

**Complaint of Discrimination
Under The Human Rights
Code (Manitoba)**

**Discrimination - Plainte
portée en vertu du code des
droits de la personne (Manitoba)**

File Number: /

MHRC USE ONLY/RÉSERVÉ À LA CDPM

N° de dossier:

Date filed/Date déposée

Name and Address of the Complainant/
Nom et adresse du plaignant

Association for Community Living
#210 - 500 Portage Avenue
Winnipeg, Manitoba R3C 3X1
Telephone: (204) 786-1607
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Name and Address of any person or class of persons discriminated
against in addition to or other than the complainant(s)/
Nom et adresse de toute personne ou tout groupe de personnes
au nom de qui ou avec qui le plaignant a porté plainte

Residents of the Manitoba Developmental
Centre
3rd Street N.E
Portage la Prairie MB R1A 3C6

Name and Address of the Respondent/
Nom et adresse de l'intimé

Minister of the Department of Family
Services and Housing
357 Legislative Building
450 Broadway
Winnipeg MB R3C 0V8

The Public Trustee
155 Carlton St., Suite 500
Winnipeg MB R3C 5R9

The Commissioner for Vulnerable
Persons
305 - 114 Garry Street
Winnipeg MB R3C 4V4

The Executive Director of the Manitoba
Developmental Centre
840 3rd Street N.E.
Box 1190
Portage la Prairie MB R1N 3C6

The Complainant alleges that in the Province of Manitoba, on a continuing basis up to and including September 25, 2006

that the Respondent(s) did contravene section(s) **9(1), 9(2)(e), 9(2)(l), 13(1) & 14(1)** of **The Human Rights Code**, or any other applicable section as follows:

See attached complaint.

I certify that the foregoing information is correct to the best of my knowledge and I believe that the events described above constitute a contravention of **The Human Rights Code**.

City/Town Complainant Signed At/

Winnipeg, Manitoba

Date

Day/ Month/ Year/
25 / 09 / 2006

Signature of Complainant

IN THE MANITOBA HUMAN RIGHTS COMMISSION
COMPLAINT OF DISCRIMINATION
UNDER THE HUMAN RIGHTS CODE OF MANITOBA

A. OVERVIEW OF THE COMPLAINT

1.The Manitoba Developmental Centre (“MDC”) was built in an era when many in society considered it acceptable for persons with intellectual disabilities¹ to be locked away and forgotten. The majority of MDC residents were placed there decades ago, when there were only two options for families – home care with no community supports or institutionalization. These residents languish there today not because there are no better options but because of stereotyping on the basis of age and disability.

2.Changes in attitudes towards the disabled since the 1960's brought with them a recognition of the desirability of integration and deinstitutionalization.² A 1971 Report entitled “Present Arrangements for the Care and Supervision of Mentally Retarded Persons in Ontario” detailed the many problems associated with the overcrowded, isolated and understaffed institutions of the day.³

3.To similar effect, a 1987 report from the Manitoba Ombudsman outlined serious concerns with the lack of programming and training opportunities available to residents of MDC. The Ombudsman considered the individuals living at the Centre to be a particularly vulnerable group. In his view, many of the residents were “forgotten souls” unable to speak for themselves and lacking anyone to speak on their behalf.⁴

¹ An intellectual disability is a condition that is usually present from birth and that causes challenges in learning and cognitive functioning. It is not the same as a psychiatric disability. An intellectual disability may be caused by inborn factors, for instance Down Syndrome, or by exposure to environmental toxins, for instance Fetal Alcohol Syndrome, or both.

² See for example, *The United Nations and Disabled Persons – The First Fifty Years*, <http://www.un.org.socdev/enable/dis50y30.htm>, Chapter IV. “The focus of the United Nations on disability issues shifted in the late 1950s from a welfare perspective to one of social welfare. A reevaluation of policy in the 1960s led to de-institutionalization and spurred a demand for fuller participation by disabled person in an integrated society.” “In 1984, the Secretary General of the United Nations identified a “growing tendency to replace institutional care with programmes that help families and communities.”

³ Report of Walter Williston, “Present Arrangements for the Care and Supervision of Mentally Retarded Persons in Ontario”, 1971.

⁴ Summary of The Ombudsman's Report on The Manitoba Development Centre, April 23, 1987.

4. It is now acknowledged that persons with disabilities have a right to be “agents of their own destiny rather than objects of care.”⁵ The United Nations has recognized that persons with disabilities “have the same fundamental rights as their fellow-citizens”⁶ including the right to liberty and to equal protection of the law⁷ as well as the right to full and equal participation in society.⁸ Among the most fundamental of these rights are the rights “to remain within their local communities” and to “receive the support they need within the ordinary structures of education, health, employment and social services.”⁹

5. The continued institutionalization of hundreds of Manitobans at the MDC cannot be reconciled with the values recognized and affirmed by the United Nations. Institutionalization is a shameful chapter in the struggle for equality and for the recognition of basic human rights. What was once considered acceptable treatment is now seen as an affront to human dignity and an obstacle to achieving individual potential.¹⁰ There is now general agreement that institutional care means a poor quality of life because it perpetuates dependence, reduces choice, and offers little opportunity for skill development.

6. Institutional care models are on the wane. In the 1990's, the provinces of British Columbia and Newfoundland closed their remaining institutions for persons with intellectual disabilities. Soon, the last three facilities for the care of intellectually disabled adults in Ontario will have closed. Residential schools and orphanages have long since disappeared. But the Manitoba Development Centre remains.

⁵ *Tallinn Guidelines for Action on Human Resources Development in the Field of Disability*, August 1989. In 1989, the Secretary General was requested by the United Nations General Assembly to bring these guidelines to the attention of member states.

⁶ *Declaration of the Rights of Disabled Persons*, Proclaimed by General Assembly resolution 3447 (XXX) of December 1975.

