisis situations. From the beginning of the change in approach, family and client participation, family consultation, family caring and family feedback, were considered to be an essential element of its success. This policy is called the "recovery model" and is, according to the Manitoba Government, the approach which lies behind all new initiatives in mental health in the province.

It must be re-emphasized that a central theme throughout ministry statements is the involvement of the family and informed participation of the patient/client.

This study looks at the actual experience of users and family members within the system through the inquiries carried out by a Provincial Court Judge under the Provincial Medical Examiners Act. The two inquiries cited above are examined from the perspective of the family and client. We also refer to an inquiry which reported ten years earlier on March 28, 1996 under The Fatality Inquiries Act. This inquiry, conducted by the Hon. Judge Howard Collerman, discusses the developing role of the judicial inquiries themselves as well as the evolving research, practices and controversies within psychiatry.

Challenged concerning his role during the judicial inquiry into the death of Sharon Dawn Kelly, in his report issued in March, 1996, Hon. Judge Howard Collerman stated:

*“A separate and wider function is becoming increasingly significant; the vindication of the public interest in the prevention of death by the public exposure of conditions that have threatened life. This separate role of the (public inquiries) in recommending systemic changes to prevent death is becoming more and more important. The social and preventive function of the inquest which focuses on the public interest has become, in some cases, just as important as the distinctly separate function of investigating individual facts of individual deaths....”*

Similarly, when he was challenged ten years later as to his jurisdiction, Judge John H. Combs, reflecting the change stated by Judge Collerman in 1996, in his inquiry report dated June 13, 2006 into the death of Sharon Joyce Horn emphasized that:

*“the scheme of the Fatal Inquiries Act is to establish an inquiry for the purpose of improving the practices and procedure of government or public agencies and institutions without attributing blame. The inquiry is not focused on culpability but on facilitating change. For this reason ... the Inquiry Judge should be free to make recommendations even if the circumstances surrounding the death cannot be determined on a balance of probabilities.”*

We are indebted to these inquest reports, as well as other inquest reports, for throwing some light into a closed, silent, world.

## **Section 2: Two Lives –Two Inquests**

### **Sharon Joyce Horn**

#### **Sharon's Story:**

Sharon Joyce Horn was born on Sept 12, 1946, the fourth of five children. Her frozen body was discovered in Brandon on January 3rd, 2004. Ten months later (October 6, 2004) the Provincial Chief Medical Examiner, called an inquest into her death. The Inquest was requested by her family, in particular Mabel Woolridge and MLA Leanne Rowat. It was conducted by Provincial Court Judge John H. Combs, and the report was released June 13, 2006.

Sharon was a patient in the mental health system in Brandon from the time she was 19 until her death at age 58. She had been diagnosed as having schizophrenia, borderline personality disorder and low intelligence. She would never be declared mentally incompetent under The Mental Health Act and so her support came from social security, not mental health. Since her illness could be managed in the community, she lived in residential care homes in Brandon from 1970 until three months before her death. She lived in the same home from 1970 to 1996. The Inquest heard that when she moved into the second home 26 years later she had no personal skills. She ate primarily with her fingers and did not know how to effectively use a knife and fork. She was afraid of taking a bath and had been used to sponge bathing. The care provider within the home supervised her medications which she was taking for depression, anxiety and some physical problems. At her new home, where the care provider was a former nurse, she was encouraged to take baths, was taught to clean her room, to use cutlery, to dress herself appropriately and suitably for the weather. She learned to take the bus or walk on her own to appointments or other activity. The "other activity" appears to be participating in programming arranged by the Community Mental Health Worker where her level of interaction with others was improving.

The help she received in that new placement appears to have been taken at the initiative of the individual providing the residential care. It did not appear to be the result of instructions to residential care providers from the Brandon Community Mental Health authorities in response to the mental health renewal approach adopted by the Brandon Regional Health Authority. It was the intention of the Community Mental Health authority to close their private home accommodation in the near future and such homes were being phased out of the system.

