

FOCUS

An abstract painting of a pond scene. The composition is dominated by vibrant, expressive brushstrokes. In the foreground, there are large, bold strokes of yellow and orange, suggesting reeds or lily pads. The middle ground features a mix of blue, purple, and pink, representing the water and reflections. The background is a deep, dark blue with some lighter, wispy strokes. The overall effect is a sense of movement and color, capturing the essence of a pond in a stylized, painterly manner.

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Escape from British Columbia

ROB WIPOND

Some people say that our province's strong mental health laws save lives.

A constitutional court challenge says they lead to discrimination, abuse, fear and the flight of psychiatric refugees.

The psychiatric nurse held out a paper cup with pills. Sarah clasped a handwritten note. Having learned not to protest loudly, the 24-year-old gave the nurse her note that read, "I have a right to my mind and my body." Then, she reluctantly put the pills in her mouth.

Sarah knew that she had to execute her escape out of British Columbia quickly, before the drugs seized control of her mind again.

Sarah (she requested her name be withheld) is sharing her story to show support for a constitutional court challenge recently launched by Community Legal Assistance Society (CLAS). The Vancouver non-profit is arguing that a key part of British Columbia's *Mental Health Act*, called "deemed consent," violates the *Canadian Charter of Rights and Freedoms*.

"At CLAS, we're routinely told that people are either considering leaving BC to avoid our deemed consent laws, or that they've done so in the past," says Laura Johnston, one of the lawyers representing three plaintiffs in the case.

CLAS has many concerns about BC's *Mental Health Act*, explains Johnston. However, this case is focused on how the "deemed consent" provision violates rights to security of the person and equality before the law. "This case isn't arguing that forced treatment can never be constitutional," says Johnston, "But it does say that forced treatment which is imposed unilaterally by a doctor with no checks or balances and no recourse to anybody else is unconstitutional."

Every Canadian has the right to allow or refuse medical treatments, even if our choice could cause injury or death—such as choosing whether to undergo risky surgery. We can write advance directives about what we will and won't accept if we lapse into a coma or otherwise become mentally incompetent, and appoint a "substitute" to make decisions for us. However, in BC, the moment we become an involuntary psychiatric patient, those rights are eviscerated. Mentally competent or not, and regardless of what's in our advance directive or what our substitute says, we are "deemed" to consent to any treatments a psychiatrist recommends.

"I was shocked when I came across these sections of [BC's] *Mental Health Act*. I thought I was misunderstanding things," says Melanie Benard, a lawyer with the Council of Canadians with Disabilities



"I WAS SHOCKED WHEN I CAME across these sections of [BC's] *Mental Health Act*. I thought I was misunderstanding things. There's a blatant violation of the equality and liberty rights of people with disabilities."

—Melanie Benard, lawyer
Council of Canadians with Disabilities

(CCD) which is one of the plaintiffs in the case. "There's a blatant violation of the equality and liberty rights of people with disabilities," she says.

Benard says psychiatric patients' rights were clarified in constitutional law 25 years ago and implemented in every province—except BC. For example, in other provinces, after being involuntarily committed, a person still cannot be involuntarily treated until a competency test is conducted. "You look at things like, does the patient understand their diagnosis? Do they understand the treatment that's proposed, the risks and benefits of undergoing the treatment?" says Benard.

"It's really discriminatory to assume that everyone with a mental health problem is mentally incapable of making their own treatment decisions," says Johnston. She says it's also important to understand how "wide-sweeping" involuntary treatment has become. "A lot of people believe that you have to be a danger to yourself or others to be involuntary, and that's just not true." In BC, anyone can be committed if a physician believes that the person has a mental disorder and that committal could provide "protection" or prevent the person's "mental or physical deterioration."

"It gives a lot of discretion to the doctor," comments Johnston.

According to government statistics, BC psychiatrists have been involuntarily committing people at unprecedented rates: 13,641 people last year—a doubling since 2002, or 73 percent increase per 100,000 people.

Though statistics weren't available, it's widely believed that the use of "Extended Leave" has increased even more dramatically. This occurs when someone is considered well enough to be released from hospital and live at home, but is still being forcibly treated. And there seem to be more people like Sarah who voluntarily seek help, only to get committed if they disagree with recommended treatments.