⁷ The United Nations, *International Covenant of Civil and Political Rights*, See in particular Parts 2, 9, and 26. See also the The United Nations, *International Covenant on Economic, Social and Cultural Rights* in particular Articles 6, 11, 12, 13 and 15.

⁸ *Standard Rules on the Equalization of Opportunities for Persons with Disabilities*, adopted by the United Nations General Assembly in 1993, preamble.

⁹ Introduction to the *Standard Rules on the Equalization of Opportunities for Persons with Disabilities*, adopted by the United Nations General Assembly in 1993, para 26.

¹⁰ Report of Walter Williston, “Present Arrangements for the Care and Supervision of Mentally Retarded Persons in Ontario”, 1971. See the reference to this report in *Gray v. Ontario*, [2006] O.J. No. 266 (Ont. S.C.) at para 8.

7. With appropriate, well-planned and thoughtful community supports, it is possible for **all** persons with intellectual impairments to be full participants in society, even those with profound disabilities and those institutionalized all their lives.

8. In its 2001 White Paper entitled “Full Citizenship: A Manitoba Strategy on Disability”, the Province of Manitoba recognized the shift away from institutionalization and isolation and made a commitment to full inclusion of persons with disabilities. In the words of the Minister Responsible for Persons with Disabilities:

People with disabilities in Manitoba face serious barriers that prevent their full participation as citizens in our society. These barriers remain in place despite the ongoing and active lobbying by people with disabilities, despite the growing popular support for the inclusion of people with disabilities, and despite a mounting pile of provincial, national and international reports that outline needed change to our social, economic and physical infrastructures. Our government and our society have been challenged: we must remake our institutions in a way that allows people with disabilities to fully participate in our society. (emphasis added)

9. In its White Paper, the Province adopted several principles to guide the development of future policies, including:

- **The Principle of Rights and Responsibilities** – Manitobans with disabilities have the same rights and the same responsibilities as other Canadians. They are entitled, as are others, to the equal protection and the equal benefit of the law and require measures for achieving equality, consistent with the Canadian *Charter of Rights and Freedoms*, provincial and federal human rights legislation and international human rights covenants.
- **The Equality Principle** – Manitobans with disabilities have the right to goods and services which will give them equality of opportunity and outcome.
- **The Respect Principle** – Manitobans with disabilities have the right to have their abilities, right of choice and dignity respected in all stages of their lives.
- **The Inclusion Principle** – The Government of Manitoba is committed to an inclusive way of thinking and acting that allows every Manitoban to feel accepted, valued and safe. Manitoba is an inclusive community consciously evolving to meet the changing needs of Manitobans.

Through recognition and support, Manitoba strives to provide meaningful involvement and equal access to the benefits of citizenship.

- **The Access Principle** – Manitobans with disabilities have a right to places, events, services and functions that are generally available in the community.
- **The Empowerment Principle** – Manitobans with disabilities have a right to the means to maximize their independence and enhance their well-being.
- **The Principle of Self Determination** – Manitobans with disabilities have the right to participate in decision-making regarding the design, organization and operation of programs providing goods and services that affect them.
- **The Freedom Principle** – Manitobans with disabilities have the right to the least restrictive environment possible.
- **The Participation Principle** – Manitobans with disabilities have the right to participate and be invited to participate in all aspects of the economic, social and cultural life of Manitoba.
- **The Principle of Early Integration into Family and Home Community** – Manitobans with disabilities have the right to programs and services that ensure early and lasting integration into society and avoid forcing individuals to leave their families and home communities.
- **The Awareness Principle** – Commitment and action to raise public awareness minimizes environmental barriers, removes systemic barriers and remedies, social attitudes evolving from ignorance, indifference and fear, presently impeding the full inclusion and participation of Manitobans with disabilities.

10. In the case of close to 380 residents of the MDC, these principles have been turned on their head. The Province has failed to meet the challenge identified by the Minister Responsible for Persons with Disabilities in 2001. The most fundamental of rights – the right to live in one's community – has been overturned by the stereotypical presumption that past institutionalization somehow makes current restrictions on one's basic liberty more palatable.

11. Despite the progress made and a heightened awareness of the rights of the disabled, far too many individuals still reside in the MDC, some for over 30 years.

Their continued placement at MDC is, in effect, a life sentence without access to essential community programs, services or enjoyment of the community. So long as they remain at the MDC, they are denied the opportunity to realize their full potential and to achieve a higher quality of life.

12.The Respondents are discriminating against MDC residents under ss. 13(1) and 14 (1) of *The Human Rights Code* on the basis of age and mental disability by failing to provide adequate services such as:

- Rehabilitation programs
- Dental care
- Medical care
- Life and physical skills training
- Education
- Vocational training and opportunities

13.More fundamentally, the Respondents are discriminating against MDC residents under ss. 13(1) of *The Human Rights Code* on the basis of age and mental disability by denying them the right to live in their community with appropriate support and funding.

B. THE ASSOCIATION OF COMMUNITY LIVING

14.The Complainant, the Association of Community Living (“ACL”), is a non-profit umbrella organization incorporated in 1953, with branches and affiliates throughout Manitoba. ACL assists persons with intellectual disabilities living in the community and their families through its programs and by offering training, information and support. Over the years, it has also developed a number of programs designed to meet the needs of institutionalized residents and to facilitate their return to the community.

15.Since 1979, ACL has worked in association with the Manitoba Marathon to raise funds and awareness on behalf of Manitobans with intellectual disabilities. During the early 1980s, ACL authored an important paper to the Premier of Manitoba with respect to the conditions experienced by Manitobans with intellectual disabilities. ACL played a leading part in the Welcome Home Program between 1983 and 1986 by assisting many Manitobans to rejoin their communities via community living. When the Pelican Lake

institution was closed in 2001, ACL played a key role in successfully finding each resident a home in the community.