Two years later, the home provider was unable to continue due to ill health and Sharon was moved to her third residential care placement. The same support was provided to her in her third residential care placement. Describing Sharon Horn's daily activities the Inquiry was told she would make her way on a daily basis to the Welcome Inn, a gathering place for people within the Mental Health System in Brandon where she would play games, read and have coffee or tea. She would attend evening events including a weekly visit to a local United Church where she would participate in some meal preparation such as peeling potatoes. At this time a proctor was assigned to assist her with her integration into the community. They would sometimes go to movies or for

walks in the Mall.

The major anxiety Sharon Joyce Horn suffered in these years occurred when she was being moved from one residence to another. Although she was doing well in her recent placement, three months prior to her death, without warning, discussion, or explanation, she was removed from her home by a decision of staff of Community Mental Health. The decision was made by the Program Manager for Adult Community Mental Health (supervisor of mental health workers); another program manager in charge of residential services; and the person in charge of residential care licensing. Sharon Horn was met on her way home and told she could not go back to her home. The decision to remove her from this home was made because of an incident with another mental health resident in the home, although Sharon was happy and receiving good care and there was not another residence available.

### **Object of Inquest**

The object of the Inquest (s.125 of Inquest) was “to establish an enquiry for the purpose of improving the practices and procedures of government or public agencies and institutions without attributing blame.”

### **Inquest Report Findings**

Even after her death the committee said they believed they made the right decision. However, from this point on, the Inquest Report finds (p. 68 & 69) that:

*“.. it is evident that Sharon Horn did not receive the level of service that she was entitled to from her care providers. Decisions were made regarding her care without the resources to support those decisions or, alternatively, with resources being available and not being fully utilized. .... The fact that nobody from Community Mental Health had any contact with Ms. Horn for a period of about ten days prior to her death at such a high risk time period was unfortunate and not appropriate. This gap in service was due to problems with communication between care providers and lack of a specific service plan during this risky transition period.”*

Myrtle Woolridge, her sister, reported a phone call from Sharon expressing her hope that God would see her through this frightening period.

In the discussion following, we note, as did the Inquiry, that the Brandon Regional Health Authority had been an early supporter of the concept of Mental Health Renewal and is held up as an example for Canadians by Senator Kirby of what can be accomplished in the field of Mental Health Renewal. But even here there are serious problems, perpetuated, we believe, by the culture of secrecy and non-accountability inherent in the system. The points listed are principles and policies (presumably being followed) from formal documents of Manitoba Health which we discuss in part 3 of this paper.

**1. Inclusion of the family as an integral part of the system.**

There is no evidence of the involvement of Sharon Horn's family with the mental health system other than her initial admissions to it in 1964 and in 1970. There was some connection between Sharon Horn and her family but none with the family and the Brandon Mental Health System. At the time Sharon Horn became a user of the system in 1970 this was not unusual. But when Brandon adopted the new mental health renewal policy in the 1980's, still no initiative was taken to involve the family.

**2. Inclusion of the client in decision making and working towards greater independence.**

Contrary to the stated vision and policy, executive decisions were made without either consultation or explanation. No attempt was made to involve Sharon Horn in decisions regarding her residence or personal development from the time she entered the system in 1970 until September 2003, when without consultation with her or her mental health worker, and without any preparation or explanation, she was abruptly torn by executive decision from the life she had been living for thirty three years.

**3. Working with the client to develop the capacity of the individual to lead a fuller life for reintegration into the broader community.**

Sharon Horn had lived all her adult life as a client of the mental health system in a residential care home where the licensed care worker provided the necessities of life but was not expected to become a part of the new mental health renewal system. It was the intention of the system to discontinue that type of service and at no time was the residential home care worker instructed to teach the client in her care. Her only support for life in the community appears to have come from the community mental health worker whose responsibility was to introduce her to the mall and to drop-in services which were available in the community.