Jonny Morris, the Canadian Mental Health Association's (CMHA) provincial policy director, says involuntary treatment has been "a long-standing issue" of polarized contention among patients, family members, service providers and community groups. Morris hopes that this constitutional challenge will "raise public awareness about

“THE WHOLE TIME that I was ever on antipsychotics I sort of fluctuated between wanting to die and thinking that I had died and gone to hell.” —Irit Shimrat



Irit Shimrat, author and editor of *The Networker*

an often hidden part of the system” and promote “respectful” dialogue about how things could be managed differently.

The initial court submission from Community Legal Assistance Society provides a glimpse into this hidden world.

The dangers of psychiatric treatments

Plaintiff Louise MacLaren is a 66-year-old retired nurse from Victoria. She’s been frequently treated against her will in hospital and at home over the decades. According to the submission, MacLaren experiences “extreme anxiety” when forced to undergo electroconvulsive therapy (ECT), which causes her “confusion and disorientation” for weeks afterwards, and permanent memory losses. While a typical ECT treatment involves 12 rounds of shocks over three weeks, MacLaren has received 300 rounds. “In 2010, staff administering ECT forgot to place a mouth guard in Ms. MacLaren’s mouth during the treatment,” says the submission. “Ms. MacLaren shattered her teeth due to the convulsions in her jaw[.]”

The other plaintiff is a 24-year-old Vancouver man with a Master’s degree in music and piano. Since 2015, he’s been forced to take antipsychotic medications at home that cause “involuntary move-

ments, muscle stiffness, muscle pain, and loss of dexterity, all of which impede his ability to play the piano.” These side effects, the submission states, cause him deep suffering “because playing piano is such a fundamental aspect of his life.”

Apart from Council of Canadians with Disabilities, the plaintiffs aren’t speaking to media. Other people, though, paint an equally grim picture of involuntary treatment.

After what she calls a “bad event” in her life, Sarah went to a Lower Mainland psychiatric hospital seeking help. She asked for a sleep medication, but didn’t want anything more. “I wanted to be able to manage what was going on for me, especially relating to the emotions that I was feeling, and the negative feelings, without medication... That was very important to me.”

However, she was also given an antipsychotic. “It was an ugly, ugly feeling,” says Sarah, describing how the antipsychotic dulled her thinking and emotions. “If a family member came to visit me, I wouldn’t feel that happiness that they were there. Which was terrifying.”

Sarah asked to stop the antipsychotic. Instead she was made an involuntary patient and told that if she didn’t take it, then security would inject her. So she continued to take the drug orally, which was almost equally repugnant to her. “The fact that I had to do this to myself... It’s you actually taking the pill and putting it in your mouth.”

For many, involuntary treatment is often violent.

Irit Shimrat is the Vancouver-based author of *Call Me Crazy: Stories from the Mad Movement*, and editor of a magazine published by the recently shuttered West Coast Mental Health Network—BC’s only charitable non-profit service organization run by and for people who’ve experienced psychiatric treatment. (WCMHN had its \$100,000 in annual funding axed by the BC government without explanation, while hundreds of millions in new funding has gone to conventional services run by mental health professionals.) Shimrat has twice gone for over a decade without any psychiatric involvement, but in between those periods has been forcibly treated over a dozen times. The last time that she “went crazy,” says Shimrat, was after both her closest friend and her mother died. “I was shattered emotionally, and I was behaving in ways that were very disturbing to my neighbours.” When in acute distress, Shimrat’s been apprehended after throwing her belongings out the window, and after running around naked yelling “Emergency!”

Shimrat says many people like her experiencing intense mental turmoil become afraid and “loud and feisty and angry and irrational” when threatened with forced treatment. In response, staff can become “mean,” she says. During one admission, Shimrat says she fought as she was stripped in front of male police and orderlies, tied to a gurney in four-point restraints, injected with an antipsychotic, and locked in isolation. “The experience of being locked up is brutal,” comments Shimrat. “But the experience of being locked up and then debilitated with antipsychotics is much worse.”