16.From its work with individuals, families, community agencies and government, ACL has expertise and a broad knowledge of all issues touching the lives of persons living with an intellectual disability. The organization strives to build dignified lifestyles by supporting families and providing community-based programs and services.

17.The goal of ACL is to further the well-being of persons with intellectual disabilities by ensuring they have opportunities for optimal personal development as well as the necessary support to realize personal aspirations. It works to foster respect for people with intellectual disabilities as equal citizens by educating and encouraging the community, and through furthering development of the community's capacity to include, support and accommodate their needs.

18.ACL believes that deinstitutionalization is key to achieving its goal. Based on decades of experience, it has learned that:

- Disadvantages that come with an intellectual disability are often compounded by the stigma, discrimination and social, educational and economic segregation and exclusion that many people with intellectual disabilities face.
- People with intellectual disabilities, when given proper information and the opportunity to experience community living, choose not to live in institutions.
- Institutions deny people basic rights of citizenship, personal control, decision-making and a sense of independence. Based on personal stories, as told by former residents, incidents of abuse, isolation and personal suffering more often than not occur in places like the MDC.
- Limitations usually associated with disability are as much related to the surrounding environment and rules of society as they are to the individual.
- People, regardless of the type or extent of their disability, do not need to live in institutions. Community options can and have been designed to accommodate a wide range of disabilities (mental/physical/sensory).
- Services in the community are no more expensive, on average, than those provided in an institution.

→ People flourish and thrive when they live in the community, either independently or with appropriate support.

19. Based on its own experiences and the research conducted over the past 20 years, ACL believes that with sufficient funding and community supports, all MDC residents could be successfully placed in the community.

C. INSTITUTIONALIZATION VS. COMMUNITY LIVING

(a) Life at the MDC

20. The MDC is located in Portage la Prairie, Manitoba and was built in 1890 as an institution for persons with mental or intellectual disabilities. It currently houses approximately 380 men and women from communities across Manitoba, although most residents are from Winnipeg. More than 40 of the residents are of Aboriginal ancestry. The severity of impairment varies. As at December, 2002, the breakdown was¹¹:

<u>Level of Disability</u>	<u>Number of MDC Residents</u>	<u>Percentage</u>
Borderline	7	2%
Mild	55	13%
Moderate	56	13%
Severe	172	40%
Profound	138	32%

21. By today's standards, living conditions at the MDC are abysmal. A \$140,000 feasibility study conducted by the Province of Manitoba in 2001 reported that:

Declining populations and cosmetic improvements to the environment (pictures, wallpaper, curtains, new furniture) have added to the residents' quality of life. **The Manitoba Developmental Centre, however, has yet to achieve the standard of physical living conditions found in present-day correctional institutions and other long-term care facilities. It is common for MDC residents to still share dormitory quarters with 4 to 8 other residents. MDC residents often share**

¹¹ Information attached to March 27, 2003 memo from Gisela Rempel Assistant Deputy Minister to Dale Kendel, Association for Community Living. The total number of residents at that time was 428. The current total is around 380.

communal style bathrooms with as many as 30 other residents while the current standard in new current long-term care facilities is a single-bedroom with a private bathroom for each resident.¹² (emphasis added)

22.MDC's current mandate is to generally only admit individuals falling under one of the following two categories:

- Adults with a developmental disability who exhibit challenging behaviours and who can no longer be safely managed by community resources until the behaviours are stabilized with appropriate medication and/or treatment regimes. For these individuals, the intent is to move them back into the community within 6-8 months; or
- Adults with a developmental disability who have a history of forensic behaviours, including violence, sex offending behaviours or arson, which has placed them in conflict with the law. These individuals are referred to MDC for permanent placement so long as they pose a risk to themselves or the community at large.

These new admissions must be pursuant to Court Order.

23.Despite the appearance that placements are meant to be temporary, the reality is that the MDC is being used as a long-term care facility for adults with mental or intellectual disabilities who were admitted in the 1960's and 1970's when institutionalization was routine and there were few, if any, community options. The average age of MDC residents is over 50 and the average length of residence at the institution is 33 years. Based on past trends, current residents of the MDC can be expected to live another 20 years, on average, in reasonably good health.¹³

24.The experience in recent years suggests that far too many of these individuals may be forced to live out their lives in institutions. The 2001 feasibility study noted a reduction in the pace of discharges:

¹² GBR Architects (2001), *Manitoba Developmental Centre: Long-Term Development Feasibility Study*, at p. 3.

¹³ GBR Architects (2001), *Manitoba Developmental Centre: Long-Term Development Feasibility Study*, at p.116. Please also see the information attached to the March 27, 2003 memo from Gisela Rempel Assistant Deputy Minister to Dale Kendel, Association for Community Living.

During the late 1990's, the number of annual discharges fell due to the lack of financial and staffing resources available to effectively transition residents into the community. Limited resources restricted discharges from MDC to only a small number who were able to easily make the transition.¹⁴

25. Similarly, between April 1, 1999 and March 1, 2005, only 35 residents were discharged from the MDC. During that same time period, there were 69 deaths, most due to natural causes in the geriatric population.¹⁵ Between 1999 and 2005, residents from MDC were more likely to leave the institution due to death than as a consequence of a return to their community.

26. In November 2005, in response to pressure from community organizations, the Project Charter for the *Manitoba Developmental Centre (MDC) to Community Transition Strategy* was approved by the Province. The Charter purports to recognize that without a comprehensive strategy “too many people” would remain in MDC because of inadequate funding, planning and supports for individuals and their families.