**4. Provision of resources within the community to permit clients in the mental health system to live in different types of housing as their capacities improved.**

There was no place to which Sharon Horn could move. As mentioned above the residential care homes were being phased out of the system and Sharon did not qualify for, or was not ready for, other types of accommodation available.

**5. Cooperation between government departments and agencies.**

As a stop gap measure, Sharon Horn was sent to the only facility in Brandon for training and assessing skill development to move into independent living. She was removed when another government department refused to fund the service. She was caught between competing agencies.

**6. Understanding by workers within the system of their own responsibilities.**

Sharon Horn's mental health worker was only recently employed, had not previously held a position in mental health and was not aware of his responsibilities. He was not part of the decision making, did not know that he would be responsible for finding accommodation, or that Sharon was not eligible for certain services to assess her capability because she was receiving social assistance.

**7. Sharing knowledge about a client within the system.**

Fear of divulging information prevented sharing of even the most rudimentary and necessary information with care workers within the system.

## Anna Maciocha

### Anna's Story

The second inquest we examined was that of Ms Anna Maciocha who committed suicide on April 5, 2004, while a patient at the PsychHealth Unit, Health Sciences Centre in Winnipeg. Anna was in the system as an involuntary patient from February 9, 2004. She was brought in and admitted by her alarmed family. She committed suicide 57 days later – still an involuntary patient.

Six months after Ms Maciocha's suicide, the Chief Medical Examiner of the Province of Manitoba called for an inquest to be held, pursuant to section 19(2) of the Fatality Inquiries Act. The Inquest sat from October 6, 2005 to December 15, 2005. In the acknowledgments in that report, A. Catherine Everett, notes the Court was assisted by a committee of representatives from the Health Sciences Centre "who took the time to meet and suggest recommendations to address the concerns raised by the evidence."

However, the report also states: "that because of time limitations on the committee their recommendations were not subjected to the same level of review and scrutiny that would usually take place through the hospital organization and that further review of these recommendations would be necessary" upon the receipt of this report. (We take that to mean that the hospital organization may reject any of the recommendations made by the Inquiry report).

Anna's story, after she was brought into the mental health system by her family on February 9, 2004, during a psychotic episode is short, and is best understood from excerpts of the evidence taken from the report of the Inquest.

The following paragraphs numbered (13) to (20) are directly from the Inquest Report in a section called **Communication with the family**. They are subdivided into Evidence, and Issues.

#### **Evidence:**

*(13) It was clear from the testimony of Ms Wisniewski that the family felt "out of the loop" when it came to Ms Maciocha's care. The family often felt they were imposing on medical staff when they made inquiries about Ms Maciocha and felt powerless to press their concerns and questions. The family feared that attempts on their part to pursue information about Ms Maciocha from nursing staff might impact negatively on Ms Maciocha's care.*

*(14) When the family met in person with Dr. Eunice Gill, Ms Maciocha was present and in a manic state so the conversation was very interrupted. The family had no*

*communication at all with Dr. Kenneth Zimmer, Ms Maciocha's attending physician when Dr. Gill was away on holidays. The family was not advised beforehand when Ms Maciocha was about to receive weekend passes and did not receive any instructions about appropriate care of Ms Maciocha when she was out on escorted passes. For example, they were not advised about Ms Maciocha's medication needs and received no instruction about what to do if Ms Maciocha's condition worsened while out on a pass. The court was advised that there is no policy in place for providing families of patients with information regarding passes or for receipt of information from the family upon the patient's return.*

*(15) On this point, the night before Ms Maciocha's death, her sister, Ms Wisniewski, brought her back early from a weekend pass as she was concerned about Ms Maciocha's deteriorating condition. She urged staff to revoke Ms Maciocha's passes, as she feared for Ms Maciocha's safety and that she would harm herself. This critical feedback from the family resulted in no formal action by primary staff. Her primary nurse took no action to revoke Ms Maciocha's passes that night. This failure to revoke Ms Maciocha's passes will remain an issue that will be discussed at greater length throughout this report.*