Antipsychotics are tranquilizing medications that are the most commonly used drugs in situations regarded as short-term “psychiatric emergencies” or long-term “psychosis.” While some people can find a tolerable dosage that quells their mind but leaves them still functional, for others—especially when they’re not allowed to participate in treatment decisions—antipsychotics can be debilitating.

“The whole time that I was ever on antipsychotics I sort of fluctuated between wanting to die and thinking that I had died and gone to hell,” says Shimrat. “All colour was drained from the world, like everything was grey, and I couldn’t remember where I was from moment

Thank you!

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to moment or why I was standing where I was standing, what I had been planning to do. There was just a sort of sense of grinding, endless tedium and pain, physical pain as well as the pain of not being able to think.”

Shimrat says she has also experienced akathisia, a restlessness and agitation that 30 percent of antipsychotic users sometimes experience and that can, in extreme cases, cause suicidal feelings and violent rages. “It’s horrible,” she says.

“I’ll never recover completely from the trauma of it,” says Shimrat. Her experiences of being involuntarily treated, she says, have been “infinitely worse than even the worst moments of my so-called mental illness.” Shimrat believes that many psychiatric patients are becoming worse and not better because “they’re having their brains tampered with” in these frightening and damaging ways.

For her part, Francesca Simpson says she’s “feeling pretty good” on medications because they “bring me down and take the edge off.” However, she wants more control over the types and amounts. She’s currently being administered a long-acting antipsychotic injection, plus two antipsychotics and a mood stabilizer daily, which she finds excessive. Since 2010 she’s been almost continuously involuntarily treated in her home by an Assertive Community Treatment (ACT) team. Simpson describes it as “intrusive,” “humiliating” and “demeaning.” She must be at home at certain times every day to have her meds “witnessed.” For the injections, she must pull her pants down. ACT staff change constantly; she prefers women but can’t refuse the “strange men” entering her home. Staff probe her personal life while looking for signs of any emerging need to re-hospitalize her. “Everything that I do is pathologized,” says Simpson.

The whole experience “used to just make me furious,” says Simpson, “but I’ve given up on that.”

Many people raise concerns that, over the long term, treating people against their wills dissuades even those who want help from seeking it, because it undermines trusting relationships with mental health practitioners. “It’s dangerous to ask for psychiatric help,” Simpson concurs. “Certainly when I get through this, if I’m ever in trouble again, I will go nowhere near that system.”

Trust and distrust of psychiatry

Several health authorities declined to provide interviews about involuntary treat-



“EVERYTHING THAT I DO
is pathologized.”

—Francesca Simpson

ment. The BC government issued a written statement saying that some patients “may not understand or realize that they need psychiatric care.” That’s also the concern for Deborah Conner, provincial director of the British Columbia Schizophrenia Society, who says BCSS could intervene in the CLAS case.

Conner bristles to hear words like “outdated” linked to BC law. “The reality is our *Mental Health Act* is actually leading the charge in doing the least harm.” Conner says the “safeguard” that BC law provides is that people don’t “languish” in hospital but get treatment quickly and continually, which she claims prevents brain matter loss. “That’s been proven,” she says. “When you have early intervention which includes medication, those treatments actually prevent ongoing brain damage.”

“There are very many people in this world of psychosis who have no way—they don’t share the same reality—they have no way of stepping outside their illness and having insight into what’s happening to them,” says Conner. “We have lots of people who said, ‘Thank God you treated me forcibly, because if you didn’t, I would be dead.’”

I mention that others describe forced treatment as traumatizing.

“Unfortunately, in some cases that’s the only way to save that person so that they can get treated and get on a path to recovery,” says Conner. “Just painting [with a broad] brush, saying in all these cases it should be treated this way and nobody should be traumatized, that’s like seeing with rose-coloured glasses.”

BCSS shares a little common ground with CLAS. “We’ve always supported family or caregiver involvement in any situation,” says Conner. The BCSS wants policies allowing people to have psychiatric advance directives and to appoint family members or others to participate in admissions and discharge planning. But BCSS stops short of wanting anything legally binding. Conner says psychiatrists must retain powers to exclude appointees who aren’t “appropriate” and to bypass advance directives.

What about people seeking help at hospitals just for depression or anxiety at levels that might not unduly interfere with their competency to make treatment decisions? Conner points out that long-term involuntary treatment requires two psychiatrists to agree. “If people are involuntarily committed, it seems to us that there’s a reason why that happened.”

