IN THE MATTER OF: A complaint pursuant to The Nova Scotia *Human Rights Act*, R.S.N.S. 1989, c. 214 as amended; HRC Case No. H14-0418

BETWEEN:

Beth MacLean, Sheila Livingstone,
Joseph Delaney and **Marty Wexler,**
for the Disability Rights Coalition

Complainants

\- and -

The Attorney General of Nova Scotia
representing Her Majesty the Queen
in Right of the Province of Nova Scotia

Respondent

\- and -

The Nova Scotia Human Rights Commission

Commission

DECISION OF THE BOARD OF INQUIRY ON *PRIMA FACIE* DISCRIMINATION

Board of Inquiry: J. Walter Thompson, Q.C.

Written Decision: March 4, 2019

Counsel: Vincent Calderhead and Katrin MacPhee for the Complainants, Beth MacLean, Sheila Livingstone and Joseph Delaney

Claire McNeil and Donna Franey for the Complainant, Disability Right Coalition

Kevin Kindred and Dorianne Mullin for the Respondent

Kymberly Franklin and Kendrick Douglas for the Commission

Heard: 2018 -February 5, 13, 14, 20, 21,
March 6, 7, 8, 12, 13, 14, 15
June 4, 5, 6, 7, 11, 12, 13, 18, 19, 20
August 7, 8, 9, 10, September 6, 18, 19, 20
October 30, November 7

TABLE OF CONTENTS

CONTENTS: **PAGE**

Acknowledgement

Susan Lattie, the mother of the named Complainant, Joey Delaney, the Complainant, Sheila Livingstone, and Diane Pothier, counsel to the Complainant Coalition, all died as this proceeding unfolded. I begin this opinion by acknowledging their deaths and their service to this important public discussion. Ms Livingstone and Ms Lattie, with courage and in the public interest, allowed their lives to be fully placed in the public realm in order to assert the rights of the disabled. Ms Pothier was a distinguished professor of law and a nationally celebrated advocate for the disabled. Her work is, in large measure, the foundation upon which the legal argument in this case has been built.

The Decision

I am satisfied that the Province of Nova Scotia, on the facts and law as presented to me, withheld or limited access to benefits the Province provides to disabled people and *prima facie* has discriminated against Beth MacLean, Sheila Livingstone and Joey Delaney in the provision of or access to services or facilities on account of mental and physical disability contrary to section 5(1)(a) of the Nova Scotia *Human Rights Act.*[1]

I am not persuaded, however, that the Province has *prima facie* discriminated against disabled people who reside in "institutions" generally or who are on a waitlist for placement in a community living service such as "Independent Living Support" or a small options home. No general rule may be applied to what, depending on the circumstances, may be an "advantage" or a "disadvantage". Each disabled person's circumstances must, in my opinion, be assessed individually and then a decision made whether the person has had "meaningful access" to services as mandated by the Supreme Court of Canada in *Moore v. British Columbia (Education).*[2] "Meaningful access" is, in my opinion, the fundamental principle which should guide the analysis of discrimination against the disabled in the provision of services. "Meaningful access" is the theme, *ad nauseam*, of this decision.

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[1] Nova Scotia *Human Rights Act*, R.S.N.S. 1989, c.214

[2] *Moore v. British Columbia (Education)*, [2013] 3 S.C.R. 360, 2012 SCC 61 (CanLII)

A Two-Step Process

I say *prima facie* because finding discrimination under the law is a two-step process. I am engaged now in the first step only. The law requires that if I find *prima facie* discrimination as a first step, then we should embark as a second step upon the consideration of any defences the Province might have to the *prima facie* discrimination. In particular, the Province will have the opportunity in a second step to argue that its policies and practices under section 6(f)(ii) of our *Human Rights Act* are within "a reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society." I expect that the Province might then argue that the Province should be excepted from a full finding of discrimination because of the multiple responsibilities of government to all its people, because of its rights to set priorities and dispense the public purse, because of the fiscal realities of a relatively poor province and because of the progress the Province is making to better take care of the disabled. This present opinion is not the final word.

A Note About Residential Facilities

There is a huge array of facilities for the care of the disabled in Nova Scotia. Some are run by the Province itself. Some are run by societies and other private organizations - "service providers", but paid for by the Province. I list those most relevant to this opinion in the hopes of reducing confusion for the reader.

The Nova Scotia Youth Training Centre in Truro is where both Sheila Livingstone and Beth MacLean resided for a time. The Province closed this facility in the mid-1990's.

The Children's Training Centre in Dartmouth was one of a number of Training Centres spread around the Province. Joey Delaney lived there for a time. The Province closed all the Training Centres in the mid-1990's.

The Nova Scotia Hospital is the Province's largest mental health facility. It is located on the harbour in south end Dartmouth, very close to the Dartmouth General Hospital, in a commercial and institutional neighbourhood. The Nova Scotia Hospital contains a number of units.

Emerald Hall is a unit of the Nova Scotia Hospital. We visited Emerald Hall as a part of this proceeding. Emerald Hall is a locked unit located on the ground floor of one building of the Hospital complex. Emerald Hall is currently programmed for 15 beds. It has a central administration centre with wings of private rooms extending from it. It has access to an area of lawn enclosed by a high fence.

Sheila Livingstone, Beth MacLean and Joey Delaney each spent many years on Emerald Hall.

Harbourside Lodge is an Adult Residential Centre located in Yarmouth. Adult Residential Centres are one level of the facilities that the Department of Community Services funds or provides. Harbourside serves 32 people with "developmental disabilities and mental health obstacles".[3] Sheila Livingstone lived out her days at Harbourside after the Province transferred her there from Emerald Hall.

King's Regional Rehabilitation Centre (King's) in Waterville serves approximately 200 people with intellectual disabilities, chronic mental illness, physical disabilities and acquired brain injuries. Over 600 staff provide care and support.[4] "Rehabilitation Centres" are another level of facility the Province provides under the Department of Community Services "Services for Persons with Disabilities Program". We also visited King's. King's is a large complex located in what was farmland, but it is now becoming a part of the Kentville suburbs. The youth criminal custodial facility is nearby. The Province placed Beth MacLean at King's in July, 1986 at the age of 14. She lived there until the year 2000 when the Province placed her in the Nova Scotia Hospital.

Quest operates in a relatively new facility constructed near the junction of Route 101 and the Cobequid Road in Lower Sackville. Quest shares the building with a facility named the Community Transition Program (CTP) designed for people who, in theory at least, are soon to be transitioned to living in the community at large. The Department of Community Services is responsible for Quest under the Community Supports Program. Its website says:

> Quest provides holistic residential support services within a biopsychosocial model of care. Quest offers residential accommodation and individualized resident support planning.[5]

The Nova Scotia Health Authority operates the CTP. Its website proclaims:

> The Community Transition Program (CTP) helps people who have complex health (physical and mental) and behavioural challenges and

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[3] Harbourside Lodge Website

[4] King's Website

[5] Quest Website

> residential/social supports needs. The goal is to transition people from inappropriate settings to an appropriate level of care within the community.[6]

Small options homes are located in residential neighbourhoods and house three or four people. Staff are provided to support the residents according to their needs. Regional Residential Services Society "RRSS" is a service provider to the Province. Community Living Services Inc. is another such service provider. The Province pays Community Living Service, RRSS, and other services to care for the disabled. RRSS operates a number of small options homes. Sheila Livingstone and Joey Delaney both lived for many years in small options homes operated by RRSS. A number of witnesses testifying at the hearing are or were employed by RRSS. RRSS proposes now to accommodate Ms MacLean and Mr. Delaney.

The Complaints

Beth MacLean

Beth MacLean says in her complaint that discrimination against her began at age 14 in July, 1986 when she was placed in King's. She says that discrimination is now continuing. She had been at the Nova Scotia Youth Training Centre in Truro for two years before her placement at King's. She remained at King's for 14 years before being transferred to the Nova Scotia Hospital in October, 2000. The Province and the Nova Scotia Hospital then agreed that she would remain at the Hospital for no longer than one year.

[As of the date of her complaint, July 22, 2014, she was still in Emerald Hall at the Nova Scotia Hospital. She later moved to Quest, where she was still living when the actual hearing finished at the end of October, 2018. As of this writing, the Province is working towards placing Ms MacLean in a small options home. For over 20 years, Ms MacLean has wanted to leave the institutions into which she has been successively placed.]

Ms MacLean says in her complaint that all her placements were to "institutions" where large groups of people lived together in a manner "that bore little or no resemblance to normal life in a home located in a community." Ms MacLean says she "wants to live in a home, on a street in a neighbourhood and to live a normal life". This goal becomes expressed, throughout the complaint, as being able "to

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[6] CTP Website

live in the community".[7]

Ms MacLean's submission becomes that the Province has been and is discriminating by denying "living in the community" to her. She says staff of the Department of Community Services recognize that she is capable of living in supportive housing in the community.[8]

Ms MacLean says her needs include:

(a) Support for all my activities of daily living
(b) 24-hour supervision
(c) A carefully planned transition to the community (preferably in the Halifax Metro area) with support from people I trust (i.e. circle of support) and an experienced provider of support
(d) Ongoing support in learning how to live in the community, travel and shop and access services in the community
(e) Ongoing support to engage in recreational activities/hobbies that are meaningful to me[9]

Ms MacLean submits[10] that she is entitled to these supports. She says that since the Province does provide income assistance to people without disabilities and this assistance enables them to live in the community, her disabilities ought to be accommodated so that she can too. She says the Province's failure to accommodate her disabilities "is discriminatory and a violation of s. 5(1)(a) access to services because of[11]disability and/or source of income."[12]

Ms MacLean requests this Board of Inquiry to:[13]

a. tell the Province that it has discriminated against her
b. order the Province to provide her "with the means to

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[7] Beth MacLean Complaint, paras. 28, 29, 30, 31, 32, 38 (c) and (d), 39, 40, 42, 44

[8] Beth MacLean Complaint, para. 36

[9] Beth MacLean Complaint, para. 38

[10] Beth MacLean Complaint, para. 39

[11] NS *Human Right Act*, s. 5(1)(o)

[12] NS *Human Right Act*, s. 5(1)(t)

[13] Beth MacLean Complaint, para. 48

immediately access the help and supports that I need to live in the community".

c. Order the Province to pay her compensation

Sheila Livingstone

Olga Cain filed a complaint dated July 23, 2014 on behalf of her younger sister, the now late Sheila Livingstone. Ms Cain says in the complaint that Ms Livingstone was disabled all her life. Ms Cain says that Ms Livingstone had mental disabilities and was completely dependent upon the Province[14] from the time she was 12 years old. Their parents asked the Province for help. The Province placed her in the Children's Training Centre in Truro where she lived for 10 years.[15] She then lived at the Halifax Mental Hospital for about two and a half years before being moved to the Abbie Lane Hospital where she remained for the next 15 years. From there, she was moved to the Regional Rehabilitation Centre at Cole Harbour for four years.[16] In 1986, she came to live in a variety of small options homes paid for by the Province and operated by the Regional Residential Services Society.[17]

Ms Livingstone lived with RRSS for 18 years but, the complaint reads, increasingly came to have exacerbations of her mental illnesses and entered Emerald Hall of the Nova Scotia Hospital from time to time for short term treatment. In July 2004, however, she was admitted to Emerald Hall for a longer time and lost her place at RRSS.[18] She spent the next nine years as a resident of Emerald Hall. In January, 2014, the Province transferred her to Habourside Lodge, an Adult Residential Centre ("ARC") in Yarmouth.[19] [Ms Livingstone, who had a succession of physical illnesses over the years, succumbed in October, 2016 at age 67.]

Ms Cain says that the Province's failure to provide Ms Livingstone with the supports necessary to enable her to live in the community during the period 2004-

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[14] Sheila Livingstone Complaint, para. 51

[15] Sheila Livingstone Complaint, para. 58

[16] Sheila Livingstone Complaint, paras. 61 & 62

[17] Sheila Livingstone Complaint, para. 63

[18] Sheila Livingstone Complaint, para. 66

[19] Sheila Livingstone Complaint, para. 68

2014 is discriminatory and a violation of s. 5(1) (a) access to services, (o) disability and/or (t) source of income of the *Human Rights Act.* (the "*Act*"). Ms McCain complains, furthermore, citing the same provisions of the *Act*, that the Province, when it did place her at Harbourside Lodge in Yarmouth, continued the discrimination because Harbourside was far from Truro where her sister lived.[20]

The complaint compares Ms Livingstone with people without disabilities who, with income assistance, may live in a community of their own choice and submits that it is discriminatory not to provide her with the support to obtain the same for her as a disabled person.[21] The complaint says that Ms Livingstone was entitled, immediately and as of right, to the supports she needed to live in the community in the same way that able-bodied poor people are entitled immediately and as of right to the income assistance they need to live in the community of their own choosing.[22]

Ms Cain requested this Board of Inquiry to:[23]

> Tell the Province that it discriminated against Ms Livingstone from July 2004 to January, 2014 contrary to s. 5(1)(a), (o) and/or (t) by placing her in Emerald Hall
>
> Tell the Province it also discriminated against her by placing her in Yarmouth far from Halifax
>
> [although it is now moot because of her death], to tell the Province to give her right away "...the supports that she needs to live in a community-based home in the Halifax Metro area of the Province, as it has and does for other people who need social assistance but who do not have disabilities".
>
> To order the Province to pay compensation for all the years it has discriminated against her.

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[20] Sheila Livingstone Complaint, para. 73

[21] Sheila Livingstone Complaint, para. 77

[22] Sheila Livingstone Complaint, para. 78

[23] Sheila Livingstone Complaint, para. 88

Joey Delaney

Susan Lattie filed a complaint dated July 22, 2014 on behalf of her son, Joey Delaney. [Ms Lattie died in May, 2016.] Ms Lattie alleged that the Province had, since 2010, discriminated against Mr. Delaney because of his source of income and his disabilities.[24] Joey was born September 10, 1972. He has always been disabled. The Province, at Ms Lattie's request, took over his care placing him at the Dartmouth Children's Training Centre at an early age.[25] In 1998, the Province placed him in a RRSS small options home.[26]

Ms Lattie said that in January, 2010, Mr. Delaney was admitted to Emerald Hall.[27] In July, 2010, clinical staff advised that he was medically ready for discharge, but his bed at his small options home had been taken. In November, 2010, the Province put Mr. Delaney on a waitlist for placement out of Emerald Hall.[28] Ms Lattie says Mr. Delaney, while still being susceptible to bouts of exacerbation of his conditions which required short term treatment, has been ready for placement in the community since.[29]

Ms Lattie said:

> 112 I feel that Joey is entitled to and should have been given the help and supports that he needs to live in the Metro Halifax community in the same way that people from Metro Halifax without disabilities who have no money are given the help they need by the Province to live in the community. The Province's failure to take into account and accommodate Joey's needs in offering supports to live in the community since July 2010 is discriminatory and a violation of s. 5(1)(a), (o) and/or (t) of the *Human Rights Act.*

The Complainant requests this Board of Inquiry:[30]

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[24] Joey Delaney Complaint, para. 92

[25] Joey Delaney Complaint, para. 98

[26] Joey Delaney Complaint, para. 99

[27] Joey Delaney Complaint, para. 101

[28] Joey Delaney Complaint, para. 105

[29] Joey Delaney Complaint, paras. 102-106

[30] Joey Delaney Complaint, para. 126

> To tell the Province that offering Mr. Delaney no option but to live in Emerald Hall is discriminatory and a violation of s. 5(1)(a), (o) and/or (t) of the *Human Rights Act*
>
> To order the Province to give him right away the supports he needs to live in the community
>
> To order the Province to pay him compensation "for all the years that it discriminated against" him.

<u>Disability Rights Coalition</u>

The Disability Rights Coalition describes itself in its complaint as a coalition of individuals and 32 organizations all from across Nova Scotia committed to "promoting the equality of interests of persons with disabilities."[31] Mr. Marty Wexler, a witness in this Inquiry, and the then Chair of the Disability Rights Coalition, signed the Coalition's complaint on July 30, 2014. The Coalition says that it is an aggrieved person as a representative of people vulnerable to discrimination on the basis of disability.[32] The Coalition says it joins this complaint "to raise the systemic nature of the discrimination typified by the three individual complainants."[33] The Coalition says with respect to the individual Complainants and many other disabled people that:

> (168) Instead of being provided with the necessary and appropriate services, they have been denied meaningful access to supports and services that will allow them to live in the community, and/or have been placed on waitlists while they are unnecessarily institutionalized and/or held in care facilities that do not accommodate their needs.

Or, as the Coalition puts it later:[34]

> The provision of social services to "persons in need" discriminates between the disabled and the non-disabled by enabling the latter, but frequently not the former, to live in the community.

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[31] Disability Rights Coalition (DRC) Complaint, para. 129

[32] DRC Complaint, para. 128

[33] DRC Complaint, para. 139

[34] DRC Complaint, para. 172

The Coalition says that the denial:[35]

> ...of supportive housing and other services in the community is a failure to accommodate the needs of persons with disabilities and violates the protections in s.5(1)(a), (o), and/or (t) of the Nova Scotia *Human Rights Act* as informed by: (i) article 19 of the United Nations CRPD *(Convention on the Rights of Persons with Disabilities*), (ii) articles 2, 9 and 26 of the *International Covenant on Civil and Political Rights* (ICCPR), (iii) the Equality Rights guarantee in s. 15 of the *Canadian Charter Rights and Freedoms* and (iv) by the constitutional commitment to providing essential public services of reasonable quality to all Canadians in s. 36(1)(c) of the *Constitution Act, 1982.*

The Coalition seeks a remedy that will compel the Province to develop and implement a plan to enable people with disabilities to access supports that will enable them to live in the community. The plan, the Coalition says, must include the ongoing supervision of the Nova Scotia Human Rights Commision and representatives for those needing the supports.[36]

A Note about the Evidence

I have chosen to review of the evidence based on my own notes. I appreciate that my recapitulation may be somewhat repetitive and tedious for the reader, but we had over 25 days of actual testimony and I feel compelled to report the stories told by most, but not all, of the witnesses.

I have also received over 9,000 pages of documents, or at least the page numbers say that I did. I would not pretend to have digested them all, but I can say the oral evidence accurately reflects the contents of the documents. The stories witnesses and the documents tell highlight the difficult and sometimes tragic circumstances in which some of our fellow citizens found themselves and the indifference of the people who, in the final analysis, have the power to change those circumstances.

Oral Evidence

The evidence as it relates to Beth MacLean, Joey Delaney and Sheila Livingstone

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[35] DRC Complaint, para. 171

[36] DRC Complaint, para. 179

consists of testimony and documents. The evidence about them is interwoven throughout my opinion, often expressing the same point, but from a different person.

We also received oral evidence, mostly from family members, about other disabled people. Their evidence provided me with something of the wider context of life for disabled people and is important to my construction of "meaningful access".

The Documents

The parties agree to virtually all of the voluminous documents being admitted as evidence and accepted as being truthful. I identify references to these documents by their page number in the volumes of the "Joint Exhibit Books", the JEB referred to in the footnotes.

The Experts

A number of witnesses testified as "experts". Their evidence is useful and, with one exception, I found it helpful. In the end, however, I find that the evidence is not "opinion" evidence in the usual sense of the term where a summonsed expert might assist a tribunal on a technical matter. The evidence is, for me, ordinary evidence of the same weight and respect as the evidence of other witnesses.

The individual cases speak for themselves. The tribunal does not need an expert opinion to find that the long term placement of the three individual Complainants was wrong. The Province agrees, at least, that the placement was unfortunate and inappropriate. One can cavil about the proper term, but my point is, again, that no "expert opinion" is required to assist in that general conclusion.

The expert evidence is really to the point of determining what is the present standard of treatment for the disabled. On this point, there is agreement. The Province does not really dispute what the best practices are. On the key point, the Deputy Minister herself says that the Province believes that institutional care is now outmoded and that the Province is indeed moving to close down institutions. Many of those who testified have, in fact, either been commissioned by the government to advise government on how best to support the disabled, been long term employees of governments themselves, or had worked under contract with them. Their views and recommendations, by and large, have been accepted by the various governments over the years and, although not on the time line advocated, are being implemented.

The Reception of Evidence

In any event, the rules for the admission in a human rights proceeding under our *Act* are permissive. The Nova Scotia *Human Rights Act* stresses in s. 34(3) the need to give "full opportunity to all parties to present evidence":

> 7 In relation to a hearing before a Board of Inquiry, a Board of Inquiry may receive and accept such evidence and other information, whether on oath or affidavit or otherwise, as the Board of Inquiry sees fit, whether or not such evidence or information is or would be admissible in a court of law; notwithstanding, however, a Board of Inquiry may not receive or accept as evidence anything that would be inadmissible in a court by reason of any privilege under the law of evidence.

Technical rules about the admission of opinion evidence thus need not be strictly applied. I acknowledge with thanks counsels entering into the spirit of this provision and enabling the evidence to be presented in full without objection. The evidence, I think I can say almost without exception, was relevant and even compelling.

Little or no evidence was challenged for credibility. Allowances may be made, however, for point of view. A reader should realize that most if not all witnesses for the Complainants are advocates for the disabled.

Just the same, I repeat, the Province has accepted the thrust of their testimony. Indeed, Lynn Hartwell, the current Deputy Minister of the Department of Community Services, pretty much agreed with such evidence as was put to her even through counsel for the Complainants. Her evidence is particularly pertinent and I shall review it in detail. The Province also, by and large, agrees with the consensus of professional and academic opinion about services to be delivered the disabled in Nova Scotia. Much of that professional and academic opinion is stated in papers prepared for the Province. I review a couple of the most pertinent ones.

The People with Disabilities

Beth MacLean is a daughter of Ben and Karen MacLean. Ms MacLean and her parents maintain a good relationship, but there is no evidence to suggest that, after the age of 10, there has ever been much thought that she could return to live with them. In fact, as later evidence will show, her parents have believed that there was too much risk to the public safety to even allow her to leave Emerald

Hall.

Ms MacLean has a mild intellectual disability[37] and, over time from an early age, for whatever reason, has not been able to control her behaviour.[38] She has lived in institutions from the time she was 10 and placed in the Nova Scotia Youth Training Centre.[39]

Ms MacLean's parents could not cope with her from a very early age. Indeed, it is to be remembered that her parents continued through time to believe that Ms MacLean presented such a risk that she should not be permitted to live in the community and, for that reason, opposed and obstructed community placement for her.

Ms MacLean attended school in Bridgewater until the age of 10. The school system then expelled her because of her aggressive and destructive behaviour.[40] The Nova Scotia Youth Training Centre in Truro admitted her in 1983. The Training Centre, except for visits home, became her residence.[41] The Training Centre could not manage her behaviour either, and refused to readmit her for the 1986-87 school year. Ms MacLean, with a special dispensation because she was still a youth, came to be placed in an adult facility, the King's Rehabilitation Centre in July, 1986.[42]

Ms MacLean lived at King's from 1986 until 2000 when an incident of destructive behaviour led to King's expelling her. On July 4, 2000, Ms MacLean was at a work placement. She reportedly became frustrated and ran outside. Staff followed her asking her to remain calm. Instead, Ms MacLean impulsively ran to some parked cars and began to scratch the bodies and the windows.[43]

King's staff restricted Ms MacLean to her living unit. Her behaviour deteriorated. She made threats to staff and other residents, and assaulted staff members. She

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[37] JEB 7170

[38] JEB 7181

[39] King's Discharge Summary dated November, 2000, JEB 7164

[40] JEB 7165

[41] JEB 7513

[42] JEB 7126

[43] JEB 7193

made it clear that she no longer wanted to live at King's and would misbehave until she got what she wanted. Staff concluded in the Discharge Summary dated November, 2000:

> Impulsive, unpredictable aggressive behaviour is a long term pattern which appears rooted in a complex interaction of biological disposition, environment and long term institutionalization[44] ...
>
> At this point she is a very severe safety risk to the other lower functioning clients, and to staff on the Gateways Unit, and cannot be maintained here safely.[45]

Staffs did not formally review Ms MacLean's status as a resident of King's while she resided there.[46] There seems to have been no process in place for such a thing then.

King's discharged Ms MacLean on October 23, 2000. She became a resident of the Nova Scotia Hospital first on a unit known as Maritime Hall, and then on a unit known as Emerald Hall. The Nova Scotia Hospital became Ms MacLean's residence for the next 15 years.