#### **Issues:**

*(16) It remains unclear from the evidence how a family is best able to exchange information with the medical team. Some very general informational materials are available on the ward for families, although the Maciocha family was never given these materials.*

*(17) In many cases, the family is a valuable source of information about the patient's condition, especially if, as in this case, the patient was an involuntary patient. The family's input into Ms Maciocha's case was critical for obvious reasons. Consent for her treatment was provided by Ms. Wisniewski. Despite the obvious need for communication with the family in a situation like this, the health care professionals who testified appeared unsure how much information about the patient could be shared with family members.*

*(18) In Ms Maciocha's case, her attending physician went on holidays and her primary nurse changed often. It appears that the Maciocha family was not made aware of these staff changes so they were often unaware of who best to speak to about Ms Maciocha's progress.*

*(19) Dr. Zimmer was unsure in his testimony as to whether he could even tell Ms Maciocha's family that he was Ms Maciocha's attending psychiatrist while Dr. Gill was away on holidays. Failure to share such fundamental information results in an untenable situation. Given that Ms Maciocha was an involuntary patient the entire time*

*that she was in the hospital, it is unclear why the medical professionals involved in her care would feel unable to discuss Ms Maciocha's treatment with her sister who was, in fact, the relative providing consent for Ms Maciocha's treatment.*

*(20) The last, and perhaps most distressing, example of failure to ensure appropriate communications with the family occurs at the time of Ms Maciocha's death. Despite existing hospital policy requiring the attending physician or resident to notify the next of kin of a patient's death (Exhibit 2, C11), no physician initiated contact with Ms Wesniewski to inform her of her sister's suicide. Instead, the police were apparently dispatched to Ms Maciocha's father's residence. Even after Ms Wesniewski phoned the ward and learned unexpectedly of her sister's suicide, it appears no one from the medical team attempted to call her back to see if she required assistance when she became overwhelmed and had to hang up.*

Studying this part of the evidence from the Report of the Inquiry we can only conclude that at no point was the service provided by the PsychWard at the Health Sciences Centre to Ms Anna Maciocha or to her family adequate. By choosing to ignore the family, they ignored the danger signals that could have prevented the death of Ms Maciocha. The approach can be described as nothing other than irresponsible, the treatment provided, careless, the level of knowledge of policy and protocol, inadequate, understanding by individuals of their own job descriptions (requirements) inadequate, communications between staff negligible.

This case appears to be judicial confirmation of personal life experiences told to us by many other families and users caught powerless and silenced within the mental health system of Manitoba.

### **Access to Physicians and Patient Requests for Treatment**

Since our focus is on family involvement and client participation, both central to the new mental health recovery approach adopted by Manitoba Health, and not with recommendations made by the Inquiry, we move next to the section in the Inquiry Report entitled: **Access to Physicians and Patient Requests for Treatment**. The numbered paragraphs following are taken directly from the report.

*(60) Ms Maciocha was in the hospital 57 days from February 9 until the day of her death, April 5. Dr. Gill was Ms Maciocha's attending psychiatrist. Between February 9 and March 26, she met Ms Maciocha eight times. Dr. Gill was on holidays from March 26 to April 5. During this time Ms Maciocha was under Dr. Zimmer's care. Ms Maciocha never saw Dr. Zimmer throughout the period while he was responsible for her care despite the fact that Ms Maciocha asked to see Dr. Zimmer and that the request was apparently brought to Dr. Zimmer's attention. From reading the chart it is clear that Ms Maciocha was deteriorating during the time period when she requested to see Dr. Zimmer. It remains unclear to the Court why Dr. Zimmer did not evaluate Ms Maciocha*

*even though she requested it, was decompensating and, further, had not been seen by an attending psychiatrist for days.*