27. ACL understands that the original intent of the *Community Transition Strategy* was to enable ten to fifteen persons to leave MDC by March 31, 2006.¹⁶ As of March 31, 2006 only two people had left MDC as a result of the “accelerated” process. From April 1, 2006 to September 15, 2006, two more individuals left MDC for community options. ACL understands that four more people are involved in planned moves to community options by November 2006. At this point in time, ACL is not aware of any further commitment, funding or process to move additional individuals back to the community.¹⁷

¹⁴ GBR Architects (2001), *Manitoba Developmental Centre: Long-Term Development Feasibility Study*, at p. 6. The Report goes on to note that all additional resources within the last 18 months were devoted to supporting the discharge of 69 residents from the Pelican Lake Developmental Centre. The Centre closed its doors in December, 2000.

¹⁵ March 10, 2005 Response by Family Services and Housing to FIPPA Request. The data includes a summary of residential deaths 1999 – 2005 and a summary of admissions and separations from the developmental centre.

¹⁶ ACL understands that \$1.5 million in annualized costs were approved with the expectation that \$750,000 would be spent in 2005 – 06. ACL has not had an opportunity to assess the reliability of these estimates.

¹⁷ The understanding of ACL is that another ten to twenty individuals may be on a list awaiting further funding.

28. While the Transitional Strategy might be considered a tiny step forward, continued institutionalization appears to be all that is on offer for most individuals at MDC.

29. According to the MDC Handbook, there are four categories of residents, namely:

- Extended care – residents with complex medical conditions that call for long term nursing, medical and therapy interventions or for short-term illnesses. As at March 31, 2005, 107 residents were in this category;
- Geriatric – these are active elderly, frail elderly or psychogeriatric residents in a long-term program intended to meet the needs of residents over the age of 55 who are experiencing changes in physiological, psychological or social functioning as a result of their age. As at March 31, 2005, 100 residents were in this category;
- Habilitation – these residents are said to show behaviours that present a risk to themselves, to others or to their environment. As at March 31, 2005, there were 89 residents in this category;
- Specialty care – this category covers individuals in one of three groups: (1) those with a dual sensory impairment; (2) those with autism; and (3) those who can be responsible for a great deal of their own personal care. As at March 31, 2005, there were 99 residents in this category.

30. Services offered at the MDC are limited and far inferior to those provided by community agencies. Even the 2001 Feasibility Study offers implicit recognition of the need for “expanded opportunities for resident inclusion in community-based programs, activities and meaningful work.”¹⁸ The following examples illustrate some of the concerns of ACL with inferior institutional care:

- **Rehabilitation** – this includes occupational therapy, physiotherapy and rehabilitation devices. Based on information received from those who provide these services at MDC, ACL believes:
 - Given the average age, degree of disability and number of MDC residents, there are an inadequate number of physiotherapists, which means the residents' actual needs are not being met. A disproportionate number of residents experience atrophy of their limbs due to a lack of sufficient care;
 - The programs at MDC are designed only for maintenance and not for true rehabilitation. For instance, individual plans only deal with day to

¹⁸GBR Architects (2001), *Manitoba Developmental Centre: Long-Term Development Feasibility Study*, at p. 116.

day needs and are not focused on returning residents to the community. Similarly, occupational therapy services are primarily limited to functioning in MDC, but not to fostering independence or developing the skills and knowledge required to function in the community.

- **Dental care** – At MDC, dental care is provided by students at the Faculty of Dentistry at the University of Manitoba on a contractual basis. Daily oral hygiene is provided by staff at the ratio of 1 worker for every 25 residents. ACL believes, a disproportionate number of MDC residents have serious tooth decay or an inordinate number of pulled teeth, leading to concerns that regular appointments are not scheduled, preventative care is minimal, and the quality of oral hygiene practices is suspect.
- **Medical Care** – ACL has concerns about an inadequate frequency of preventative and routine medical/physical examinations as well as the residents' opportunity to choose who provides their care.
- **Life and physical skills** – MDC primarily offers life skills training relevant to institutionalization. Programs and activities that challenge residents or foster independence are generally not available and skills that would be helpful to community living such as cooking, banking, cleaning or laundry are largely non-existent.
- **Education** – Education and learning are lifelong experiences. ACL believes that some MDC residents have had the opportunity to attend school, to take educational classes and to pursue literacy and other forms of education. However, ACL believes that these services have not been made available to many MDC residents. ACL believes that communication tools available in the community such as computer software, voice recognition applications and Bliss symbolic boards¹⁹ are less likely to be made available to residents at the MDC than to individuals in the community.
- **Vocational training** – Supported employment programs or work experience opportunities are not available to all of the approximately 380 residents at MDC. There is a supported employment program at MDC that enlists 40-45 residents in paid work at the institution. Residents working within MDC receive some remuneration. An additional 82 residents attend Resident Employment Workshops at MDC, with 45 attending half-time and 37 attending full-time. Small training allowances are paid for workshop personnel.²⁰

¹⁹ A board filled with symbols that the individual can point to in order to facilitate communication of needs, thoughts and emotions.

²⁰ Response by the Department to FIPPA Requests 128/05 and 127/05. ACL expects that all residents of MDC would be suitable candidates for community placement. The experience of ACL and empirical research in many jurisdictions confirms that community options can and have been designed to accommodate a wide range of disabilities (mental/physical/sensory) Those residents performing work or in workshops would be easily accommodated within the community given a

31.The contrast between institutionalization and community living is best expressed by those who have walked in both worlds. To give a sense of daily life at MDC, attached are two articles written with the assistance of former MDC residents, Corey and David (Attachments A and B). In their own words, they describe the overcrowded, poor conditions as well as the lack of respect, choice and self-determination they experienced in their lives at MDC. Corey and David also highlight the difference that community living has made to their lives.

32.The concept of choice and self determination is fundamental to the difference between institutional and community living. The impoverished institutional concept of choice is exemplified by a comment found in a recent Accreditation Survey regarding MDC:

There is a choice in the menu selection in that the main menu offers an alternative for each meal.²¹

33.This frail characterization of choice is brought into sharp contrast with the reality of community living by the words of former MDC resident, Corey found in Attachment A:

Now, when I get up in the morning, I decide what I'm going to have for breakfast . . .and I can have anything I want. . . Now I get to choose what I want to have for dinner and I help to make it.

