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

Respondents

and

The Nova Scotia Human Rights Commission

Commission

BRIEF SUBMITTED ON BEHALF OF THE COMPLAINANTS, BETH MACLEAN, SHEILA LIVINGSTONE AND JOSEPH DELANEY AND THE DISABILITY RIGHTS COALITION

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I. CONCISE OVERVIEW

1. The evidence before the Board overwhelmingly establishes that the Complainants have proven each of the three elements required to find *prima facie* discrimination.

2. The Complainants—as 'persons in need' of social assistance—have shown that their treatment by the Respondent Province is dramatically inferior to that received by persons who are also dependent on social assistance but who either have no disabilities or, if they do, are not ones that require residential supports.

Complaint

3. The human rights complaint in this matter was filed August 1, 2014, and amended on being referred to a Board of Inquiry by the NS Human Rights Commission (**NSHRC**) on May 8, 2015.[1]

4. As a complaint of broad systemic discrimination, it is not directed at any single government employee, department or entity. It claims that the Province has violated the rights of persons with disabilities in failing to accommodate their differential need for community based supports and services and imposing disadvantages not experienced by others through, for example, the unnecessary institutionalization of persons with disabilities.

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[1] See Complaint, Exhibit 17.

The Parties

5. The Complainants consist of three individuals, Beth MacLean, Joey Delaney, and Sheila Livingstone, as well as a group complainant, the Disability Rights Coalition (**DRC**).

6. Marty Wexler and Barb Horner, both members of the DRC, testified that the DRC is a non-profit group formed by persons with disabilities and their allies in 2001 following the release of an independent report evaluating Nova Scotia's community residential services for persons with disabilities, and that its purpose is to advocate for improved community based options for persons with disabilities and to promote the equality interests of persons with disabilities, in a manner consistent with the UN Convention on the Rights of Persons with Disabilities.

7. The Respondent, the Province of Nova Scotia, did not contest the DRC's standing as a party on the basis of it being an "aggrieved person." Human rights tribunals have heard claims of systemic discrimination brought by groups in a number of different contexts, including an early human rights decision from the Supreme Court of Canada that set out the test for systemic discrimination in the context of a human rights complaint, *Canadian National Railway v. Canada (Canadian Human Rights Commission) (Action travail des femmes)*[2] a case alleging sex discrimination in an employment context . Chief Justice Dickson described the complainant as "a public interest pressure group" and the complaint as "not that of a single complainant or even of a series of individual complainants; it was a complaint of systemic discrimination practised against an identifiable group."[3] More recently, in a decision of the Canadian Human Rights Tribunal, in the *First Nations Child and Family Caring Society,* the tribunal decided a complaint of

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[2] *Action travail des femmes* [1987] 1 S.C.R. 1114

[3] *Ibid,* at para 2-3.

systemic discrimination brought by non-profit group, the Caring Society, and the AFN, a national advocacy organization.[4]

Two stage hearing – violation and possible justification

8. In July 2016, the Board of Inquiry accepted the parties' proposal that the hearing into the human rights complaint would take place in two stages. At this first stage, the burden of proof is on the Complainants to demonstrate on the balance of probabilities that their rights have *prima facie* been violated; the so-called 'violation stage'.

9. The first stage hearing took place over a nine-month period from February to September, 2018 and included 29 days separate hearing dates during which testimony from 35 witnesses was heard.

10. Should the Board find that a *prima facie* violation has occurred, the Board will convene a hearing for the second stage, where the Province will bear the burden of proof to show that the violation is justified.

Disclosure and admissibility of documents

11. The Board of Inquiry issued four separate decisions in response to interlocutory motions for disclosure from the Respondent. In its fourth decision dated October 24, 2017, the Board reaffirmed its previous decisions that the Respondent would not be required to disclose any documents created after March 2016 and disclosure would not be compellable.

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[4] *First Nations Caring Society*, 2016 CHRT 2 para 12.

12. As ordered by the Board, a declaration of disclosure dated May 17, 2017 was filed by Joe Rudderham, Executive Director of the Respondent's Disability Supports Program, indicating that the Province had disclosed all documents as directed by the Board, with the exception of documents giving or created to obtain legal advice, and documents over which the Respondent claimed Cabinet privilege. Mr. Rudderham did not testify at the hearing.

13. In the event, the Respondent voluntarily disclosed several documents that updated earlier disclosures, such as 2017 DSP waitlist numbers that form part of the record in this proceeding.

14. The vast bulk of the documents disclosed in this proceeding are provincial government documents, written over the course of more than three decades, by a multitude of named and unnamed government employees, regarding services for persons with disabilities.

15. Subsequent to the completion of the disclosure process, the parties agreed that certain of those government documents, as well as some others, would form part of the evidentiary record, that is, admitted for the truth of their contents, without the necessity of calling the author or proving the document according to the strict rules of evidence. Those documents are contained in the Joint Exhibit Book (JEB, Volumes I-XI) and a Supplementary Documents Exhibit Book. In addition, further documents were introduced and admitted into evidence through the course of the hearing (Exhibits 13-79).

II. THE EVIDENCE

Weighing the Evidence

16. There is a great deal of evidence before the Board which would not be admissible in court. There is a great degree of second or even third-hand hearsay before the Board. Many lay

witnesses were permitted to offer opinion evidence. The Board must now weigh the great degree of evidence before him. Clear criteria should be applied to weigh this evidence. Expertise and independence should increase the weight granted the evidence.

17. The Province relied almost entirely on evidence from DCS employees (Lynn Hartwell, Carol Bethune, Trish Murray, Renee Lockhart-Singer, Denise MacDonald-Billard, and Neil MacDonald). The only non-DCS employee it called as a witness was Betty Rich. Often, these DCS employees were testifying in the presence of their superiors.

18. In contrast, the complainants called a number of witnesses who are not employed by the Province, or are employed by a separate branch of the public service. Few, if any, of the complainants' witnesses testified in the presence of anyone with power over the circumstances of their employment. The complainants' witnesses therefore possessed a greater degree of impartiality than the Province's witnesses and their evidence and should be assigned more weight as a result.

19. The complainants also called a number of expert witnesses. The testimony they offered within the realm of their expertise, for instance, about the harms of institutionalization, should be granted much more weight than the opinion evidence on the same topic offered by lay DCS witnesses.

Historical Disadvantage and Stigma

20. The history of discrimination against people with disabilities in Nova Scotia is one of isolation, segregation, and stigmatization. From the eighteenth to the mid-twentieth centuries the only treatment or "support" offered to Nova Scotians with disabilities was in segregated, isolated settings such as the "Poor house", county homes or mental hospitals. Many of the current RRCs are found on the grounds of those former institutions, such as the RRC in King's County which is found on County Home Road.

21. The bio-medical approach to disability reigned during this period wherein disabilities were perceived as individual defects or deformities. The focus of any intervention was exclusively on curing the perceived deficit. If the deficit was not curable, social and economic exclusion of the individual was justified. People with disabilities were presumed incapable of equal participation in community life. [5]

22. The habilitation and rehabilitation model gained influence in the mid-twentieth century in Canada. This model was rooted in the idea that “individuals could still progress along developmental pathways or recover from illness in ways that do not meet the ‘normal’ benchmark, but to maximize their capacities.” [6] Dr. Bach situates the 1944 provincial Royal Commission report on disability within this habilitation and rehabilitation era. This report concluded that, while people with disabilities could become ‘valued citizens’ with proper supports, institutions should remain in use for people who could not be supported in the home or in the community .[7]

23. The habilitation and rehabilitation approach to disability was supplanted by what Dr. Bach identifies as the social and human rights approach to disability in the last decades of the twentieth century. This model understands disability is the “result of the interaction between some of a person’s characteristics...with the social and physical environments in which people live.”[8] A core component of the social and human rights model is the full inclusion of people with disabilities in society. Dr. Bach claims that community advocacy groups and many Nova Scotian government reports have embraced this approach to disability. However, there remains a disconnection between the government's endorsement of this approach and its continued operation of institutions which isolate, segregate, and exclude persons with disabilities. [9]

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[5] Exhibit 12, Dr. Bach Expert Report, pgs. 2, 3. The expression of the bio-medical model in Nova Scotian public policy is explained by Bach at pages 5, 6.

[6] *Ibid* at pgs. 3, 4.

[7] *Ibid* at pgs. 7-9

[8] *Ibid* at pg. 4.

[9] *Ibid* at pgs. 12-16.

24. Dr. Catherine Frazee was qualified as an expert in the field of disability studies and provided testimony concerning disability. She identified “ableism” as underpinning many discriminatory attitudes and practices against persons with disabilities. Under ableism, embedded norms and expectations are based on the experience of non-disabled people. In this way, people with disabilities are stigmatized as deficient in comparison with mainstream norms. Laws and policies are shaped by and for people without disabilities and reflect ableist assumptions. So too is the physical environment. An example is found in the characterisation of certain needs as “special”. The needs and desires of people without disabilities are perceived as normal and natural, whereas the needs of people with disabilities are labelled as “special.” The stigmatized label of a “special” need clings, even when the need at issue is actually a simple one, such as the need for housing, education, or support with daily activities.

25. The ideal citizen in the ableist paradigm is one who performs paid work, pays taxes, and makes no demands on the state’s resources. People with disabilities who are not provided the opportunity for meaningful work, and thus are able to contribute less to the government's tax revenue are perceived as non-contributing citizens. The limitations on the resources allocated to this group are seen as justified because their claims to the state’s resources are seen as burdensome and expensive. The moratorium on small option homes is an expression of this ableist ideology. Even though people with disabilities have an urgent need for the service, their support needs are perceived as beyond the pale of responsible budgeting. [10]

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[10] Testimony of Catharine Frazee, June 4, 2018; Exhibit 37, Dr. Frazee’s Report.

Beth MacLean ("Beth")

26. The complainants called Beth MacLean, Joanne Pushie, Jim Fagan, Dr. Sulyman, Nicole Robinson, and Krista Spence as witnesses regarding Beth MacLean. The Province called Carol Bethune and Denise MacDonald-Billard to testify about Beth.

27. Beth's medical records show that she has, over time, been diagnosed as having the following disabilities: a mood disorder, and an intellectual disability (which has been considered 'mild' or 'moderate' at times).[11] The Province has not disputed that Beth is a person with disabilities who is financially dependent upon the Province for social assistance in order to have her needs met.