*(61) In fairness, it should be noted that Ms Maciocha was seen frequently by a resident or medical student. In the last week of her life, the medical student was the only medical staff, other than the nurses who was seeing Ms Maciocha regularly. This student (a second year med student) had not even been on the ward a week and had received no specific suicide risk training. Ms Maciocha also requested the staff to contact her former psychiatrist who had some familiarity with her condition, to consult about her case. She advised that she had spoken to this psychiatrist and he was expecting their call. No one ever called him.*

*(62) Lastly, Ms Maciocha was aware that Wellbutrin had helped with her depressive episodes in the past and she made more than one request to be put back on this drug. Despite the fact that she was becoming more and more depressed as the days wore on, no one prescribed this antidepressant for her. Although the Court heard evidence that an antidepressant would have to be monitored carefully to ensure that the drug did not trigger a manic episode, given that Ms Maciocha was hospitalized, clearly she could have been monitored. This potential side effect should therefore not have been a bar to receiving the drug. The resident at one point did suggest another drug to Ms Maciocha for her to consider..... Yet still, all of the medical staff who heard Ms Maciocha's requests and knew that she wanted to start antidepressants simply deferred the medication decision until Dr. Gill's return. The delay was unfortunate, given Ms Maciocha's extreme depression and need for treatment.*

Other issues dealt with in the report are Granting or Revoking Passes; The Pass Book; Suicide Assessment Process and Training; Charting; Resources; and Critical Occurrence Procedures but again, although we recognize all the issues are inter-related, we are concentrating on events that impact directly on the family or the user. The issue of passes is crucial because of its look into the system, the client, and family participation.

The evidence received from Dr. Yaren and Dr. Gill was that passes are critical in helping restore patients to full autonomy and that to grant or revoke a pass is a matter of clinical judgment for health care professionals. The exercise involves a risk-benefit analysis by the treating psychiatrist and the rest of the medical team. The role of the passes is to help both the medical team and the family assess the realistic progress of the individual and how the patient is responding to treatment. However, the whole process broke down in the case of Ms Maciocha. Not all staff were aware of the theory, the sign in and sign out were not enforced, there was no assessment done either before or after use of the pass, alarms from the family to rescind passes because of the seriously deteriorating condition of their sister were not heeded, and there was conflicting evidence from staff concerning events and knowledge of either protocol or policy.

It is not necessary to list, as we did in the first case of infringements of the vision and policy of mental health renewal claimed to be directions to RHA's in Manitoba, since none of the policies seem to have been understood, and certainly none were in evidence. The disturbing question from this inquiry is "Why?" And why are the experiences of the patient and her family so clearly parallel with those of others caught within the system of Manitoba Mental Health. For that we turn to the section, "The Never, Never Land of Mental Health Reform" after looking at the growth and development within the Manitoba Government, of mental health renewal.<sup>1</sup>

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<sup>1</sup> ( While we have called our discussion "The Never Never Land of Mental Health Reform", it is revealing to see the Winnipeg Regional Health Authority presenting an all day program entitled "Family Involvement in Mental Health...The Impossible Dream?" On November 23, 2006. )

### **Section Three: Evolution of the Theory, Vision and Policy of Mental Health Renewal**

The fundamental shift in the treatment of the mentally ill from the late 1970's has been discussed briefly above (pages 4-5)

In May 2005 a policy paper issued by Manitoba Health entitled *Family Member and Natural Support Participation in Mental Health Service Planning, Implementation and Evaluation*, applicable to all Manitoba Regional Health Authorities and Selkirk Mental Health Centre, was approved (Review Date May 2007). It states this policy built on work that was done during the process of reform of mental health services in Manitoba beginning in 1988 and keynotes significant developments as follows:

**1988:** process began and according to the background to this policy paper *“this period marked the beginning of significant implementation of the proposed elements of family member participation and collaboration between Manitoba Health, self-help groups, Regional Mental Health Councils, the Advisory Committee on Mental Health Reform, service providers and recipients of mental health services and their families.”*

**1990:** document *Vision for the Future: Guiding Principles and Policies for Mental Health Service Providers*. This included the fundamental principle that mental health services shall augment and reinforce helping networks in the community *‘such as family, friends, clergy and self-help groups as well as other government departments and agencies’*.