The Crown charged Ms MacLean with criminal offences arising out of the incidents at King's. There is little in the record about the proceeding, but I gather that Ms MacLean was found guilty by a court and put on some form of order discharging her with conditions.

Christine Pynch, Beth MacLean's "Care Co-ordinator" with Community Services, advised, as early as March 20, 2001, that Ms MacLean had no "diagnosable psychiatric illness", that "Beth is inappropriately placed and that Ms MacLean did not like it at the hospital and did not belong there".[47]

Dr. Diane Eastwood, a psychiatrist at the Nova Scotia Hospital, in a report dated November 14, 2000, said:

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[44] JEB 7171

[45] JEB 7172

[46] JEB 7206

[47] JEB 7209

> Ms MacLean has demonstrated no evidence of an Axis IV psychiatric disorder. Her difficulties with behavioural control should be addressed in a structured, settled setting where her needs for 1-to-1 interaction with staff can be met. Her problems do not appear to preclude continued development of plans for community integration.[48]

I also quote parts of emails from Avis Faulkner RSW, of the Mental Health Program of the Capital District Health Authority, Nova Scotia Hospital Site, to John Campbell of the Department of Community Services dated March 11[49] and March 21, 2002. The March 11 letter reports in part:

> ...This individual does not have a psychiatric diagnosis, but is developmentally delayed with serious behavioural issues.
>
> After BM's return from Court in late 2000, it was our understanding from a meeting held right after the New Year which involved Nancy Beck and I and the Dept. of Community Services from the Valley office, that we would provide approximately one year of care. This was based on the court order that BM stay away from the Unit manager at KRRC for approximately one year of care. This was based on the court order that BM stay away from the Unit manager at KRRC for 12 months, to provide respite, and to conduct any assessments that the team felt might be used for managing her current behaviours. ......
>
> So at this point we have a non-psychiatry patient, who has had assessments and made behavioural gains on an inpatient psychiatry rehab unit, and who is in need of long-term appropriate housing and day-programming outside the hospital. She has been able to set and meet specific goals and her goal at present is to leave this facility. I believe that this developmentally delayed individual needs to be supported by the systems geared to the developmentally delayed as she benefits from activity and structure and we have been able to better identify her triggers to aggression.
>
> This individual has been managed on a "respite-type" arrangement from Kings RRC at the Nova Scotia Hospital since late 2000. In February 2001, at a meeting of representatives from this facility and

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[48] JEB 7160

[49] JEB 7226

> Department of Community Services, it was agreed that this arrangement would last for 12 months and that Department of Community Services would ensure an alternate placement at that time. This is particularly important as the individual has utilized a tertiary psychiatric services inpatient bed for approximately 16 months when she does not have a psychiatric illness. (emphasis in original)
>
> The clinical team of Maritime Hall has ensured that a neuropsychological assessment was completed on this individual and has built an individual support program which has allowed her to make very good progress from an initial high level of aggression and supervision. Her goal is now to leave this facility, and she is working hard to achieve it.
>
> Our service continues to experience a high level of demand for treatment of persons with extremely complex and disabling psychiatric illnesses. I think that is very important that our collaboration in finding a suitable non-hospital placement for this individual move forward in a more timely manner, as previously agreed.
>
> ... I will look forward to hearing about next steps as soon as possible.

The March 21, 2002 letter reports in part:

> Beth has continued to make excellent progress in her behaviour, social and functional performance...
>
> Beth is very pleased with her progress and mood is generally happy. She reports that she notices a positive change in herself and is looking forward to leaving the hospital. She has been continuously asking about her discharge and appropriately needs to be kept informed of progress in this regard. This type of communication is imperative to Beth maintaining a positive outlook and motivation to continue to do well.[50]

I am satisfied from the above that Ms MacLean's behaviours, whatever may be said about them while she was at King's, had improved after a year to the point where

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[50] JEB 7235-6

the Province should have placed her in a small options home, or at the very least, some other facility. No witnesses and no documents say that there was any change in Ms MacLean over the ensuing years. The Province, impervious to all, continued to ignore her.

I refer to other remonstrances to the Province later in this opinion. Suffice it to say for now, however, that I cannot imagine how frustrating and even soul-destroying it must have been for Ms MacLean to live in hope and to have those hopes dashed day by day. I cannot imagine how frustrating it must have been for the good and faithful servants of the Province, all dedicated to Ms MacLean's welfare, to have their opinions and advice ignored in 2002 and for the next 13 or 14 years. The Province met their pleas with an indifference that really, after time, becomes contempt.

Sheila Livingstone's sister, Olga Cain, was her primary support. She and her daughter, Jackie McCabe-Sieliakus, described Ms Livingstone's life.

Ms Cain said Ms Livingstone was the 12th of 15 children. Ms Cain was the third. There were 17 years between them.

Ms Livingstone, from birth, had epileptic seizures. The family used to put her in a pan of cold water because they had no other treatment. Then Ms. Livingstone would come out of it.

When Ms Livingstone was 12, the family got her into the training school in Truro. Ms Cain said one could not understand Sheila and she was not being taught anything at home. She was not learning things. She was not even properly toilet trained. She learned how to take care of herself at the school, but unfortunately she learned lots of other things too. In Truro, she became more protective of herself, and did not want people to touch her. Sheila would come home pretty near every weekend. Then she didn't want to go back to Truro. She didn't like it there, but she could not stay home. She would revert at home.

Then Ms Livingstone was placed for a time at the Abbie Lane Hospital. Ms Cain described the Abbie Lane as a "hell hole".

After a time at the Abbie Lane, the Province placed Ms Livingstone in a small options home on Robert Allen Drive in Halifax, and then for 15 years to a small options home on Topsail Boulevard in Dartmouth. Ms Cain said Ms Livingstone was happiest on Topsail. Ms Livingstone's niece, Jackie McCabe-Sieliakus, told us; "She was very happy there - it was like a home". It was, she said, a fantastic place for her to be. There were only three disabled people in the home. She was friendly with co-residents. The staff were very good. Ms Livingstone had a room to herself. Her room was always open. She had a single bed, her drawings, two dressers, and family pictures. The home had a nice yard. The doors were not locked. For a time, Sheila went out from the home five days a week to a job doing envelopes.

Ms Cain and Ms McCabe-Sieliakus said Ms Livingstone flourished while at Topsail. She did not need to worry about someone coming up and whacking her as she feared at Emerald Hall. Topsail was safe. Families would come bringing babies. Ms Cain said she would never bring her children to Emerald Hall - it was too scary.

Ms Cain described how Ms Livingstone came to be permanently placed in Emerald Hall. She could hardly talk and it was difficult to understand her, but staff who took an interest could do so. She said the staff at the Topsail small options home changed. A new staff member at Topsail could not understand Ms. Livingstone. Ms Cain said that Ms Livingstone hit that person and ended up at Emerald Hall.

Ms Cain described Emerald Hall. The doors are locked. Sheila was afraid. She liked to sit in the common area. She could not protect herself; she said people would hit her. There was nothing at Emerald Hall for patients to do. Patients just sat around. Ms Cain said she could not take her sister out all by herself. She had to take a staff member with them. Sheila would want to stay out longer, but she and Sheila would have to return when the staff member needed to. Sheila did not have to take a staff member out with her while she lived at Topsail. Ms Cain said there was talk of Ms Livingstone going into a nursing home. She said she was agreeable on behalf of Sheila, but the nursing home would not take her, saying they were not set up to cope with Sheila's condition.

Ms Livingstone would get frustrated when she could not be understood and then she would get angry. At Topsail, Ms Livingstone's speech was much better. In Topsail, it was all one family. At Topsail, staff would work to help her to express what she wanted to say, but at Emerald Hall she was on her own. There was no one to call upon who understood her because the staff were always changing. It takes months and years to be able to understand and communicate fully with Sheila. At Emerald Hall, staff kept coming and going.

Ms Livingstone did have a psychiatric illness. Ms McCabe-Sieliakus agreed that her aunt's psychiatric illness would affect her behaviour. Ms McCabe-Sieliakus knew that sometimes she would act out, but she believes that it was she who was being assaulted rather than she assaulting someone. Ms Livingstone was fearful and unhappy. Ms McCabe-Sieliakus said she would get conflicting stories when she inquired and often did not know what to believe.

Ms Cain said the Province offered to place Ms Livingstone at Harbourside Lodge in Yarmouth. Ms Cain says she was told Ms Livingstone could either go to Harbourside or stay at Emerald Hall. The Yarmouth hospital is attached to Harbourside. It provides a residence for veterans and the mentally challenged. Ms Cain would, in a heartbeat, have chosen a place like Topsail small options home. Every week, Ms Livingstone was complaining that she was being hit at Emerald Hall. For her safety, for her sake, Ms Cain agreed to the placement at Harbourside. Harbourside was a good place. Ms Livingstone was safe there.

A Harbourside report notes the "Very close relationship with sister, Olga". Ms Cain lives in Stewiacke. Ms Cain had to stay in Yarmouth overnight to visit Ms Livingstone.[51]

Ms Livingstone had lived for many years in a small options home. She was often in and out of hospital for treatment of her chronic illnesses. One note dated March 3, 2006 says she'd had 58 admissions to the Nova Scotia Hospital.[52] The Province provided extra staffing for her support at Topsail.[53]

Ms Livingstone's September, 2004 admission to the Nova Scotia Hospital turned into a very long stay, but the evidence is clear that the professional staff of Emerald Hall recognized she was suitable for placement somewhere else and should not remain there. The reports mention Adult Residential Centres and nursing homes. Regardless of where the placement might be, the point was to get her out of Emerald Hall. She would act out, make threats, strike out, and certainly the Province seized on her behavioural difficulties to block access to services, but I am well satisfied that what was said about her in a Community Services Individual Assessment and Support Plan dated June 11, 2012 is accurate:[54]

> Residual symptoms of psychosis-muttering accusations of others, occasional unprovoked strike or scratch (no one actually gets hurt) Increase in agitation, threatening language, self-abuse and physical aggression towards others.

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[51] JEB 8666

[52] JEB 8265

[53] JEB 8252

[54] JEB 8679

> Can be unpredictable at times, will sometimes mutter, her face will turn very red, breathing quickens.
>
> Always check for physical causes of change in behaviour as Sheila has numerous health issues.

Ms Livingstone was disabled and ill. She was no danger to anybody.

As of April 14, 2005, the Province classified Ms Livingstone for placement in a Department of Community Services facility outside the Emerald Hall unit of the Nova Scotia Hospital operated by the Department of Health. I refer to a letter dated April 14, 2005 from a Care Coordinator with Services for Persons with Disabilities of the Department of Community Services to someone at the Riverview Adult Residential Centre:

> She has been classified ARC level of care and is now awaiting placement. Family have indicated that they would like her to be placed in the Pictou area as she has family there. Sheila has a long history of institutionalization both in Health and Community Services facilities. For the past 15 years she was with RRSS in a small options home however always struggled with her mental health. It is felt by the hospital team that she does better in structured setting and thus we are applying for admission to Riverview.[55]

RRSS, in the meantime, seemed to have been prepared to take Ms Livingstone back. Carol Ann Brennan, of RRSS, wrote inquiring in March, 2005, but was advised that Ms Livingstone's psychiatrist thought her too ill for a community placement and that an institutional setting would be better.[56]

There were subsequent bumps where Community Services said she was unfit for such a placement, but there is no evidence that her condition deteriorated in any significant way thereafter. The Department of Health was no help either, ostensibly because of her behaviour, refusing to accept her into long term care in July, 2008[57] and in November, 2010[58] despite assurances from Emerald Hall that

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[55] JEB 8558

[56] JEB Vol. XI Tab 27

[57] JEB 8529

[58] JEB 8555

electroconvulsive therapy had helped minimize her misbehaviour.[59] Of course, she suffered from several chronic illnesses which would require access to medical services and hospitalization from time to time, as it did while she was a resident of Topsail, but that would not detract from the fact that Emerald Hall was a bad placement for her and she should have been resident elsewhere thereafter.

The staff of Emerald Hall continued to push for Ms Livingstone's placement. Joanne Pushie, a social worker at Emerald Hall and strong advocate for her clients, wrote the Care Coordinator, Services for Persons with Disabilities on January 2, 2013, requesting the Department of Community Services to "take immediate steps to secure an appropriate community placement" for Ms Livingstone . I quote:[60]

> ...The issues leading to her admission were addressed by the clinical specialty inpatient team and Ms Livingstone was medically discharged on November 23, 2011.
>
> The Department of Community Services was notified of Ms Livingstone's discharge and it has been the inpatient team's expectation that she return to an appropriate placement. Unfortunately she has remained on Emerald Hall preventing the team from providing treatment to other patients...

Ms Livingstone moved to Harbourside Lodge on January 29, 2014. Staff reported that she was doing well.[61] As of March 4, 2015, she was waitlisted for "a level 4 residential option" which included small options homes.[62] Ms Livingstone died at Harbourside Lodge in October, 2016.

Joey Delaney was born September 17, 1972. Witnesses and the written record make it clear that Mr. Delaney is, and has always been, severely disabled. He only speaks a few words. He also communicates with gestures, and a lot of screaming. His sister, Tammy Delaney, said he can hum his ABC's, can say his name, and communicate with grunts and pointing. He has epilepsy. He has chronic severe bowel problems. He is prone to self-harm, especially by banging his head. He wears a helmet. From time to time, he strikes out at caregivers. All of these have

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[59] JEB 8549

[60] JEB 8626

[61] JEB 8657

[62] JEB 8674

shown themselves to be intractable conditions in spite of years of staffs trying to alleviate Mr. Delaney's distress. His condition is complicated by hypomania from time to time, that is to say that his mood would become elevated.

Much of Mr. Delaney's distress relates to his bowels. He is chronically constipated and afflicted with gas. Staff have to deal with his need to defecate, to assist him with the process and to clean him afterwards. Staff believe that his bowels cause him pain and lie at the root of much of his screaming. The great difficulty is that he cannot say what is troubling him nor ask for help when he needs it. I was struck by one anecdote that seemed to encapsulate the challenges. Mr. Delaney came into a pattern of screaming during the evening. One evening he was given a snack. Then there was no screaming. The anecdote suggests that Mr. Delaney was hungry, could not ask for something to eat, and screamed. Having eaten something, he quit screaming.

Mr. Delaney's sister, Tammy Delaney, told us about Mr. Delaney's early life. He was born in September, 1972. He lived with the family until he was six or seven. He was having seizures, he was not safe; he would do things that were very, very dangerous. Once he ran off a second floor and fell to the ground. He could not be managed at home. He needed 24 hour supervision. In 1979, he was taken into care and placed into the Dartmouth Children's Training Centre on Pleasant Street, close to the Nova Scotia Hospital. He came home for weekends, for Christmas and Easter. He was still very hyper, he would not sleep well, and still needed constant supervision. If he was not watched, he would spontaneously run out into the street.

The Children's Training Centre closed. The Province had to find a new placement for him. Department of Community Services staff, in May, 1996, prepared an "Individual Placement Plan". The plan noted that his epilepsy was "only adequately controlled". The report also notes that Mr. Delaney was "prone to severe constipation".[63] The report concludes that the "Ideal Placement" would be a small options home with his own bedroom, two house mates and a "caring, empathetic staff, trained to work with a profoundly developmentally delayed young man."[64] On August 12, 1996, according to a child placement form, Mr. Delaney was so placed in a small options home on Chapel Street in Dartmouth. The Province later transferred him to a small options home on Skeena Street.

Tammy Delaney described his life in a small options home. Joey Delaney went

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[63] JEB 7759

[64] JEB 7767

there at age 20. It was a home on the street. One felt nice in it, felt welcomed. The staff were great. She would visit, but most often their mother would go by herself. The home was warm and inviting. Joey knew that this was his home, and he felt comfortable there. Joey would be doing his own little thing. One could relax, have a cup of coffee and be with Joey. He would play with puzzles, and phone books. He would roam around and grab a puzzle, or get his shoes if he wanted to go out.

Joey did not come home overnights, but the family would take him out for the day. Joey also had a little job with the Dartmouth Adult Services Centre, in Burnside, doing something with plastics which lasted until his admission to Emerald Hall. He came and went from Skeen Street by bus accompanied by staff. Emerald Hall, Ms Delaney said, was not a nice place to be, nor a nice place to visit him.

The Province transferred Mr. Delaney to Quest in February, 2015, after approximately five years at Emerald Hall. Tammy Delaney said she found Quest to be just the same as Emerald Hall. Then he was removed from Quest and transferred back to Emerald Hall because of his screaming. Ms Delaney concluded her testimony by saying the Province had just advised her that it was then in the process of finding a small options home placement for him.

I refer to the materials, mostly from the Nova Scotia Hospital, which record Mr. Delaney's long term stay at Emerald Hall. Mr. Delaney's behaviour and his health had deteriorated late in 2009 and into 2010. He was screaming, banging his own head, hitting staff and other residents. He had a number of admissions beginning in 2009 to Emerald Hall and after a time, staff formed the opinion that he needed a higher level of care than could be provided in a small options home.[65] He lost his bed at the Skeena Street small options home in July of 2010. He was then classified for placement in a Regional Rehabilitation Centre. In other words, he was, by July 21, 2010, "medically discharged" from Emerald Hall.[66]

The notes of a Clinical Care Planning Meeting[67] of September-October, 2012 say that:

> Joey has been classified and ready for placement for over a year. The only barrier to placement is availability. Joey has never been offered

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[65] JEB 7794-96

[66] JEB 7917

[67] JEB 8013

a placement in metro or outside of HRM.

Ms Pushie wrote the Care Coordinator again on November 28, 2012 pleading with the Department "to take immediate steps to secure an appropriate community placement" for Mr. Delaney.[68]

Dr. Mutiat Sulyman, on behalf of the Emerald Hall clinical team, wrote Claire McNeil, counsel to the Coalition in these proceedings, on April 22, 2013 outlining Mr. Delaney's history and status.[69] Dr. Sulyman confirmed that by the end of July, 2010 "the issues leading to Joseph's admission to Emerald Hall were addressed and he was considered ready for medical discharge with the expectation that he would return to the community." She remarks that as of the date of the letter, he had not been offered a placement. She concludes by saying that "his care needs can be very well managed in the community" and that:

> Mr. Delaney will require a small option home with 24 hour supervision and support with the activities of daily living, in particular daily adherence to his bowel regime and ongoing supervision of bowel function.

An Individual Assessment and Support Plan dated January 19, 2015 confirms his status saying his needs may be met with community resources and the long term goal is to place him in a small options home.[70]

In evidence are nursing notes from Emerald Hall during February and March, 2013, that is to say at about the time of Dr. Sulyman's letter to Ms MacNeil. There is no doubt, on reading these notes, that Mr. Delaney was a very challenging patient. He banged his head, he yelled and moaned, he often fell down, he was chronically constipated, often agitated and sometimes aggressive.

In evidence is also an "Interdisciplinary Discharge Summary" prepared at Quest. The Summary records that Mr. Delaney was admitted to Quest on February 26, 2015 and discharged back to Emerald Hall on January 24, 2017.[71]

The Summary encapsulates years of medical reports and is consistent with the

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[68] JEB 8018

[69] JEB 8030-33

[70] JEB 8061

[71] JEB 8078 - 8198

oral and documentary evidence about him. The Summary also states the reasons for his return to Emerald Hall:

> 1. Biological
>
> (j) Medical History
> Client has history of constipation which can lead to severe agitation and aggression. Client requires daily enemas and rectal tubes for abdominal relief. Client also has a history of seizures and has a seizure protocol. Client also has a history of falls and utilizes the Broda chair for safety when he is unsteady and also wears a helmet.
>
> 2. Psychiatric Functioning
>
> (b) Mental Status
> Joey has a diagnosis of Severe Mental Retardation and Cyclical Mood Disorder. Joey lacks insight and judgment. No overt evidence of psychosis. Thought form and content cannot be assessed. May be minimally oriented to place but not time, date of situation but can follow simple directions. He is dependent on others for grooming and appearance. Unable to assess memory but does appear to remember familiar people and places as well as location of objects. Non-verbal but can make routine needs known through gestures at times. Mood has been unstable. Will yell when distressed or agitated.[72] ...
>
> 3. Social History
>
> (8) Recent History;
>
> factors leading to present placement
>
> Joseph's condition became unstable the last few months while residing at Quest. Client was increasingly agitated and spent most of his day in distress which portrayed as client continuously yelling, self-abusing (hitting his head) and attempting to hit or pinch staff. Client's cause of distress is unknown. Medications were changed in thoughts that Joseph's increased agitation was due to his bi-polar disorder but the agitation continued. Fleet enemas and rectal tubes were also done daily in case of abdominal distress, they provided only

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[72] JEB 8081

> brief relief. Client was discharged due to increased vocalizations and agitation which was disturbing to other clients.

Mr. Delaney remained a resident of Emerald Hall as of the conclusion of the hearing in October, 2018.

Richard Rector testified on behalf of the Complainants. Neither he nor any of the other disabled people about whom evidence was given are parties to this proceeding and I can make no rulings about them. Their evidence is, however, illustrative of the lives of the disabled and their interaction with the care system the Province provides.

Mr. Rector is 32. He had lived at the Quest facility in Sackville for, he says, far too long. He found the facilities boring and regimented. He was assaulted and had fights with a very difficult resident. He says; "It felt like Alcatraz." Mr. Rector said he told everybody he wanted to leave. He said he would go anywhere to get out. Now he lives in a group home in Windsor which he finds to be "sort of OK". He says that at the home in Windsor he is pretty well able to come and go as he likes although there is always someone wanting to know what he is doing. He goes home alternate weekends to stay with each of his separated parents. One lives in Smith Settlement, which is up the Eastern Shore beyond Musquodoboit Harbour. He said he would not mind living near Smith Settlement. His other parent lives an equal distance away from Windsor.

Leslie Lowther, the mother of Richard Rector, testified. Ms Lowther said Richard was on an ATV crossing a road when a car hit him. He suffered brain damage. He was in a coma for four months. He has improved since then, but his personality changed. He can be aggressive and he is big. His leg was badly injured, but he can walk. He can shower, dress himself and eat on his own. His short term memory is not good. His long term memory is better.

Ms Lowther is separated from Mr. Rector's father. Mr. Rector's father is disabled himself. Richard began to live with him, but that was not working out. Richard moved to a facility for those with brain injuries in Lunenburg County known as Peter's Place. This placement did not work out either. The facility was in "the middle of nowhere". Other residents are mostly in wheelchairs and non-verbal. Mr. Rector called his father to come and get him. Mr. Rector ended up at the Quest facility. Mr. Rector did not like Quest. Ms Lowther said things started to go downhill. Clients of Quest have varied conditions. One person, all he would do is yell. Mr. Rector is sensitive to noise. He found no one on staff to whom he could relate. The facility was often short of staff, but in any event, they did not take the time to sit with him and get to know him. She described Quest as a warehouse. She saw no programs for him. The staff solution, if he acted out, was to deprive him of his passes home or his work placement. He fell into a depression, he just did not care about anything. After four years, he was moved from Quest to the Community Transition Program facility in the same building. Ms Lowther was told that he would be at CTP for 18 months; he was there for five years. She found no difference. There was no programming. There were people at CTP who would never leave and some who he had known at Quest. There was one other client at CTP who was particularly difficult and tried to choke him.

After nine years, the Province placed Mr. Rector in a small options home in Windsor. The home has three or four staff. He has access to the kitchen. He assists in meal preparation. The group eats together. He has been working at a local food bank where, Ms Lowther says, "the people absolutely love him". He can walk to Tim Horton's. He keeps busy.

Ms Lowther says she does not see aggression. Mr. Rector will redirect himself if he gets upset. If he does not, then staff lets the anger take its course and then forget about it. They talk to him. They ask him what he needs. They do not tell him. There is a quiet room, but it is up to the client whether he will use it.

Mr. Rector still comes home, alternating weekends with both parents. Mr. Rector Sr. lives in Jeddore. Both sides of the family are on the Eastern Shore. The ideal would be a small options home there.

Mr. Rector, of course, is not a party to these proceedings. I do, however, make a few points. The Province did support Mr. Rector in a specialized facility for people with brain injuries and then at Quest-CTP. I cannot say that these placements were a denial of meaningful access as such, although it does seem to me that the length of time he spent at Quest-CTP made it such a denial at some point.