34.The MDC can be prettied up – its services can be improved – but at the end of the day, it remains nothing more than an institution paying little more than lip service to personal liberty and choice. At its core, it offers only a sad, aging testament to a discredited and discriminatory past.

suitable plan and supports.

²¹ Canadian Council on Health Services Accreditation, *Accreditation Survey Report*, Manitoba Development Centre, October 11 – 14, 2005, p .76.

D. COMMUNITY LIVING

35. In Manitoba, there are currently about 4,000 individuals of varying levels of mental and intellectual disability successfully participating in community living programs. Existing community agencies, including the ACL, tailor their programs to meet the needs of participants. Their programs range from group homes with around the clock attendant care to independent living arrangements with minimal supervision. Attached is a list of community agencies currently operating in Manitoba that provide services designed to maximize self-determination, independence and dignity (Attachment C).

36. While the options offered via community placement are not perfect, they are tailored to meet the needs of each individual. Suitable community placements are made after evaluation and planning to ensure proper supports are in place. Comprehensive individual plans are established and monitored to ensure the skills, opportunities, well-being and quality of life of each person needing support services are available to the greatest extent possible.

37. Community programs are intended to support inclusion and involvement and to promote life skills, group activities, social and recreational events, vocational training, employment and rehabilitation. They aim to teach participants ways to maximize their independence by encouraging them to make their own decisions about everything non-disabled persons take for granted, such as what to eat, where to live or where to work.

38. With the assistance of support workers, interests and needs of the individual are assessed. Appropriate individual plans do not stagnate. They constantly evolve so the person may achieve their full potential and quality of life.

39. In comparison to the limited and inadequate services available at MDC, the supports offered in the community include:

- **Rehabilitation** – Each individual living in the community has a support worker who pays close attention to his or her rehabilitation needs and

arranges appropriate services by a practitioner. Together, each individual situation is assessed and planned to ensure the individual is able to participate in life in the community to the greatest extent possible;

- **Dental care** – Individuals with intellectual disabilities living in the community get dental care and regular preventative check-ups from a dentist of their choice. They are taught proper dental hygiene and, if required, receive assistance in maintaining healthy teeth.
- **Medical Care** – Individuals with intellectual disabilities living in the community get medical care and regular preventative check-ups from a doctor of their choice.
- **Life and physical skills** – Programs such as those provided by the ACL teach the life skills necessary to attain the greatest level of independence. Individual plans include such things as banking, cooking, cleaning, laundry, grocery shopping, job hunting, and paying bills.
- **Education** – Literacy and communication courses are offered in a community setting with a focus on the individual's interests and wishes.
- **Vocational training** – Individual plans contain efforts, if possible, to find day programs or job training opportunities to enhance self-determination and independence. Once ready to work, participants are given support in finding a job that is right for them.

40. The “Five Accomplishments of Ordinary Life” that guide the development of individual plans and form the foundation of community living ideals are:

- Community participation and relationship development;
- Community presence – sharing ordinary places;
- Making choices and expressing individuality;
- Roles and relationships that promote dignity and respect; and
- Opportunity for skill development.

41. The common thread woven throughout the programs and services accessible in the community is choice. Agencies such as the ACL believe that the road to successful inclusion, self-worth and dignity is paved with options and respect for decisions made by the individual. Persons with disabilities cannot be “agents of their own destiny” in an institutional care model.

E. NO NEED FOR INSTITUTIONS ANYMORE

42. A growing body of empirical research reveals that persons who are either never institutionalized or who move into the community after decades of institutional life, do significantly better in terms of personal growth and realizing full potential.

43. Specific research on deinstitutionalization from around the world over the past 20 years reveals remarkably consistent results. Studies carried out in the U.S., Canada, Australia, Denmark, England, France, Ireland, the Netherlands, New Zealand, Norway and Sweden all demonstrate that individuals are better off in most ways when they leave institutions for community living.

44. One factor accounting for the clearly established superiority of community living is simply the smaller size of the community home, as smaller group size for daily work and functioning produces higher satisfaction, productivity and efficiency. Community living also works because individuals are encouraged to make their own decisions. Choice is key to achieving the ultimate goals of self-determination, self-respect and dignity. Life in an institution such as the MDC, on the other hand, is regimented and marked by overcrowding, limited freedom and excessive control of a person's life.²²

45. Historically there have been four rationales for institutionalization, and all of them have been discredited by research done since the shift towards inclusion of persons with disabilities. Deinstitutionalization has proved to be extremely successful and has dispelled many false presumptions and negative stereotypes, in particular:

→ It is not true that people with severe or profound disabilities cannot benefit from community homes – No support exists for the proposition

²² One would expect the current residents at MDC to be more restrained in their comments than those who have left the institution and experienced life in the community. However, a desire for greater liberty was expressed by some current residents who were asked to provide their comments during the recent Accreditation Survey. "Some residents wanted more liberty to wander around the grounds and felt restricted because they could not do this. More opportunity for boating, fishing and swimming would be appreciated, as would more recreation generally, especially bowling." Canadian Council on Health Services Accreditation, *Accreditation Survey Report*, Manitoba Development Centre, October 11 – 14, 2005, p. 18.

that some individuals with intellectual disabilities are too “low functioning” to succeed in the community. Studies show that in fact the opposite is true, as the benefits to persons with severe or profound disabilities are initially rapid and immediate and continue over time. It has now been proven that level of disability does not preclude an individual from thriving when released from an institution given an appropriate plan and adequate supports in the plan.²³

- **It is not true that people who exhibit severe challenging behaviours cannot be managed in community settings** – Research over the last two decades confirms that deinstitutionalization, on average, tends to reduce challenging behaviours. The MDC's own policy reflects this, as its mandate is to only provide a temporary placement of individuals displaying challenging behaviours until the person can be returned to the community.
- **It is not true that people with significant medical needs can only be properly cared for in large, hospital-like institutions** – Quality medical care of the same, if not greater level, than that provided in an institution is accessible in the community.
- **It is not true that people of an advanced age who have spent essentially their whole lives in an institution do not want to leave, would not benefit from a new home and should be left where they are** – ACL's experience working with individuals institutionalized for decades is borne out by the research.²⁴ Persons of advanced age, even into their 90's, have done better in the community. Long term institutionalized individuals report that although they initially felt fear of the unknown, they soon found delight in new experiences and opportunities. Similarly, studies show that the vast majority of families originally opposed to moving their loved ones into the community for fear of uprooting them or disrupting their lives soon strongly favoured the move once they saw how successful it was.