**1992:** document *Building the Future of Mental Health Services in Manitoba* emphasized the principle that *“local citizens, consumers and communities shall participate in the planning, development and delivery of mental health services to community members.”*

**2002:** In February 2002 Manitoba Health issued a *Vision Statement for Mental Health Renewal* which outlined the values and beliefs of the mental health system and the direction in which the system is moving and stipulated that *“Mental Health Renewal activities will be aligned with this vision statement.”*

Note: *the statement was made by Manitoba Health in consultation with consumers of mental health services, family members and friends of consumers and service providers. There is no mention of participation by the psychiatrists – an omission that seems to be critical.*

**2005:** Policy Title: *Family Member and Natural Support Participation in Mental Health and Service Planning, Implementation and Evaluation*. Policy is applicable to Regional Health Authorities and the Selkirk Mental Health Centre. Date approved May 2005; date of review May 2007. The purpose of the policy is to provide direction to Regional Health Authorities (RHA's) and the Selkirk Mental Health Centre in the development of their plans for meaningful family members and natural support participation that will:

- (a) Offer support to family members and other natural supports;
- (b) Enhance opportunities to work towards authentic working relationships between consumers, family members, other natural supports, service providers, mental health managers, system planners and policy makers; and
- (c) Improve the quality of services and consumer satisfaction through effective mental health services and consumer satisfaction through mental health service planning, implementation and evaluation.

Further, plans developed by the health authorities for the enhanced participation of families and natural supports will be based on the core values of

- (a) respect;
- (b) collaboration and participation; and
- (c) shared responsibilities.

In addition resources are to be made available to both for an effective strategy for family/natural support and for client participation, as well as a communications plan to make sure all are aware of the services available to them.

#### **Section Four: The Never Never Land of Mental Health Renewal**

Our observation, as we try to understand why Mental Health Renewal appears to have been doomed, is that it is not possible to achieve a workable policy if the wrong people are around the table. Without the cooperation of all players, it is not going to happen.

We look now at two Statutes assented to during the very time mental health renewal was being espoused by Manitoba Health.

(1) The *Personal Health Information Act (PHIA)* became law on December 11, 1997 with a review to take place in December 2004. The review discussion paper issued by the Minister of Health in January 2004 for the information of the public states that:

*The PHIA protects Manitobans' rights to access their own personal health information and to have that information protected from inappropriate collection, use, disclosure, retention and destruction.*

*A brief summary for Health Professionals explains the penalty for its violation is a fine of up to \$50,000, which can be imposed each day that a violation continues. There are strict limits as to who, within the system is entitled to receive information gathered under the Act.*

*The Act provides for an Ombudsman whose role is to supervise compliance with the Act generally and to deal with complaints about specific violations of the Act. However it stipulates that Trustees have no general duty to assist the Ombudsman but that they must comply with orders or requests from the Ombudsman.*

(2) The *Mental Health Act* was assented to June 29, 1998. It was proclaimed in force October 29, 1999. Section 118 of this act is called Protection from Liability and reads:

*No action for damages or other proceeding lies or may be brought personally against the director, a medical director, a psychiatrist, a physician, a member of the Review Board established or designated for Manitoba under Part XX.1 of the Criminal Code(Canada), or any other person acting under the authority of, or engaged in the administration of this Act or the regulations for anything done or omitted in good faith in the performance or exercise, of any duty or power under this Act or the regulations, or for any neglect or default in the performance or exercise, or intended performance or exercise in good faith of such a duty or power.*

The two Acts, *PHIA* and the *Mental Health Act* have the effect of silencing the system and creating barriers even between paid workers within the system. Any one in authority within the system or anyone under the purview of that authority is absolved from any responsibility in law\*. There appears to be no accountability in the system for misjudgment, for neglect, even abuse. In short, these laws are incompatible with the attempt to introduce the new policy of Mental Health Renewal. Mental Health Renewal is a Vision and an Approach--it is not law. Even the self-help agencies, because of the source of some of their funding, and because of their relationship (for example paid services for clients of the mental health system) with their particular Health Authority, are constrained in their response. It forms part of employee dependency within a closely controlled corporate system.