Mr. Rector and Ms Lowther still seem to be unhappy that he is now living in Windsor rather than closer to her and his father. I would venture to say, however, that the placement in Windsor does provide him with meaningful access. I am not persuaded that a disabled person may expect to claim a residence in the community of his or her choosing. Windsor is about an hour and a quarter drive from Smith Settlement. I do not find that to be an unreasonable commute for his visits with family or their visits to him.

<u>Jennifer Gallant</u> testified on behalf of the Complainants. She is an RN. She had a disabled son who died at the age of 19. She used to work at the CTP. She said CTP operates out of an institutional building, rather like a nursing home, but with added security. Ms Gallant described life at the CTP. Residents, by and large, had

multiple diagnoses. The CTP had a central staff station with offices and work spaces. Staff tended to gravitate to the central station and stay there rather than engage with the clients. CTP was quite distinct in operation from Quest. There were clients from Quest who moved up to CTP, but CTP clients did not pass to Quest. One area of CTP was provided for one particular individual and his bedroom remained locked. Meals were brought up on a trolley. Clients did not have access to a kitchen. Breakfast was not scheduled and clients could sleep in, but would be awakened for activities if they had some scheduled. Other meals and snacks were served at scheduled times. All areas had cameras and security staff were always on duty. CTP was noisy. It was clean. Staff worked shifts and turnover was high. Clients did not often have the same staff from day to day. Clients confronted one another either verbally or physically almost everyday. If a physical altercation developed, then staff would take the clients involved to their rooms, or in some cases, to the Therapeutic Quiet (TQ) room. Protocol called for a check every five minutes while they were in TQ. The client would be released when he or she became calm. Each client would have activities planned, but whether the client could engage in the activity on a particular day would depend on how the client was doing and whether there were staff or a vehicle available. General access to the community varied. Some were permitted to come and go, some were not. Ms Gallant's understanding was that CTP was a transition facility and that clients were to remain for a maximum of 18 months. She said four or five of the clients had been at CTP for a very long time and remained there. During her time, two passed away, three went to other institutions, and two to a group home. Clients came to CTP because there was no other place. They came from Quest, or from Emerald Hall, or from their own homes and one fellow was simply homeless. There would have been no other place available for them to go. Clients did not do well in CTP; they became more isolated, they became bored, they became aggressive. Time has no meaning. Even seasons of the year lose relevance.

<u>Wendy Lill</u> testified. She co-chaired the "*Roadmap*"[73]committee. She has a son with Down's Syndrome. Sam is now 32 years old. He is not affected so much with physical problems, but has difficulties with language. He went to school with a full-time teacher's assistant. There were some difficult times when he, in frustration, acted out. He went through Dartmouth High, finishing at age 19. He has been employed at Sheriff Hall for 10 years. Ms Lill says the family was

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[73] *Choice, Equality and Good Lives in Inclusive Communities, A Roadmap for Transforming the Nova Scotia Services to Persons with Disabilities Program* was submitted to the Minister of Community Services, by The Nova Scotia Joint Community-Government Advisory Committee on Transforming the Services to Persons with Disabilities (SPD) Program in June 2013, JEB 2852

advised to have Sam placed on a waitlist for a small options home immediately when he turned 19. At age 26, he was accepted into a small options home nearby and continues to reside there.

Ms Lill says disabled people and their families developed a huge amount of distrust and cynicism because of the difficulties faced in care and the difficulties in obtaining supports. She was asked whether cost was a consideration in placing people. She said that it was the unacknowledged elephant in the room in the *Roadmap* discussions. All were aware that any change in the paradigm would require money. There were also issues around bringing families to accept change and around the loss of the jobs involved in operating institutions.

Ms Lill said while the present government accepted the *Roadmap* report, she and others have been disappointed at the pace of implementation. A real effort has been made to get treasury on side, but she said she does not know when priorities may change at the governing level. A lot of talk was going on, but the waitlists grew just the same. No financial commitment, she said, is in view.

It strikes me that the Province has, throughout, provided Sam Lill with services as a disabled Nova Scotian. Ms Lill did not express dissatisfaction with the services he had obtained. Her comments were directed to the general. The services Sam receives are not exceptional. Many others in similar circumstances receive them too. The point is that the Province does provide services of the kind that were in effect denied to or limited for the individual Complainants.

<u>Barbara Horner</u> testified for the Complainants. Her daughter, Mallory, was born in Alberta. Ms Horner said she was told then that Mallory would be nothing more than “a vegetable”, and should be put in an institution.

Ms Horner was able, however, to access early intervention. Alberta offered various options including respite and nursing services enabling Mallory to live at home. She said she never would have gotten through without these services. [Respite, I have learned, is a term used to describe services the Province provides families to support disabled members in the family homes or by accommodating the disabled members in a facility for short times.]

The Horner family moved to Nova Scotia when Mallory was four. It soon became clear that the funding was not available for the respite support to enable Mallory to stay at home. Nova Scotia was offering only $52.00 a month for respite if Mallory lived at home. Mallory moved into a Children’s Training Centre (CTC).

The CTC was an institution. Ms Horner said she never saw kids having a chance to learn. Around 25 kids resided at the CTC, and, in addition, other kids came in for respite. She pretty quickly realized that people support people, that there was an "institutional attitude" within, and no overall leadership. Ms Horner said that any time she raised an issue, she was told to mind her own business.

Mallory suffered burns at the CTC and had to be taken to the IWK Hospital. The burns to Mallory drove Ms Horner into her life of advocacy.

Ms Horner herself worked for the Nova Scotia Association for Community Living. At the time, access to respite dollars was a huge issue. Ms Horner said raising disabled children is expensive, with greater demands for equipment and such services as speech therapists. Caring for a child is emotionally, financially and physically exhausting. It is tough on a marriage, and tough on other children in the family.

People have to be put on a waitlist to gain access to community living. The advice is to put a son or daughter on the waitlist as soon as they become of age because it is so long.

Ms Horner worked through Mr. Roland Thornhill, a then cabinet minister, and senior members of the Department of Community Services. She has been able to obtain the supports to enable Mallory to live in the family home. Mallory has had two staff. Both have been with her for many years. Services are provided in the home, 9:00 to 5:00 every day, and Mallory accesses respite care twice a month outside the home.

Ms Horner had been told that Mallory would not live to be 20, but now she is "healthy as all get out". Mallory is 33, funny and determined. She has cerebral palsy which has impacted her intellectually. She has cerebral cortical blindness. Mallory is not verbal. She does use vocalization, body language, and eye movement to communicate.

Mallory went through school with an incredible group of friends. Kids advocated for her. They insisted, for example, that they would not go on a school trip without her. Now, she is in the community everyday. People know her. She volunteers twice a week at the IWK.

Ms Horner did formulate one plan for the care of Mallory, but the Province said there was not the funding for that kind of model. The Province, however, has recently offered Mallory a place in a small options home. Ms Horner said she was concerned that if she accepted it for Mallory, then Mallory would lose the relationship she has developed with her longtime care workers. Her caregivers could only work as casuals in the placement.

Ms Horner "squawked" and it seems that as a result, the Province has provided the services Mallory needs. It appears to me that she has had meaningful access.

Jenny MacDonald testified on behalf of the Complainants telling the story of her son Sam, her family, and their efforts on his behalf. Mr. MacDonald is disabled. He is now 32 and lives in the basement of the family home. Mr. MacDonald has a developmental disorder known as Smith-Magenis Syndrome. He was born with congenital abnormalities which, over time, required over 20 surgical procedures. He suffered a "SIDS type episode". He is blind in one eye. He has poor hearing and wears two hearing aids. He is prone to infections, particularly of the urinary tract. He is very verbal, but he talks fast and is difficult to understand if one is not used to his manner of talking. He is not shy and is quite capable of seeking out what he needs. He left school at 19. He wants a job. He wants to be on his own and to have independence. He must, however, always be supervised. He may choke on his own food because he puts too much in his mouth. He has a high pain threshold. He will go out in the cold without a coat and hat. He needs meals to be prepared for him.

The family has been looking for a placement for years. Mr. MacDonald was offered a placement at the Riverview Home in Stellarton. He has been there for short times as a respite for his family. Mr. MacDonald likes the staff. They stay in touch with him, but there had been incidents with other residents and he does not want to live there. Mrs. MacDonald would like to see him living with a couple of other people where there is a support person there with them, especially overnight. He and his family think a small options home "would be great", but Mrs. MacDonald has come to believe that such a placement is just not going to happen.

Mrs. MacDonald says her son is frustrated, but she is also worried that because he doesn't like change, he may now or become resistant to moving. She fears that the longer a placement takes, the longer it will be before he can get his life going. He is not learning. His skills are not improving at home.

The Province does provide monthly financial support. Mrs. MacDonald hires people to be with her son, but finding and retaining them is difficult. She now worries about what will happen when she and her husband are simply no longer able to look after him or die.

Mr. MacDonald is an example of a recurrent theme through the hearings - parents, often aging and becoming infirm themselves, caring for grown disabled children in their own homes and looking to the Province for their children's future support.

While, as will be seen from the testimony of the Deputy Minister of Community Services, the Province is indeed increasing supports for such people, the reality for many will be care in some residence outside the family home. Again, depending on the circumstances, I can see that a failure to provide another residence to the disabled person, and leaving them in the care of increasingly disabled parents or other care givers, may constitute a failure to provide meaningful access.

Brenda Hardiman testified for the Complainants. She has a daughter, Michelle Benn, who is now 30, and two other children. Ms Benn had a traumatic birth which left her with cerebral palsy, epilepsy and an organic brain disorder. At two, she began to have seizures and tantrums that were longer and more violent than normal. She now functions at the level of a 12 or 13 year old. Her verbal skills are higher than her cognitive capacity might indicate.

At five, Ms Benn moved to live with her father. That did not work out and the Department of Community Services became involved. An alternate family, whose surname is Robertson, took in Ms Benn. She lived with that family for 10 years and retains a "fantastic" relationship with them. The placement was working well for Ms Benn, but circumstances changed over time. The Roberstons had a young son of their own. They began to look for a separate residence for Ms Benn, one which would allow them to care for her during the day, but return to their own home alone at night. They all approached Community Services who advised that due to a moratorium, new small options homes were not available.

Community Services offered a placement at Quest. Ms Hardiman said she did not know about Quest, but said she had worked in a Regional Rehabilitation Centre and had become adamantly opposed to institutional living. She tried her hardest for Ms Benn not to live at Quest, but was told that if she and Ms Benn did not accept the placement at Quest, then she, Ms Hardiman, would be on her own to look after her daughter and no funding would follow. Ms Hardiman believes DCS staff "ripped" Ms Benn from the Robertsons.

Ms Hardiman describes Quest as stark, a hospital, a warehouse, a jail facility. It is locked down. Staff have to let clients in and out. There were frequent incidents with other clients. Meals would arrive cold, and staff could not reheat. There were programs to teach clients how to live in the community, but Ms Benn had lived in the community for years. Ms Benn would call home crying. They both felt hopeless and at the mercy of DCS.

Ms Benn did act out, and had learned some bad behaviours from other residents.

Although staff at Quest tried to manage her, the staff response was often hands on, dragging Ms Benn to her room or to the TQ room.

Ms Hardiman said Ms Benn was charged criminally with throwing a foam letter and a shoe at a staff member. She went to court many times before the Crown dropped the charge because proceeding was not in the public interest. Ms Benn liked some staff, but not those who laid the charges against her. It was "toxic" for her to be with them.

Ms Hardiman said she focussed on getting Ms Benn out of Quest. She became a more public advocate for Ms Benn and eventually met with the then Premier. That's when things seemed to change. Ms Hardiman had squawked. Ms Benn has been moved to a small options home.

Ms Benn has a good relationship with staff at the small options home. Ms Hardiman says she has never heard Ms Benn complain. Ms Hardiman says Ms Benn is extremely well supported. Ms Hardiman is very, very happy with the service provider, RRSS. Although Ms Benn has worked in the community as a cleaner part-time making minimum wage, she is not working now. Staff, when she started working, went on the bus with her until she got used to it.

Ms Benn's misbehaviours do continue. She will have tantrums. She may become aggressive and the police may have to be called to help stabilize her, but generally small options home staff manage the outbreaks. Ms Benn has never been charged or even removed from the home. Ms Benn, too, has learned. She will catch herself and go to her room or accept a PRN (i.e. a medication when necessary) voluntarily.

Ms Hardiman's evidence suggests to me that placement in a facility such as Quest may be a denial of meaningful access. The evidence also shows, as does the evidence about Ms Livingstone, Mr. Delaney, Ms Benn and Mr. Rector, that people do well in small options homes. Long term placement in Quest or the CTP may constitute a denial or limitation of meaningful access. Again, I do not mean to say that placement in an institution is, by definition, a denial of meaningful access, but rather to say that, depending on the individual and the circumstances, it may be.

Betty Rich testified on behalf of the Province. She said she has five children, one of whom is her son, Joey. Joey is one of twins, now aged 50. He is diagnosed as having cerebral palsy. He never walked on his own. For a while, he did walk with a walker, but does not now. He is totally dependent on supports for bathing and for meals. He lives at Quest with 11 other men who were the last to be moved from Cole Harbour. Others were placed in the community. Ms Rich said Joey was offered a community placement, but she refused because she did not believe it would best serve Joey's needs. She says he needs a controlled setting.

Joey was treated at the Izaak Walton Killam Hospital and then went to the Youth Training Centre in Truro for a few years. She had hoped he could come home to be with her and the family in Cape Breton when the school closed. That did not work, and although she had hoped to avoid this, she had to arrange for him to go to Braemore. Braemore was a facility much like King's but located in Sydney. The facility is now known as the Breton Ability Centre.

Ms Rich choked up as she explained that her son's experience at Braemore was not good. Mr. Rich was in a dorm with eight others. It was noisy. One could not get rest. She knew she had to do something. He had been there a year and was losing any skills he did have. She said there is no comparison between Braemore and what he has now at Quest.

Mr. Rich transferred to the Halifax County Regional Rehabilitation Centre. Mrs. Rich said he had a favourable experience at Cole Harbour. The staff were exceptional and the Centre and its programs were generally well run. He had activities, entertainment, his own room and access to grounds. Ms Rich would spend eight hours at a time there. He lived mostly with the men he still lives with. Some of the Cole Harbour staff stayed with the group when they closed Cole Harbour. She commends those staff.

Ms Rich, who lives in Cape Breton, said she could not think of distance. She could only consider her son's best interests. They had to be served. Joey is now close to the best medical care he can get. He has not had a seizure since the 1990's.

Ms Rich said for a time when Cole Harbour closed, her son had been placed in a unit on the bottom floor of Sunrise Manor, a senior citizens housing project on Gottingen Street in Halifax. Ms Rich described the placement as "disgraceful". She was promised that he would be at Sunrise for 18 months, but as that time came near, no one would discuss a move with her. She tried for six years to have the Province find another placement for him. She says she thought that if she kept kicking the door, then it would open.

The Province eventually placed Joey at Quest. She says that, unlike at Sunrise, Joey has not been put away. At Quest, he is a part of a community with a group of fellows he has lived with for years.

Ms Rich said Joey needs a controlled environment; if he has a bad day, then his behaviour has to be accommodated. There has to be provision made for that. She knows; she lived it. A small options home was very tempting, and she did have to think about it, but she does not think that a small options home would be able to cope. She thinks he could not get better than what he has now. At Quest he has a nice room, good view, a beautiful yard and is safe. "Right here where he is, is what gives me peace" she said. She believes he is now getting the best possible care for his needs.

There has been a meeting about closing Quest. Ms Rich says people at the meeting were not keen on the idea. She says that when you hear the negative comments about places, you begin to second guess yourself, but after 50 years, in her conscience, Quest is the best situation for him. Joey has two brothers here in Halifax. His twin sister is a nurse and lives in Truro. She and her children spend a lot of time at Quest. They all agree Quest works for Joey.

Ms Rich said that it was not for anyone else to decide what is best for Joey and her family. She would not take the liberty of deciding for someone else.

Ms Rich, in my view, shows the complexity of accommodating disabled people. There are not simple answers. Ms Rich is credible. She was highly critical of some placements. It sounds to me that the placement at Sunrise Manor for the extended time after the closure of Cole Harbour was a denial of meaningful access. Her appraisal of Quest, however, for her son and the community of people he has resided with for many years, strikes me as reasonable. The point is that "institutions" for some people in some circumstances may be the appropriate placement and represent meaningful access for them. One cannot, in my view, say that any particular place or "institutions" may not, in and of themselves, be a denial of meaningful access.

Beth MacLean herself testified. She has a speech impediment, but she was vivacious and gave frank, clear, coherent, cogent evidence. She reviewed her own history. She said she did not like it in Truro. She was often locked in her room. Her parents would come visit. The question then was whether she would go back home.

Ms MacLean said she went to King's when she was 14. She did not like it there. Ms MacLean referred to a particular staff member by name. "I pounded the shit out of her", Ms MacLean said.

Ms MacLean said the food was terrible. She did not have her own bedroom. She visited a small options home when she went to a birthday party at one.

She was 29 when she went to Maritime Hall at the Nova Scotia Hospital. Staff told her that she would be at the Hospital for one year. They kept her longer. They moved her to Emerald Hall.

She preferred Maritime Hall. She had more freedom to come and go. Emerald Hall was a "shit hole". She stayed in her room all day watching TV. She got out sometimes. It depended on her behaviour. She told staff she was only supposed to be at the Hospital for one year. They did not listen to her.

Counsel asked where she wanted to live. She said "Out of there". Counsel asked more specifically about a small options home. She agreed that is where she would like to be.

Ms MacLean transferred to the Community Transition Program facility a couple of years ago. She said she liked it better.

Ms MacLean described what happened at the small options home on the Kearney Lake Road. She was there for Christmas. Staff told her to go to bed and she said no. Staff would not let her have yogurt first. She had paid for it and she wanted it. They said no. This "pissed her off". Staff called the police. Two came and they handcuffed her. She was taken back to CTP. She talked to her care coordinator. Ms MacLean said she wanted to live in a small options home. The care coordinator offered Cape Breton or the Quest facility. She said she continues to want to live in a small options home in Halifax or Dartmouth, a home on one level with a bathroom on that floor.

The Evidence of the Clinical Staffs

Joanne Pushie is a social worker who has had extensive experience in many facets of healthcare and, in particular, experience working over many years with and on behalf of those who have dual diagnoses of intellectual disabilities and mental or behavioural disorders.

Ms Pushie served as a Care Coordinator for the County of Halifax, and then in 1996, moved to the same position with the Nova Scotia Department of Community Services. Ms Pushie described the evolution of responsibility for community services. Municipalities in Nova Scotia formerly provided them, including supports to the disabled in small options home and other community residences. The Province subsidized these services and eventually in the mid-1990's took them over completely.

Ms Pushie said that she found services for her clients became more difficult to arrange when the Province took over. She found she did not have as much ability to arrange community-based options. She said that it became known throughout Community Services that those services were limited and more were not being funded.

Later in her career, starting in 2011, Ms Pushie became a member of the Dual Diagnosis Program of the Central District Health Association. She became, in that capacity, familiar with Emerald Hall at the Nova Scotia Hospital.

Joanne Pushie described what it was like to live at Emerald Hall. Other witnesses confirmed her description. I accept it.

Emerald Hall is an acute psychiatric unit forming part of a psychiatric hospital in Dartmouth, the Nova Scotia Hospital. The purpose of Emerald Hall is to provide short term psychiatric treatment to people who are very ill and then, when their illnesses have stabilized, see that they are, depending on their needs and existing supports, discharged to their families, the community, or some care facility.

Emerald Hall is locked. Staff turnover is high and staff rotate on shifts making the building of personal relationships with residents difficult. Residents have to conform to the hospital clock. Meals arrive on hot carts. Even bathing is scheduled. Residents are not able to leave unless a staff or family member can take them out. Excursions in groups are dependent upon the availability of staff members and hospital vehicles. Visitors are welcome, but as one would expect in a hospital, privacy and opportunities for normal social interactions are limited. Psychotic patients are present. They are often noisy and disruptive. Emerald Hall is not a rehabilitation service and so programming is limited. A resident's ability to function may deteriorate over time as tasks are performed for them. They lose even the ability to carry out personal care and soon need staff for even ordinary tasks. Residents lose social skills, their ability to interact socially and their ability to relate to the community. Residents may lose the skills to navigate and live in the community. Residents may not have family and friends in the area. Visiting may involve travel. Residents may lose connection with friends, family and the community at large.

Ms Pushie remembers no one who, in her time, was under any actual legal requirement to be held at Emerald Hall. There was, in law, no restraint upon them leaving. Every client she remembers could simply leave Emerald Hall at any time if they had a home to return to, or if it were possible for them to look after themselves or they had the resources to pay for their own supports. Some clients had been held for over a decade even though their treatment was complete.

Emerald Hall was not functioning as an acute psychiatric unit and had not been for a long time. Emerald Hall, she said, in reality, was a custodial place.

Ms Pushie says she was astounded at the delay in the discharge of those whose illness had stabilized and who were medically ready for discharge. She says that she found that 60-70% of those who had been acutely ill were ready to leave, but still resident in Emerald Hall. Their treatment had been completed, they no longer needed the acute service Emerald Hall was purposed to provide and it was no longer in their best interest to remain there.

Ms Pushie says that she believes the clinical team at Emerald Hall wanted the unit to function as it was designed. Unit staff would meet to identify who was ready to leave, to discuss the options available for them and move to have their placement considered. The staff sought support from lawyers to force movement in the placement process.

Ms Pushie said a good part of her job as a social worker was to advocate on behalf of her clients to the Department of Community Services. She wrote a forceful, even outspoken, letter to the Director of Services for Persons with Disabilities for the Department of Community Services dated March 17, 2011 asking on behalf of the Emerald Hall clinical team for a meeting to devise "an immediate strategy to deal with the placement needs of developmentally disabled persons who remain unnecessarily on Emerald Hall."[74] The letter is of general application and does not refer to anyone in particular. Ms Pushie said, in part:

> Emerald Hall is an 18 bed Provincial Inpatient unit designed to provide acute short term treatment for developmentally disabled persons with a dual disorder.
>
> Due to the absence of placements the unit has become a residential holding center (sic) for people who no longer require acute service. At present seventy per cent of the inpatient population is awaiting community integration through the Department of Community Services with some individuals waiting over a decade for placements. The result of this bottleneck is that acutely ill developmentally persons cannot be admitted for treatment.
>
> The absence of opportunity for community reintegration could be perceived as a form of discrimination towards the most vulnerable

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[74] JEB 8558-59

> citizens of our province. Patients awaiting placement are deserving of the fundamental rights of all citizens. All developmentally disabled persons have the right to live in the least restrictive environment possible, access to meaningful work and leisure activities, family relationships and friendships in the community. These are basic human rights that are being denied due to the absence of appropriate and timely community transition planning and inadequate placement opportunities. Remaining on an acute psychiatric unit for years awaiting placement is at the very least unjust.

Ms Pushie said her letter resulted in a visit to review who was ready to leave, but no plan of action plan followed.

Ms Pushie spoke about the *Joint Review of the Emerald Unit and the Community Outreach Assessment Service (Coast) Nova Scotia Hospital* prepared by Dorothy Griffiths Ph.D. and Chrissoula Stavrakaki and dated April 24-26, 2006. This report is in evidence.[75] Dr. Griffiths also testified. There will be more from her later and a summary of the *Roadmap.*

Ms Pushie referred particularly to the Executive Summary of the *Roadmap* and in particular the following passage:

> The inpatient unit has become a long term holding unit for many of the 19 residents, who no longer need this service. It was estimated that approximately 50% of the population of this program are being hospitalized without justification and some are being held against their wishes in a locked psychiatric unit, despite a lack of grounds on which to currently retain them. The individuals are being confined without justification because no community options are available for them within the system. There is need for a variety of community options to support specific needs. This would include congregate living settings for individuals with significant behavioural challenges. Consequently, these individuals are living in a more restrictive environmental setting than is needed, appropriate, or advisable, because of a moratorium on placement development in the Department of Community Services. This moratorium has apparently been ongoing since 1999 under a Revitalization Initiative. The delay of discharge at this time appears to be strangling the current unit in its attempt to serve the existing population and verging on the

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[75] JEB 3714

> violation of Rights and Freedoms of the individuals long time destined for release.