F. DISCRIMINATION ON THE PART OF THE RESPONDENTS

46.ACL believes that all MDC residents could be successfully placed in the community and that they should not be allowed to languish any longer in an institution. ACL alleges discrimination by the Respondents, individually and jointly, against long term

²³ It should be acknowledged that faulty design and lack of appropriate supports in the plan will affect community capacity.

²⁴ The experience from the Pelican Lake closure also offers ample support for this conclusion. A “short-term” alternative to MDC was opened at Pelican Lake in 1974. Many of the individuals who came to live at Pelican Lake were transferred from MDC. Many remained there for more than 25 years before being successfully re-integrated into their communities.

MDC residents because the Respondents have failed to make all reasonable efforts to find community placements and failed to act with the best interests of MDC residents in mind.

47.ACL alleges that when it comes to deciding where they will live, MDC residents are treated differently than individuals with intellectual disabilities living in the community, and this differential treatment is based on a combination of both age and mental disability.

48.Long term MDC residents were placed there during an era when institutionalization was the norm. If they were younger, and only now requiring support services for the first time, ACL believes it is almost a certainty they would be living in the community. Additionally, because MDC residents were living there at the time the old *Mental Health Act* was replaced by the current legislation, they were left far more vulnerable to institutionalization than those living in the community.

49.Individuals living in the community today can only be placed at the MDC if a court is satisfied that reasonable efforts have been made to place them in the community, there are no other alternatives and it is in the individual's best interests. It is clear the current statutory regime recognizes that institutionalization is a last resort.

50.On the other hand, for individuals living at MDC prior to the coming into effect of the *Vulnerable Persons Living with a Mental Disability Act*, the authority regarding continued placement resided with the Commissioner for Vulnerable Persons rather than a Court. ACL believes that as the continued placement criteria has been applied, long term MDC residents have suffered from the stereotypical presumption that continued institutionalization is more acceptable or beneficial because the person already resides in an institution. This view is perhaps best captured by the words of the 2001 Feasibility Study:

The majority of residents were admitted as young children, went to school, and grew up together and developed relationships, which have stood the passage of time. Approximately 150 (33%) of the present

residents have lived at MDC for over 40 years and call the Manitoba (sic) Development Centre home. The residents have lived as a large family in a small community. The desire is to maintain the relationships that have developed”²⁵ (emphasis added)

ACL believes that this comment also would have effectively described the views of people living at Pelican Lake between 1974 and 2000 before it was closed through thoughtful planning.

51. In the view of ACL, long term residents of ACL are more likely to be confined to an institution for the rest of their lives than those living in the community because they were born at an earlier time when individuals with disabilities were to be hidden in shame rather than integrated as full members of our society. Their likelihood of remaining institutionalized is exacerbated by the stereotypical presumption that up to forty years of discriminatory treatment somehow makes another twenty years of continued institutionalization in this “home” more palatable.

52. As a result of the discriminatory treatment by the Respondents individually and together, MDC residents continue to live in substandard conditions and are denied access to far superior programs, services and opportunities available in the community. More fundamentally, they are denied the freedom and diversity of choice that can only be realized through adequately supported community living.

53. The following summary of the legislative scheme as a whole shows the statutory obligations and responsibilities of each of the Respondents. It also highlights the statutory recognition of the rights of vulnerable persons to realize their full potential, to have their wishes respected, and to be fully included in society.

(a) **The Statutory Scheme as a Whole**

54. The care for and provision of support services to MDC residents is governed by *The Vulnerable Persons Living with a Mental Disability Act*. The Minister of the Department

²⁵GBR Architects (2001), *Manitoba Developmental Centre: Long-Term Development Feasibility Study*, at p. 117.

of Family Services and Housing (“the Department”) is responsible for administering the Act. The Department's Services for Persons with Disabilities Division oversees community and institutional residence facilities by developing policies, programs, budgets and standards.

55. The preamble to the Act recognizes that:

- vulnerable persons should be encouraged to make their own decisions;
- their support network should be encouraged to assist the vulnerable person in making decisions so as to enhance independence and self-determination; and
- any assistance with decision making provided to a vulnerable person should be done so in a manner which respects the privacy and dignity of the person and should be the least restrictive and least intrusive form of assistance that is appropriate in the circumstances.

56. The Department is empowered under the *Act* to regulate and fund support services to persons with mental and intellectual disabilities either living in the community or in an institution. Those services include life and physical skills training, vocational training, educational opportunities, dental care and rehabilitation.

57. The Department's mission is to improve the quality of life for Manitobans through the social, economic and labour market inclusion of all its citizens. To accomplish its goals, the Department is to work towards inclusion in society of children and adults with disabilities by promoting self-sufficiency and independence and by increasing community-based programs and opportunities for community involvement and input.

58. The Vulnerable Persons' Commissioner (“the Commissioner”) is appointed under s. 29 of the *Act* and is responsible for exercising a number of powers and statutory duties, including protection of individuals with intellectual disabilities.

59. The Public Trustee is a corporation sole under the name “The Public Trustee of Manitoba” with perpetual succession and an official seal, who may sue and be sued in the corporate name. The Public Trustee is the official guardian in the Province of

Manitoba and is appointed by the Lieutenant Governor in Council under s. 1(1) of *The Public Trustee Act*.