*\*It is true that a person or a treatment team ought not to be penalized if they make an honest mistake and the liability section recognizes that. However, the system most often closes rank to protect itself. This makes it almost impossible to get to the truth of the matter. It has also led to more acts, [see for e.g. Public Interest Disclosure (Whistle Blower Protection) Act] recently introduced to protect whistle blowers to help create some protection and openness in the system. It is also true, however, that within the system the acts are interpreted as being more restrictive than necessary – both by government officials and by authorities and workers within the health system.*

Central to the whole system is the separation of the Health Ministry from the

Administration of the health services in Manitoba. The government and the citizen have lost control. The Government is no longer politically responsible or accountable for the administration of the system. The Regional Health Authorities and the Selkirk Mental Health Centre are not held responsible for impeding policy initiatives advocated by the Manitoba Health Ministry to renew the Manitoba mental health system. Judging from events related in this document, the Regional Health Authorities are not accountable for hospital administrations presumably under their aegis.

Central also is the exemption from public scrutiny of the legal and medical associations who have been given power of regulation, control and oversight of their professions. No one, it appears, regulates the regulators. One serious outcome of this is that it impedes public debate, and even the informed public's right to know. Neither legal nor medical professions appear to have provided input into the legislative review and amendments to The Mental Health Act in 1997. We have not heard either the College of Physicians and Surgeons or psychiatrists within the mental health system express opposition to family and patient involvement espoused by Manitoba Health. They obviously have objections considering the lack of progress in this area. Yet they do not speak publicly. They continue to dominate the direction of the public system without accountability.

We are faced with a dilemma that is a part of government and public life today. That is the corporatization of government services through regulation and delegation of authority without adequate monitoring or accountability. Our task is to attempt to make changes in one area only – bringing about change that will make effective practice of the vision of mental health renewal in Manitoba regarding family/client awareness, respect, collaboration, participation, shared responsibilities and open communication.

## **Section Five: Recommendations to the Provincial Council of Women of Manitoba**

1. THAT the Provincial Council of Women of Manitoba and its many federates, talk with others about their experiences within the mental health system, and collect the stories, so all will hear.

It is only through our mass public involvement in the process that we can hope for dialogue that will include all parts of the system – policy makers, regulators, monitoring bodies, the public. Open dialogue is the first step to mental health renewal as action, not only vision.

2. THAT the members and federates concentrate on this project during the period January 2007 to March 2007.

This time-frame would allow us to be well prepared to appear at the legislative review of the Policy of Mental Health Renewal at the target date of May 2007.

3. THAT the Provincial Council receive stories of experiences from individuals and organizations who may not be associated with a group but who may wish to participate. The responses could be received by mail, fax or e-mail. The stories may include recommendations, but is the story itself that will have the most impact: good and bad.

4. THAT the Provincial Council of Women in Manitoba recommend an expanded use of inquiries since the judicial inquiries under The Fatality Inquiries Act, seem to provide the only source of untainted information to citizens. Their objective, as is ours, is not to blame, but to improve the system.

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## **Bibliography**

The Manitoba Courts Web Site includes an index and texts of recent Inquest Reports issued by the Provincial Court of Manitoba pursuant to the provisions of The Fatality Inquiries Act of Manitoba. To obtain a print copy of an Inquest Report on the list or of an older Inquest Report, contact the Office of the Chief Medical Examiner in Manitoba at 945-2088 or 1-800-282-8069.

The web site is: [http://www.manitobacourts.mb.ca/inquest\\_reports.html](http://www.manitobacourts.mb.ca/inquest_reports.html)

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Legislative Reading Room (260 Legislative Building, 450 Broadway, Winnipeg MB.)  
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