Ms Pushie says the passage expressed exactly how she felt.

It is important, I think, to recognize the date of Dr. Griffith's report - April 24-26, 2006. The Province was clearly told then, if not earlier, about the misplacement of disabled people in Emerald Hall.

Ms Pushie also worked as a clinical social worker at the East Coast Forensic Psychiatric Hospital for a year. The work was often a matter of looking for funding and placements for people under "conditional discharges". People on conditional discharges are seeking to leave the hospital to live full-time in the community. Her clients in the forensic system would be no different than other mentally ill people she worked with. Her clients would be put on a waitlist for a community option or a facility. Forensic patients did have some priority for placement, but placement still remained difficult to obtain.

Ms Pushie has known Beth MacLean since 2011 and remains a friend to this day. They are in touch with each other once a month or so. Ms Pushie said Ms MacLean had complained to her about life at King's. Ms MacLean did not like it. She lacked control over her own life. She needed permission, for example, to leave the facility. She did not like being held to a schedule, having to share a bedroom with two others, and to share a community bathroom. She did have a job at King's folding towels and she had some opportunity to go to the corner store. She did not, however, receive any education. Ms MacLean has a speech impediment, but she did not receive any help with that either.

Ms Pushie reviewed Ms MacLean's unsuccessful placement at the Kearney Lake Road small options home. Ms Pushie said she had not known the placement was coming. She visited the home and became quite concerned about the premises and its location. She said she became worried the placement might fail.

The Kearney Lake home is elevated with a lot of steps. Ms MacLean has difficulty walking and wanted a home on one level. The home is located on a hillside at a busy intersection. Ms Pushie said she found the home rather small and not cheerfully decorated. Ms MacLean did have her own room. The home had two permanent staff and one casual. The placement only lasted three weeks before Ms MacLean returned to CTP.

Ms Pushie says Ms MacLean still wants to live in a small options home and eventually, if possible, to move to a supervised apartment. Ms Pushie says she knows that Ms MacLean needs supports.

Dr. Mutiat Sulyman MD, DCP, FRCPC is a psychiatrist and heads up the team on Emerald Hall. She began to work on Emerald Hall in July, 2012. As already noted, Emerald Hall is designed for those who have both severe and profound intellectual disabilities and severe psychiatric issues. Treatment of patients such as these are her specialty. The unit is designed for people who are acutely ill coming in for a short term treatment. Emerald Hall is locked at all times. Its capacity, when she started, was 15 beds. The unit had been larger, but the number has been reduced.

Patients are often non-verbal. One must rely on others to give their history and, in any event, staff need an extended observation period to determine appropriate responses. Usually staff need a period of three to six months in Emerald Hall to assess and treat an Emerald Hall patient.

Dr. Sulyman said that if the patient comes from their parent's home, then they are more likely to return, but if they come from a residential service, then oftentimes they are not able to return to the residence. Emerald Hall, she says, has become a holding unit. Patients are often stuck because they have no place to go. Staff have recently been working very hard to keep people in the community out of fear that they will be stuck once admitted. Their goal has been to prevent admissions as much as possible.

Dr. Sulyman said that of the nine current patients, probably six or seven are medically ready to leave. Some have been waiting for years. Staff meet every week to discuss the patients ready for discharge. Recently, there have been a number of discharges to the CTC in Sackville. Staff hear from the Community Services care co-ordinators at the weekly meetings that lack of community capacity keeps patients in Emerald Hall. One patient is discussed every six weeks. Staff hear of general waitlists of five or even 10 years. Staff are told, however, that their patients are at the top of the waitlist.

Dr. Sulyman said that holding patients at Emerald Hall, after they have been treated for their acute condition, has an impact on them. Emerald Hall does not prepare people for community living. Everything at Emerald Hall is programmed. Patients have no say. Long term patients become withdrawn, apathetic, and more dependent on the staff to the point where they do not want to leave to live in the community. Long term patients tend to keep having relapses, and eventually assume the sick role. Patients lose their independence, their sense of responsibility, their confidence, their sense of self, and their self-esteem. The patients get little exercise and then their physical condition deteriorates. They engage in power struggles with staff. They withdraw and become more passive or respond to staff with aggression and self-harm. That is the way they have learned to cope.

Dr. Sulyman said that, in her view, everyone can live in the community if provided with the right and appropriate supports. There will always be a need for a place like Emerald Hall because there are times when people will need treatment in a hospital. Hospitals are where you go when you are ill. Then you leave when you are well again.

Counsel asked Dr. Sulyman about aggressive behaviour. She explained that there are aggressive patients, but for those with intellectual disabilities, their aggression can mean so many things. Staff always try to determine the function of the behaviour, to learn why they behave the way they do. In someone who is non-verbal, it is staff's job to carry out an investigation to determine the root cause. One must understand the context of the behaviour. A patient may have developed maladaptive behaviours, including aggression, to obtain what they need. Sometimes staff may create the conditions that lead to the aggression. One has to analyse the antecedents to a misbehaviour. People with autism, for example, are sometimes sensitive to light and to colour and may be provoked by it. It is unrealistic, Dr. Sulyman said, to expect that people with intellectual disabilities and autism will not act out. They will have learned maladaptive behaviours to communicate their needs. Aggression serves a function for the patient. Staffs have to teach them other means of communicating.

Dr. Sulyman said Sheila Livingstone was her patient on Emerald Hall when she began working there. Ms Livingstone, she says, was a target of other patients because she was older and was usually just sitting in a common area.

Dr. Sulyman said her predecessor, Dr. Mary Tomlinson, medically discharged Ms Livingstone on December 14, 2007. Dr. Sulyman said Ms Livingstone suffered from dementia. She would have been better off in a calm, quiet environment. A nursing home would have been a better place given her age and diagnosis. She was never dangerous. She would scratch or pinch when staff supported her in the activities of daily living, but she does not recall anyone being afraid of her. Sometimes she would become acutely confused, on top of her chronic confusion, which could lead to her being angry, but you would expect that in a nursing home or anywhere else. It is a normal aspect of the dementing process.

Dr. Sulyman spoke of Joey Delaney. She said that, according to the records, the issues which had led to his admission had been addressed by July of 2010. She does not diagnose him as having a mood disorder. She says that he has been psychiatrically stable throughout her experience with him.

Dr. Sulyman said it was, and is, the opinion of the team that Mr. Delaney should have been, and should be, returned to live in the community. He was placed at the Quest facility for two years. Quest, even though he had no psychiatric diagnosis, discharged him back to Emerald Hall in January, 2017 because he was very, very loud. He was disturbing other residents. Dr. Sulyman says that Mr. Delaney does not or cannot talk. When Mr. Delaney is loud, he is trying to communicate something. Generally, she believes his noise is related to his bowel difficulties.

Mr. Delaney was given some tests after his return to Emerald Hall. The suggestion came back that he was constipated and a change in laxative was recommended. This was effective. He was then able to defecate by himself. Staff now only use the bowel tube as a PRN, i.e. when necessary. Staff knows that his bowels affect his behaviour. For the most part now, he is happy. Once he is feeling well, with room to pace and the objects to occupy him, then he is content. The team continues to advocate for his return to the community.

Counsel asked Dr. Sulyman about Dr. Griffiths' report. She said she has read it. She said much of the report sounded like the recommendations that she had made for evidence based psychiatry to her own bosses. Some recommendations about hiring a "behavioural analyst", and about the education of staff have been implemented. Practices have improved. Understanding the reasons why a patient will present with aggression has evolved over the past 20 years and continues to evolve. One must conduct a comprehensive assessment to get at the root causes of patient behaviour. A patient may, for example, be depressed and acting out simply because they do not want to be bothered.

Dr. Sulyman said that she takes with a grain of salt any report that a patient is aggressive or violent. She would want to understand exactly what it is that the report is actually talking about.

Krista Spence now works at Connections Halifax, a community service operating to support those with mental illness, but she worked at Emerald Hall from March 2011 until July 2013. She said she was hired to facilitate more community access for multi-challenged patients, but the work was not what she expected it to be. She found out that Emerald Hall was not set up to facilitate community access. Community access was not a priority. Patients in crisis, limited staffing and limits on resources all interfered. The result was the regular disappointment of patients who would have been expecting an outing. Patients faced years of waiting after medical discharge. Patients' social skills would deteriorate. Their self-confidence would decline. Their conversation skills would decline.

Ms Spence said she worked with Beth MacLean. She found Ms MacLean to be warm and very gregarious. Ms MacLean, she said, needed and looked for social interaction. She really liked being around people. She loved to talk.

Ms MacLean was probably the highest functioning patient on Emerald Hall, but would get out of the unit and the hospital maybe once a week. Sometimes she would not get out at all for two weeks or even longer. Generally, she took cancellations well, but sometimes would express frustration. Ms MacLean would yell and swear and has thrown objects, but Ms Spence said she was not an aggressive person. In terms of the unit, Ms Spence did not see her as any threat. Some patients' aggression was unpredictable, but that was not so of Ms MacLean. Ms MacLean was the least of her worries. Ms MacLean was also someone whom one could de-escalate. In any event, Ms MacLean was not physically able. Ms Spence said she was aware Ms MacLean was seeking a placement in the community, although Ms MacLean expressed it more as a wish to leave Emerald Hall.

Ms Spence said she found Sheila Livingstone to be a classic senior citizen. Ms Livingstone was pretty quiet. She spent a lot of her time sitting in her chair near the nursing station. She depended on the rapport with staff. She was not keen on going out. She could be grumpy. She was not in great health and she was difficult to understand. She was not physically capable of being aggressive. She might try to hit or scratch when upset, but Ms Spence said that this was more about saying "Stay away from me".

Counsel asked whether Ms Livingstone was herself a victim of assaults. Ms Spence said she had seen other patients hit her. Ms Livingstone would sit in the centre of the unit and it was not uncommon for an aggressive patient to hit her.

Ms Spence said she left her position at Emerald Hall because her interest was in helping people be better. She had anticipated that the job would be an opportunity to do that. It was not. It was heartbreaking, she said, to see people held there for years. She said she found it hard to work where people would decline. Staff themselves would, over time, be affected. Staff felt dis-empowered and were not happy.

The Service Providers - Wexler, Brennan, McConnell, Wicks

Marty Wexler, MSW RSW is a social worker by profession, but drifted into the operation of homes in the community for the disabled. He has been the President of Community Living Services Inc. since 1986. Mr. Wexler was also the Chair of the Claimant Coalition and signed the complaint initiating this *Human Rights Act* process on its behalf.

Mr. Wexler said Community Living Services will provide the residential services if government provides the necessary resources. He believes that anyone may be accommodated, regardless of disability. Mr. Wexler said one adapts to the needs of disabled aggressive people by learning what causes them to act out, by learning how to manage their environment in order to avoid provocation or triggers and how to defuse a situation. One works with the individual resident.

Mr. Wexler said he did not know any of the individual Complainants, but he said that he has read about them and, in his view, they are representative of many others his service accommodates and of many others seeking placement. He said that with proper planning, any of the three could be accepted as residents by his organization. Not every person is suitable for every residence. Some people will not be a good fit to live with some other residents and an alternative would have to be found, but in general, anyone can be accommodated.

Mr. Wexler explained his perspective on the history of the development of community housing in Nova Scotia. He said his organization had founded their homes when municipalities were still responsible for administering community services. Halifax could set up new small option homes, but Halifax was responsible for only 25% of the costs with the Province paying the balance. Halifax found the provision of the service to be relatively cheap. When the Province took over community services, however, the creation of new small options homes came to a halt. Initially, he said, it was thought that the Province was simply reviewing the program, but he says that 30 years later there were still no new small options homes being created. A backlog of people on a waitlist developed. If someone moved out of an existing small options home, then the space would be filled from the waitlist, but there were no new spaces provided. He said those who "squawked" long enough and loud enough were the ones to be placed.

Mr. Wexler commented on life in hospitals or other large institutions. He said one almost has to live in one to understand. You give up so much. You need permission to get toothpaste. You must follow rules and be better than good to fulfill them. He compared it to being in jail with no end of time. Staff congregate in the office and do not mix on the floor. People are left lying around. Staff do what they can, but there is only so much one can do in that environment beyond keeping the place clean, and being sure people are well fed. Program staff are the first to be cut or have their hours reduced.

Mr. Wexler explained some of the history of the Disability Rights Coalition. It came about after the Kendrick Report.[76] A large number of groups coalesced around the idea that this report recommended the proper direction. Everyone was excited by it. People were galvanized by the Report's dynamic, flexible and creative person-centred approach and the recommendation to design supports around the individual, rather than fitting them into categories. Advocates for the disabled had also been excited when the Province took over community services, but then everything stopped. Then the advocates thought things would change after the Kendrick Report, but they did not and the Coalition came together.

Mr. Wexler explained how one deals with those who have behavioural problems and are aggressive. One has to learn how to recognize when someone is about to strike out, and how to work that through with the client. One learns on the basis of the experience how to defuse situations and to manage difficult behaviour. Acting out is mostly self-inflicted and self-destructive.

Mr. Wexler said he found it hard to say who he could not support and not build a plan around. If he could find enough staff to support the client, then he could make a plan. Money is the difficulty. It is very expensive to provide a client with multiple staff.

A small options home is not just a place to hang your hat and sleep. If that were the case, a client might as well be inside an institution. One has to formulate a plan and provide the services necessary to truly integrate the client into the community.

Carol Ann Brennan testified for the Complainants. She is currently the Chief Executive Officer of the Regional Residential Services Society. Notably, the Province seconded her to work on the *Roadmap* project.

Ms Brennan explained that RRSS accommodates people with a primary diagnosis of intellectual disability who are at least 18 years old. Many of those with intellectual disabilities also have mental illnesses. RRSS is the largest service provider of this kind and currently supports approximately 170 people. All funding comes from government.

RRSS anticipates that its clients will need supports in all aspects of their lives. The homes are in neighbourhoods and accommodate three or four clients. RRSS

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[76] *An Independent Evaluation of the Nova Scotia Community Based Options Community Residential Service System, Commissioned by Community Services, dated January 29, 2001, prepared by Michael J. Kendrick Phd., and generally referred to as the "Kendrick Report".*

tries to place clients in their own neighbourhoods, near public transportation. Many will participate in programs outside the home. All small options homes are rented. RRSS owns some group homes. RRSS residences are in urban Halifax. More and more of them now require retrofitting including the installation of sprinkler systems. Rents consume only 7.5% of the cost. Salaries for about 105 on the front line and about 18 administrative staff consume almost all the rest. Only one client is self-funded and their trust fund will be depleted shortly. Vacancies for new clients have, in recent decades, only arisen through clients moving to nursing homes or dying.

Ms Brennan confirmed that RRSS could have accommodated Mr. Delaney and Ms Livingstone once their medical conditions had stabilized. She knew them both because they had been residents of RRSS homes.

Ms Brennan also linked the curtailment of new small options homes to the shift from municipal to provincial operation. There was a large increase in funding, but the money went to increases in pay for staff. Staffing is a challenge. More and more do not want to work back shifts. Many are students and remain employees for only three or four years.

<u>Bev Wicks</u> testified on behalf of the Complainants. Ms Wicks is a now a consultant in the fields of disability and human service, but from 1979-2006 she was the Executive Director of RRSS. She explained some of the history. She said that when the Province took over the provision of services, administration became more sophisticated with accountants, more workers, negotiations with unions and so on.

In the beginning, group homes where thought of positively, but it became apparent listening to families and residents, that group homes were not what worked best nor were they the goal to which everyone needed to be headed. Municipalities began to create small options homes. The 80's were "the golden age of services". The golden age, however, came to an end around 1995 and "the dark ages began". What had changed was the cost-sharing arrangement. She understands the Canada Assistance Plan (CAP) of the Federal government changed from a percentage of spending to a block grant. Costs were no longer shared. The Province bore them all. No one was told of a "moratorium", but a lot of confusion and uncertainty developed and no more facilities were forthcoming. Regional Residential Rehabilitation Services' expansion came to a halt. Waitlists began to develop. The whole system became crisis driven. This was devastating to people who were living in hope that the system could respond to their needs.

Ms Wicks said she participated in the creation of the Kendrick Report. She described the work as being a search for best practices. Everyone involved in the

Kendrick Report process was of the same view about best practices, but actual practice was totally at odds with what was actually being done. There was the hugest possible gap.

Suzanne McConnell is a Director with the Regional Residential Services Society. She has known Joey Delaney since 2007. He was then a resident of 24 Skeena, one of three, and she had supervision of that residence. Mr. Delaney had epilepsy. Staff had some training on how to deal with it. She described him as being a lot of fun. He had two house mates. He went to Dartmouth Adult Services Centre from Monday to Friday, travelling with others and an escort. When he was home, he would engage in puzzles and his phone books. He would get his shoes if he wanted to go out. He would use gestures for the most part, but he had a few words. He was pretty good about getting his point across, especially if it was a no.

Counsel asked about a reputation for being aggressive. Ms McConnell said Mr. Delaney would scream if he was not feeling well or agitated. If he was agitated and staff had to get close, then sometimes he would strike out. He would scream, act out, bite, and strike if uncomfortable due to bowel issues. He would squeal and do somersaults if he was happy.

Mr. Delaney ran into health difficulties in 2009. He was eventually placed in Emerald Hall and lost his place on Skeena Street. Ms McConnell said that he had become challenging at home and that he was increasingly unsafe. Ms McConnell said that RRSS remained committed to have him come home if he could, but she never heard from anyone about him again. She was never told he had been medically discharged. She acknowledged that his needs were high, but she said RSSS, with the proper planning, could have adapted a residence to accommodate him.

The Experts

I will review the evidence of each one who testified and their corresponding written statements.

James Fagan is the Director of Residential Services at RRSS. Mr. Fagan prepared three reports in which he says that RRSS would have, if the Province provided the proper supports, accepted Mr. Delaney, Ms MacLean and Ms Livingstone into a small options operated by them.

Mr. Fagan spoke of RRSS supporting people with intellectual disabilities to obtain their goals. RRSS' commitment is life long, that is to say, the expectation is that an individual would stay in the home until they die or can no longer live in the facility they provide. Of the approximately 300 clients RRSS has received over the years, only two have moved out for other reasons. RRSS has 64 facilities; eight group homes, 38 small options, and 16 supported apartments. Eighteen people live in supported apartments. There are two apartments in which two residents live.

Approximately 35 of their clients have a dual diagnosis, that is to say, they have, for example, the diagnosis of a mental illness and an intellectual disability. Some of these cases are extremely challenging, but RRSS has received them just the same and the individuals have lived with RRSS for decades.

Only two or three clients have paid their own way. One has been the beneficiary of an estate which will soon be depleted and then that person will be publicly supported as well. I, myself, noted on a visit to a small options home that one resident came from a prominent and wealthy family. I inquired of Mr. Fagan who had paid for her support. Mr. Fagan said she had always been publicly supported as a resident with RRSS. He agreed that sustaining someone in a small options home is beyond the means of almost every family.

Mr. Fagan explained that when he started there were larger group homes, but through the 1980's there was a growing awareness that group homes were not the best solution. RRSS decided to provide small options homes. RRSS opened 30 small option homes between 1986 and 1995. Then the Department of Community Services put a moratorium in place. RRSS has only opened two homes since. RRSS has advocated for more homes, but the moratorium has remained.

Mr. Fagan said RRSS wants the people they support to have the opportunities to choose the lives they want to lead and to be as integrated into the community as possible. Typically, people are assigned to a particular house and usually will stay there indefinitely. The hope is that staff will come to know the residents well. Some of their staff have been in a home for decades and have deep relationships with the residents.

Mr. Fagan said RRSS wants to be sure that the person is a good fit for a particular facility. For example, some homes are not accessible for a physically disabled person, and so would not be suitable for them. There is little turnover in residents and it may be five years for someone on a waitlist before, in their current facilities, a vacancy appears.

Mr. Fagan said that an application had been made on behalf of Beth MacLean. A bed opened up in a particular small options home after a resident's death. Mr.

Fagan said that upon review, RRSS decided that Ms MacLean would not be a fit for this home and so declined to accept her. The others in the home were high demand clients, and RRSS did not believe it could integrate Ms MacLean. It was not a case of RRSS being unable to support her, but rather that RRSS could not support her in that setting at that time.

Mr. Fagan said that he found in the reports a consistency in Ms MacLean's behaviour. He found that Ms MacLean did not respond well to being told what to do or to restrictions. Either might provoke outbursts. All in all, he found Ms MacLean to be reminiscent of others RRSS had accommodated. RRSS had residents who were more challenging.

Ms MacLean, in late 2016, was placed in a home on the Kearney Lake Road. This placement quickly failed because of an incident which led to the police being called and Ms MacLean being handcuffed. Ms MacLean was returned to live at the CTP facility where she resides as of the time of this writing.

Mr. Fagan said he felt opportunities had been missed to de-escalate Ms MacLean's outburst. Such incidents were to be expected with Beth. Denying her the opportunity to eat her own yoghurt should have been known to be a provocation. One could not have been surprised at her response. In any event, no one was hurt and no irreparable harm done to relationships. At RRSS, even if 911 had to be called, the person would have come back to the house after things had settled down. Mr. Fagan says that such an incident would not change RRSS's decision. Ms MacLean would continue, he said, to be an acceptable resident. RRSS now has an agreement with Province to provide a small options home for Ms MacLean and hopes to soon accommodate her.

Counsel referred Mr. Fagan to the *Roadmap*, where the following proposition is stated; "All people can be supported to live in the community..." This, Mr. Fagan said, is very consistent with RRSS' philosophy.

Mr. Fagan's testimony is supplemented by three written reports which he wrote and which were received into evidence. He usefully, in his report on Ms MacLean,[77] condenses Ms MacLean's institutional history:

> Beth has lived in institutions since she was 12 years old. In 1983, Beth was placed briefly at Bonnie Lea Farm. Later in 1983 (until 1985) Beth attended the Nova Scotia Youth Training Centre. From

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[77] Exhibit 27

> November 1985 to January 1986 Beth lived at the Nova Scotia Hospital, Youth Treatment Wing. In 1986, Beth was admitted to Kings Regional Rehabilitation Center (KRRC) where she stayed until October 2000. Beth was charged and convicted after two separate incidents at KRRC, one in 1995, the other in the summer of 2000. Subsequent probation and breach of probation rulings in the fall of 2000 are documented prior to her admission to the Nova Scotia Hospital (NSH) in October, 2000.
>
> Her first placement at NSH was on Maritime Hall (MH). She moved to Emerald Hall (EH) in July 2007 where she lived until 2016. In June 2016, she moved to the Community Transition Program (CTP) in Lower Sackville. Beth was briefly placed (December 2016-January 2017) in a home with Metro Community Living (MCL). When the MCL placement broke down, Beth was readmitted to CTP in January 2017 where she lives presently.

Mr. Fagan says in his written report that, in his view, Ms MacLean "could have been successfully integrated into a group home or small option setting during the same time she was living at KRRC" and thereafter. He estimates the cost of care at an RRSS facility to fall within the range of $463.50 to $841.86 per day depending on the number of staff required from time to time.

Mr. Fagan said he knew Sheila Livingstone well. She had been a resident with RRSS for over 18 years. Ms Livingstone, during that time, had been hospitalized for short periods and then returned to her home. He said RRSS has provided care to those whose condition was very similar to Ms Livingstone. The reports about her are consistent. Any variability would be within their experience. There would be admissions to hospital, but these should not result in the loss of her home. He said that, in his view, RRSS could have supported her from as early as 2005.

Mr. Fagan said that RRSS would have hoped to have been given the opportunity to accommodate Ms Livingstone again after her medical issues were resolved. Mr. Fagan said the Department of Community Services never did reach out to RRSS to take her back after she lost her bed.

In his written report,[78] Mr. Fagan summarizes Ms Livingstone's institutional history and her complex diagnoses:

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[78] Exhibit 29

> Sheila was a resident of RRSS on two separate occasions. First, she lived with RRSS from December 1976 to March 1977. She returned to RRSS in May 1986 and remained with us until September 2004 (more than 18 years).
>
> In between, she lived at the Abbie J. Lane Hosptial (1977-1982) and then the Cole Harbour Regional Rehabilitation Center (1982-1986).
>
> Sheila was discharged from RRSS and lived at Emerald Hall at the Nova Scotia Hospital from 2004 until January 2014. She was transferred to Harbourside Lodge in Yarmouth (her discharge and Emerald Hall and admission to Harbourside Lodge took place in January 2014)
>
> After an extended illness, Sheila died in October 2016.