28. Beth has been institutionalized for almost all of her life. She is now forty-seven years old. She has been institutionalized since she was ten years old. Between ages 10 and 14 she lived at the Nova Scotia Youth Training Centre, at Bonny Lea Farms, the Annapolis Youth Training Centre, the IWK, and the Nova Scotia Hospital. She lived in Kings' Rehabilitation Centre from ages 14 to 29. She spent almost 16 years in the Nova Scotia Hospital.[12] She was transferred to the Community Transition Program just over two years ago. Ms. Bethune for the Province agreed that all of these facilities are institutions funded in whole or in part by the Province.[13]

29. The Province's primary witness with respect to Beth MacLean, Ms. Bethune, only became her care coordinator in 2016. Ms. Bethune attended several days of the hearing prior to providing testimony. She was present for Joanne Pushie and Beth MacLean's evidence. Christine Pynch was Beth's care coordinator for the vast majority of the period between her arrival at the NS Hospital in 2000 until June of 2016.. She retired just a few months ago and was present for Ms. MacLean's evidence. While the Province could obviously

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[11] Book IX, Vol. 2, Tab 108; Book IX, Tab 85; Book IX, Tab 20; Book IX, Tab 47.
[12] Book IX. 21. May I, 2002 DCS CSA Form B re Beth, p. 2.
[13] Testimony of Ms. Bethune, September 6, 2018.

have compelled Ms. Pynch to have ‘the best evidence’ available for the Board, Ms. Bethune was called by the Province to speak to many years of Beth’s life for which she was not involved in the file and, as a result, her testimony was often a mixture of simply speaking to Ms. Pynch’s case notes or, as she readily admitted, speculating about ‘what may have happened’ in particular situations. [14]

Beth MacLean’s Time in Kings Regional Rehabilitation Centre (1986-2000)

30. Beth was admitted to Kings, a facility for adults, as a 14-year old girl. Because of her age, special Ministerial permission was required for her admission. [15]

31. On direct examination Ms. Hartwell testified that children shouldn’t be in institutions. In the context of speaking about the closure of the children’s training centres, she stated “the closing of the children’s was the right thing to do...Children should be with families they shouldn’t be in facilities.”[16] Ms. Bethune agreed that Kings’ was not intended to house children but refused to say that it was inappropriate for Beth to be placed in an adult institution.[17]

32. Beth MacLean testified that she did not like living at the Kings Regional Rehabilitation Centre. She was fourteen when she arrived there, which was “too young,” she was supposed to be eighteen to live there. She said she received no education while living there. She was not allowed to help prepare her food, which was, in her words, “disgusting.” She had two roommates and shared a bathroom with other residents. She spent much of her time there in the lobby.[18]

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[14] Testimony of Ms. Bethune, September 6, September 19, 2018.

[15] Book IX, Tab 90, JEB pg. 7598.

[16] Testimony of Lynn Hartwell, August 9, 2018.

[17] Testimony of Carol Bethune, September 6, 2018

[18] Testimony of Beth MacLean, March 6, 2018.

33. Ms. Pushie testified about her knowledge of Beth's time in Kings from her conversations with Beth. She said that Beth told her that she didn't like Kings. She told Ms. Pushie about the lack of control she had over her over life. She had to sign out to leave facility, have to be on schedule that met facility's needs, not hers. She had to share a bedroom with 2 other people. She had a community bathroom instead of personal space.[19]

34. Beth's evidence about the quality of her life while at Kings went unchallenged by the Province. Thus, in her evidence, Ms. Bethune agreed that she had never seen any documentation suggesting that Beth had been provided an education at Kings.[20] Documentation from Beth's file states that she had never been "gainfully employed" at Kings.[21] While at King's Beth went to a birthday party at a Small Option home. She thought it was "nice."[22]

35. Beth had no care coordinator assigned to her by the Province during the entirety of her time at Kings. As such, the Province performed no annual assessments to ensure that she was appropriately placed, or to see if she wanted to be placed in a community-based setting instead. Ms. Bethune's predecessor Christine Pynch flagged this issue, writing to her supervisor that this problem did not just impact Beth-no 'block-funded clients in homes for special care were provided were assigned care coordinators who performed annual assessments'.[23]

36. Beth was determined to leave Kings. She deliberately engaged in behavior that would facilitate her exit from that institution. A psychiatrist who assessed Beth stated:

> Her behavior was stable with an average number of difficulties and incidents until early July 2000, when she severely vandalized several cars in a parking lot while at a community work site…. In

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[19] Testimony of Joanne Pushie, February 20, 2018.
[20] Testimony of Ms. Bethune, September 6, 2018.
[21] Book IX, Tab 6, page 2/35, JEB p. 7164.
[22] Testimony of Beth MacLean, March 6, 2018.
[23] Book IX, Tab 9; IX. 3. DCS Case notes, p. 17, JEB p. 7148; Testimony of Carol Bethune, September 6, 2018.

> particular, she has clearly articulated that she wants to leave the Rehabilitation Centre and wants to go to prison, and that the best way to get there would be to increase her aggressive behaviour and attack others. It appears that after fifteen years at the Rehabilitation Centre, and seeing no way to leave through any positive means given her difficulties and those of the Community Service System, Beth determined that aggressive behaviour was her only means to depart and acted in such a manner regardless of the consequences for her relationships to other people and the difficulties she would face.[24]

37. Ms. Bethune agreed that Beth "was taking charge of situation and wanted out" of Kings.[25] The Department of Community Services, the Department of Health, and the Nova Scotia Hospital entered into an "agreement/arrangement" so that Beth could live in the Nova Scotia Hospital for "up to one year."[26] The arrangement was referred to as "respite" care.[27] Under the terms of this one-year agreement Beth entered the Nova Scotia Hospital for what stretched into a sixteen year stay.

Maritime Hall

38. Maritime Hall is a psychiatric rehabilitation unit. During the time of Beth's detention there, it did not treat persons with dual diagnoses (intellectual disabilities and mental health concerns). It did not provide programming suitable for persons with intellectual disabilities and its staff were not specialists in the treatment of people with intellectual disabilities.[28] Joanne Pushie testified that the significance of this was that most of the people Beth was surrounded by had no difficulties with their activities of daily living. They had different support needs than Beth. She testified that she expected that this was likely intimidating for Beth.[29]

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[24] Book IX, Tab 6, pg. 8, JEB p. 7170.
[25] Testimony of Carol Bethune, September 6, 2018.
[26] Book IX. Tab 3, pg. 17/22, entry for October 23, 2000, JEB p. 7148.
[27] Book IX, Tab 21, pg. 4/12, JEB p. 7247.
[28] Book IX, Tab 10. March 20, 2001.
[29] Testimony of Joanne Pushie, February 4, 2018.

39. Beth was in her twenties and thirties while in Maritime Hall. There was no dispute from the Province that her age meant that she was properly DCS' responsibility, and was far too young for support under the Department of Health (e.g., possible placement in a nursing home). [30]

40. Ms. Pynch's case notes state that Beth was "unclassifiable" (i.e., ineligible for residential supports with the DSP) at the time of her admission to Maritime Hall.[31] However, there is no evidence that any assessment or classification was actually performed on Beth either prior to or after her entry to this institution.[32] Ms. Bethune acknowledged that there was no evidence in the file to suggest that she was assessed either prior to or after her entry to Maritime Hall. She further agreed that the policy cited by Ms. Pynch in the case note about her unclassifiability was irrelevant to the circumstances."[33]

41. Beth testified that she was only supposed to be in Maritime Hall for one year "but they kept me longer." She spent most of her time on Maritime Hall locked in her room "24/7" watching TV. She could leave the unit if sufficient staffing was provided. She didn't like the food and had no control over what she ate or when she ate it. [34]

42. Ms. Bethune agreed that Beth's time in Maritime Hall was "very challenging" due to the restrictions on her liberties she was forced to endure.[35] Documentation from Beth's file corroborate her testimony about the amount of time she spent on that unit locked in her room without opportunities for recreation and employment. The same documentation establishes that DCS was aware of the severe restrictions placed on Beth's liberties on

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[30] Testimony of Carol Bethune, September 6, 2018.

[31] Book IX. 3, pg. 17/22, entry of October 23, 2000, JEB p. 7148.

[32] *Ibid*

[33] Book IX. 3, pg. 17/22, entry of October 23, 2000, JEB p. 7148; Testimony of Carol Bethune, September 6, 2018.

[34] *Supra* note 51

[35] *Supra* note 54

Maritime Hall.[36] Within months of Beth's admission she told her DCS care coordinator, Christine Pynch that she "she doesn't belong here and doesn't like it here." [37]

43. A recreation assessment performed on Beth while in Maritime Hall stated that Beth

> Spends most of her time in seclusion. Isolated from others for almost 23 hours a day she takes her meals alone in her room...This secluded and sedentary existence negatively impacts Beth's physical, social, psychological, spiritual and intellectual health in a variety of ways, including contributing to… In my opinion this form of "lifestyle" will only exacerbate Beth's behavioural problems and retard her potential to improve in virtually all areas of human growth and development.[38]

44. Ms. Bethune read this assessment and agreed that spending great deals of time locked in her room alone "probably impeded her development and health."[39]

45. Within a month of Beth's admission to Maritime Hall, the unit's psychiatrist wrote to DCS that since Beth did not meet the criteria to be formally admitted to the hospital, there was no legal basis for her detention.[40] The same psychiatrist sent an assessment to DCS which stated that Beth had "no evidence of a...psychiatric disorder. Her difficulties with behavioural control would best 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."[41] Ms. Bethune agreed on cross-examination that one-to-one staffing could have been provided in a Small Option home by DCS. She agreed that there was no evidence in Beth's file that DCS actually considered finding or funding a small option home for Beth at any point during her detention at Maritime Hall.[42]

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[36] IX. 3. P. 18/22, JEB p. 7149; Book IX. Tab 3, entry April 28, 2005, JEB pp. 7151 and 7152.
[37] Book IX. Tab 10. March 20, 2001.
[38] Exhibit 77, Recreation Assessment for Beth MacLean, April 5, 2001, by Karrie Scribner, p. 1.
[39] Testimony of Carol Bethune, September 6, 2018
[40] Book IX. Tab 3, pg. 17/22, JEB p. 7148.
[41] Book IX, Tab 5. November 14, 2000 Fax Cover Sheet, JEB p. 7160.
[42] Testimony of Carol Bethune, September 6, 2018.