60. Vulnerable persons, including individuals with mental and intellectual disabilities, who are unable to make decisions about their personal care or property, have substitute decision makers appointed under Divisions 3 and 4 of the *Act*. Personal care decisions encompass those relating to health care and physical, emotional, psychological, residential, education, vocational or social needs.

61. The Commissioner is responsible for appointing substitute decision makers and on receiving an application under the *Act*, is required to investigate whether the person is in fact a vulnerable person, whether that person has a support network and whether reasonable efforts have been made to involve the support network. If after the investigation the Commissioner finds these criteria have not been met, the application is to be dismissed. At that point the Commissioner has the authority to request that the Executive Director take steps to involve a support network or to develop or review an individual plan.

62. If the Commissioner determines a substitute decision maker is required, a hearing panel is convened that makes a recommendation as to the selection of an appropriate substitute decision maker, the powers the substitute decision maker should be granted, the duration and any terms and conditions that should be imposed.

63. After considering the recommendations of the hearing panel, the Commissioner must decide whether or not a substitute decision maker is warranted and under what terms and conditions.

64. Substitute decision makers have virtually absolute authority under the *Act* to make decisions of profound importance that involve every aspect of daily life, including:

- deciding where, with whom and under what conditions the vulnerable person is to live;
- deciding whether to give, refuse or withdraw consent to health care;

- deciding whether the vulnerable person should participate in any educational, vocational, training or lifeskills programs; and
- deciding whether the vulnerable person should participate in social or recreational activities.

65.If an appropriate substitute decision maker cannot be found, the Commissioner must appoint the Public Trustee, who is then required to fulfill all duties and obligations imposed under the *Act*. ACL believes that the Public Trustee is substitute decision maker for the vast majority of MDC residents.

66.As substitute decision maker, the Public Trustee must fulfill a number of statutory duties under the *Act*, in particular, he or she is required to:

- Exercise powers and duties in good faith and perform duties diligently;
- Provide explanations to the vulnerable person about those powers and duties;
- Foster independence in the vulnerable person;
- Encourage participation of vulnerable person in decision making;
- Implement the least restrictive and intrusive course of action.

67.Additionally, when making personal care decisions:

- The Public Trustee must consider the vulnerable person's wishes;
- If the Public Trustee has no knowledge of the vulnerable person's wishes and has used reasonable diligence to ascertain them, he or she should consider the vulnerable person's values and beliefs;
- The Public Trustee should consider the best interests of the vulnerable person if he or she has no knowledge of the vulnerable person's wishes, values and beliefs; or if he or she cannot follow those wishes, values or beliefs without endangering their health or safety.

(b) **Deciding where a vulnerable person will live**

68.There are separate and distinct provisions in the Act when it comes to deciding

where persons with intellectual disabilities will live. The key distinction under the statutory scheme relates to whether individuals are living in the community or are already in an institution such as the MDC.

69. Intellectually disabled persons living in the community cannot be placed in an institution without a court order. Section 63(6) of the *Act* requires the court, before agreeing to institutionalize a person, to be satisfied that:

- the applicant has made reasonable efforts to find a placement other than in an institution and no suitable alternative placements are available;
- it is in the best interests of the person to be placed in an institution;
- there is an institution willing to accept the person.

70. A person who at one time was living in an institution but has lived in the community for at least six months cannot be re-institutionalized without approval of the court.

71. For persons already living in an institution, however, the transitional provisions laid out in s. 166 of the *Act* established an entirely different process. When Part II of *The Mental Health Act* was replaced with the current *Act*, the Public Trustee, as substitute decision maker for the majority of MDC residents, was required under s. 166 to make an application to the Commissioner for approval of their continued placement at the MDC.

72. Instead of requiring a court order, the *Act* gives authority to the Commissioner, rather than a judge, to decide whether there should be continued placement in a developmental centre. Before making that decision, the Commissioner is to consider the same criteria that the court must take into account under s. 63(6) for those living outside the institution and is also to be satisfied that the individual resided in a development centre such as the MDC immediately prior to the coming into force of the *Act*.

73. Section 166 creates the essential template for continued institutionalization. The

initial decision on placement does not rest with a judge but with the Commissioner. Moreover, the stereotypical presumption that prior institutionalization somehow makes continued institutionalization a more defensible option flows readily from s. 166.

(c) **Discrimination by the Commissioner
and the Public Trustee**

74.ACL alleges discrimination against both the Public Trustee and the Commissioner:

- by the Public Trustee, as substitute decision maker, for recommending the continued institutionalization of most MDC residents; and

- by the Commissioner for approving the Public Trustee's recommendations.

75.The discrimination by these Respondents relates to s. 166 of the Act. That section requires the substitute decision maker (in most cases the Public Trustee) to obtain approval from the Commissioner for the continued institutionalization of MDC residents. That section also requires the Commissioner to consider whether all reasonable efforts have been made to find a community placement as well as the vulnerable person's best interests when making that decision. These are the same factors that must be taken into account by a judge before an order can be made sending a vulnerable person away to live at an institution.

76.However, s. 166(1) also requires the Commissioner to consider whether the vulnerable person is already living in an institution, and this is not something a judge is required to take into account.

77.ACL alleges that this additional factor has a discriminatory effect on MDC residents and results in their continued institutionalization. ACL believes that the requirement by the Commissioner to also consider whether the person is living in an institution is being interpreted to mean that long term MDC residents are better off in their current "home" and need not be moved into the community. ACL also believes that instead of making

all reasonable efforts to find community placements for MDC residents and making decisions that are in their best interests, the Public Trustee and the Commissioner have kept MDC residents institutionalized primarily because they are already there.