Mr. Fagan described Ms Livingstone's diagnoses as follows:

> When last seen in December 2015, Sheila's primary diagnoses included: schizophrenia, seizure disorder, mental retardation (intellectual disability), speech impairment, vascular dementia and behaviour problems.
>
> Secondary health diagnoses were cancer, hypertension, heart failure, atrial flutter, congestive heart failure, blepharitis and aspiration pneumonia. It should be stated that there have been a variety of diagnoses over the years. The above noted were current as of 2015.

Mr. Fagan says in his written report that no information came to light in his reading of her files that was significantly different from RRSS' previous knowledge of Sheila. He says that "Sheila always required periods of time where significant support either medically or behaviourally was necessary." He concludes that RRSS could have supported Ms Livingstone from 2004 through 2016. The estimated costs would range between $463.00 and $515.61 per day depending on the number of staff required.

Mr. Fagan said he was also familiar with Joey Delaney from the time Mr. Delaney resided at RRSS' Skeena Street small options home. Mr. Fagan says RRSS always made it clear that it wanted Mr. Delaney back when his condition stabilized, but RRSS was not contacted when Mr. Delaney was medically discharged. RRSS, he said, would have been open to setting up a new facility for Mr. Delaney. He could foresee a home with one or two others. Mr. Delaney would have to have some separation within the home because Mr. Delaney would be expected to continue to scream. An accommodation of his screaming would have to be made. Mr. Fagen noted that he had seen him do somersaults again while at Emerald Hall. This was a sign that Mr. Delaney was feeling better.

Mr. Fagan, in his written report,[79] summarized Mr. Delaney's institutional history as follows:

> Joey was a resident of RRSS for nearly 14 years; from August 1996, following a move from the Dartmouth Children's Training Centre, until his discharge to the Nova Scotia Hospital (Emerald Hall) in July 2010. Joey lived at Emerald Hall until March 2015 when he moved to Quest in March 2015 before being readmitted to Emerald Hall in January 2017.

In his report, Mr. Fagan speaks of Mr. Delaney's screaming and yelling. He says that Mr. Delaney's screaming "could be virtually constant over the course of a day" and "often there was nothing that seemed to mitigate either the vocalizations or what might have been distressing for Joe." Mr. Delaney's readmission to Emerald Hall resulted from the "inability of Quest to continue to support Joe with ongoing GI issues with accompanying chronic high levels of loud vocalizations."

Mr. Fagan's report says that, notwithstanding the above, RRSS is able to provide care for Mr. Delaney in the community. As for the past, Mr. Fagan says that while it was to be expected that there would be hospitalizations, these would not necessarily have precluded him from living in a small options home. Mr. Fagan believes that despite the unusual nature of the gastric distress and the interventions that distress required, Mr. Delaney "would have been able to return to an appropriate location within RRSS in late 2011, perhaps earlier." He estimates the cost of care for Mr. Delaney at an RRSS facility to fall, and thereafter vary, within the range of $608.97 to $847.34 per day depending on the number of staff required from time to time.

<u>Dr. Michael Bach</u> is a Phd. in sociology and equity studies and is currently the Managing Director of the Institute for Research and Development on Inclusion and Society. "IRIS" is essentially a research arm of the Canadian Association for Community Living. He testified and provided a written report.[80]

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[79] Exhibit 28

[80] Exhibit 12

Dr. Bach advocates what he describes as "a social and human rights" approach to disability as a third tier in the evolution of how a society provides supports for its disabled. This third tier has evolved as Nova Scotia, and other jurisdictions, came to understand that the disabled should not in general be supported in larger facilities, but rather be enabled to live normal lives among the rest of us. This understanding is common among the parties, but Dr. Bach advances a rights-based policy based on the idea that the disabled have the right, citing section 19 of the *United Nations Convention on the Rights of the Persons with Disabilities,* "to live in the community with choices equal to others." Dr. Bach would have no "institutions" and have the Province grant each person with disabilities a block of funding to purchase their own supports. In his view, no one should be where they do not want to be. He speaks of an "entitlement to the supports needed to meet their disability related needs." Dr. Bach criticizes any funding of the place rather than the person, and any funding of the person at a place at per diem rates.

An arrangement that "denies choice and control to a person about their place of residence" becomes an institution. He cites the *UN Committee on the Rights of Persons with Disabilities* in support of the proposition that "institutions are arrangements that deny autonomy and choice in supports and where and how one will live".[81]

Dr. Bach acknowledges that there are:

> ...some excellent examples of person-centered support approaches in Nova Scotia, meeting the needs of people with complex disabilities in ways that enable their citizenship and community inclusion[82] ...

But, he says:

> Far too many individuals currently supported by the Disability Supports Program and the growing numbers on waitlists, daily have their rights to citizenship and inclusion denied.[83]

He refers to:

> ...unmet need, social isolation, violent victimization, preventable

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[81] Ibid.

[82] Ibid.

[83] Ibid.

> deaths, entrenched poverty, homelessness, lack of opportunity and a perpetuating stigma[84]...

The thrust of Dr. Bach's evidence seems to be that I should accept his views and tell the Province, as the Complainant Coalition urges at paragraph 171 of the complaint, that the denial:

> ...of supportive housing and other services in the community is a failure to accommodate the needs of persons with disabilities and violates the protections in sections[85] ...

Dr. Bach also makes the point that categorizing people according to a formula of need does not necessarily lead to the best individualized supports. Individuals' needs will differ according to a host of factors, and their needs have to be addressed accordingly. He links what he calls a categorical approach to the institutional approach.

He concludes that the system in Nova Scotia is broken.

Dorothy Griffiths C.M., O.Ont. Phd. is a Professor in the Department of Child and Youth Studies at Brock University in St. Catherine's, Ontario. She and Chrissoula Stavrakaki prepared and submitted the report on Emerald Hall to the Province in April, 2006 described above.

Dr. Griffiths said she and her colleague had been retained out of a major concern that a number of individuals were not moving forward into the community. Emerald Hall had been set up to move people to the community, but found that it could not. Nor could the unit take anyone else in.

More generally, and as to behaviour, Dr. Griffiths said an individual may be in an environment, a social environment which explains why they are acting in the way they do. Or they may not have the social tools to deal with a situation. One has to look at everything to see why a person is acting the way they do and why they are in distress. In the past, individuals were treated profession by profession; now they are treated by a team. The field has adopted this as the standard of practice. No one profession can, in particular, effectively serve someone who has a dual diagnosis of mental illness and intellectual disability.

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[84] Ibid.

[85] Ibid.

Dr. Griffiths said it is now known that in larger settings, patients do not relate to staff in the same way as they should. When you have five or more patients, then staff spend more time with each other. Smaller settings encourage staff-patient interaction.

Dr. Griffiths said one should plan with the individual, and their supports, to determine what the individual needs to succeed. Putting someone in a place simply because there is a vacancy may not work. If the placement is not designed for them, if it does not match their needs, then they may relapse. When one plans effectively based on patient needs, it is more likely that goals will be attained and the resources secured to attain future goals.

People do better in the community. People will retain learning more in a natural environment where they can exercise the skills they are taught. Research since the 1970's, but especially since the 1980's, has shown that there is a function to acting out. An individual may be trying to avoid an activity for some reason, or they may have a specific need. Acting out is often a matter of communication.

Dr. Griffiths said upwards of a third of intellectually disabled people may experience a mental health problem as well. Intellectually disabled people also suffer a high rate of abuse and neglect. Placement in an inappropriate environment can provoke difficult behaviour as can neglect or abuse.

The teaching of community life skills for those who will remain in an institution indefinitely makes for a deep hopelessness, not only among those being treated, but also among the staff dedicated to the teaching.

Choices and taking control of one's own life are important. People need autonomy, and that autonomy is important to behaviour.

Louise Bradley and Dr. Scott Theriault

I find it convenient to review their evidence together. Ms Bradley is currently the President and Chief Executive Officer of the Mental Health Commission of Canada and has been since April, 2010. From 1996 until 2006, however, she was part of the administration of mental health services in Nova Scotia, finishing as Health Services Director. Her responsibilities included the administration of forensic psychiatric services for those found not criminally responsible (NCR) or found unfit to stand trial on account of mental disorder under the *Criminal Code* of Canada. Dr. Theriault is currently Clinical Director for Mental Health and Addictions Programs for the Nova Scotia Health Authority, but he has also worked as a forensic psychiatrist at the East Coast Forensic Psychiatric Hospital since 1998.

Ms Bradley and Dr. Theriault spoke of the difficulty the Nova Scotia forensic psychiatric services has had placing its patients into community housing.[86]
In a nutshell, the difficulty has been the same as the difficulty facing other disabled people in Nova Scotia over many years in accessing community living. Ms Bradley testified that NCR's are dually stigmatized as being both "mad" and "bad". In fact, she says, the vast majority of NCR's have little criminal history.

Ms Bradley and Dr. Theriault explained that a Board of Review is established under the *Criminal Code*. This Board regularly reviews the status of each NCR and determines, in general, whether an individual should be detained as an inpatient, given a conditional discharge or discharged absolutely. A conditional discharge means that the individual may live in the community while retaining their connection with the staff of the forensic hospital. He or she will be required to keep the peace and be of good behaviour, to report to staff as required, to maintain their mental health and so on. The connection enables staff to assist them to maintain their recovery and to keep the public safe.

Some will be able and socially competent enough to return to a normal life on their own. Some will be able to return to their families. Many NCR's, however, like other disabled people being discussed in these hearings, require significant supports to live successfully in the community.

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[86] I feel obliged to explain my own experience on the Board of Review and the court application in this proceeding which arose out of it. My experience extends back to 1980 and runs with some lapses through to December, 2018. Everyone under the jurisdiction of the Board of Review would fit the definition of disabled under the *Human Rights Act*. While the criminal jurisdiction distinguishes the staff and Board work from the civil system for the care of the mentally ill, forensic staff do rely on the cooperation of the Department of Community Services to reintegrate their patients in the same way as has been described for staffs at Emerald Hall and other facilities.

In the spring of 2000, the staff of the East Coast Forensic Psychiatric Hospital who advise the Board, told the Board at a hearing that the Province was not creating more community housing for the mentally ill and the impact this was having on their ability to reintegrate the patients to whom the Board had granted conditional discharges. I knew the then Minister of Community Services. The Minister had in fact briefly served on the old Board of Review. I wrote him a letter as a private individual saying that I found what I referred to as an "embargo" unfortunate and received a reply.

The Province discovered that correspondence in preparation of the voluminous materials which became evidence. The Province applied to have me recuse myself from this proceeding submitting that the correspondence and indirectly, I suppose, my service on the Board of Review, would provoke a reasonable apprehension of bias in an objective person. I dismissed the application in July, 2016. The Province appealed my decision to the Appeal Division of the Supreme Court of Nova Scotia. The court's decision dismissing the appeal is found at *Nova Scotia (Attorney General) v. MacLean* 2017 NSCA 24.

Ms Bradley testified that during her tenure in Nova Scotia, forensic staff had great difficulty in finding a supportive living placement in the community for NCR's who had been granted conditional discharges. Dr. Scott Theriault, who testified immediately after Ms Bradley, said civil servants engaged in the forensic psychiatric service had, to no avail, advocated for access to community living for these conditionally discharged patients. Both referred to their own Memorandum to the "Members of the Renewal Committee" dated October 24, 2003. In their introduction, they say:

> ...As indicated during that presentation, we feel quite strongly that the patients for whom we care and serve within the Forensic Mental Health system face tremendous challenges in coping with serious and chronic mental disorders in not having access to reasonable and supportive community living. This seriously jeopardizes their chances of rehabilitation and hence unnecessarily confining them to a custodial environment.
>
> We therefore offer the following comments by way of explaining the serious legal and ethical breach of trust to our patients along with recommendations, which would help repair the situation.

Both he and Ms Bradley confirmed earlier evidence advising that patients languishing in hospital become institutionalized and lose their capacity to look after themselves. They, knowing they have been declared fit to live in the community, lose hope when placement never happens. Some, living without hope and having nothing to lose, act out. Dr. Theriault's sense overall is that the Province simply does not make the resources available to provide patients with the places and the supports to enable them to live in the community. Dr. Theriault says that the Province did create a group home to serve forensic patients on conditional discharge from the Hospital, but he says patients are now staying in the group home because there are not the other facilities or services in the community to provide them with the supports they need in order to move them along.

<u>Catherine Frazee</u> is a Professor Emeritus at Ryerson. She taught there from 2001-10. She was, among many other important positions, the Chief Commissioner of the Ontario Human Rights Commission. Dr. Frazee said she tried to understand residential supports and services from a disability studies perspective and to see them through an "anti-ableist" lens.

Dr. Frazee said size is a clear marker of an institutional living arrangement, but the determinative factor is the issue of control over everyday decisions. The paramount concern of an institution, she said, is efficiency, rather than the aspirations of those who live there. Institutional policies put too much emphasis on productivity, and too little on other citizens whose abilities do not lend themselves to living in those terms.

Folks who require support, who have disabilities, and have no money, are put at a disadvantage because they are not contributing to the community. The world unfolds in accordance with the needs of those who are able. The disabled are left to be seen as unproductive, and exclusions flow from that. Only now is a challenge beginning. So, for example, people work in sheltered workshops, but are underpaid. An immigrant cannot bring a child with disabilities. One does not have to look too far to see how disabled people are affected. The reasons are unintended and invisible until consciousness has been raised in order to see the dynamics at play. Rarely are people deliberately malevolent. There is not a wide-spread antipathy to the disabled, although there is discomfort, and a wish to avoid. Not being disabled, she said, is presumed to be a superior state. Many consequences flow and all are harmful to disabled people.

Dr. Frazee suggests the moratorium was an expression of austerity logic. She said that providing the salaried personnel, and facilities, would be expensive. That is how ableism plays out; providing supports is too expensive. She suggested that, short of provincial bankruptcy, expense is not an excuse.

Dr. Frazee relates the denial of facilities to the disabled to the perception that they are less than the ideal. This leads to following a calculus of attributed value; it will be assumed that a program is too costly if the payback is too low. Government or the society will invest massively in some things, but not for those who do not make the grade as valued citizens. A great deal flows from the dominant perspective, which diminishes those who do not share it.

Dr. Frazee said the research is clear that institutions have no real benefit and are places that cause great physical and psychological harm. They are deeply dehumanizing. This not a controversial conclusion in the field of disability studies. Disadvantage is a policy issue, not a medical issue. Disability is inherently social and if one works from that perspective, then one will look to different solutions. Dr. Frazee also says that only an ableist would consider it acceptable that disabled people live indefinitely with parents and not be able to live as a normal adult. The problem, she says, is not that there are many people with immense needs; the problem is a policy which has inflicted harm, has perpetuated itself, and has become far more severe than it was at the beginning of the moratorium. People have been poorly treated in a very significant way. People are stigmatized. The more we isolate these individuals, then the more difficult becomes the stigma.

Dr. Frazee argues that it is inherently punitive to have people stuck in an institution or their parent's basement. If there were a policy that effectively removed indigenous people, people would now understand that it is racist.

Dr. Frazee says that the ableist perspective sees the person who needs support as something less than a full citizen and as a person of less value except insofar as they generate work for the caregivers. In deciding on a moratorium, the government is making a choice to freeze addressing the needs of disabled. It is not as if the government went bankrupt. The expenditure would be a relatively small component of the overall budget. The moratorium impacted only those who are most devalued. By making this choice, by not making alternative arrangements, humane ones for those who are in the need, we see how ableist perception plays out. Devalued citizens languish. One has to assume that the mind set, which finds this cycle of exclusion and devaluation acceptable, has continued.

Counsel for the Province objected to Dr. Frazee's testimony. I did admit it. I do, however, feel obliged to resist Dr. Frazee's evidence of an "ableist" systemic prejudice analogous to racism or sexism. If I am speaking from a position of privilege and am "un-woke", then so be it.

Dr. Frazee described "ableism" as being the discrimination or prejudice against people who have disabilities. She said that ableism can take the form of ideas, assumptions, stereotypes, attitudes and practices which, however unintentionally, place disabled people at a disadvantage. She said that the Province's attitudes and practices are manifestations of "ableism".

I must say, however, that I do not know who it is that she is talking about as being "ableist". All of the individuals who testified, including specifically the Deputy Minister, Lynn Hartwell, gave every appearance to me of the utmost respect and the most positive attitudes towards the disabled. I saw quite the reverse of any "systemic ableism". Most, if not all, have devoted their lives to the support of the disabled and to their successful integration as full members of the community. I have never seen so much as a taint of what Dr. Frazee is talking about in all of the 40 years of my engagement with those who work with and for the mentally ill and disabled. These folks constitute "the system". To dismiss all those good people as "ableists" as she defines it seems to me to be judgmental and condescending.

One might reply that it is not the good people who work with the disabled we are talking about, but rather what I might call "the ultimate powers that be" who carry with them a prejudice that diminishes the value of the disabled. First of all, that appears to mean that we are speaking of the few over the years sitting around the table of the Governor-in-Council. I expect, however, that the Minister of

Community Services and all of the Department, from time to time, earnestly supported the recommendations of the reports they commissioned to advocate for their clientele. Nothing turns on her evidence, but I give it little weight.

The Civil Servants

Patryk Simon testified on behalf of the Complainants. He is presently Manager Intake, Registration and Reporting, Mental Health & Addictions, for the Nova Scotia Health Authority. He had collected and analysed data about the wait times experienced by residents of the East Coast Forensic Psychiatric Hospital who had received conditional discharges. His analysis demonstrates that, indeed, residents of the Hospital, like the other disabled people, are subject to long waitlists for placement.

Carol Bethune, a Senior Care Co-ordinator, testified for the Province. She herself has worked with Beth MacLean since 2016 and had reviewed her files. She describes Ms MacLean as extremely social, inquisitive and possessed of a great sense of humour. Ms MacLean enjoys art, swimming and journals. She does have "challenges" when emotionally dysregulated.

Ms Bethune said that Ms MacLean was engaged in programs when she was at King's, but things started to erode as she decided she wanted out. Her behaviour became disordered. There were incidents with rocks and cars, and these led to her being discharged. She was placed in Maritime Hall at the Nova Scotia Hospital where she had a tough time. She spent as much as 23 hours a day in her room. Counsel asked why? Ms Bethune said staff made a clinical decision as a part of her behaviour modification program. She would be brought back to her room if she acted out. Ms Bethune said she thought it all very sad.

Counsel asked why Ms MacLean transferred to Emerald Hall. Ms Bethune agreed there was no medical reason for her to go to Emerald Hall. There was no other place for her. The thought was that she would have had more opportunities to receive occupational and recreational therapy.

When Ms MacLean becomes dysregulated, then her behaviour escalates. She may start throwing things, knocking things off a table, or tv's off walls. She does not hit people.

There have been times when Community Services found Ms MacLean to be "unclassifiable", which means to say that the Department would not accept her into any of its programs. There were also times when possible placements were interfered with because she was said to be incompetent to make her own decisions and her presumed substitute decision makers, that is her parents, thinking her dangerous, refused to allow her to be moved into the community. Her parents refused to consent to placement for Ms MacLean in 2012 and 2014. They said they did not want to be responsible for Ms MacLean's hurting someone. They claimed their daughter was unpredictable and that her behaviour could not be managed. Now that it has been determined that Beth does have capacity, then Ms Bethune would look to Beth, and not to her parents, although the parents do influence Beth's decision.

Ms Bethune explained how the placement of Ms MacLean in the Kearney Lake Road small options home fell apart. Ms MacLean had bought some yogurt. She wanted to eat it. Staff said no. The dispute escalated. Ms MacLean was unable to take redirection. She would go into her room and come back out again. Staff did not offer a PRN, that is to say a medication to calm her down. Generally, Ms MacLean understands that she should take one, and although she might initially refuse, she can be persuaded to accept it. The staff at the home called a supervisor, then the police. The police came. Ms MacLean settled. Later, however, when staff told her to go to bed, she said it was not 9:00 p.m. and refused. Again, the dispute escalated. Police were called again and removed her. The small options home discharged her.

Ms Bethune agreed that Ms MacLean's behaviour was predictable. She said any staff is only as strong as its least competent member. If someone cannot identify triggers, then there may be incidents. Ms MacLean had been doing very well at CTP at being redirected and would go to her room. Ms Bethune would not say that the dispute at Kearney Lake was well handled. One should not get into a power struggle over food, yogurt, nor bedtime.

Counsel asked how things have been going in a general way at CTP for Ms Maclean. Ms Bethune said things had been going very well, but there had been bumps along the way. Counsel asked if there had been aggression. Ms Bethune said Ms MacLean is really sensitive to her environment. She is living with nine other people. When one acts up, she may too. She may throw something, or she may bang her own head. If staff are unable to redirect her, and she will not take a PRN, or cheeks rather than swallows the PRN, then she might go to seclusion.

In June or July, she did knock over someone who was in a wheelchair at CTP. On April 5th, she flipped a table at a Subway. Ms Bethune does not know what the trigger was. Ms MacLean became upset. A woman with a small child were nearby. Ms MacLean just acted out regardless of their presence.

There was also an incident at a nearby Petro Canada. Staff, watching her from a distance, were concerned that she went to an area that was not familiar to her. Staff are not sure how the incident evolved. An RCMP officer was getting gas. There was a woman with a stroller. Ms MacLean put her hand on the stroller, went into the Petro Canada, knocked something over, then went out and said to the officer; "OK arrest me". The officer took her back to CTP.

Ms Bethune said department staff have continued to work with Mr. Jim Fagan moving forward to a placement with RRSS. Ms MacLean continues to want to leave CTP, but she is worried about the transition. Ms Bethune and Mr. Fagan are both reassuring her.

Lynn Hartwell, the Deputy Minister of Community Services, testified for the Province. Ms Hartwell's evidence is authoritative and clear. I was impressed by it.

I have remarked that there is little divergence between the evidence and the opinions of the Complainants' witnesses and the evidence of most of the Province's witnesses. The lack of divergence is manifested in the evidence of Ms. Hartwell. The differences are not about principles and goals, but rather about the speed with which goals may be attained. I daresay few would be more pleased if the Province provided her Department with the resources to do more for the disabled.

Ms. Hartwell said it was clear that departmental approaches had not kept up with the evolution of thinking in the care of the disabled. As a result, departmental policies were not having the impact the Department now wanted them to have. The Department has been going through a foundational rethinking of what support should look like. The Department is not taking the status quo as a given, but rather looking at the best practice. Ms Hartwell said a significant shift is going on, a turning of the ship is very much underway.

Community Services administers the Disability Support Program. The DSP provides support to those who need support with their daily activities to enable them to live their best lives. The Department is looking beyond beds to provide a more robust supply of services. Fifty-four hundred people are receiving support under the Disability Support Program.

Ms Hartwell, when she was a less senior civil servant, was a principal of the *Roadmap* committee. A starting assumption of the *Roadmap* was that everyone can live in the community. That continues to be the view of the Department of Community Services.

The Department receives strong advocacy from families. Families' acceptance of large communal facilities has diminished. Many believe that a larger facility does not provide the level of community the disabled should have. The Department has gradually reduced the number of people living in facilities. Others, however, are concerned to see their loved ones safe and do not want to have them leave the institutions they are in. Ms Hartwell said that if one is going to honour the spirit of the R*oadmap*, then one has to respect them and meet clients where they are. One cannot force them.

Ms Hartwell says she has learned that staff and residents have worked very hard to create a sense of community within larger facilities. Ms Hartwell says she has great admiration for people who work with the intellectually and mentally disabled. Their jobs are very difficult.

The Department also still hears concern expressed about having small options homes in neighbourhoods. One also must work with the community to receive them. One must consult and one must take time.

The system of care for the disabled was just bits and pieces when the Province took over from the municipalities in the mid-1990's. Many small option homes were not licensed, and they varied in quality. This prompted the conversation about what the standard of care should be and how to set up the best practices; "how to determine the how". The so-called "moratorium" followed, but Ms Hartwell's understanding is that the "moratorium" was never a formal policy, but rather a part of a process focussed on providing alternate community supports.