46. Maritime Hall staff repeatedly informed DCS that Beth was being harmed by her stay in Maritime Hall. It was not in her best interests to be there. The unit was an inappropriate place for someone with an intellectual disability. She wanted to leave and was becoming frustrated and disappointed as her stay lengthened. They advocated for DCS to follow-through on its agreement to find her a DSP placement outside the hospital.[43] Ms. Bethune agreed that the tone of some of these communications was "urgent" and "frustrated."[44]

47. During the first couple of years that Beth was in Maritime Hall DCS engaged with the clinical team's efforts to discharge Beth from the hospital. DCS began exploring institutional placement options for Beth outside the hospital, even before it performed an assessment or classification of her.[45] Ms. Bethune agreed that DCS appears to have assumed that she was classifiable prior to May 2002, since it began pursuing placement options for her. There was some internal confusion about who within DCS was responsible for Beth. [46]

48. In March 2001, DCS began paying the NSHA for some of the costs associated with her care. DCS also paid comfort allowances to Beth from 2001-2007. [47] Ms. Bethune agreed that comfort allowances were only payable to persons who were considered eligible "persons in need" of DSP support. She was unable to explain why DCS paid thousands of dollars towards the cost of her care , but she speculated that it was due to the special arrangement under which she was held at Maritime Hall.[48]

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[43] Book IX. 10. March 20, 2001; Book IX. 15. March 11, 2002 email from Avis Falkner; Book IX. 16. March 11, 2002 email from Avis Falkner; IX. 18. March 21, 2002; Book IX. 17. March 20, 2002 letter from Maritime Hall to Hyson.

[44] Testimony of Carol Bethune, September 6, 2018; Book IX. Tab 25.

[45] Book IX. Tab 11 May 14, 2001 email from Pynch; Book IX. Tab 12. May 16, 2001 DCS emails; Book IX. Tab 13. September 24, 2001 internal DCS emails re Beth; IX. 14. November 9, 2001 Confidential Meeting Notes; Book IX. Tab 3, pg. 18/22, JEB p. 7149.

[46] Testimony of Carol Bethune, September 6, 2018, Book IX. 19. April 5, 2002 DCS internal emails.

[47] Book IX. Tab 3, pgs. 18, 19, 20 /22, JEB pp. 7149, 7150, 7151 and 7153.

[48] Testimony of Carol Bethune, September 6, 2018.

49. A DCS assessment was performed on Beth in April 2002. Ms., Bethune agreed that the assessment's author wrote that Beth was 'ready for a community setting' and that 'Beth is very much wanting to live outside unit environment…she keeps track of it day by day.'[49] Beth "classified" as eligible for residential supports with the DSP in May 2002. Her classification "level" as "Developmental Residence Three."[50] Beth was considered for a placement at Riverview ARC, but she was not offered a placement. There is no evidence that DCS took any other steps to find her a place to live outside the hospital after this May 2002 classification.[51]

50. In November 2002, a DCS Field Assessment Officer classified Beth at an "RRC" level of care.[52] Again, there's no evidence that DCS took any other steps to find her a place to live outside the hospital after this classification in November 2002. There is no evidence that DCS took any steps to find Beth a place to live outside the hospital between November 2002 and February 2003.[53] In that month, another assessment was performed which stated that "Beth is now ready for a community setting with the proper supports in place."[54] She was also assessed in March 2003. This assessment reiterated that she was ready for a community-based placement.[55]

51. In April 2003, Beth was reclassified again, this time back to a Developmental Three level of care.[56] Beth was waitlisted at a "Developmental Residence Three" in November 2003, **seven months** after her classification in April 2003.[57] Ms. Bethune agreed that there was no evidence in the file that she was waitlisted for another region in between April and

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[49] Book IX. Tab 21, JEB p. 7253; Testimony of Carol Bethune, September 6, 2018.
[50] Book IX. Tab 23.
[51] Book IX. Tab 25; Book IX. Tab 3, pg. 19/22, JEB p. 7150.
[52] Book IX. 26.
[53] Book IX. Tab 3, pg. 19/22, JEB p. 7150;Testimony of Carol Bethune, September 6, 2018.
[54] Book IX. Tab 27, p. 7277.
[55] Book IX. Tab 28, p. 7290.
[56] Book IX. Tab 30.
[57] Book IX. Tab 35.

November 2003 and that this would have delayed her being considered for DSP openings.[58]

52. There is no evidence that DCS took any steps in 2004 to find a place for Beth to live outside the hospital.[59] In January 2005, the psychiatrist on Maritime Hall conducted an assessment on Beth and concluded that "Ms. MacLean has benefited maximally from our services and her needs are best met by community placement."[60]

53. In January 2005, Pynch ran into Beth while conducting other business at the hospital. Beth told Pynch that "she has a lawyer to get her into a small option home."[61] Beth was deemed unclassifiable for residential supports in March 2005. The decision-maker cited the fact that "Beth continues to live behind a locked three-quarter door with frequent observation for a larger percentage of her day...her behavior remained unpredictable and she had a frequent incident with her developmental worker when she was at the mall and police had to be called."[62] Beth's lawyer wrote to DCS and suggested, in the context of the recent unclassifiability ruling by DCS, that she be moved back to King's. Denise-MacDonald Billard replied by stating that Beth was unclassifiable and was therefore ineligible for DSP residential supports.[63]

54. Beth appealed the classification decision. The DCS decision was upheld, the decision maker cited the amount of time she was locked in her room, her "aggressive" behavior, and the fact that she required one-to-one staffing.[64] This decision "while only an appeal decision" was perceived by Denise MacDonald-Billard DCS as a vindication of its classification criteria.[65] Ms. MacDonald-Billard explained that the decision was seen as

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[58] Testimony of Carol Bethune, September 6, 2018.
[59] Book IX. Tab 3, <u>JEB p. 7151</u>; Testimony of Carol Bethune, September 6, 2018
[60] Book IX. Tab 36, <u>p. 7332</u>
[61] Book IX. Tab 3, pg. 20/22, <u>JEB p. 7151</u>.
[62] Book IX, Tab 3, pg. 21/22, <u>JEB p. 7152</u>.
[63] Book IX, Tabs 37, 38.
[64] Book IX. Tab 41.
[65] Book IX. Tab 42.

important because DCS had talked to the Hospital about how locking her behind a door would prevent her being classified by DCS. They refused to do so and instead requested that DCS change its classification criteria. DCS did not want to do this. [66]

Emerald Hall

55. After almost seven years in Maritime Hall Beth was transferred to Emerald Hall in July 2007. Beth testified before the Board that that Emerald Hall was a “shithole.” She explained to the staff there that she was only supposed to be in hospital for one year. Recorded in the DCS case notes is the fact that Beth told Christine Pynch that she didn’t like Emerald Hall and wanted to live elsewhere. [67]

56. Krista Spence worked as a Developmental Worker in Emerald Hall from March 2011 to June 2013 and knew Beth during her time there. She was hired to reform the Unit’s limited recreation activities. She testified that Beth was one of the people on the Unit whose limited recreational opportunities caused the clinical team particular concern. This was because she had “very low aggression” levels, needed and wanted social interaction and stimulation, and was considered the “highest functioning” person on the unit. Recreation remained under-resourced on the Unit. As a result, Beth was only able to leave the unit once every week or two. It would depend on the level of staffing available in the unit and the current health of its other residents. Outings were frequently cancelled and this caused Beth disappointment and frustration. She did some “menial tasks” with the Occupational Therapy Assistant.[68]

57. Nicole Robinson worked with Beth from December 2015-June 2016. She found Beth easy to work with. She enjoys socializing, and going for walks and outings. She did not identify physical aggression as an issue with Beth. She worked with Beth on her verbal

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[66] Testimony of Denise MacDonald-Billard, June 18, 2018.
[67] Testimony of Beth MacLean, March 6, 2018.
[68] Testimony of Krista Spence, March 7, 2018.

communication skills. Although Ms. Robinson does not like to use the phrases “higher functioning” or “lower functioning,” she agreed that Beth is considered “higher functioning” than other residents at Emerald Hall. [69]

58. Beth was assessed by DCS in March of 2008. She was recommended for an “RRC” level of care and an RRC facility. [70] Either a review or a classification meeting was held in June of that year. The officer didn’t arrive at a conclusion about her classifiability. Ms. Bethune agreed that the summary of the meeting doesn’t indicate whether it was a classification decision. [71] (Also, this classification is not included in a letter written by Ms. Pynch summarizing Beth’s classification history).[72]

59. In December 2008, Ms. Pynch made a case note entry in which she recorded that Beth’s lawyer was advised they should close their file on Beth. Further, “the long-term plan will be RRC when she is ready and they will plan for Cobequid RRC.” Ms. Bethune agreed that there appears to have been a pre-determination of where Beth would live at a time when her classification status was unclear, and that the possibility of a SO home was foreclosed “at that moment in time.” [73]

60. In fact, Beth was DCS classified in March 2009 at a “Developmental Three” level. From this point to the present she has been “classified” by DCS and therefore eligible to live in any one of the DSP’s support options, including small option homes. Ms. Bethune agreed that the classification decision did not note that Beth had experienced any recent changes i.e., improvements in her condition that might have accounted for the change of classification. [74]

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[69] Testimony of Nicole Robinson, March 8, 2018.
[70] Book IX. Tab 48, JEB p. 7366.
[71] Book IX. Tab 3. Pg. 15/22, JEB p. 7146; Testimony of Carol Bethune, September 18, 2018.
[72] Book IX. Tab 73.
[73] Book IX. Tab 3, pg. 14/22, JEB p. 7145; Testimony of Carol Bethune, September 18, 2018.
[74] Testimony of Carol Bethune, September 18, 2018; Book IX. Tab 50.