78.ACL alleges that the Public Trustee and the Commissioner are discriminating against MDC residents because they are basing their decisions on negative, harmful and false stereotypes and misconceptions about disabled persons.

79.The research is clear that even individuals with profound disabilities who have spent decades in an institution can successfully be placed in the community and thrive in an environment that fosters self-determination, self-respect and dignity.²⁶ It is **not true** that returning long term residents of an institution to the community will cause undue disruption or that these individuals will not be able to adapt to life in the community. A successful return to the community is a planning issue and relates to the arranging of appropriate supports to meet the needs of individuals.

80.ACL believes the fact that relatively few long term MDC residents have been released to the community in past years is a strong evidence that the Public Trustee and the Commissioner are not fulfilling their statutory obligations to protect vulnerable persons and to promote full inclusion of persons with disability in the community.

81.A comparison of orders made by the court to decisions made by the Commissioner for continued institutionalization shows the concerns of ACL are well-founded. In the last 7 years, only 12 admissions have been approved by the court.²⁷ In contrast, ACL believes that almost all continued placement applications, likely numbering in the hundreds, have been approved by the Commissioner. This is convincing evidence that what is in the minds of both the Public Trustee and the Commissioner is not whether a suitable alternative placement is available or could be created or whether it is truly in the best interests of the individual to remain at MDC. Rather, the key question appears

²⁶ An essential precondition to a successful result is a thoughtful, respectful planning and design process with adequate resources for a successful implementation of supports. Adequate resources include both capital and operating funds.

²⁷ March 10, 2005 Response by Family Services and Housing to FIPPA Request. The data includes a summary of residential deaths 1999 – 2005 and a summary of admissions and separations from the developmental centre.

to be whether the individual is already institutionalized.

82. Further evidence to support the allegations of ACL is found by looking to the situation at the Pelican Lake Training Centre, another institution for disabled persons in Manitoba. Due in part to a recognition that the cost of renovation was likely to be staggering, the Pelican Lake institution was closed in 2000 and all residents were placed in the community. Many of the residents at Pelican Lake were individuals who had resided at MDC in 1973 prior to the establishment of Pelican Lake. In terms of intellectual disability, the status of the former residents of Pelican Lake is quite comparable to the status of many residents of MDC.²⁸

83. The fact that sixty-eight of the seventy residents of the Pelican Lake institution found homes in the community is further evidence of discrimination against MDC residents.²⁹ If long term residents at Pelican Lake, many who had formerly lived at MDC, could successfully be returned to the community, then there is no justification for keeping long term residents at MDC.

(d) **Discrimination by the Minister**

84. ACL also alleges discrimination by the Minister against long term MDC residents because the Minister has acted contrary to statutory obligations and to the government's own policy on inclusion by making funding decisions that have a discriminatory effect. ACL alleges that the Minister's decisions have effectively guaranteed the continued institutionalization of many individuals at MDC and left them without hope of ever realizing their full potential.

85. This reality was recognized by the authors of the 2001 feasibility study who noted:

During the late 1990's, the number of annual discharges fell due to the lack of financial and staffing resources available to effectively transition residents into the community. Limited resources restricted discharges

²⁸ It should be noted that because of the terrain at Pelican Lake, only mobile residents resided there (ie. no one who needed the use of a wheelchair or walker).

²⁹ ACL believes that all but two of the seventy Pelican Lake residents successfully rejoined the community. ACL believes that one individual left the province while another resides at MDC.

from MDC to only a small number who were able to easily make the transition.³⁰

86. Notwithstanding a wealth of evidence that services in the community are no more expensive, on average, than those provided in an institution, the Minister has chosen to continue funding placements at the MDC instead of community-based homes that will accommodate their needs. Arguably, the Minister's commitment to fund \$40 million in capital expenditure on MDC has also increased the likelihood of continued institutionalization for far too many MDC residents.

87. In essence, the combined effect of the Minister's actions is to take a step back towards institutionalization by diverting financial resources away from community living and towards continued institutionalization. The less than stellar success of the 2005 *Community Transition Strategy* in moving individuals from the waiting list to the community offers further evidence of the discriminatory effect of the Minister's actions.

(e) **Discrimination by the Executive Director – Individual Plans**

88. ACL also alleges discrimination by the Executive Director under the *Act* against long term MDC residents. The Executive Director is appointed under s. 7 of the *Act* and is required to develop an individual plan for each and every vulnerable person receiving support services. Individual plans are intended to detail such things as daily routine, goals for personal growth, treatment plans, progress, expression of interest in activities, family involvement and behavioural management plans.

89. Section 11(2) of the *Act* authorizes the Executive Director to review the individual plans and vary them when appropriate. Section 12 of the *Act* requires the Executive Director to take all reasonable steps to ensure the vulnerable person and the substitute decision maker have an opportunity to participate in the development of the individual

³⁰ GBR Architects (2001), *Manitoba Developmental Centre: Long-Term Development Feasibility Study*, at p. 6. The Report goes on to note that all additional resources within the last 18 months were devoted to supporting the discharge of 69 residents from the Pelican Lake Developmental Centre. The Centre closed its doors in December, 2000.

plan.

90.ACL alleges the Executive Director is discriminating against MDC residents by failing to develop individual plans that are in their best interests and that are designed to achieve full inclusion. ACL believes that due to the limitations of the services offered at the MDC, the individual plans established by the Executive Director will only provide them with what they need for institutional life and will not enable them to return successfully to the community.

G. UNDUE HARDSHIP

91.ACL believes that with proper planning, all long term MDC residents could successfully be placed in the community where they could benefit from programs and services offered by community agencies. It believes there is no justification for keeping MDC residents institutionalized and that returning them to the community would not cause undue hardship.

92.As the onus of proof of undue hardship is on the Respondents, ACL respectfully reserves its right to provide additional information once it has received their reply to this complaint.

DATED this day of September, 2006.

ASSOCIATION OF
COMMUNITY LIVING