At the same time, the provincial takeover of municipal small options homes increased the costs of the system. Part of the discussion was about ways to manage those costs, and whether small options homes were becoming the only path. Notwithstanding the fact that few new small option homes have been created, the overall budget has doubled in the last 10 years and so there were all kinds of investments being made to broaden services.

Everyone involved in the *Roadmap* evinced an urgent desire for change. Ms Hartwell said the process was informed by the *UN Declaration on the Rights of the Disabled*. The Province is doing the work of progressive implementation of the goals of the *UN Declaration*.

Advocates wanted larger institutional type facilities closed altogether and within a short time, but it was clear to the Department that this would take some time. The Department consulted with the experience in other jurisdictions. There was a general concern about moving people wholesale out of institutions. No jurisdiction that she is aware of has done it exactly right. Getting it right, she said, was more important than getting it fast.

Ms Hartwell spoke of the closing of the Children's Training Centres as an example. She said closing the centres was certainly the right thing to do, but while deadlines may make others feel better, the process did not work as well as it should have if the purpose to was to best look after kids. The transition also put stress on the people who actually worked in the system.

Ms Hartwell said the closure of the Quest facility is a current case in point. The Department does not want to create a sense of panic in these families. The Department does not want to create the idea that something is going to happen over which the individual disabled person and their families have no control. Families want to be a part of what is going to happen. The Department does not want to set out a time line. Doing that, Ms Hartwell says, would not engage these people.

Overall numbers at Quest have gone down. While the object is not to admit more, people are, in fact, being admitted as a temporary measure. Placement at Quest is not supposed to be a long term solution and the Department is telling families that. The reality is that the Department "can't not serve people" and has to find a way to balance a system. The Department is moving towards closure and, although this may be a challenge, has set a guideline of three years. The Department is trying now to create a community-based model before it closes the institutional one. Safe, secure and appropriate care is the goal.

The Department's goal is planning that is not only centred on the disabled person, but is directed by that person and lets the client take the lead insofar as that is possible. The Department also wants to have frontline people assisting with decision making rather than having a central control.

Ms Hartwell says the Department is aware that there is a fair level of distrust in the community. Some think that government people are not the best ones to help plan and some have suggested that people be funded and then left to their own devices with supports of their own choosing. The Department believes there are risks involved, and independent service providers, such as those who operate small options homes, must in any event be supervised.

The fundamental belief, however, is that people must make as many decisions for themselves as possible. One must appreciate the ability for some would be limited, but staff have to learn to assist people to make their decisions.

Ms Hartwell explained that the Department has been expanding services to the disabled. She described the "Independent Living Support" service which provides assists to enable people to remain in their own homes or in what has been called "supervised apartments". Supports have been provided for up to 21 hours a week, but that now has been expanded to over 30 hours.

Ms. Hartwell told Mr. Calderhead that the Department had received a clear signal two budgets ago that the "moratorium" was over. The Department is opening eight new small option homes over two years.

No one is now regarded as being "unclassifiable". If a staff member is running into a problem of placement, then the case is elevated immediately and dealt with.

Mr. Calderhead cross-examined Ms Hartwell about the relationship between the Disability Supports Program and the Department's Income Assistance Program. Both programs are constituted under the *Social Assistance Act.*[87] For both, eligibility is determined by being a person in need based on a budget deficit system, comparing income with expenses. The shelter allowance for someone who is a beneficiary of Independent Living Support would be the same as the shelter allowance under Income Assistance. Both Income Assistance and the Disability Supports Program refer to basic needs and special needs. Income Assistance has accommodative features. For example, Income Assistance will increase benefits for those needing a special diet and will provide for a higher wage for some before assistance is clawed back. Many of the special needs policies are the same. Ms Hartwell said she was not sure if the Income Assistance and the Disability Support programs are entirely mirrored, but the intention is that the programs be as consistent and as seamless as possible.

Ms Hartwell agreed with Mr. Calderhead that people on income assistance receive that assistance as of right when they qualify. That assistance is mandated by law. Income assistance is portable. No one is told where to live to receive the benefit.

Ms Hartwell agreed that, under a DSP, a person once found to be in need may be put on a waitlist, but she added that there is no waitlist for a disabled person needing basic income support where they presently live. The basic program has a budget, but the funding is a function of need. Other programs may be limited by availability and resources. There may be people whose preference might be a small options home. A worker would work with them to meet their needs at their present residence. If a small options home remains the choice, and a place is not available,

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[87] *Social Assistance Act*, R.S.N.S. 1989, c. 432

then the person may have to wait and one may have to move from one's own community to access a home.

Ms Hartwell agreed that there is no cap on the number of people who may receive income assistance. If budgets are exceeded, then the Department may have to find money elsewhere.

Ms Hartwell said the Department is aware of the great cost ramifications of the *Roadmap*. The costs are the continuing costs, almost entirely for salaries, and require a multi-year commitment. Moving towards the goals of the *Roadmap* has been confirmed by the present government.

Ms Hartwell agreed that the Province wanted to be sure that policy was reflective of the *United Nations Declaration*, and inspired by a rights-based process. She agreed that the Province has embraced the *UN Declaration*. She agreed that people are to have access to supports in a way that is responsive to their choices. Segregation and isolation are to be avoided. She agreed that implementation means that disabled people are to have access according to their needs and access which responds to their own choices.

Ms Hartwell said the Province is now doing the work to get away from the congregate facilities. The idea is one of progressive realization. She believes that the Province's efforts are steps towards the realization of the goals. The Province is not, however, able to immediately implement the goals. Ms Hartwell agreed that there are some cases that do demand immediate implementation of placement. She agreed that there are people in the forensic mental health system through the East Coast Forensic Psychiatric Hospital who are unable to move out because there are no spaces available.

Ms Hartwell agreed that the largest waitlist is for small options homes. She agreed that the formal waitlist may be shorter than the total of those who actually want placement. There may be parents who are looking after disabled offspring who may be discouraged by the length of the waitlist and may not be applying. The growing waitlist is an expression of a need that the Province is not meeting, but she says the Department is making inroads into moving people into the community.

The budget has doubled without increasing the service. Ms Hartwell says she does not envision a world where the Province can put hundreds of millions into the service. It is not correct to say there is "a cap" , but the Department does have budget restraints.

The Services Offered through the Disabilities Support Program

Various witnesses described the various programs offered through the Department of Community Disability Supports Program. Here, I have borrowed from the Province's post-hearing brief to provide a summary of the programs and the numbers of people served by them. The Province does, at considerable expense, provide services to a significant number of disabled people. Inasmuch as this process has largely been an attack on the Province's care for the disabled, one should, I think, recognize and appreciate that many disabled people are already receiving the services the Complainants seek to have provided for all.

The Province offers these services to disabled people. No one is denied service, but some services are not immediately available to them upon approval of qualification for them. A disabled individual, although qualified for a particular service, may have to wait for its delivery. For example, "Flex" is available upon qualification, but one will have to wait for a small options home.

> **A summary of the services provided to eligible participants through DSP include:**
>
> - **Direct Family Support for Children** - Direct Family Support for Children (DFSC) and Enhanced Family Support for Children (EFSC) provide funding to enable families to support their child with a disability at home. DFSC and EFSC provide funding for the purchase of respite services to assist with scheduled breaks for family care givers. An enhanced funding component may be available for children and families who meet EFSC eligibility criteria.
>
> - **Flex Program** - The Flex Individualized Funding program provides supports and services to adults with disabilities who live at home with their families or who live independently with support from their family or personal support network. The program provides self-directed and self-managed funding to eligible participants.
>
> - **Adult Service Centres** - Community-based vocational day programs for adults with disabilities.
>
> - **Alternative Family Support Program (AFS)** - provides support for persons with disabilities to live in an approved, private family home. The participants must be unrelated to the AFS provider.

- **Independent Living Support (ILS)** - provides funding for hours of support services from a Service Provider, based on the assessed needs and circumstances of an eligible participant who is semi-independent but requires support to live on their own.

- **Licensed Homes for Special Care** - provide support and supervision in homes with three or more beds. These options include:

  - **Small Options Homes (SOH)** - three to four persons are supported by qualified care providers in a community home. The home and the staffing are provided by various private service providers.

  - **Group Homes and Development Residences** - provide a continuum of developmental rehabilitation programs for individuals with disabilities within a 4 to 12 person residential setting.

  - **Residential Care Facilities:** provide a residential support option to typically ten or more adults with disabilities who require minimal support and supervision with routine personal-care activities, community skills and activities, and illness supervision. Individuals are provided with limited direct support and do not have major health or behavioural support needs.

  - **Adult Residential Centres ("ARC")**: provide long-term structured supports and services, typically to twenty or more adults with disabilities, to enhance their development of interpersonal, and activities of daily living skills. Approved staffing is provided at all times by on-site professional staff.

  - **Regional Rehabilitation Centres ("RRC")**: provide both rehabilitation and developmental programs, typically to twenty or more adults with disabilities, who require an intensive level of support and supervision related to complex behavioural challenges and skill development needs. Approved staffing is provided at all times by on-site professional staff.

The following is a breakdown of the various service options and numbers of people using each service in fiscal 2016 - 2017:

Type of Service	**Number of People**
Direct Family Support for Children	676
Flex Individualized Funding	1402
Adult Service Centres (day programs)	2000
Alternative Family Support	167
Independent Living Support	741
Small Options Homes (including homes with 1 - 4 persons, includes adults and children)	695
Group Homes & Developmental Residences	583
Residential Care Facilities	424
Adult Residential Centres	370
Regional Rehabilitation Centres	185

There are currently approximately 5,250 individuals in the DSP. The cost of the program has exceeded $300,000,000.00 per year in recent years.

The *Roadmap*

There are many reports before me, but the *Roadmap* was the most prominent among them, and I have chosen to summarize it.

The Province commissioned the *Roadmap* in March 2013 to:

> Develop a roadmap for transformation of Nova Scotia Services to Persons with Disabilities Program (SPD), guided by the United Nations Convention on the Rights of Persons with Disabilities (CRPD)
>
> The roadmap was developed based on commitments of the Government of Nova Scotia to reshape the system of supports for persons with

> disabilities by moving beyond the institutional model to a person-centred, community-based approach, guided by the principles and vision laid out in *Putting People First,* that "Nova Scotians will enjoy good lives of their choosing in inclusive and welcoming communities".
> In undertaking our analysis of the SPD and in developing recommendations we have been informed by the content and the intent of the United Nations Conventions on the Rights of Persons with Disabilities which has been ratified by Canada with the full support of the Government of Nova Scotia.

Among the issues addressed were "Reliance on Institutional Care", Outmoded service delivery system" and "Few options for those with complex health and behavioural support needs". The associated explanations state that there are some 1,100 people living in large, congregate care facilities and nearly 1,000 people are on waitlists for services as offered by the SPD program. The recommendations[88] are based on shifting from 'place-based options' to provision of individualized disability and family supports as identified through person-directed planning.

These include:

- funding supports to the individual either directly or through family or through a third party administrator. Personal disability and family supports must be attached to people, not programs, services or physical structures. Accessing needed disability and family supports should not be contingent upon living in a particular type of residential option.[89]
- a clear commitment to phasing out the use of ARCs, RRCs, and RCFs
- ensuring people with disabilities have access to the full range of affordable and accessible housing in the community so that "if disability based housing is required as a last resort, limiting development of this option to a maximum of 4 people (developed on a dispersed, neighbourhood-based approach)."[90]

The *Roadmap* assumes:

- The *Canadian Charter of Rights and Freedoms*, the Nova Scotia *Human Rights*

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[88] JEB 2857-8

[89] JEB 2883

[90] JEB 2889

Act and the *UN CRPD* guarantee equal rights, respect and dignity in all aspects of life, without discrimination on the basis of disability and require all sectors to take measures to assure that equality.

- All people can be supported to live in community

- Government's role will change in a transformed system - from delivery to facilitation, partnership and a major (though not necessarily sole) funder.

The Law Applied

In my opinion:

- the Province has *prima facie* discriminated against Beth MacLean by placing and retaining her in the Nova Scotia Hospital, by retaining Joey Delaney at Emerald Hall after his health had stabilized in July, 2010, and by retaining Sheila Livingstone in Emerald Hall after her bout of mental illness had stabilized.

- All disabled people are, by virtue of the Supreme Court of Canada's opinion in *Moore,* entitled to meaningful access to generally available services. Extended time on a waitlist, depending on the individual circumstance, may be a limiting or a denial of a benefit or opportunity available to others and *prima facie* be discrimination.

- Even if placing and retaining Joey Delaney, Beth MacLean and Sheila Livingstone at the Nova Scotia Hospital was not *prima facie* discriminatory in and of itself, then it was *prima facie* discriminatory over the long term to limit or deny them meaningful access to other available services.

- The definition of disability under the *Human Rights Act* includes all the disabled and not just those who are served through the Department of Community Services. Discrimination does not recognize silos.

- One cannot say, however, that disabled people generally are discriminated against by being placed on a wait list or by any particular placement. Each case must be examined to determine whether the particular individual has been denied meaningful access.

One starts with the meaning of discrimination under the Nova Scotia *Human Rights Act*:

> Meaning of discrimination
>
> 4 For the purpose of this Act, a person discriminates where the person makes a distinction, whether intentional or not, based on a characteristic, or perceived characteristic, referred to in clauses (h) to (v) of subsection (1) of Section 5 that has the effect of imposing burdens, obligations or disadvantages on an individual or a class of individuals not imposed upon others or which withholds or limits access to opportunities, benefits and advantages available to other individuals or classes of individuals in society. 1991, c. 12, s. 1.

I distill the provision to read as follows:

> A person discriminates where the person:
>
> makes a distinction
>
> based on a characteristic
>
> that has the effect of
>
> imposing disadvantages on an individual
>
> not imposed on others or which withholds or limits access to benefits
>
> available to other individuals.

In my opinion, the Province's placement or retention of Joey Delaney, Beth MacLean and Sheila Livingstone in the Nova Scotia Hospital and in Emerald Hall was, in and of itself, *prima facie* discriminatory. The Province imposed disadvantages not imposed on others.

In doing so, the Province breached s. 5(1) of the *Act* which provides:

> 5 (1) No person shall in respect of
>
> (a) the provision of or access to services or facilities...
>
> discriminate against an individual or class of individuals on account of....

(o) physical disability or mental disability

I note that the Supreme Court of Canada has said that there may be discrimination against some people within a class of individuals. In our context then, Ms MacLean, Ms Livingstone and Mr. Delaney may be said to have been discriminated against within the class of the disabled generally. One cannot say, under the law, that there has been no discrimination simply because they are all the same with other disabled people receiving provincial services and so there is no distinction to be made among them. I refer to Gonthier J. for the court in *Nova Scotia (W.C.B.) v. Martin.*[91] He quotes Sopinka J. in his opinion on a *Saskatchewan Human Rights Code* case, *Battlefords and District Co-operative Limited v. Gibbs*[92]:

> ...I note first of all that in order to find discrimination on the basis of disability, it is not necessary that all disabled persons be mistreated equally. The case law has consistently held that it is not fatal to a finding of discrimination based on a prohibited ground that not all persons bearing the relevant characteristic have been discriminated against.
>
> <u>Thus, a finding of discrimination on the basis of disability, even though only a subset of disabled employees is mistreated, is permissable according to the case law.</u> [emphasis added by Gonthier, J.]

<u>The Province Makes a Distinction</u>

Joey Delaney and Beth MacLean were never mentally ill. Sheila Livingstone did suffer from some mental illness, among many other ailments, but her mental illness became stable. In my opinion, Beth MacLean, Joey Delaney and Sheila Livingstone were treated differently than other disabled people. They were all placed in an acute care unit of a psychiatric hospital. Neither Ms MacLean, nor Mr. Delaney, had ANY psychiatric illness. Ms Livingstone had one, but recovered from it. Beth MacLean never had any physical illness requiring hospital admission either. Mr. Delaney and Ms Livingstone did have serious physical afflictions, but they were treated from time to time for them and discharged. The Province placed them in a mental hospital regardless of their actual mental health.

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[91] *Nova Scotia (W.C.B.) v. Martin,* [2003] S.C.R. 504, at p. 255

[92] *Battlefords and District Co-operative Limited v. Gibbs,* [1996] 3 S.C.R. 566

The Province's placing them in a unit designed and operated for and occupied by people in an acute stage of a mental illness, and then withholding or limiting their access to other Community Services' facilities, distinguished them from other disabled people. Being on a waitlist while residing in an acute care unit of a psychiatric hospital is to be distinguished from being on a waitlist while residing at home or another facility. Ms MacLean, Mr. Delaney and Ms Livingstone were, among all people on waitlists for residential supports, distinguished by having, through their placement at Emerald Hall, disadvantages imposed upon them not imposed on others on Community Services waitlists. Ms MacLean, Mr. Delaney and Ms Livingstone were, among all people on waitlists for residential supports, distinguished by having, through their placement at Emerald Hall, opportunities, benefits and advantages open to others on Community Services waitlists, limited or withheld from them.

I think drawing an analogy with the East Coast Forensic Psychiatric Hospital makes the point clear. Both the East Coast and the Nova Scotia are hospitals operated by the Province's Nova Scotia Health Authority. Both treat people who are mentally ill. No one would suggest, I think, that placing a mentally disabled, but not mentally ill person in the East Coast and leaving them there on a waitlist would be indistinguishable from leaving them on a waitlist in their own home or another facility. In my view, placing people in a unit of a psychiatric hospital for the acutely ill is analogous to having placed them at the East Coast. Ironically, I daresay, their day-to-day lives would have been richer and their opportunities for reintegration greater at the East Coast.

Beth MacLean, in particular, would have been better off to have been found not criminally responsible by reason of mental disorder for her transgressions at King's and sent to the East Coast than to have been relegated to the Nova Scotia. The pressure to have her properly placed would have been greater and more effective from the criminal justice system to have her moved into the community than the pressure the staff of the Nova Scotia were able to apply to the obdurate Department of Community Services.

Their very placement and retention in the acute care unit of a mental hospital speaks for itself in distinguishing them from disabled people placed in other Community Services or Health and Wellness facilities or awaiting placement while living elsewhere.

Based on a characteristic

Beth MacLean and Joey Delaney are disabled, and Sheila Livingstone, during her lifetime, was disabled. Those are facts. They have a characteristic protected from discrimination under s. 5 of the *Human Rights Act.*

<u>That has the effect of</u>

The Province placed Joey Delaney at Emerald Hall and held him there because of his difficult bowel problems and his screaming. The bowel problems were a function of physical disability and his screaming was a function of his physical and his intellectual disability. Joey Delaney does not speak. He has chronic, intransigent physical ailments. He screams to communicate distress.

The Province did place Mr. Delaney at Quest for a time, but then returned him to Emerald Hall. The only reason for bunging him back into Emerald Hall seems to have been his screaming. I accept the opinion of Dr. Sulyman. He had no psychiatric illness. He was in no need of acute psychiatric services; not then, not ever. The evidence is clear that his screaming is his way of expressing his discomfort, not of psychosis. No doubt his screaming is disturbing, but the question is how one accommodates it. The Province's only solution was Emerald Hall. The evidence is that RRSS would accommodate him screaming and all, taking the necessary steps to reduce its impact on others. I find that Mr. Delaney's disabilities, particularly the manifestation of them in screaming, had the effect of the Province deciding to place him and then retain him in Emerald Hall.

The Province placed and then retained Sheila Livingstone at Emerald Hall because of her physical ailments, her intellectual disability, her mental illness and her tendency to scratch and hit people. She had difficulties communicating too. One had to work hard and to be patient to understand her. She would occasionally pinch or scratch. The tendency to scratch and hit was, in part, a function of her disabilities and also a function of the placement the Province made.

The evidence is clear that other facilities, be they small options homes or facilities such as Harbour View, could cope with her misbehaviour such as it was. Any threat that this sick, older woman might present could not justify her placement at Emerald Hall.

Ms Livingstone was a sick older woman not to be distinguished, in my view, from another sick older, and perhaps temperamental, older person. As I have held above, such people are disabled within the definition of disability under the *Human Rights Act.* Sheila Livingstone's disabilities were, I find, a factor in the Province's placement and retention of her in Emerald Hall.

Beth MacLean has been denied a community placement throughout her life because of her misbehaviours. I find that her intellectual disability was a factor in her misbehaviours. They were life long. One hesitates to deny her autonomy by saying that her behaviour was a function of a stimulus-response phenomenon over which she had no control. Indeed, Ms MacLean is described by a number of witnesses to be a sociable and quite charming person who has insight into her disability, understands what is happening when she is asked to redirect herself and cooperative with staff seeking to de-escalate. I agree that the Province's denial to her, or limit of her access to life in the community, was also a factor in her misbehaviour. It would not be fair to blame her for behaviour that the Province itself caused through its own placement decisions, her wishes, and the neglect of her own Province inspired expectations. I find that as a result of her intellectual impairment, her misbehaviour was her disability.

It is also clear that the Province placed her at the Nova Scotia Hospital simply because of her misbehaviour. She had misbehaved at King's. She was charged criminally. Her discharge prevented her from returning to King's. The Province's solution was to place her at the Nova Scotia. The law provides for misbehaviours through both the criminal justice and the mental health systems. The Province, however, just stuck her in Emerald Hall.

...An adverse impact...

I am satisfied that Beth MacLean, Joey Delaney and Sheila Livingstone suffered an adverse impact with respect to the services offered generally to disabled people through their long placement at Emerald Hall, the acute care unit of a psychiatric hospital. They each have had different lives and each must be assessed separately, but they do have one thing fundamentally in common. Each was confined, against almost all medical advice, for long periods of time in an acute care unit of a psychiatric clinic awaiting a placement in some other care facility. That, in my opinion, is all that needs to be said to persuade me of adverse impact. The Province's *de facto* committal of them to Emerald Hall speaks for itself.

I repeat. The proper function of Emerald Hall is to provide short term care to stabilize those who are having a psychiatric crisis and need hospital care. Emerald Hall was not designed, nor is it staffed or operated, to provide long term care. The function of Emerald Hall was not to be the long term residence for anyone, let alone people who either, like Ms MacLean or Mr. Delaney, did not suffer from a mental illness at all, or who, like Ms Livingstone, had recovered from one.

There is no evidence that residence in Emerald Hall has anything but an adverse impact. No one suggests that Emerald Hall is conducive to the expansion of the human spirit. Indeed, the evidence consistently speaks of the deleterious effects of life in such a setting. One loses life skills. One becomes more dependent upon others for basic needs. One loses self-confidence and self-esteem. One becomes apathetic and withdrawn to the point where some do not want to live in the community. One loses contact with friends and relatives. One loses track of time. One's physical condition deteriorates. One loses opportunities to be outside, to engage in employment, to engage in recreation, to go to the movies, to go to Tim's and everything else that we take for granted to occupy and entertain ourselves. Patients begin to engage in power struggles with staff and begin to respond to staff with aggression or self-harm. Rehabilitation and the expert staffs hired to provide rehabilitation are frustrated. Staff quit the service at Emerald Hall because there is no point to rehabilitation since come what may, the likes of MacLean, Delaney and Livingstone are not going anywhere. Staff turnover is high. Residents cannot develop solid relationships with staff.

The evidence shows that placement in Emerald Hall denied the three of almost every opportunity for something resembling a normal kind of life. Ms MacLean is pretty competent. She could have, but for her occasional bad behaviour, lived with relatively few supports in the community. Mr. Delaney could have spent most of the years he has passed at Emerald Hall in a small options home. His disabilities and physical medical difficulties were, by all the evidence, manageable. Ms Livingstone was an older disabled woman with multiple health problems. Krista Spence described her as a classic case for a nursing home. She coped quite well in Harbourside. She should have been in such a facility, if not a small options home, upon her medical discharge by the staff of Emerald Hall. Deputy Minister Hartwell, no less, acknowledged that the three should not have been held at Emerald Hall.

The evidence of the malign effects of confinement at Emerald Hall contrasts sharply with the evidence of life in a small options home - "opportunities, benefits and advantages" under the *Act*. The evidence of those speaking for Joey Delaney and Sheila Livingstone consistently describes the benefits to them during their residence in the RRSS homes. The evidence is that both were happy. The evidence about others living in small options homes is consistent. Mr. Rector is relatively happy in a small options home. Michelle Benn is doing well. Sam Lill is doing well too.