61. Ms. Bethune was not surprised that Beth went more than four years without a classification being performed on her file by DCS. She testified that DCS takes a passive approach to hospitalized DSP participants. DSP staff do not proactively request hospital staff to perform assessments or classifications. Rather, they wait for requests to be initiated by [the Respondent's] hospital staff. She agreed that this can result in DSP participants in hospitals waiting "for years, indefinitely" for an assessment by DSP. She acknowledged that she "didn't know" the policy basis for DCS' practice of taking a passive role when someone is hospitalized. [75]

62. Beth was referred to DASC industries by the Emerald Hall staff in October 2009. The staff wrote that "Beth would thrive in such an environment."[76] Several months later DASC wrote to Ms. Pynch, stating they had tried to reach her repeatedly about Beth's application.[77] Ms. Bethune agreed that there was no indication in the case notes that Ms. Pynch ever replied to this letter. [78]

63. In late 2009, the Emerald Hall clinical staff wrote to Ms. Pynch, and expressed that Beth was doing really well and likely wouldn't need COAST team follow-up in the community, and requested that she broaden the scope of placement options that DCS was considering for Beth. [79] In March of 2010 Beth was assessed at a "Developmental three" level of care. The assessment decision noted that "Beth is requesting to live in a small option to live in when she leaves the hospital. Beth is very clear that she doesn't want to live in a larger facility, even with 8 people."[80] Shortly afterward she was "reclassified" to a "Developmental two" level of care. Ms. Bethune agreed that there was no explanation provided for the change in her DCS classification status. [81]

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[75] Testimony of Carol Bethune, September 18, 2018

[76] Book IX. Tab 51, JEB p. 7386.

[77] Book IX. Tab 59.

[78] Testimony of Carol Bethune, September 18, 2018.

[79] Book IX. Tab 52.

[80] Book IX, Tab 56, JEB p. 7402.

[81] Book IX, Tab 58; Testimony of Carol Bethune, September 18, 2018.

64. In May of 2010, the DCS placement coordinator asked for a recent assessment of Beth to see if she could fit into any expected upcoming openings in small option homes. Ms. Bethune agreed that DCS was trying to fit her into existing openings, and DCS had not considered creating a new small option home for her. [82] Beth was considered and rejected for an available placement ("**Fairfax**"). Ms. Bethune agreed that there was no explanation in the file about why she was not offered this opening aside from a reference to the "staffing complement". [83]

65. In August of 2010, the medical team at Emerald Hall filled out an assessment of Beth and noted that Beth could be supported to live outside the hospital. [84] Beth was reclassified as Developmental Three at this time. The classification decision noted that "when Beth doesn't have regularly scheduled activities through the week the incidents of aggression noticeably increase." [85] Beth was waitlisted that month, developmental residences were selected by Ms. Pynch as Beth's first choice, and then small option homes. Ms. Bethune agreed that this did not align with Beth's own stated preference for her living situation.[86] Beth was not waitlisted after her March 2009 classification. Ms. Bethune speculated that she might have been waitlisted for another region. Nothing in the file to suggest this occurred. [87]

66. Ms. Pynch filled out another assessment form for Beth in September of 2010 and repeated her earlier statement about Beth's clear preference for a small option home. In her own comments she stated "Beth will talk about wanting a small option home, however she has never resided in a small option home…"assumption that Beth fantasized about it." Ms. Bethune agreed that Ms. Pynch made an assumption that Beth was fantasizing about a small option home, and that part of the reason Beth had never lived

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[82] Book IX. Tab 60; Testimony of Carol Bethune, September 18, 2018.
[83] Book IX, tab 61; Testimony of Carol Bethune, September 18, 2018.
[84] Book IX. Tab 62.
[85] Book IX, Tab 3, pgs. 10, 11/22, JEB pp. 7141 and 7142.
[86] Book IX, Tab 64, JEB p. 7440, Testimony of Carol Bethune, September 18, 2018.
[87] Book IX, Tab 70; Book IX, Tab 72, Testimony of Carol Bethune, September 18, 2018

in one was because she had lived in the hospital for many years, and this was due in part to the moratorium on small option homes. [88]

67. In February 2011 Ms. Pynch performed a classification review. Her "Developmental three" status remained consistent. Nothing else related to a placement occurred on her file in 2011.[89] A medical assessment performed in June of 2012 stated that Beth's conditions had been stable "for years". [90]

68. In July of 2012, Ms. Pynch noted that Beth's parents were concerned about her leaving the hospital. Ms. Bethune expressed familiarity with the phenomenon of parents being fearful of their child's deinstitutionalization. She referred to the fear of deinstitutionalization as "fear of the unknown." [91] Ms. Bethune also acknowledged that Beth's mother had called Beth a "monster" at least once. Ms. Bethune took exception to this. She finds it offensive. [92]

69. Beth was classified again at a "developmental three" status in August 2012. The classification officer noted that she had been stable for a long time. [93]

70. In August of 2012, another DCS assessment was performed on Beth. Ms. Pynch repeated the statement from earlier assessments about Beth being very specific about wanting a small option home. She also stated in her comments "Beth has been consistent about talking about living in a small option home." [94] Beth's parents expressed to Ms. Pynch in September 2012 that they refused to make any decisions about a placement for Beth.[95]

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[88] Book IX, Tab 66, JEB p. 7460; Testimony of Carol Bethune, September 18, 2018.
[89] Book IX, Tab 3, pg. 9/22, JEB p. 7140; Testimony of Carol Bethune, September 18, 2018.
[90] Book IX, Tab 74, JEB p. 7496.
[91] Book IX, Tab 3, page 7139, case note for July 18 2012; Testimony of Carol Bethune, September 18, 2018
[92] Testimony of Carol Bethune, September 6, 2018.
[93] Book IX, Tab 3, JEB p. 7137.
[94] Book IX, Tab 77, JEB p. 7527.
[95] Book IX, Tab 3, page 6/22, JEB p. 7137.

71. No steps were taken by DCS to try and find Beth a place to live outside the hospital between September 2012 and April 2013. In April and May of 2013 Ms. Pynch was involved in conversations about how Beth's parents refused to entertain placement offers for Beth. In June of 2013, Dr. Sulyman performed a capacity assessment and concluded that Beth had capacity to instruct counsel regarding placement decisions. [96]

72. No actions were taken by DCS to find a placement for Beth between spring 2013 and February 2014. In February of 2014, Ms. Pynch made a case note that she was told by Dr. Riives that Beth "lacked capacity", but that her parents were now consenting to placement.[97] Ms. Bethune concurred that this entry is ambiguous about what kind of decisions Beth lacked capacity to make. Ms. Bethune agreed that there were no capacity assessments performed on Beth between June of 2013 and February 2014. She also agreed that that Dr. Riives was not a psychiatrist. [98]

73. Within three weeks of the first version of the human rights Complaint having been filed, Beth had been referred to RRSS for a possible placement with RRSS in early March 2014 ("**Kincardine Drive**"). Jim Fagan's uncontradicted evidence which commented on the RRSS decision to decline that placement proposal was that RRSS did not believe that particular opening at that particular time was a good fit for Beth. He stressed that RRSS believed it could support Beth in the community, just not in that particular house with those particular roommates. [99]

74. In March of 2014, Joanne Pushie faxed Dr. Sulyman's June 2013 capacity assessment to Ms. Pynch and wrote she "thought it might be helpful."[100] Ms. Pynch received the fax.[101] Nonetheless, Ms. Pynch nonetheless consulted Beth's parents about a potential

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[96] Book IX, Tab 78.

[97] Book IX. Tab 3, pg. 5/22, JEB p. 7136.

[98] Testimony of Carol Bethune, September 18, 2018

[99] Testimony of Jim Fagan, March 12, 2018; Book IX, Tab 86.

[100] Book IX, Tab 82.

[101] Book IX, Tab 3, pg. 5/22, JEB p. 7136.

placement offer in the fall of 2014.[102] Beth was not accepted for this placement opportunity ("**Thomas Lane**"), largely due, ironically, to her lengthy period of confinement in the Nova Scotia Hospital. [103]

75. In October 2014, Beth's lawyers sent a letter to Dauphinee Carol, Christine's Supervisor, which stated that they were Beth's representatives with regard to placement offers. They also reiterated that Beth sought a single-level small option home in the Central Region. They looked forward to hearing from the Province about any "potentially suitable community-based placements for Beth."[104] DCS took no steps to find Beth a place to live outside the hospital between October 2014 and March 2015. [105] In March 2015, Ms. Pynch waitlisted Beth for a small option home placement. She listed no other preferred placement options. [106]

76. Beth was assessed by DCS again in July of 2015. The assessor reiterated that Beth remained consistent in her desire for a small option home. [107] A new waitlist form was submitted which noted that Beth had capacity to instruct her legal counsel surrounding placement decisions. [108] Beth was classified at a "level five" under the Province's new classification system. [109] There is no evidence that DCS made any efforts to find Beth a place to live outside of Emerald Hall between July 2015 and June 2016. [110] In May of 2016, Dr. Sulyman performed a capacity assessment at the request of the NSHA's legal counsel. She concluded that Beth had "capacity to make placement decisions." [111]

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[102] Book IX, Tab 3, pg. 4/22, JEB p. 7135.
[103] Book IX, Tab 88, JEB 7590.
[104] Book IX, Tab 89.
[105] Book IX, Tab 3, pg. 4/22, JEB p. 7135;
[106] Book IX. Tab 91.
[107] Book IX. Tab 93, JEB p. 7609.
[108] Book IX, Tab 94.
[109] Book IX, Tab 95.
[110] Book IX, Tab 3, pgs. 3,4/22, JEB pp. 7134-35.
[111] Book IX. Tab 98

77. In June of 2016 Ms. Pynch received a placement offer from the Community Transition Program ("**CTP**"). She wrote in her case notes that she complied with Beth's written request to communicate with her legal counsel about the offer. [112] Beth's legal counsel confirmed her acceptance of the placement offer because it was the "only offer" she had received after fifteen and-a-half years in the Nova Scotia Hospital. Beth still wanted a small option home placement and expected that she would remain at CTP temporarily while a suitable placement was secured. [113] Ms. Bethune became Beth's care coordinator on July 20, 2016. She confirmed that Ms. Pynch told her that she was obligated to run placement offers through Beth's legal counsel. [114]

Community Transition Program

78. Beth testified that CTP is "better" than the Nova Scotia Hospital. She has her own room key. She can't leave the Unit by herself.[115] Joanne Pushie testified that CTP is similar to Maritime and Emerald Hall. It is an institution. It is not locked, but a bell must be pressed to enter and exit the building. It imposes a high degree of surveillance upon residents.[116]

79. Ms. Bethune made no case note entries from the time Beth entered CTP until seven days after her transfer to a small option home on Kearney Lake Road ("**KLR**") for a short period of time while at CTP in December 2016. She stated that the opening in the home emerged due to the death of a resident. Undocumented conversations with CTP, KLR, complex case, and Beth's parents occurred. [117] Despite knowing that Joanne Pushie was involved with Beth as a friend/advocate, she was not notified of the offer until after Beth moved.[118]

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[112] Book IX, Tab 3, pg. 3/22, JEB p. 7134.
[113] Book IX, Tab 102.
[114] Testimony of Carol Bethune, September 18, 2018.
[115] Testimony of Beth MacLean, March 6, 2018.
[116] Testimony of Joanne Pushie, February 20, 2018
[117] Book IX, Tab 3, pg. 2/22, JEB p. 7133; Testimony of Carol Bethune, September 18, 2018.
[118] Testimony of Joanne Pushie, February 20, 2018.