I suggest that it sounds like Conner is putting a lot of trust in psychiatrists. “When you have two psychiatrists who’ve done a thorough review and assessment and where they have family input, that’s the trust,” responds Conner. She concedes that such assessments can be difficult, but believes that medically-trained psychiatrists are best qualified to make them.

In contrast to Conner, Shimrat argues that involuntary psychiatric treatment is primarily a means for policing very upset and/or very socially disruptive but otherwise law-abiding people, that has become culturally acceptable because it is masked as science-based health care. “Psychiatry is seen as a branch of medicine and distress is seen as a form of illness,” says Shimrat. “And so with the mindset that they’re saving lives and improving things for people, the practitioners feel that they’re morally in the right.”

Certainly, pharmaceutical industry money and influence have had profound impacts on psychiatry and our cultural beliefs. Governments, families and patients alike are often swayed by psychiatrists’ assertions of “proven” and “evidence-based,” where more accurate would be “some studies seem to suggest...” Barely a day goes by, for example, that we don’t hear about blood tests for depression, brain scans for anxiety disorders, the genetics of schizophrenia, brain damage caused by psychosis, and unequivocally “safe and effective” psychotropic pharmaceuticals. If any one of these “discoveries” were ever truly validated, though, it would be Nobel Prize-worthy. However, the last time psychiatry garnered a Nobel was for lobotomies—since then, Nobel committees have apparently more rigorously vetted psychiatric claims.

Instead, the widely promoted “chemical imbalance” theory of mental disorders has been so resoundingly debunked that prominent psychiatrists like Ronald Pies have taken to insisting that it was only an “urban legend” which no “well-informed psychiatrists” ever believed. The American Psychiatric Association recently clarified that no mental disorders can be detected through any biological tests. “Anti-anxiety” drugs are just addictive sedatives. “Antidepressants,” “antipsychotics” and “mood stabilizers” are marketing names for drugs with clinical pharmacology descriptions stating that their “therapeutic mechanism of action is unknown”—while their known harmful side effects are legion, including sometimes brain damage. And there’s a growing body of research suggesting that, over long-term use, most psychiatric medications are doing most people more

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harm than good, while being extremely difficult to withdraw from.

The ultimate recourse for involuntary treatment proponents is to argue that disordered people “lack insight” while, as BCSS board member John Gray has written, “[C]ompulsory treatment will usually restore someone’s freedom of thought from a mind-controlling illness...”

Though superficially compelling, these are philosophical—not medical—assertions that provoke many questions. How often and for how long do we keep aggressively “freeing” someone’s mind, exactly, before the person becomes free enough to refuse our interventions? Who among us has the rightful authority to determine who has “proper” insight into reality? Is it crazy to be driven mad by an insane and destructive society, or is it a sign of sensitivity that should be nurtured and supported rather than drugged away? Meanwhile, if we simply claim that the answers are “obvious” to anyone “sane,” then we cut off an important human legacy and potentiality—our ability to deeply question ourselves and our culture.

Stigma, stereotypes...sanism

If final judgments to psychiatrically treat people against their wills are not truly being driven by indisputable medical science, then what is driving them?

A person in BC can appeal a committal to a three-person tribunal. Hearings are not open to the public, not bound by rules of court process, and notoriously erratic. Patients are often forcibly drugged during hearings. Though every patient has a right to a legal aid lawyer, hundreds annually cannot get one because government hasn’t provided sufficient funding. Less than one-fifth of patients win.

In August, a patient sued to push the BC government to fund enough legal advocates. “It’s very troubling that despite numerous calls on the government to increase funding to ensure that everyone who is entitled to legal aid gets it, that they’ve pretty much ignored the problem,” says Kate Feeney of the BC Public Interest Advocacy Centre, co-counsel in that case. (Government began negotiating, so the case adjourned until December.) Many argue that this whole farce is but one example of how prejudiced society is against psychiatric patients—pointing to how even the BCSS and CMHA have done little over the years to raise alarm about this legal representation crisis.