The Province knew that it should not hold people in Emerald Hall who were not mentally ill. The Province's own staffs repeatedly told the Province it should not. The Province's outside consultants repeatedly told the Province it should not. The involvement of counsel and indeed this proceeding, now four and a half years old, moved it not. I refer to Dr. Griffiths' specific report of April, 2006. The Province knew then that it should move people who were disabled, but not acutely ill mentally, out of Emerald Hall. The Province, year in and year out, was simply obdurate.

I have no doubt that Joey Delaney, Beth MacLean, and Sheila Livingstone suffered an adverse impact through their placement at Emerald Hall. Beth MacLean, Joey Delaney, Sheila Livingstone and others, however, having come to Emerald Hall ostensibly for acute psychiatric care, found themselves unable to leave and so became indefinite term residents. Joanne Pushie said she knew of no longer term residents who were confined on Emerald Hall as a result of the order of any authority. They are confined to Emerald Hall because neither they, nor their families, had the capacity to look after them and they were dependent upon the Province. While in theory, a resident is free to go, Emerald Hall effectively became a custodial place. One is reminded of The Eagles' *Hotel California*:

> "Relax", said the night man
> We are programmed to receive
> You can check out anytime
> But you can never leave

Not imposed on others

The parties contested the definition of the group to be served by the Province. To whom was the service being offered and did the Complainants suffer an adverse affect relative to all? I will deal with that issue later in the context of "meaningful access". Suffice it for the moment to say again that I am satisfied that the very placement of Ms MacLean, Mr. Delaney and Ms Livingstone in Emerald Hall was a disadvantage not imposed on other disabled people and their retention was a denial of advantages available to other disabled people.

Available to other individuals or classes of individuals in society

The Province does provide a wide range of supports, including residential supports, to the disabled through its Department of Community Services and its Department of Health and Wellness. There are many disabled individuals living in small options homes, or supported apartments or in their homes benefiting from the Province's programs. In my view, these services are available to other disabled individuals, but have been withheld or limited for Ms MacLean, Mr. Delaney and Ms Livingstone.

Moore and Meaningful Access

I am also satisfied that Ms MacLean, Mr. Delaney and Ms Livingstone, once placed in Emerald Hall, were then denied "meaningful access" to services generally available to other disabled people as described by the Supreme Court of Canada in *Moore v. British Columbia (Education)*. *Moore* is binding upon me.

It is important to realize that we are discussing services to the whole population of the disabled in Nova Scotia. Even if we narrowed the discussion to those disabled people in need seeking services through the Department of Community Services, we would still be confronting the needs of thousands of people at a cost of hundreds of millions of dollars. We are not discussing the relatively narrow services for the deaf at hospitals as in *Eldridge v. British Columbia (Attorney General)*[93] or children with severe dyslexia in schools as in *Moore*. In my opinion, however, the principle of "meaningful access" is the same. It is just the scale of its application that is different. The question becomes a very large one; how does human rights law apply to services to the disabled generally and particularly to waitlists for disabled people seeking services from the Province?

I copy the factual and legal background to *Moore* from the headnote:

> J suffered from severe dyslexia for which he received special education at the public school. In Grade 2, a psychologist employed by the school district recommended that since he could not get the remedial help he needed at his school, he should attend the local Diagnostic Centre to receive the necessary remediation. When the Diagnostic Centre was closed by the school district, J transferred to a private school to get the instruction he needed. His father filed a complaint with the B.C. Human Rights Tribunal on J's Behalf against the school district and the Province on the grounds that J had been denied a "service..customarily available to the public" under s.8 of the B.C. *Human Rights Code*. The Tribunal concluded that there was discrimination against J by the District and the Province and ordered a wide range of sweeping systemic remedies against both. It also ordered that the family be reimbursed for the tuition costs of J's private school. The reviewing judge set aside the Tribunal's decision, finding there was no discrimination. A majority of the Court of Appeal dismissed the appeal.

The Supreme Court of Canada unanimously, per Abella, J., allowed the appeal. The court substantially reinstated the findings of the human rights tribunal that Jeffrey Moore had been discriminated against by denying to him the particular recommended service within the public school system. The tribunal found that the effect was to exclude him from public education.

There is an arguable distinction between *Moore* and the Complainants. Mr.

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[93] *Eldridge v. British Columbia (Attorney General)* [1997] S.C.J. No. 86

Delaney, Ms MacLean and Ms Livinstone all received services. None of them was excluded from Provincial services to the disabled. They were not, like Jeffrey Moore, excluded from the system. In fact, the Province had looked after them virtually all their lives.

What I understand *Moore* to be saying, however, is that if services are generally available to disabled people, then the Province *prima facie* discriminates if it does not grant "meaningful access" to those services. I do not understand *Moore* to stand on the narrower ground that discrimination only arises when an individual is in effect denied access to the public education or, in our case, services to the disabled. In other words, I do not understand *Moore* to say that discrimination only arises when the denial of a service deprives the disabled person of the "means" of access to a public benefit.

Our *Human Rights Act* speaks not only of the <u>withholding</u> access to benefits, or I suppose of the means of access, but the *Act* also speaks of discrimination by <u>limiting</u> access to benefits. Thus, our *Act* on its face does not restrict discrimination to "withholding" or denying the means of access. Limiting is enough. "Meaningful access", it seems to me, ought to be seen in this light; that is to say that to deny meaningful access may be to limit access and thus be discriminatory. The access of Ms MacLean, Mr. Delaney and Ms Livingstone to residential services available to other disabled individuals, if not in effect withheld, were, in my opinion, limited.

If indeed *Moore* only stands on the narrower ground of a denial of a service, then the implication arises that the Province, as long as it provides any service at all, may freely exclude people from other services generally available without fear of being determined to have discriminated. I may err, but I understand the law in Canada to be, on the contrary, that government may be discriminating against disabled individuals if it does not provide "meaningful access" to the services the government has constructed to be available to disabled people generally.

Justice Abella opened her analysis by saying that the relevant provision of the B.C. *Human Rights Code* is to be understood in this way:

> [26] ...That means that if a service is ordinarily provided to the public, it must be available in a way that does not arbitrarily - or unjustifiably - exclude individuals by virtue of their membership in a protected group.

Justice Abella then quoted from the opinion of Rowles, J.A. in the British Columbia Court of Appeal:

> [28] I agree with Rowles, J.A. that for students with learning disabilities like Jeffrey's, special education is not the service, it is the *means* by which those students get meaningful access to the general education services available to all British Columbia students:
>
> > It is accepted that students with disabilities require accommodation of their differences in order to benefit from educational services. Jeffrey is seeking accommodation in the form of special education through intensive remediation, to enable him equal access to the "mainstream" benefit of education available to all...*In Jeffrey's case, the specific accommodation sought is analogous to the interpreters in Eldridge: it is not an extra "ancillary" service, but rather the manner by which meaningful access to the provided benefit can be achieved.* Without such special education, the disabled simply cannot receive equal benefit from the underlying service of public education. (emphasis in original opinion of Abella, J.)

The decision then considers what the service was and confirmed the Tribunal's opinion that the service is education generally. Abella J. then says:

> [32] A majority of students do not require intensive remediation in order to learn to read. Jeffrey does. He was unable to get it in the public school. Was that an unjustified denial of meaningful access to the general education to which students in British Columbia are entitled and, as a result discrimination?

Then later, she writes:

> [36] But if the evidence demonstrates that the government failed to deliver the mandate and objectives of public education such that a given student was denied meaningful access to the service based on a protected ground, this will justify a finding of *prima facie* discrimination.

I am satisfied that the Province failed to deliver the mandate and objectives of services to the disabled such that Beth MacLean, Joey Delaney and Sheila Livingstone were denied access to the services based on their respective disabilities.

I also refer to *Eldridge v. British Columbia (Attorney General)* per LaForest J. for the court. The hearing impaired sought sign language interpretation under the *Charter* in order to properly access medical services. In paragraph 73, the court says:

> ...This court has repeatedly held that once the state does provide a benefit, then it is obliged to do so in a non-discriminatory manner; ...In many circumstances, this will require governments to take positive action, for example by extending the scope of a benefit to a previously excluded class of persons;[94] ...

Eldridge confirms this principle in a *Human Rights Act* case:

> The principle that discrimination can accrue from a failure to take positive steps to ensure that disadvantaged groups benefit equally from services offered to the general public is widely accepted in the human rights field.[95]

Moore also states the factors generally to be applied to a determination of *prima facie* discrimination:

> [33] As the tribunal properly recognized, to demonstrate prima facie discrimination, complainants are required to show that they have a characteristic protected from discrimination under the Code, that they experienced an adverse impact with respect to the service; and that the protected characteristic was a factor in the adverse impact.

This is, in my view, really an iteration of s. 4 of our *Human Rights Act.* The principles of discrimination are supplemented by the principle of "meaningful access" to services generally to disabled. "Meaningful access" does not exist as a freestanding right; discrimination must be founded upon the *Act.*

Disability Under the *Human Rights Act*

To determine "meaningful access" under the *Act,* we must understand the definition of disability under the *Act* and the services to which "meaningful access" applies. The *Act* says:

> (l) "physical disability or mental disability" means an actual or perceived

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[94] Eldridge, para. 73

[95] Eldridge, para. 78

> (i) loss or abnormality of psychological, physiological or anatomical structure or function,
>
> (ii) restriction or lack of ability to perform an activity,
>
> (iii) physical disability, infirmity, malformation or disfigurement, including, but not limited to, epilepsy and any degree of paralysis, amputation, lack of physical co-ordination, deafness, hardness of hearing or hearing impediment, blindness or visual impediment, speech impairment or impediment or reliance on a hearing-ear dog, a guide dog, a wheelchair or a remedial appliance or device,
>
> (iv) learning disability or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language,
>
> (v) condition of being mentally impaired,
>
> (vi) mental disorder, or
>
> (vii) dependency on drugs or alcohol;

The definition is broad and deep enough to include almost every affliction that one could imagine. Almost everyone, at some time or another, will be or appear to be physically or mentally disabled within the meaning of the *Act*. Most of us will look to the health care system and depend upon it to sustain us in our disability. Some of us will look to the Department of Community Services. All of us, however, unless we drop dead after a healthy life, have been or will be disabled within the meaning of the *Act*.

Someone waiting in some pain and with restricted mobility for knee replacement surgery is "disabled". In my view, for the purposes of disability analysis, waiting for knee replacement surgery is scarcely to be distinguished from a disabled person in need seeking a placement in a small options home. For the purposes of legal analysis, I have trouble seeing a difference, given the definition of disability, between an otherwise healthy person awaiting a knee transplant, suffering pain and limits to mobility, and other people of whom the Complainants are representative awaiting a placement in a small options home. They are all "disabled" awaiting the provision of a government service. They are also dependent upon the Province for the service. One cannot obtain knee replacement surgery in Nova Scotia except through the government health service. Some may have the means and inclination to travel to India or the United States to get a new knee, but the reality for almost all of us is that we wait patiently on a list, putting up with the pain and immobility, until our number comes up. While the *Employment Support and Income Assistance* and the *Social Assistance Acts* do actually require the administration to provide services, the issue in my opinion, is whether services are generally available, not whether the government is required to provide them. Knee surgery is generally available.

Services Generally Available

The hearing addressed itself to services available to disabled people through the Department of Community Services. Services to the disabled are also available through the Department of Health and Welfare. I shall deal with Community Services first.

We are speaking of two statutes administered by the Department of Community Services; the *Employment Support and Income Assistance Act*[96] and the *Social Assistance Act*. The *Employment Support and Income Assistance Act (ESIA)* and the *Social Assistance Act* both provide services to the disabled, but generally the *ESIA* provides basic and supplementary income support and the *Social Assistance Act* provides for residential supports. Each speaks of people in need and say that the Minister shall provide "assistance". (emphasis added) Disabled people may require supplementary supports under either one or both statutes. There is simply a scale of need covered by both statutes read together.

These two Acts of the legislature provide a continuum of services to the disabled in need from the basic income support, through assistance with special needs to full-time expensive residential care and support. I am satisfied, too, from her evidence that this is the way Deputy Minister Hartwell herself views the legislation she administers. I can see, for the purposes of their application to the disabled, no substantial difference between the two Acts, except in terms of the scale of the services they offer. The scale of the opportunities, benefits and advantages, or the fact that as one escalates one may encounter waitlists, does not, in my view, make any significant difference for the disabled.

The *ESIA* not only provides for basic income support to people who are able-minded and the able-bodied, but also a wide range of supplementary income supports that clearly will apply to people who are disabled within the definition of the *Human Rights Act*. I emphasize "special needs" because the definition very quickly takes one into the realm of services to the disabled.

The *ESIA* defines assistance:

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[96] *Employment Support and Income Assistance Act*, Stats. N.S., c.27

> 3 In this Act,
>
> (a) "assistance" means the provision of money, goods or services to a person in need for
>
>> (i) basic needs, including food, clothing, shelter, fuel, utilities and personal requirements,
>>
>> (ii) <u>special needs</u>, (emphasis added)
>>
>> (iii) employment services;

A person in need is defined as follows:

> 3(g) "person in need" means a person whose requirements for basic needs, <u>special needs</u> and employment services as prescribed in the regulations exceed the income, assets and other resources available to that person as determined pursuant to the regulations. (emphasis added)

Section 24 of the Employment Support and Income Assistance Regulations, N.S. Reg. 25/2001 defines "<u>special needs</u>":

> **Special needs defined**
>
> 24(1) In the Act and these regulations, "special needs" means needs for any of the following items or services, but does not include a need for an item or service listed in subsection (2):
>
>> (a) an item or service with respect to any of the following:
>>
>>> (i) dental care approved in accordance with the *ESIA Dental Fee Guide* approved by the Director,
>>>
>>> (ii) optical care,
>>>
>>> (iii) pharmacare coverage,
>>>
>>> (iv) special diet,
>>>
>>> (v) transportation,

> (vi) child care,
>
> (vii) implementation of an employment plan,
>
> (viii) funeral arrangements;
>
> (b) an item or service prescribed in policy by the Director;
>
> (c) an item or service that is determined despite clauses (2)(b) and (d) to be a special need in accordance with Section 24A.
>
> **Special need essential for health**
>
> 24A(1) An applicant or recipient may submit a request for assistance on the form approved by the Director for an item or service that is excluded from the definition of "special needs" by clause 24(b) or (d) and that is
>
> (a) prescribed within the scope of their practice by one of following health practitioners who is licensed to practise their profession in Nova Scotia as essential for the health of the applicant or recipient or dependent child of the applicant or recipient:
>
> (i) physician,
>
> (ii) dentist,
>
> (iii) nurse practitioner; and
>
> (b) provided by a medical professional licensed or registered to practise in Nova Scotia.

The Province, through the Minister, is obliged to provide those services. Section 7(1) of the *ESIA* says:

> 7 (1) Subject to this Act and the regulations, the Minister <u>shall</u> furnish assistance to all persons in need. (emphasis added)

One applies and if qualified, then one receives the benefits. Sections 11 and 12 of the *ESIA* provide for an appeal of a decision for anyone who has applied for or received assistance.

Thus, in addition to basic income support to people who are in need and not disabled, the *ESIA* will provide additional support to people who have "special needs". Many of those having "special needs" would be disabled people within the definition of the *Human Rights Act.*

The *Social Assistance Act* defines a "person in need" as follows:

> 4(d) "person in need" means a person who requires financial assistance to provide for the person in a home for special care or a community based option.

The *Municipal Assistance Regulations*[97] made under s. 18 of the *Social Assistance Act* provides a definition of financial assistance:

> 1 (e) "assistance" means the provision of money, goods or services to a person in need, including
>
> > (i) items of basic requirement: food, clothing,...
> >
> > (ii) items of special requirement ...
> >
> > (iii) health care services; reasonable ... services ...not covered under the Hospital Insurance Plan or under the Medical Services Insurance Plan
> >
> > (iv) care in homes for special care
> >
> > (v) social services including... home care and home nursing services
> >
> > (vi) rehabilitation services.

Section 9 (1) of the *Social Assistance Act* provides:

> Subject to this Act and the regulations the social services committee <u>shall</u> furnish assistance to all persons in need, as defined by the social

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[97] *Municipal Assistance Regulations,* N.S. Reg. 76/81 (as amended)

services committee, who reside in the municipal unit. (emphasis added)

The *Social Assistance Act* also provides a service for the disabled in the form of support for sheltered employment under s. 27 of the *Act.*[98]

Section 19 of the *Social Assistance Act* provides for an appeal by incorporating by reference the process established under the *ESIA*.

Thus, there is a complex network of services available to the disabled who cannot afford the service themselves. Disabled people in need seek and receive services under both Acts. The services begin with simple income assistance under the *ESIA*. One applies for income assistance. If one qualifies, then the assistance is approved and one begins to receive the service. One's application may be rejected. Then one may appeal.

Disabled people in need may require more services than the basic income assistance. They may have "special needs". They may need extra income support to be able to provide for the dietary needs engendered by their disability. The Province has provided for these added dietary needs under the *ESIA*. Thus, for example, the Province recognizes that someone suffering from a chronic illness such as Crohn's disease, AIDS or Cystic Fibrosis may qualify for supplementary income under the *ESIA* to pay for the increased cost of the their nutrition. People afflicted with those conditions fit within the definition of physical disability under the *Human Rights Act.*

The income supplement is not provided "as of right" to individuals with, for example, Cystic Fibrosis. One does not simply ask and have it given unto them. One would have to apply as a person with special needs, presumably satisfy the Department that one has the need for this supplement due to their illness, and then receive approval. Again, approval might be refused. Then, the person would have the option of appeal.

All services are subject to qualification and adjudication with a right of appeal. Regardless of what the result of an appeal may be, if a Board of Inquiry under the *Human Rights Act* were satisfied that the disabled person arbitrarily did not receive the dietary supplement, then, in my opinion, it might be open to the Board of Inquiry to find in the refusal a failure to provide "meaningful access" to the service of a supplemental income for dietary need arising out of a disability.

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[98] *Rehabilitation and Social Development Approval and Assistance Regulations* N.S. Reg. 54/79

The same principle applies for the provision of the service of, for example, a small options home. One goes through a process, a "classification", and if suitable, then the small options home will be provided. One may appeal a classification.

In my opinion, whether one gets an increased dietary allowance as a disabled person in need is, in principle, indistinguishable from the question of whether one gets to live in a small options home. A disabled person in need may be refused "meaningful access" and so discriminated against just as well for the dietary income supplement or the small options home.

I am satisfied that the opportunities, benefits and advantages the two Community Services statutes, which counsel have presented to me, provide a continuum of supports to disabled people and that, as the Complainants have submitted, one cannot meaningfully distinguish the two. This is particularly true if one views the statutes from the point of view of disabled people; they will not care what legal or bureaucratic boxes are constructed to serve them. Nor, in considering discrimination, should I.

Department of Health and Wellness

A Parallel System within the Department of Health and Wellness

The parties led little evidence about the care and support provided the disabled within the Province's Department of Health and Wellness. I have, however, taken the liberty of repeating the following from the Department's website to show how extensive their services are. I do so because, in my view, in considering discrimination against the disabled, there can be no distinction between services within the two Departments. Again, discrimination analysis cannot recognize silos.

> Nova Scotia Health Authority
> Continuing Care Quick Facts
>
> Continuing Care programs and services help people live safely in the place they call home. There are a wide range of services available including home support, home nursing, home oxygen services, community occupational therapy and physiotherapy, caregiver benefit program, family relief and respite, personal alert assistance program, self-managed care, community wheelchair loan program, bed loan and long term care.
>
> Nova Scotia Health Authority (NSHA) is responsible for intake, assessment, placement and coordination of these services. Care

coordinators assess needs, identify the programs and services that best meet them, set up these services and work on an ongoing basis with individuals and families to ensure they receive the care they need.

NSHA contracts with private agencies, licensed and/or approved by the Department of Health and Wellness, for the delivery of continuing care services. We also deliver some services including home nursing and long term care, operating 146 long term care beds at seven facilities.

By the Numbers 2016-17:

Home Care
- $255 million annually (net)
- ~28,000 clients
- 3 million home support hours
- 1 million nursing visits
- 20 private agencies (for-profit & not-for-profit)
- 4 oxygen vendors
- 2 equipment vendors

Long Term Care
- $565 million annually (net)
- 7,851 beds serving ~ 11,000 people annually
- 6,923 nursing home beds
- 927 residence care facility beds
- 1 community based option bed
- 137 facilities (for-profit, not-for-profit, NSHA)[99]

The disabled people about whom we heard evidence were, in fact, served by both Departments as disabled people. Emerald Hall at the Nova Scotia Hospital is a Health, not a Community Services facility. Quest is a Community Services facility under the DSP. Community Transition is a facility under the Nova Scotia Health Authority.

The Denial of Meaningful Access

In my opinion, Sheila Livingstone, Beth MacLean and Joey Delaney were also discriminated against in that, as disabled people, they were denied "meaningful access" to services generally available to disabled people.

Specifically, the Province has limited or denied Joey Delaney access to a residence suitable to his needs and the disturbance caused by his disability. Emerald Hall told the Province Mr. Delaney was ready to leave in July, 2010. The fact is,

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[99] NS Health Authority online: www.nshealth.ca/sites/nshealth.ca/files/about_continuing_care_-_quick_facts.pdf

however, that the Province made no placement until he moved to Quest in February, 2015. Then his screaming was too much so they returned him to Emerald Hall in January, 2017 rather than create a small options placement for him. Mr. Delaney required a specialized residence of the kind Mr. Fagan said in evidence RRSS could have created if provided the resources. Putting him back into Emerald Hall as a solution to his screaming is, to me, a manifest failure to accommodate his disability and a denial of "meaningful access". Although the Province says a small options home placement is now being created for him, the fact remains that, in spite of everything, including this process, he was still in Emerald Hall at the conclusion of the hearing in the fall of 2018. The Province denying him that residence for now over eight years is, in my opinion, a denial of "meaningful" access.

The Province told Ms MacLean in October, 2000 that she would only be at the Nova Scotia Hospital for a year. The Province repeatedly told her thereafter that she would be moving out. The Province broke its word to her and has held her for nigh on to 20 years entirely against her own wishes as a competent woman and contrary to the overwhelming consensus of professional advice. The Province denied her meaningful access as a disabled individual to a service generally available to other disabled people - a small options home.

Sheila Livingstone's case is different from that of Ms MacLean and Mr. Delaney. She, in my opinion, due to her age and myriad infirmities might properly have been placed in a small options home, a nursing home or some other "institutional facility". Harbourside Lodge is an "institution", not a small options home, but apart from its distance from Halifax about which I will comment later, I am satisfied Harbourside was an appropriate placement for her. She received proper care and was content. I restrict my finding of discrimination against her to the fact that she was placed and held at Emerald Hall for well over nine years.

All professional staff who testified and whose reports I have read argued strenuously that Ms MacLean, Ms Livingstone and Mr. Delaney be placed somewhere else. Lawyers put their shoulder to the wheel. Effort and advocacy over years came to naught. The uppermost echelons of government were, by all the evidence, utterly impervious to it all. The Province would not find or create a solution. They could have done something. They chose not to. The moratorium prevailed.

One wonders about the dynamic of indifference. Departmental staff and, I am persuaded, the Department as an entity itself through its repeated commissioning of reports and studies, begged for the resources to place Ms. MacLean, Ms Livingstone, Mr. Delaney, and I presume others, out of Emerald Hall. Successive governments of all political stripes simply ignored everyone over decades and condemned our most vulnerable citizens to a punishing confinement. I cannot think in systems here. The "system" through its people knew well what had to be done and strenuously recommended it. People with the final authority were blind, deaf and especially dumb to the effects of what they were doing.

I reject the argument that the Province had no option but to retain the three in Emerald Hall. There was no shortage of evidence presented to me about what could have been done, what ought to have been done, or at least tried - design and implement a plan for the three to live in the community. None of the people experienced in these matters, Dr. Bach, Mr. Wexler, Dr. Griffiths and Jim Fagan, thought that it would have been particularly difficult to do so. Deputy Minister Hartwell readily acknowledged that all disabled people may be accommodated in a small options home. Certainly, on the basis of their testimony, I am satisfied that Ms MacLean and Mr. Delaney could have been accommodated in the community and Ms Livingstone in a nursing home or some similar facility.