80. Ms. Bethune acknowledged that she did not contact Beth's legal counsel prior to the move. Her explanation for her failure to do so was two-fold. First, she felt that was not obligated to do so since she believed Beth had capacity to make placement decisions after Dr. Sulyman's May 2016 capacity assessment. She acknowledged that Ms. Pynch informed her in June of 2016 of Beth's counsel's request to run placement offers through counsel. The second explanation she provided was that she left Beth's legal counsel voicemails. She acknowledged that she did not document these messages at the time. She did not explain why she left voicemails if she believed she was not obligated to run placement offers through Beth's legal counsel.[119]

81. Beth testified about the events which led to her discharge from KLR. She was angry due to the denial of her yogurt. She paid for the yogurt. She "threw the table." The police were called and she was handcuffed. [120]

82. Ms. Bethune characterized the events leading to Beth's discharge from KLR as an "extreme outburst" which resulted in over $1000 in estimated property damage. On direct and cross examination, she acknowledged that the staff working during the incident was unaware of Beth's de-escalation plan. The staff was not trained to administer a PRN, and they did not have an oral PRN to deliver. They called Emergency Health Services to administer it. She agreed that the staff were dramatically ill-prepared to deal with the situation. She acknowledged that she was aware CTP investigated the incident. Ms. Bethune was asked about CTP's conclusion that Beth only damaged one door and that KLR's claim she caused extensive damage was unsubstantiated. She replied that she understood that Beth caused about $400 in damage to the home. [121]

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[119] Testimony of Carol Bethune, September 18, 2018; Book IX, Tab 3, pg. 2/22, JEB p. 7133.
[120] Testimony of Beth MacLean, March 6, 2018
[121] Testimony of Carol Bethune, September 18, 2018.

83. Jim Fagan met with the staff from the KLR small option home to discuss the incident. He testified that RRSS would have handled the situation very differently. RRSS staff would not have denied her yogurt, this was not a battle worth fighting. RRSS would have had a de-escalation plan in place and followed it. A PRN would have been offered to Beth to calm her down. She would have been given the chance to discuss the matter rather than ignoring Beth once she was escalated. He characterized this as a moderate incident. No one was hurt. RRSS would not have discharged Beth for the incident. RRSS staff would have been encouraged to apologize to Beth for the denial of the yogurt. [122]

84. Beth returned to CTP in January of 2017. She said she told Ms. Bethune after her return to this institution that she still wanted to live in a small option home. Beth testified that she still wants to live in a "small option in Halifax or Dartmouth, one level, with one bathroom on that floor". [123]

Sheila Livingstone

85. The complainants called Olga Cain, Jackie McCabe-Sieliakus, Dr. Sulyman, Jim Fagan, Joanne Pushie and Krista Spence to testify about Sheila. The Province called Renee Lockhart-Singer to testify about Sheila.

86. Sheila Livingstone was born on 14, 1947. Sheila Livingstone died in October 2016 while living at Harbourside Lodge ARC in Yarmouth.[124] Her sister and statutory decision-maker, Olga Cain, decided to continue with the complaint after Sheila's death to try and prevent other people from suffering as Sheila and her family did. [125]

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[122] Testimony of Jim Fagan, March 12, 2018.

[123] Testimony of Beth MacLean, March 6, 2018

[124] Book XI, Tab 102

[125] Testimony of Olga Cain, March 6, 2018.

87. Sheila medical records show that she has, over time, she was diagnosed with the following disabilities: schizoaffective disorder, vascular dementia, a seizure disorder, a moderate intellectual disability, chronic renal insufficiency, and chronic heart failure.[126] The Province has not disputed that Sheila was a person with disabilities who was financially dependent upon the Province for social assistance in order to have her needs met.

88. The Province's only witness with respect to Sheila, Ms. Lockhart Singer, only acted as her care coordinator from January 12, 2009 until September 30, 2013. She was on leave for fourteen months of this period.

89. Ms. Lockhart-Singer attended several days of the hearing prior to providing testimony. She heard Trish Murray, Joanne Pushie, and Jackie McCabe-Sieliakus' evidence. Cathy Wood was Sheila's care coordinator for much of the time period covered by the complaint. While the Province could obviously have compelled Ms. Wood to have 'the best evidence' available for the Board, Ms. Lockhart-Singer was called by the Province to speak to many years of Sheila's life for which she was not involved in the file and, as a result, her testimony was often a mixture of simply speaking to Ms. Wood's case notes or, as she readily admitted, speculating about 'what may have happened' in particular situations.

Sheila's Life Pre-Emerald Hall

90. Olga Cain is Sheila's older sister. Sheila's mother was her statutory decision-maker with respect to treatment, financial and placement decisions until her death in 1997. Sheila's brother Roy and sister Georgina were Sheila's SDMs for care, financial and placement decisions until 2006. [127] In November 2006 Olga became Sheila's SDM for these three realms of decision-making. [128] She remained the SDM until Sheila's death. [129]

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[126] Book XI, Tab 13

[127] *Ibid*

[128] Book XI, Tab 16, JEB p. 8342

[129] Testimony of Olga Cain, March 6, 2018

91. Olga testified that Sheila was sent to a Children's Training Centre when she was twelve. There were fifteen children in the family. The family lacked resources and expertise to care for Sheila. Olga testified that Sheila learned some useful skills while at the Centre. However, she didn't like it there. She had no privacy. She became very protective of herself while living there and no longer liked being touched. [130]

92. After the Children's Training Centre, Sheila lived in the Nova Scotia Hospital from January-March 1964, the Halifax Mental Hospital from March 1964-October 1966, the Abbie Lane hospital (October 1967-December 1976, March 1977-January 1982), Vernon Street Group Home (December 1976-March 1977), and Cole Harbour RRC (January 1982-May 1986). She lived in a developmental home with RRSS on Robert Allen Drive from May 1986 until 1989. In 1989 until 2004 she lived in a RRSS small option home on Topsail Boulevard.[131]

93. Sheila lived in Emerald Hall from July 9th 2004 until January 29th 2014.[132] She lived at Harbourside Lodge in Yarmouth from January 29th 2014 until her death on October 2016.[133]

94. Olga testified that Abbie Lane was a "hellhole." One of the psychiatrists would punish residents by putting them in a cement room, naked. She described Cole Harbour RRC as a "cave," "understaffed", "it wasn't a good place." [134]

95. Ms. Lockhart-Singer agreed that Sheila was institutionalized for much of her adult life.[135] She also agreed that Sheila lived in the community with RRSS for 18 years while having diagnoses of:

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[130] Testimony of Olga Cain, March 6, 2018.
[131] Book XI, Tab 8; Testimony of Jim Fagan, March 12, 2018
[132] Book XI, Tab 84.
[133] Book XI, Tab 102; Book XI, Tab 4, pg. 15/37, JEB p. 8168.
[134] Testimony of Olga Cain, March 6, 2018
[135] Testimony of Ms. Lockhart-Singer, August 7, 2018

> …mental health issues, obsessive compulsive behaviour and occasional difficulties with aggression, an intellectual disability and schizoaffective disorder, as well as heart troubles, chronic renal failure, diabetes, cancer, and fluid on her lungs. [136]

96. Sheila was classified as "Developmental three" residence when she lived in the Topsail small option home.[137] Ms. Lockhart-Singer agreed that this classification did not present a barrier to her living in the community.[138]

97. Olga Cain and Jackie McCabe-Sieliakus testified about Sheila's life when she lived in the community.

98. Olga didn't remember visiting Sheila while she lived on Vernon Street or on Robert Allen Drive. Olga lived in Toronto during this period. Olga's mother told her that Sheila was happy living on Robert Allen Drive.

99. Olga visited Sheila at her home on Topsail Boulevard "dozens of times." She visited her there consistently. She described it as the "happiest place" for Sheila. Sheila had her own room, it was "just like being home." The workers were good to Sheila. They held parties and celebrated holidays. They ate meals together. Sheila helped with the chores. The staff and residents sang and danced. Olga recalled that one of the workers brought her baby to visit with the residents. Sheila was taken out often for shopping and for meals, which she loved. She had a TV. She had a job working with envelopes. She took a bus to go to work every day. [139]

100. Jackie McCabe-Sieliakus was Sheila's niece. Olga is her mother. She was involved in Sheila's care and would assist her mother with this when she was unavailable.

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[136] *Ibid*; Book XI, Tab 8, <u>JEB pp.</u> 8234 and 8235

[137] Book XI, Tab 7, <u>JEB p</u>. 8219.

[138] Testimony of Ms. Lockhart-Singer, August 7, 2018

[139] Testimony of Olga Cain, March 6, 2018

101. She visited Sheila at Robert Allen Drive often. When she visited Sheila there they would go out, have dinners, they held parties, and she had a job. She visited Sheila often at the Topsail home. She described Sheila as “flourishing” at Topsail. She “seemed happy” there. She would laugh sing, and do crafts. She had chores she would perform, like setting the table. The home was warm and inviting. Sheila had painted her bedroom purple. She had family pictures and drawings on the wall. She was comfortable there. The atmosphere was family-like. The staff brought their kids to visit the home. Jackie brought her own kids to visit Sheila at Topsail. They were not afraid to visit her there. Sheila could leave Topsail without staff when accompanied by family. She had a job working with envelopes. [140]

102. Jim Fagan testified about the eighteen years that Sheila lived in the community with RRSS. He stated that she was very out and active in the community. She had regular contact with her family. She liked having parties on holidays. She liked shopping and purses. She worked in a sheltered industry. [141]

103. There was a strike of RRSS workers in May 2003. Sheila spent this month hospitalized as a form of emergency care. [142] Sheila was diagnosed with uterine cancer in October 2003 for which she underwent surgery in December 2003. She underwent several short-term admissions to Emerald Hall in late 2003 and early 2004 after she received her cancer diagnosis, and when she was recovering from surgery.[143] Sheila was classified by DCS at a “developmental three” status in February 2004. She continued to live at Topsail Boulevard with RRSS with that classification status. [144]

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[140] Testimony of Jackie McCabe-Sieliakus, March 7, 2018.
[141] Testimony of Jim Fagan, March 12, 2018.
[142] Ibid; Book XI, Tab 4, page 20/37, JEB page number 8173.
[143] Book XI, Tab 6, JEB pp. 8214, 8215.
[144] Book XI, Tab 21.