Lawyer Benard believes stigma, stereotypes and **sensational news stories about rare cases of violence drive** much of society’s support for involuntary treatment. “We feel like we need to be protecting these people at all costs and that we know what is best for them better than they can themselves.” Benard notes that organizations run by people with disabilities or with experience as psychiatric patients, like Council of Canadians with Disabilities, often take different positions from most mental health organizations, which are typically run by mental health professionals and family members of patients. “Sometimes there is a conflict between protecting the rights of a person in crisis and the desires and wishes of those around them,” says Benard.

Because of these ubiquitous prejudices, Shimrat says that she’s “really happy” about the constitutional challenge but also skeptical. **“Whatever is going to be on paper is unlikely to change what happens on the ground.”** Indeed, Ontario’s rate of involuntary treatment seems to be only slightly lower than BC’s.

A former BC tribunal chair says she saw appeal panels frequently exhibit a “deference to” and “over-reliance on” psychiatrists’ perspectives. Michael Perlin, an expert on US mental health law, blames it on “sanism.” Perlin’s books show, in encyclopaedic detail, that a near all-permeating deference to psychiatrists exists within judicial processes, coupled with an “irrational prejudice of the same quality and character of other irrational prejudices” towards people diagnosed with mental disorders.

Sarah splits BC

Sarah requested an appeal. Her psychiatrist didn’t have to, but chose to stop forcibly medicating her. Faculties back intact, Sarah researched and discovered that Alberta’s laws were different. She began preparing an escape plan, just in case.

The review panel for Sarah’s appeal reached a 2-1 split decision—leaving Sarah incarcerated. She began a silent protest, giving staff handwritten objections when they handed her drugs. For two days, her tight-lipped protest also provided a cover for tonguing and not ingesting the pills. But her psychiatrist soon proposed an antipsychotic injection that would keep Sarah drugged for weeks. Sarah worried that her thinking would become so foggy she’d never be able to execute her plan. “I knew I had to leave,” she says.

Into a small satchel bag she stuffed a change of clothes. Cash she’d been withdrawing to avoid using a trackable credit card. Her iPad. She acted like she was going for a smoke break, walked to where she could get a taxi, and got out where she could disappear into a crowd. She changed her clothes in a public bathroom and threw out the ones she’d been wearing at the hospital. She cut off her hair. Then she bought a ticket for a red-eye bus to Alberta.

“It was the most nerve-wracking bus ride of my life,” says Sarah. “I had a feeling every time we stopped that there would be RCMP waiting for me.”

The driver announced when the bus had crossed into Alberta and begun the descent from the mountains. “I actually got very emotional as I crossed the border,” says Sarah. “I’d spent the entire night in the dark...It was really beautiful, early in the morning, the sun was coming up...I was crying, and there was somebody sitting a couple seats from me, said ‘Are you okay?’ And I was like, ‘Yeah, I’m fine.’”

But as the bus sped into Calgary, she saw her picture appear on the RCMP website as a “missing person,” along with a warrant for her arrest.

There are other ways

Media coverage of the CLAS constitutional challenge has been sympathetic, and there seems to be mounting support for possible mental health law changes in BC to remove “deemed consent” and allow people to have competency tests, advance directives, and substitutes.

The CMHA’s Morris says there should be general equality between the way people experience both physical and mental health care. “What would it take to ensure that people with mental illness are afforded all of the similar rights and protections [as everyone else]?” Morris also notes that forced treatment is often related to a late-stage crisis that might have been prevented with more voluntary supports in our communities, and improvements in other “social determinants of health” like housing, income, employment, and education.

Similarly, Chris Summerville of the Schizophrenia Society of Canada says that his organization is recognizing advances in understanding of how people can recover through self-empowerment and assistance in meeting their biological, psychological, social, spiritual and communal needs. In

contrast to the BC Schizophrenia Society position, Summerville feels BC law could be updated to have “a little more care and caution” built into it.

Francesca Simpson and Irit Shimrat suggest that if we at least made our psychiatric hospitals warm, respectful places that provided plenty of options and supports for people to voluntarily explore enhancing their own wellness, we wouldn’t have to worry much about people not wanting to go for help, or “languishing” in them. Offering robust counselling and psychotherapy services in our hospitals would seem to be a logical start—rather than relying almost totally on drugs and ECT, as is now the case.