"Meaningful access" does not stand alone. It must be linked to analysis under the definition of discrimination in the *Act* or the factors in paragraph 33 of *Moore*. Disability is a constant and so is their disability as a factor in their placement. The questionable factor in discrimination analysis is whether the three were still placed at a disadvantage. In other words, would they still have "experienced an adverse impact with respect to the service"[100] to be placed at Quest, or CTP, or King's, or another facility for all those same years? In my view, the answer is still yes. The evidence is clear that Ms MacLean and Mr. Delaney could have been placed in a small options home. The evidence is clear that living in a small options home is better than living in a larger facility. They are, in my view, at a disadvantage as long as they are not living in a small options home properly prepared for them.

The Province does have the people who understand misbehaviour and can both work to change the misbehaviour and educate others to do the same. Nicole Robinson, a Certified Behavioural Analyst, Dr. Sulyman and Dr. Griffiths, Mr. Wexler among others, all explained the practice of determining what may cause someone to act out and then working to change the antecedents to misbehaviour in order to avoid it. The difficulties caused by the disabilities then can be analysed and moderated. The staff of RRSS are fully aware of such techniques and, I am satisfied, have the experience to cope with difficult residents. The Province, I am sad to say, compounding its indifference, simply wastes the skills and dedication of its good people.

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[100] *Moore,* para. 33

Joey Delaney and Sheila Livingstone lived in small options homes for years and, by all the evidence, did pretty well. I do not see evidence in the record that overall anything significantly changed in their conditions from the years they were in the small options homes through the years they were in Emerald Hall. Ms Livingstone and Mr. Delaney did, from time to time, require hospital care for their various medical conditions, but hospital admissions are to be expected for all. Hospital admissions are no reason to deprive people indefinitely of placements for which they otherwise qualify.

Arbitrary and Unjustified

Justice Abella interpreted the *B.C. Human Rights Code* in *Moore*[101] to say that if a service is ordinarily provided to the public, it must be available in a way that does not arbitrarily - or unjustifiably - exclude individuals by virtue of their membership in a protected group. For the reasons expressed above, I find the placement and retention of Joey Delaney, Beth MacLean and Sheila Livingstone in Emerald Hall, that is to say the denial or limiting of access to other residential facilities to have been arbitrary and unjustified.

The Province, in its arguments, returns to the idea that Ms MacLean and Ms Livingstone presented a danger to others as a justification for holding them at Emerald Hall. I accept that their behaviours were indeed challenging to deal with, and probably Ms MacLean's will continue to be so, but a wide variety of professional staffs described their behaviour as not being exceptional for people with their disabilities and quite within the competence of trained caregivers to cope with. I cannot accept that the Province had to be so rigid and so inflexible. The circumstances demanded imagination and creativity, but it was more convenient for the Province to be rigid and inflexible posing what, in my opinion, were simply bureaucratic obstacles to getting them out of Emerald Hall. If indeed they were so dangerous, then they should have been treated as such, with all the protections for them in those processes.

There were from time to time obstacles to placement. The Department of Health refused to consider accepting Sheila Livingstone. Beth MacLean's parents thought her dangerous and refused to consent to her placement in the community. Community Services, I fear because it was convenient, seems to have deferred to them. Ms MacLean was determined at some times to be "unclassifiable" and excluded from access to Department of Community Services facilities. I view this to be a bureaucratic obstacle that cannot withstand a discrimination analysis. In

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[101] *Moore*, para. 26

my view, it is no answer to discrimination to use classification to justify retention in Emerald Hall or a denial of meaningful access. A refusal to classify someone would, it seems to me, be a denial of access to services altogether like the British Columbia refusal of access to the school system for Jeffrey Moore.

Nor, in my opinion, can parents' approval or disapproval of a course of action recommended by professional staffs be permitted to block "meaningful access". In any event, I am satisfied that Beth MacLean was always competent to make her own decisions about placement in fact, and more certainly as a matter of law. One is presumed to be competent until declared otherwise. The Province argues as if the reverse were true; Ms MacLean was to be treated as incompetent and her parents deferred as substitute decision makers over the advice of staff and her own wishes. There is no evidence of any process by which Ms MacLean was deprived of her civil rights. There was no application under the *Incompetent Persons Act* or within other procedures provided by law. While parents' opinions are entitled to respect, they cannot be allowed to dictate over the human rights of the adult child. It was absurd to deny her the capacity to mean what she said; she wanted out of Emerald Hall.

In summary, I find that the Province *prima facie* discriminated against Beth MacLean and Joey Delaney by the failure, against the recommendations of all knowledgeable people and over years, to place them in small options homes, thereby denying them meaningful access to a service generally available to disabled people after the Nova Scotia Hospital determined them to be ready for community integration.

What, then, in summary, is "meaningful access"? I do not mean to be prescriptive, but the circumstances of the individual, time, the appropriateness of an existing placement, and the recommendations of professional staffs engaged with the people will each be important.

Ms MacLean's Placement at King's County Rehabilitation Centre

Beth MacLean's residing at King's must be addressed. She was placed at King's when she was 14 because neither her parents nor the Children's Training Centre could cope with her. She remained at King's for 14 years before being transferred to the Nova Scotia Hospital in October, 2000. Ms MacLean submits that her placement at King's was discriminatory as well.

First of all, I am not satisfied that placement at King's is a disadvantage and discriminatory. I am not satisfied, on the basis of the evidence before me, that placing Ms MacLean in King's in 1986 was inflicting a disadvantage on her.

It is anachronistic to impose current conceptions of the proper care for the disabled and try 30 years later to judge what ought to have been done for Beth MacLean at King's. Again, "meaningful access" has to be determined in context. The context here, in large part, is historical. There is not the evidence in the context of the time to say that the placement at King's, given the difficulties which arose at the Truro Children's Training Centre and the options for care that were then conceived of, was a discriminatory decision. There is no evidence to say, for example, that placement at King's was disadvantageous to her relative to the placement at the Children's Training Centre. Children's Training Centres were "institutions" too. Training Centres did not close until the mid-90s. One might as well say that the Training Centres were all discriminatory as such.

I also remember that inasmuch as we have learned that institutions generally do not provide optimum care, deinstitutionalization is a process that has been going on now for some time and will continue to go on. It seems rather glib to me to say that the Province back then simply ought to have constructed a small options home with all the supports Beth MacLean requires.

One should also, I think, be sympathetic to the dilemmas facing those responsible for the provision of care to the disabled in the context of the time. Ms MacLean has not been an easy case. Putting her in a mental hospital, in my opinion, was manifestly wrong, and creating a small option for her should have been done, but I cannot say that placement at the Training Centre or at King's was discriminatory.

Beth MacLean's behaviour does remain challenging. It may be that she has become so accustomed to living in institutions that she will be unable to cope with community living in a small options home. Such a placement has already failed once. One can agree that the placement was not properly prepared and the staff at Kearney Lake might have handled Ms. MacLean's challenges better, but at the same time one cannot say that at all times and in all circumstances it was always "the system's" fault. It would be naive, I think, to exclude the possibility that she may return to some form of institutional living without thereby being denied "meaningful access".

Placement at a Distance

The Province eventually offered a placement in Yarmouth, but it gave Ms Cain no option but to agree to Sheila Livingstone's placement there. Ms Cain wanted her sister out of Emerald Hall. Harbourside Lodge in Yarmouth is over 350 kilometres from Stewiacke where Olga Cain lives. Olga Cain and Sheila Livingstone were very close. Ms Cain is an older woman. Sensibly, she had a niece, including the witness, Jackie McCabe-Sieliakus, travel with her to visit. Visits were expensive.

Ms Cain and the niece had to stay overnight in Yarmouth when they visited.

To so limit Sheila Livingstone's access to her only family and community supports was, in my view, a denial of meaningful access. Each case will depend on its own circumstances. I would not say, by contrast, that placing Mr. Rector in a home in Windsor rather than a home in Smith's Settlement would be a denial of meaningful access. In my view, however, the Province cannot willy-nilly place people at a significant distance from family and friends without risking a denial of meaningful access.

Services as of Right

The Complainants submit that since people in need receive basic income support under the *ESIA*, then all services to the disabled in need are similarly entitled to receive, "as of right", any of the panoply of services available.

As I have said, all the disabled obtain services under the *ESIA* or the *Social Assistance Act* by applying for them. There is a process of qualification and of appeal, if thought necessary. The distinction becomes that, while most will receive the support they request upon qualification, many seeking some residential supports will be placed on a waitlist. A disabled person seeking a placement in a small options home will be processed through and, if qualified, will be eligible for the placement. The regulations under the *Social Assistance Act* say the service "shall" be provided. They will receive the service. The Department says, however, just not yet.

Services are being provided disabled people. Many are already well served living in small options homes. We are not speaking here of a denial of services to the disabled.

The Province has, for example, provided Beth MacLean, Joey Delaney and Sheila Livingstone with services throughout almost all their lives. That, the Complainants argue, is insufficient. They argue that the Province discriminates if it does not, more or less immediately, place Beth MacLean and Joey Delaney in small options homes, and provide particular services for all those other disabled people on waitlists.

The Complainants' submission boils down to the argument that waitlists are *prima facie* discriminatory. I disagree. Some services can be rolled out as a matter of routine to people in general. Others will be more complex and will require a work up. Each disabled person will have to be assessed individually and a placement worked out with them for a placement that best suits their needs. I accept that finding an appropriate place for a disabled person may take time.

In any event, and more importantly, the relationship between waitlists and discrimination is, in my view, to be determined individually on the basis of meaningful access as prescribed by *Moore*. The rule is meaningful access and meaningful access can only be determined in the individual case.

In Need

The Complainants phrase their argument as if they are speaking only of poor people incorporating this idea to raise the issue of discrimination on the basis of "source of income" under section 5(1)(t) of the *Act*. I take a different view. I am not satisfied that a distinction may be drawn in the provision of the services we are talking about between those who have money and those who do not. The reality is that almost no significantly disabled individual could afford to sustain themselves, nor could or would their families sustain them in a small options home or almost any residential facility. It is simply too expensive. The cost of the services sought by the Complainants, and the cost of providing anything more than basic services to the disabled, are so far beyond the means of almost all of us that, in my opinion, the option of spending one's own money is almost entirely theoretical. I refer to the per diem costs Mr. Fagan described for the care of Ms MacLean, Ms Livingstone and Mr. Delaney as examples. Almost no client of RRSS over the years has been self-sustaining.

One does not think of paying for a knee replacement. The reality is that one depends on the Province as a disabled person seeking the services of the Province's health care system and, for many of those services, one waits. I acknowledge that a cognitively intact otherwise healthy individual awaiting a knee transplant may have difficulty proving a denial or limitation of meaningful access, but my point is that it would be open to them to claim discrimination if they were denied the service arbitrarily or unjustifiably.

In my view, although I confine its application to Ms Livingstone, Ms. MacLean and Mr. Delaney in this proceeding, the disabled are entitled to meaningful access to services generally. Disabled individuals on a waitlist may indeed suffer *prima facie* discrimination. Meaningful access for each of them is the overarching principle and meaningful access is not a function of being in need under the *ESIA* or the *Social Assistance Act.*

The Argument of the Complainant Disability Rights Coalition

The Coalition applies the disability discrimination analysis to the support of the disabled in Nova Scotia taken as a whole. The Coalition applies the analysis particularly to disabled people living in institutions who seek a placement in the community. I refer to their complaint, several paragraphs of which are quoted above. Their argument, as it developed in the evidence, also applies to disabled people seeking services generally. I refer to the evidence of Dr. Bach, Dr. Griffiths and Dr. Frazee. Their evidence argues that disabled people are entitled to services adapted to their needs wherever and however they choose to live.

I also refer to paragraph 393 at page 121 of the Complainants' post-hearing brief:

> The Board is being called upon to apply s.5 of the *Human Rights Act* to hold that for the Province to, *inter alia,* institutionalize persons with disabilities as a means of providing them with residential supports is discriminatory.

I also quote from the end of the Complainants' post-hearing written submission:

> The Province's support for the provision of supports and service through residential care options to the Complainants and other persons with disabilities in congregate care or institutionalized settings is *prima facie* discriminatory and a violation of section 5 of the *Human Rights Act*;

I do not accept that I would be justified in making such a draconian pronouncement under the *Human Rights Act* or in my role as a Board of Inquiry serving under it. The theme of my opinion is, however, that all is governed by "meaningful access" for the individual.

In my view, meaningful access provides the code and no general analysis of the role of "institutions" or another analysis based on free-standing rights can apply. I say, in other words, that one cannot construct a freestanding right to any particular service on demand by any disabled person. The argument for a generalized human right to access to a particular service detaches the right from the *Human Rights Act* itself.

I refer to the opinion of our own Court of Appeal in *Canadian Elevator Industry Welfare Trust Fund v. Skinner.*[102] *Skinner* involves a claim to payment for medically prescribed marijuana under a private health plan. Mr. Skinner argued successfully before a Board of Inquiry under the *Human Rights Act* that the plan's refusal to pay

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[102] *Canadian Elevator Industry Welfare Trust Fund v. Skinner,* 2018 NSCA 31 (CanLII)

for the benefit was discriminatory. The court disagreed. The court said that the health plan's restriction of payment to only those medications which had been approved by Health Canada was not discriminatory. The court's interpretations of the *Human Rights Act* are binding on me.

In particular, I refer to the Appeal Court's statements that although human rights legislation enjoys quasi-constitutional status, and should be given a liberal interpretation, "...this does not permit interpretations inconsistent with the legislation."[103] "... the starting point is the definition of discrimination in s.4 of the *Act...*"[104] The court, as part of its critique of the Board of Inquiry's opinion, said that the Board had expanded the "service" or "benefits" available.[105] and says that the Board had transformed "the benefit described in the Plan - prescription drugs approved by Health Canada-into prescription drugs personally beneficial to each claimant".[106] "Substantive equality" "is not a freestanding basis for impugning distinctions created by personal disadvantages".[107] "There must be a connection between the distinction and the adverse treatment or effect- s. 4 of the *Act* says so. So does the Supreme Court."[108]

I repeat, for convenience, the interpretation *Moore* imposes:

> [33] As the tribunal properly recognized, to demonstrate prima facie discrimination, complainants are required to show that they have a characteristic protected from discrimination under the Code, that they experienced an adverse impact with respect to the service, and that the protected characteristic was a factor in the adverse impact.

An adverse impact is the "burdens, obligations or disadvantages" in the definition of discrimination in our *Human Rights Act*. The Coalition argues that one must presume that "institutions" impose an adverse impact and all disabled people in "institutions" must be discharged more or less immediately to community facilities. In my view, however, stipulating a right to be in a small options home rather than

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[103] *Skinner*, para. 31

[104] *Skinner*, para. 32

[105] *Skinner*, para. 58

[106] *Skinner*, para. 64

[107] *Skinner*, para. 66

[108] *Skinner*, para. 73

an "institution" presumes that "institutions" are burdensome and disadvantageous *per se*, and indeed that any place where the individually disabled person does not want to be is burdensome and disadvantageous. This approach disregards the adverse impact requirement of discrimination.

Sheila Livingstone, for example, was placed at Harbourside Lodge. Harbourside Lodge, by the evidence, is an institution. Its location in Yarmouth was unsatisfactory, but for Ms Livingstone, one would be hard pressed to say that she suffered a burden or a disadvantage by her placement there. The evidence from Ms Livingstone's family was that, while a return to a small options home would have been ideal, Harbourside was a good placement and she was content there.

I also refer to the evidence of Betty Rich, whose disabled son, Joey, was a resident of Braemore in Sydney, of the Halifax County Rehabilitation Centre in Cole Harbour, of Sunrise Manor in central Halifax and then of Quest. Braemore, Cole Harbour and Quest are certainly "institutions". Sunrise Manor, although the evidence is scant, turned out to be one too. Ms. Rich said that Braemore and Sunrise Manor were bad placements. Ms. Rich says she was content with Cole Harbour and is now with Quest. She said she and her able adult children agree that Quest is the best place for him. Who can gainsay them?

Deputy Minister Hartwell explained the resistance some families have to the closure of Quest. I accept that families other than the Rich's are not unhappy with the care their loved ones are receiving in "institutions" and are nervous of change. Ms Hartwell stressed the importance of the Province being sensitive to their needs.

The Coalition also argues that a disabled person living with their parents, already supported in some measure within the scheme, may demand and receive a placement in a small options home. Again, in my view, this ignores the requirement of "adverse impact" under the Act and constitutes discrimination simply on the basis of the disability.

Let us also take the case of Jenny MacDonald's disabled son, Sam. He is now 32 and lives in the basement of the family home. Sam does receive Community Services supports. Ms MacDonald worries about what will happen when she and her husband are unable to look after him any longer or die. Ms MacDonald would like to see him placed in a small options home.

Sam MacDonald is receiving services and is living "in the community" with a fair degree of autonomy relative to the nature of his disabilities. Sam MacDonald, in my view, may indeed not be receiving meaningful access to a placement generally available to disabled people, but I cannot say that all people living at home with the support of Community Services are suffering an adverse impact. One cannot be so categorical. One cannot say that Sam MacDonald, as of right, can insist on his immediate placement in the small options home. His circumstances would have to be analysed and a conclusion made that he was suffering an adverse impact and was being denied meaningful access to the benefit of a small options home before concluding that he had been discriminated against. To do otherwise, in my view, is inconsistent with the rule in *Moore* and detaches the concept of adverse impact from discrimination as defined by our *Human Rights Act*.

All disabled people in Nova Scotia seeking services from the Department of Community Services are subject to the same regime. This regime involves a process of application, approval, and for the more complex disabilities, waitlists. I do not understand the *Act* to say that regardless of the Province's scheme for the care of the disabled, the individual may demand a particular service and that it would be discriminatory for the Province to deny it.

Note, too, that the three were cared for in a Health facility at Emerald Hall. Quest, where Joey Delaney and others mentioned in this opinion lived is also a Health facility. Again, the point is the integration of services for the disabled. One cannot isolate the Department of Community Services. There is flow back and forth.

Moore does address the issue of systemic discrimination.. Abella, J. says that "A practise is discriminatory whether it has an unjustifiably adverse impact on a single individual or systemically in general" and that "... the focus is always on whether the complainant has suffered arbitrary adverse effects based on a prohibited ground" and that "...the human rights issue will generally be whether the complainant has suffered adverse affects."[109]

I am not satisfied that all disabled people who do not have immediate access to services, that is to say are on waitlists, or people who are not on waitlists but are residents of "institutions", are suffering adverse affects. No general statement, in my view, can be made. Adverse affects on each individual will have to be assessed before meaningful access can be determined.

I also find support for my opinion in *Martin* (supra). Gonthier J. comments that the court should:

> ..take into account a fundamental characteristic of disabilities when compared to other enumerated grounds of discrimination; their

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[109] *Moore*, paras. 58-61

> virtually infinite variety and the widely divergent needs, characteristics, and circumstances of persons affected by them."[110]

Gonthier, J. continues:

> ... The question in each case will not be whether the state has excluded all disabled persons or failed to respond to their needs in some general sense, but rather whether it has been sufficiently responsive to the needs and circumstances of each person with a disability.[111]

The context of *Martin* was different rules for people with chronic pain under workers' compensation legislation and the *Charter*, but I find the comments about the variety of disabilities and the importance of considering each person with a disability are apposite in our case as well.

The Coalition, in effect, is saying that waitlists are discriminatory *per se*. The enormity of the consequences of such a rule are plain to see. Not only would the demand for small options homes be engaged, but also the demand for a range of medical services and the placement of people occupying hospital beds awaiting transfer to a nursing home or similar facility. Again, I come back to a simple rule; "meaningful access" in the individual case.

The Coalition's argument leads me to another concern related to whether there are adverse effects or not; that is what I called during the hearing "the granular" nature of discrimination under the Coalition's argument. It seems to me that if one constitutes a freestanding right to services, a right vested in the disabled person to services tailored to their needs and desires and delivered promptly upon application and approval, then any denial of a particular service becomes discriminatory. One lives in a group home in the community with seven other people, but one wants to live in a small options home with three other people. One lives in a small options home, but wants to live alone in a supported apartment. One lives in a small options home in Windsor, but wants to live in a small options home in Smith Settlement. Discrimination may become fine indeed. Discrimination becomes a dispute about the quality of the service. In my view, it is not an imposition of an adverse effect, a denial of meaningful access and discriminatory, for the Province to say it will grant the one service, but not the other or, subject always to meaningful access, a particular quality or location of service.

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[110] *Martin*, para. 80 at p. 557)

[111] Ibid.

The difficulty legally, in my view, is that almost anything that may be encompassed in the current model that does not suit the individual's choice may be regarded as "discrimination". The entitlement would extend to all who are "disabled" within the meaning of the *Human Rights Act*, a vast group indeed, and a service can only be denied, as the argument goes, by "discriminating" against the disabled. Discrimination then becomes any service which a disabled person chooses and the Province denies. The right to a particular service tailored to the individual becomes a freestanding right liberated from any limitation and, in particular, from the definition of "discrimination" under the *Human Rights Act.*

Dr. Bach would have the Province vest the funds in the individually disabled person and allow them to choose their own services, guided by "navigators" and other supportive people, but I do not see that such a policy is mandated by our human rights law, or more pertinently, that to deny the disabled such benefits is a denial of meaningful access and discriminatory.

The Coalition submits that the United Nations and the opinion of the Supreme Court of the United States in *Olmstead v. L.C.*[112] should inform the interpretation of the Nova Scotia *Human Rights Act* to the point of incorporation in support of their argument that institutions are discriminatory *per se* . In any event, in my opinion, "meaningful access" is our current informed understanding. *Moore* is our *Olmstead* setting out the rights of the disabled in the context of provincial human rights legislation.

Furthermore, the reach of *Olmstead* and the *United Nations Declaration* extend beyond my mandate under the Nova Scotia *Human Rights Act.* One might as well throw away the *Act* altogether as construct a right for Nova Scotians under either or both. I, in my capacity as a mere Board of Inquiry, am bound to the ground of the *Act.* It is a leap too far to constitute the *United Nations Declaration* or *Olmstead* as the law in Nova Scotia and, with *Moore* in place, incorrect as well.

In any event, on reading *Olmstead,* I find it to be more nuanced than argued before me. At page 605, Ginsberg J. says "For other individuals, no placement outside the institution may ever be appropriate." Ginsberg J., at page 602, makes it clear that the courts should defer to the wishes of the individuals themselves and to the reasonable assessments of professionals. The Complainants, it seems, would trample both.

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[112] *Olmstead v. L.C.* , 527 U.S. 581 (1999)

Ginsberg J. goes so far as to say[113] that:

> If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavours to keep its institutions fully populated, the reasonable-modifications standard would be met.

This sounds like "meaningful access" to me.

My authority to tell anybody to do anything arises strictly from the Nova Scotia *Human Rights Act*. The *Canadian Charter*, in my view, while relevant, does not extend my authority, nor does the Supreme Court of the United States or the United Nations. With respect, I think it would be foolhardy for me, *ex cathedra* so to speak, to dictate the lives of hundreds of people living in institutions. Some modesty and restraint are in order.

In any event, the Province accepts the *United Nations Declaration* as a matter of policy. I accept the Deputy Minister's testimony that the Province will continue to work towards its implementation. I acknowledge the frustration with the speed of the process, but as *Moore*[114] says "A margin of deference is, as a result, owed to government and administrators in implementing these broad, aspirational policies."

The Province's acceptance of the *United Nations Declaration* and its various reports including the *Roadmap* are, in my view, to be regarded as "aspirational".

The Purposes of the *Human Rights Act*

Our *Act* sets out the Province's own aspiration for human rights in a statement of the purpose.[115] The purpose of the *Act* is to recognize the inherent dignity and the equal and inalienable rights of all members of the human family, to recognize that human rights must be protected by the rule of law, and to recognize that the government and all public agencies have the responsibility to ensure that every individual in the Province is afforded an equal opportunity to enjoy a full and productive life. These purposes have informed my decision. It may, however, cost

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[113] *Olmstead*, p. 606

[114] *Moore*, para. 35

[115] *HRA*, s. 2

tens of millions a year to fulfill these aspirations for the disabled. That is for the next phase of this proceeding, but I finish this first step with a caution; one should not be glib about what witness Wendy Lill described as the elephant in the room during the *Roadmap* discussions of services for the disabled - cost.

Dated: March 4, 2019

J. Walter Thompson, Q.C.
Board of Inquiry