Emerald Hall

104. Olga testified that she did not have the ability to care for Sheila while she was on Emerald Hall. She had other caregiving responsibilities. None of Sheila's other family member had the time to be Sheila's caregiver. Olga did not have the financial resources to hire care for Sheila, and neither did the rest of her family. [145]

105. Olga testified about Sheila's experience at Emerald Hall. She spoke of Sheila rushing visitors to her room and locking the door. She was scared and uncomfortable there. She had few recreational opportunities and rarely left the unit. She suffered frequent assaults.[146] Jackie testified that Sheila seemed "extremely fearful" on Emerald Hall. Her speech worsened on Emerald Hall. The staff at Topsail knew Sheila's speech patterns well and helped her communicate. The high volume of staff on Emerald Hall led made this kind of familiarity with Sheila impossible. Her communication worsened, which Sheila found very frustrating. The family was unable to take Sheila off the unit as often as they liked because they needed staff accompaniment. Their visits on Emerald Hall occurred in locked rooms and were short. [147]

106. Joanne Pushie knew Sheila from the time Ms. Pushie began working on the unit in January 2011. She described Sheila as someone who really enjoyed outings, who derived purpose from having activities to do, had with mobility issues, and who had a really dedicated family. [148]

107. Dr. Sulyman began treating Sheila in July 2012. She testified that Emerald Hall was not a designed to support someone who was dementing , which Sheila was at that point. She was aware that Sheila was assaulted by others on the unit. She was very vulnerable there

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[145] Testimony of Olga Cain, March 7, 2018
[146] Testimony of Olga Cain, March 6, 2018
[147] Testimony of Jackie McCabe-Sieliakus, March 7, 2018.
[148] Testimony of Joanne Pushie, February 20, 2018

due to her age and medical conditions. She testified that no one was afraid of Sheila. The only injury she ever caused someone was a mild scratch. Her mental and physical health were stable for the period that Dr. Sulyman treated her.[149]

108. Krista Spence worked with Sheila from 2011-2013. She testified that Sheila was not physically aggressive. She was not physically capable of being physically aggressive. She could occasionally be verbally aggressive, which Ms. Spence dealt with by giving her space. Sheila liked activities and was very independent in her self-care. [150]

109. DCS' only contributions to Sheila's care during her time on Emerald Hall were comfort allowances and some special needs expenses. [151] Ms. Lockhart-Singer confirmed that Sheila was considered by DCS staff to be an eligible "person in need" during her time at Emerald Hall even though she was not considered eligible for residential supports throughout the entire period. [152]

110. Ms. Lockhart Singer acknowledged that she never met Olga or spoke to her on the phone. She agreed that Joanne Pushie was able to reach Olga during the same time period. [153]

111. Sheila was admitted to Emerald Hall for what became a ten-year stay on July 9th 2004. Upon her admission, the Emerald Hall clinical team identified the "discharge plan" as "plan to return to Topsail."[154] On September 17 2004 Sheila's DCS care coordinator, Cathy Wood, wrote that she "would give Sheila the benefit of the doubt then will cancel the bed" and would "hold her bed" until September 30, 2004. [155] Ms. Wood did not, in fact, "give Sheila the benefit of the doubt" and hold her bed until September 30. On September

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[149] Testimony of Dr. Sulyman, March 14, 2018

[150] Testimony of Krista Spence, March 7, 2018

[151] JEB, Tab XI. 6, pg. 8216; JEB XI, Tab 103

[152] Testimony of Renee Lockhart-Singer, August 7, 2018.

[153] Testimony of Rene Lockhart-Singer, August 8, 2018

[154] Book XI, Tab 16, pg. 2/148, JEB p. 8293

[155] Book XI, Tab 4, PAGE 6/37, JEB, page 8159

20, 2004 Cathy Wood informed Sheila's sister and the Emerald Hall team that the funding Sheila's bed with RRSS was cut. [156] Sheila cried when she was told she would not be returning to RRSS. [157]

112. When funding for Sheila's home with RRSS was cut, the per diem funding that had been allocated to Sheila when she lived there ended. [158]

113. Emerald Hall staff began the process of trying to refer Sheila for placement with DCS in January 2005.[159] In March 2005 Cathy Wood assessed Sheila as at an ARC level of care.[160]

114. Also in March of 2005, Carol Ann Brennan of RRSS wrote to Cathy Wood. Sheila had been hospitalized for over 6 months at this point. But Ms. Brennan nonetheless expressed that RRSS had held her bed for her. RRSS remained willing to continue to support Sheila and Ms. Brennan inquired whether any changes could be made to the way they supported Sheila for her to continue to be supported by RRSS.[161] Ms. Wood replied, stating that Sheila was experiencing schizophrenic- type symptoms, that were 'not new to us.' Ms. Lockhart Singer agreed that the reference to the symptoms not being 'new to us' meant that Sheila experienced the same symptoms while living in the community. [162]

115. On March 31, 2005, a few days after this email exchange occurred Cathy Wood visited Emerald Hall and was told by Dr. Tomlinson that Sheila could be live in an ARC.[163] Dr. Tomlinson filled out a medical assessment form on April 11 2005 on which she stated Sheila could live in an ARC. [164]

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[156] Book XI, Tab 4, PAGE 6/37, JEB, page 8159
[157] Book XI, Tab 16, pg. 6/148, JEB, page 8297
[158] Testimony of Renee Lockhart-Singer, August 8, 2018.
[159] Book XI, Tab 4, PAGE 6/37, JEB, page 8159
[160] Book XI, Tab 28, JEB pp. 8524 and 8530.
[161] Book XI, Tab 27, JEB p. 8521
[162] Testimony of Renee Lockhart-Singer, August 7, 2018.
[163] Book XI, Tab 4, 8159
[164] Book XI, TAB 32, JEB p. 2

116. Sheila was medically discharged from the hospital on April 11, 2005.[165] She was formally classified on April 13, 2005. [166] Her funding for residential supports with DSP were not resumed when she became classified. [167]

117. Ms. Lockhart Singer agreed that Sheila could have been supported to live in the community with an ARC classification. She acknowledged that there was no evidence in the file that DCS ever reached out to RRSS and requested that they resume supporting Sheila despite RRSS' very recent offer to continue their support of her. [168]

118. Ms. Lockhart Singer agreed that the decision of where to live rests with the individual, or, when they lack capacity for placement decisions, their SDM. It does not rest with DCS or hospital staff. [169] On April 6 2005 social worker on Emerald Hall recorded a phone call with Sheila's then-SDM, Georgina Landry. Ms. Landry expressed a desire for Sheila to live in a group home. The author replied that the clinical team believed Sheila did well in a congregate care setting. [170] The social worker on Emerald Hall made another note on April 13, 2005:

> Writer phoned client's next of kin, Mrs. Georgina Landry, and informed her of the outcome of the classification meeting. She asked where the ARC's are in the province and we talked about this. She said that she thought the family would prefer Sheila going to the one near New Glasgow as two brothers and cousins live in that area….writer told her that she would let care coordinator, Cathy Wood, know her thoughts re placement. Following this call, writer left a message for Mrs. Wood regarding this. [171]

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[165] Book XI, TAB 31
[166] Book XI, Tab 29,JEB p. 8533
[167] Testimony of Renee Lockhart-Singer, August 8, 2018.
[168] Testimony of Renee Lockhart-Singer, August 7, 2018.
[169] *Ibid*
[170] Exhibit 65, EH Progress Notes, April 6, 2005, p. 1.
[171] *Ibid*, pp. 2-3.

119. Ms. Lockhart Singer agreed that nothing in the note suggested that Ms. Landry was informed Sheila could live in a community based setting with an ARC classification. [172] On the same day Cathy Wood recorded in her notes that Ms. Landry had expressed a preference for Riverview. [173] Sheila was waitlisted for facility-based options only by DCS.[174]

120. Sheila experienced kidney issues which led Emerald Hall staff to request DCS to pause their placement search on June 10 2005. [175] By November 2005, the Emerald Hall staff indicated that Sheila was medically stable and they considered her healthy enough for a long-term placement. [176]

121. Aside from this period from June-November 2005, the Emerald Hall staff were consistent for the remainder of Sheila's time at Emerald Hall that she could be supported to live outside the hospital. They made consistent efforts during the remainder of her time at Emerald Hall to find her a placement outside the hospital. [177]

122. Despite the consistency in the Emerald Hall team's recommendations, Sheila experienced fluctuations in her DCS classification status during her time on Emerald Hall.

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[172] Testimony of Renee Lockhart-Singer, August 7, 2018

[173] Book XI, TAB 4, JEB p. 8159

[174] Book XI, TAB 36, JEB p. 8562

[175] Book XI, TAB 4, JEB p. 8160

[176] Book XI, TAB 16, JEB pp. 8324 at 8325; BOOK XI, TAB 16, JEB pp. 8326 at 8327

[177] Book XI, TAB 13, p. 8264; Book XI, TAB 39, JEB p. 8571; Book XI, TAB 4, pg. 8160; Book XI, TAB 47; Book XI, TAB 16, JEB p.8362; Book XI, TAB 32, p. 8549; Book XI, TAB 50, pg. 8610; Book XI, TAB 51; Book XI, TAB 13, p. 8264; Book XI, TAB 52, 8616; BOOK XI, 13, JEB p. 8266; BOOK XI, TAB 60, JEB p. 6538; BOOK XI, TAB 13, p. 8268; BOOK XI, TAB 13, JEB p. 8272; BOOK XI, TAB 62, p. 8546; BOOK XI, TAB 13, p. 8269; XI, TAB 63; XI. 13. Pg. 8274; Book XI, TAB 13, pg. 8276; BOOK XI, TAB 77, pg. 8620; BOOK XI, TAB 83.