Shimrat points to alternative approaches such as exercise, arts, mind-body practices, and non-drug emergency response methods like peer respite homes and Open Dialogue family interventions. “There are other ways,” says Shimrat. “But that knowledge is suppressed and disrespected because of the strength of the status quo.”

Johnston says she’s “under no illusion” that the constitutional challenge will cure the mental health system or society. But she hopes that at least the BC government will “engage with stakeholders and many different people and organizations to craft a new, fair legal framework for treatment for involuntary patients.”

“Not detainable”—in Alberta

Sarah turned herself in to Calgary police. She overheard the officer explain to her psychiatrist in BC that, under Alberta mental health law, Sarah didn’t appear detainable. “It was a good feeling,” she says. “But I knew it was a very scary next chapter of my life, starting it completely from the ground up.”

Sarah is now in Ontario, where she has supportive family, and is studying natural ways of improving well-being. “I’ve been very fortunate in certain respects,” says Sarah. “What am I missing? My friends. My family... I was seeing somebody, that was a positive thing in my life, and that’s gone now.”

She finds the term “psychiatric refugee” strong, but also feels it’s in some ways apt. “I would love to come back,” says Sarah. “If the laws change, I probably would.”



Rob Wipond has been reporting on the lack of civil rights in the BC mental health system since 1998. He is the recipient of a number of journalism awards for his writing in *Focus*.

Lowering your stress—and saving you money



Photo by Gary Utley

Left to right: Ruby Popp, Gail Perkins, Alicia Pearce

If you find yourself putting off doing your books, or pulling out your hair when you finally get at them, take advantage of Gail K. Perkins’ professional bookkeeping services and spend your own time doing something more fun.

Gail has been helping folks in Victoria with their bookkeeping and taxes for 35 years. She started her accounting career in Victoria with the Provincial Government and later worked in a wide range of businesses including as the Controller and Information Technology Manager for the Butchart Gardens. Gail was a member of the Certified General Accountants Association for 25 years.

A lot of her current clients are small business owners and professionals who she helps on a monthly or quarterly basis. Where employees are involved, or profit margins slim, or a new venture is just getting off the ground, there’s good value in having bookkeeping regularly—not just at tax time.

Part of the value lies in the fact that mistakes take longer to sort out than the expense of getting it done correctly from the start.

Extra care needs to be taken to follow rules for statutory holidays, overtime, and deductions when employees are involved. Penalties can be costly—and as Gail notes, non-deductible. “It’s crucial to stay onside with Revenue Canada,” she warns.

She and her staff help clients avoid running into costly problems with GST—both on the filing side and ensuring that GST embedded in certain expenses is claimed. Whether you are an artist, consultant, day care provider, or construction company owner, Gail and her team will ensure you are not missing deadlines or opportunities to avoid unnecessary expenses.

Besides the fact that one late payment can cost more than her services, Gail works to make her service affordable in various ways. “We can show you how to organize your paperwork to minimize your bookkeeping fees. We’ll send e-mail reminders about

upcoming tax filings—and even deliver your remittance cheques directly to each agency for you.”

Registered massage therapist Sally Gardner has relied on Gail’s bookkeeping for 20 years. “I like Gail’s values. And she’s clear and concise and always gets back to me right away if I call with a question. I’ve always felt confident and comfortable with her—and I recommend her to friends who are also pleased.”

Gail and bookkeepers Ruby Popp and Alicia Pearce pride themselves on being detail-oriented, thorough, and up-to-date on Canada Revenue regulations—as well as being easy to talk to and having a good sense of humour. They work with a number of accounting programs, including Sage, Xero and Quickbooks, providing software training if desired.

The firm does both corporate and personal tax returns. Ideally, Gail oversees the bookkeeping for a business and does tax returns for both the business and the owners, allowing her to provide the best tax planning. “We can do good tax planning for couples if we do the whole family, especially if children have any part in the corporation. Money can be saved,” Gail assures.

People with rental properties or who employ caregivers have also found Gail’s services helpful. “For a number of clients with caregivers, we do the payroll two times a month—including a PDF of the pay slip and e-transfer of the wage. It’s inexpensive, gets done on time and without penalties.”

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