123. In March of 2006 Cathy Wood wrote to the DCS placement coordinator about Sheila moving to Riverview in the context of discussing a “trade” between Kings and Riverview.[178] Ms. Wood expressed confidence in that email that Sheila would be classified at an ARC level of care. Ms. Lockhart Singer stated that she “doesn’t normally” hear movements of people between institutions referred to as “trades.” She agreed that Ms. Wood seems to have expected in March 2006, based on her conversations with medical staff, that Sheila would be classified ARC. She acknowledged that there was no evidence in the file that Ms. Wood consulted with Sheila’s SDM before recommending an ARC placement. [179]

124. Ms. Wood informed Lucy MacKinnon, Sheila’s assigned classification officer, of the consensus between herself and the medical team that Sheila could be supported to live outside the hospital.[180] Sheila was deemed unclassifiable in March 2006. Ms. MacKinnon cited Sheila’s “aggressive behavior” and her physical health issues. [181] The Emerald Hall team requested a copy of the DCS classification decision in writing.[182] Ms. Lockhart Singer acknowledged that she had never heard of this happening before or since in her 20 years as a DSP care coordinator. [183]

125. In May 2006 the Emerald Hall team noted that they were denied summary of the decision to reject ARC placement by Lucy McKinnon: “May 17 brother Roy asked for second opinion on decision made to deny placement. Concern expressed for quality of life.”[184]

126. In June of 2006 Roy Livingstone, Sheila’s brother, was sent a letter about the classification decision “at his request.” The letter did not explain that there was a time limitation to

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[178] BOOK XI, TAB 39, JEB p. 8571

[179] Testimony of Renee Lockhart-Singer, August 8, 2018

[180] BOOK XI, TAB 41

[181] BOOK XI, TAB 4, <u>JEB p.8160</u>

[182] BOOK XI, TAB 4, <u>JEB p.</u> 8160

[183] Testimony of Renee Lockhart-Singer, August 8, 2018

[184] BOOK XI, TAB 43, JEB page 8583

appeal classification decisions.[185] Ms. Lockhart Singer agreed that he had a statutory right to the reasons for the decision, he should not have had to request this.[186]

127. Sheila was not assessed or classified for placement again for over a year.[187] In July of 2007 Ms. Wood assessed Sheila and recommended that she be supported in an ARC.[188] On August 16 2007 the social worker on Emerald Hall called Lucy MacKinnon and asked about her classification. Lucy MacKinnon replied that she would check with Kings RRC to see if she was eligible.[189] Sheila was denied classification in August 2007 because King's RRC did not believe they could support her.[190]

128. In December 2007 the Emerald Hall team referred Sheila to long-term care with the Department of Health.[191] Sheila was accepted into long-term care in March 2008.[192] However, she was then denied classification for long-term care facilities in July 2008.[193]

129. As of July 2008 Sheila was considered unclassifiable for residential supports with both DCS and DOH. In June of 2009 she was referred by the Emerald Hall team to the complex case committee.[194] The team was notified that Sheila's name would be "kept on the list" but DCS was not participating in the complex case committee at that time due to resource issues. [195]

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[185] BOOK XI, TAB 44
[186] BOOK IV, TAB 4, JEB 812; Testimony of Renee Lockhart-Singer, August 8, 2018
[187] Book XI, Tab 4, pg. 6, 7, JEB pp. 8159-60.
[188] BOOK XI, TAB 49, pg. 8601
[189] Exhibit 67
[190] BOOK XI, TAB 4, JEB p. 8161
[191] BOOK XI, TAB 51, pg. 8613; BOOK XI, TAB 52, JEB p. 8616
[192] BOOK XI, TAB 55
[193] SEE BOOK XI, TAB 57
[194] BOOK XI, TAB 60
[195] IX, TAB 59, JEB p. 8536

130. Ms. Lockhart Singer became her care coordinator on January 12 2009 but did not perform an assessment of Sheila until the fall of 2011.[196] Ms. Lockhart Singer spent much of her time working on Sheila's file debating with the NSHA about which organization was responsible for funding Sheila's special need expenses. [197]

131. Between August 2007 and November 2011 DCS did not perform a single classification of Sheila. Sheila was classified by DCS in November 2011.[198] Sheila was waitlisted for an RRC in "any region" in December 2011.[199] Ms. Lockhart Singer acknowledged that she filled out the form without speaking to Olga, Sheila's SDM, about where she wanted Sheila to live.[200] Sheila remained classified with DCS and waitlisted for placements under the DSP from that point onwards. [201]

132. In June of 2012 Ms. Lockhart Singer filled out an assessment form for Sheila in which she recommended Sheila live at the psychiatric unit at Kings. She described her as "rarely aggressive." She noted that she "occasionally mutter(s) accusations at others, occasional unprovoked strike or scratch (no one actually gets hurt)." [202] She acknowledged that this assessment was also completed without a discussion with Sheila's SDM.[203] Sheila was classified ARC in June 2012. The classification decision notes that the classification was pursued after the a unit at Kings indicated they might have a place for her.[204]

133. There is extensive documentation of the assaults that Sheila endured while on Emerald Hall. Some of the progress notes documenting the assaults chronicle bleeding and bruising that resulted from the attacks. The notes also document Olga's expressions of

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[196] Testimony of Renee Lockhart-Singer, August 8, 2018; JEB XI-70

[197] Testimony of Renee Lockhart-Singer, August 8, 2018; Book XI, Tab 4, pgs. 9-15, JEB pp. 8162-8168.

[198] Book XI, Tab 4, pgs. 8-10, JEB pp. 8161-8163; JEB XI-70

[199] XI. 71.

[200] Testimony of Renee Lockhart-Singer, August 8, 2018

[201] JEB Vol. XI. TAB 72, pp. 8576 et seq.

[202] BOOK XI, TAB 75, JEB p. 8599.

[203] Testimony of Renee Lockhart-Singer, August 8, 2018

[204] BOOK XI, TAB 76

serious concern about Sheila's safety on Emerald Hall. [205] Ms. Lockhart Singer denied any knowledge of Sheila being assaulted on Emerald Hall, despite being her care coordinator for much of the relevant period and having access to her medical file. [206]

134. Olga and Jackie testified to their very grave concerns about Sheila being assaulted on Emerald Hall.[207] Sheila was offered a placement in Yarmouth at Harbourside ARC in January 2014. [208] Jackie, Olga, and Joanne Pushie all testified that Olga and Jackie did not want Sheila to be in an institution, or so far away from home. However, the offer was accepted due their very grave concerns about the assaults she was suffering on Emerald Hall. [209]

135. Sheila was transferred to Harbourside on January 29, 2014.[210] Jackie and Olga visited Sheila at Harbourside several times. They testified that Sheila appeared more comfortable there. They believed it was preferable to Emerald Hall, although less advantageous than her home on Topsail Boulevard. The expense of travelling from Truro and the long-distance made it very difficult to visit her. [211]

136. Olga, Jackie, and Sheila's legal counsel all persistently pursued a transfer for Sheila from Harbourside to a small option in Metro, or Sunset ARC. [212] She was waitlisted for these options. [213] Sheila was offered a spot in the Sunset ARC a month before her death. Olga declined it due to her failing health. [214]

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[205] JEB XI. Tab 17.
[206] Testimony of Renee Lockhart-Singer, August 8, 2018
[207] Testimony of Olga Cain, March 6, 2018; Testimony of Jackie McCabe-Sieliakus, March 7, 2018
[208] BOOK XI, TAB 4, JEB p.. 8168
[209] Testimony of Olga Cain, March 6, 2018; Testimony of Jackie McCabe-Sieliakus, March 7, 2018; Testimony of Joanne Pushie, February 20, 2018
[210] SEE JEB BOOK XI, TAB 84
[211] Testimony of Olga Cain, March 7, 2018; Testimony of Jackie McCabe-Sieliakus, March 7, 2018
[212] JEB BOOK XI, TAB 4, pg.8169, 8170
[213] JEB BOOK XI, TAB 91. p. 8670
[214] JEB BOOK XI, TAB 99, pg. 8709

Uncontested Evidence Regarding Joey Delaney

137. The complainants called Tammy Delaney, Jim Fagan, Suzanne McConnell, Joanne Pushie, and Dr. Sulyman to testify with regard to Joey Delaney. Joey does not have a broad range of verbal expression and was not called as a witness.

138. The Province called Trish Murray to testify about Joey, who was Joey's Care Coordinator from January 23, 2009 until April 15, 2015. She acknowledged that in her entire tenure as Joey's care coordinator she never once met Joey's mother and SDM, Susan Lattie. She only spoke to her on the phone once, to get consent for Joey to move to Quest.[215]

139. Joey Delaney was born on September 10, 1972. His records show that he has the following disabilities: a severe intellectual disability, cyclical mood disorder, chronic constipation, epilepsy, and hypothyroidism.[216]The Province has not disputed that Joey was a person with disabilities who was financially dependent upon the Province for social assistance in order to have his needs met.

Pre-Emerald Hall

140. Tammy Delaney is Joey's sister. She is two years older than him. Her earliest memories of Joey are of a "crazy, curly headed wild child." Joey's earliest years were spent in the family home in Halifax with his parents, Tammy, and their older brother. He began having seizures at a very young age. He would do unsafe things, like jump off the second story of the home onto the lawn. He would hit his head "open," he hardly slept, and he required 24/7 supervision. The family simply could not provide the care he needed to be safe. Joey entered the Dartmouth Children's Training Centre when he was about 4 or 5.

141. The family visited him frequently in the CTC. Tammy described it as "like a hospital." It was located close to the Nova Scotia Hospital. He came home on weekends and holidays.

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[215] Testimony of Trish Murray, June 20, 2018.
[216] JEB Book X. Tab 55; JEB Book X, Tab 37.

The family tried to care for him at home again, but they were unable to meet his care needs. He re-entered the CTC.

142. Joey and Tammy's parents separated. Tammy lived with her mother, Susan Lattie. Tammy testified that Susan got along well with the staff at CTC. She didn't have an issue with him being there. When Joey was offered a small option home upon the closing of the CTC, Susan was "afraid, but excited for him."[217]

143. Joey was discharged from the CTC to a small option home with RRSS on August 12 1996. He was almost 24 years old.[218] Joey lived in small option homes with RRSS from 1996 until his admission to Emerald Hall in 2010, at total of 14 years.[219] He initially lived in a small option home on Chapel Street.[220] The residents of the house were moved to a home on Skeena Street due to challenges with the physical features of the Chapel Street home.[221] Joey had a DCS "Developmental Three" classification while living with RRSS.[222]

144. Tammy Delaney described the home on Skeena street as a "regular home on a street." It had a "cozy living room." It was "always welcoming." The staff were "great." They would offer visitors coffee, they threw birthday parties for the residents and celebrated holidays. She would visit there with her mom, her brother, and one of her kids. Her mother was Joey's primary family contact, she visited him the most. Susan took him home with her for visits. Joey had a job in Burnside, he worked Monday to Friday. He took a bus to work. She testified that he was comfortable there.[223]

145. Suzanne McConnell is now in a senior management position with RRSS. From 2007 until his admission to Emerald Hall she was the supervisor responsible for the residents in his

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[217] Testimony of Tammy Delaney, March 6, 2018

[218] JEB Book X. Tab 4.

[219] Testimony of Jim Fagan, March 12, 2018.

[220] JEB Book X. Tab 4.

[221] Testimony of Jim Fagan, March 12, 2018.

[222] Book X, Tab 8, page 7799; Book X. Tab 14 at JEB p. 7817; Testimony of Trish Murray, June 20, 2018.

[223] Testimony of Tammy Delaney, March 6, 2018.

home. Her office was based in the Skeena Street Home. She was there 3-5 days a week. She described Joey as a lot of fun. He would squeal and do somersaults when happy. He had two roommates. He worked Monday-Friday through DASC, a sheltered workshop. He liked puzzles. He liked tearing pages out of phone books, and had a roommate who enjoyed piecing them back together. RRSS rented a cottage for a few days in the summer in the Annapolis Valley, and Joey enjoyed doing this. The staff at the Skeena Street home had specific training to care for Joey during epileptic seizures.[224]

146. Joey's electrolyte levels dropped so dangerously low in late 2009 that he was put in the intensive care unit to treat this. The doctors identified that one of his medications used to treat his epilepsy caused the drop in his electrolytes. He was taken off the medication. The medication had stabilized Joey's moods. He was discharged from the hospital in January 2010, but Suzanne McConnell noted a significant decline in his wellbeing. He was agitated and upset. He couldn't settle down. He hit himself and others.[225]

147. Joey was admitted to Emerald Hall on January 22 2010 "due to medication changes."[226] The Emerald Hall social worker wrote that the plan upon his admission was "med changes- will do well and return to small options home."[227] Joey remains on Emerald Hall to the present day.

Emerald Hall and Quest

148. Tammy testified that she did not have the capacity to provide care for Joey for the entire time period covered by the complaint. She cannot afford to purchase the care he requires. She has a full time job at the Red Cross, and a part time cleaning job on weekends and evenings. She has been raising her granddaughter for the past three and a half years. Her granddaughter has PTSD and Tourette's and is a "handful." Her daughter

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[224] Testimony of Suzanne McConnell, March 8, 2018.
[225] *Ibid*
[226] JEB Book X, Tab 18.
[227] *Ibid*

and her grandson also live with her. Her daughter has borderline personality disorder. Her mother lived with her until her death two years ago. Her husband died two years ago. He had been sick for twelve years prior to his death. Joey has no other family members able to care for him.[228]

149. Tammy has visited Joey while on Emerald Hall. However, it is very difficult for her to do so. She cares for her granddaughter who struggles to visit Emerald Hall. There is frequent screaming on the Unit. Emerald Hall is "not welcoming" to visitors. Most family visits happen in a locked room. It was much nicer, easier, and more welcoming to visit Joey in his Skeena street home than on Emerald Hall.[229]

150. Joanne Pushie overlapped with Joey on Emerald Hall for several years. She testified that he like to play with toys, he could be affectionate, and he enjoyed outings. She testified that he was classified with and waitlisted for placement by the time she began on Emerald Hall in January 2011. His mother, Susan Lattie, was very ill but nonetheless a strong advocate for her son. She wanted him to live in the community. She visited with Joey on Emerald Hall. When she became palliative and unable to visit the hospital she gave Ms. Pushie open-door access to her home so she could stay updated about Joey.[230]

151. DCS cut the funding for Joey's home in the community with RRSS because he was in the hospital for more than 30 days. Ms. Murray acknowledged that she made the decision to cut the funding for Joey's care with RRSS. She agreed that she made a phone call on June 9 2010 to the social worker on Emerald Hall and informed them that his funding was cut since he had been in the hospital for more than 30 days.[231]

152. This is consistent with Ms. McConnell's evidence. She testified that RRSS communicated to DCS in May 2010 that RRSS remained willing to support Joey in the community once he

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[228] Ibid.

[229] Testimony of Tammy Delaney, March 6, 2018.

[230] Testimony of Joanne Pushie, February 20, 2018.

[231] Testimony of Trish Murray, June 19 and 20, 2018; Book X, Tab 20.

was medically stable. In fact, RRSS staff and residents visited Joey in the hospital several times after his admission to Emerald Hall in January 2010.[232]

153. RRSS was provided notice that Joey's funding was cut on July 20, 2010.[233] Ms. McConnell testified that the decision to cut someone's funding rests with DCS, not RRSS. The decision about continuing funding is not RRSS' to make.[234] Jim Fagan confirmed that RRSS does not make the decision to cut someone's funding. That decision is made by DCS.[235]

154. Joey was classified by DCS at an RRC status on June 11, 2010, only two days after Ms. Murray made the decision to cut the funding for his support with RRSS.[236] He was medically discharged from the hospital on July 21, 2010.[237] RRSS was not contacted by DCS after this point, nor was it asked to resume its support of Joey after either his classification or his medical discharge. RRSS remained willing to care for Joey. Ms. McConnell continued to visit Joey on Emerald Hall in her personal capacity. She was not compensated for doing so.[238] The Province's witness, Ms. Murray, confirmed that she did not contact RRSS and ask it to consider resuming caring for Joey.[239]

155. Ms. Murray did not meet with, phone, or write a letter to Ms. Lattie about DCS' decision to cut his RRSS funding.[240] Ms. Murray agreed that the effect of her failure to notify her meant that Ms. Lattie was deprived of her statutory right to appeal Joey's classification decision which resulted in a loss of funding.[241]

156. Joey's funding for residential supports and services did not resume upon his classification. The overwhelming majority of his care costs have been born by the NSHA since his

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[232] Testimony of Suzanne McConnell, March 12, 2018
[233] <u>JEB</u> Book X, Tab 25
[234] Testimony of Suzanne McConnell, March 12, 2018
[235] Testimony of Jim Fagan, March 12, 2018
[236] Book X, Tab 21, <u>JEB p. 7896</u>.
[237] Book X, Tab 27.
[238] Testimony of Suzanne McConnell, March 8, 2018
[239] Testimony of Trish Murray, June 20, 2018.
[240] Book X. Tab 29 September 11, 2010
[241] Book 4, Tab 4, page JEB 904; Testimony of Trish Murray, June 20, 2018.

admission to Emerald Hall. DCS has, however, provided funding for comfort allowances and some special needs expenses.[242]

157. Joey remained “classified” by DCS from June 11, 2010 onwards. He has been waitlisted for DSP residential supports from that date. From June of 2010, Joey has been considered eligible by DSP for its residential support options.[243] Ms. Murray agreed that Joey could have been supported in a small option home with an RRC classification. However, she testified that DCS “was going for RRC facilities” for Joey.[244]

158. Throughout his time on Emerald Hall the medical team consistently indicated that Joey could be supported to live outside the hospital.[245] Dr. Sulyman testified that Joey became her patient when she began working on Emerald Hall in September 2012. She testified that Joey was medically discharged and awaiting a placement in the community when she began working on the Unit. In April 2013 she wrote a letter on behalf of the Emerald Hall team in which she stated that Joey was ready for discharge to the community as of June 2011. She stated that:

> Mr. Delaney will require a small option home with 24-hour supervision and support with the activities of daily living…in closing it is the position of the Emerald clinical team overseeing Mr. Delaney’s admission that his care needs can be very well managed in the community. [246]

159. DCS took no steps to find Joey a place to live outside the hospital for the year following his classification. On June 27, 2011 Ms. Murray faxed Joey’s classification information to Kings RRC.[247] Ms. Murray testified that she faxed the information because she was

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[242] Testimony of Trish Murray, June 20, 2018.
[243] Book X, Tab 41, JEB p. 7990.
[244] Testimony of Trish Murray, June 20, 2018
[245] Book X, Tab 43; Book X, Tab 45; Book X, Tab 47; Book X, Tab 48.
[246] Book X, Tab 47, JEB pp. 8032-3.
[247] Book X, Tab 8, pg. 14/19, JEB p. 7794; Testimony of Trish Murray, June 20, 2018.

notified by the waitlist coordinator that they had a vacancy. She agreed that Kings would have been a long-distance from Joey's mother, who was very ill by this point.[248]

160. The Kings staff came to Emerald Hall to assess Joey.[249] Ms. Murray assumed that the Kings staff didn't think he was a good fit. She didn't follow up with the Kings staff.[250] Ms. Murray received a query in July 2011 from the Braemore RRC about a placement opportunity for Joey. [251] She faxed his information so he could be considered for the opening the next day.[252] Ms. Murray agreed that she did not speak to Ms. Lattie (Joey's mother) about this before she faxed his information to Braemore. She did not recall if she ever followed-up about the opening.[253]

161. DCS took no action to find Joey a place to live outside the hospital between July 2011 and May 2012. On May 18, 2012, Ms. Murray attended a care planning meeting on Emerald Hall. She committed in that meeting to updating Joey's assessment.[254] She agreed that she did not do this. When informed that the next assessment on his file is from January 2015 she stated "there was a potential" that she did not perform one before that date.[255]

162. In November 2012, Ms. Pushie sent a letter to Ms. Murray on behalf of the clinical team on Emerald Hall. The letter references a phone call which occurred in November 2012 in which Ms. Pushie informed Ms. Murray that Joey's SDM was seeking a community placement for Joey in the HRM.[256]

163. DCS took no steps to find Joey a place to live outside the hospital between May 18, 2012 and December 2014.[257] On this date Ms. Murray noted that she sent a medical

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[248] Testimony of Trish Murray, June 20, 2018.
[249] Book X, Tab 8, pg. 13/19, <u>JEB p. 7794</u>.
[250] Testimony of Trish Murray, June 20, 2018.
[251] Book X, Tab 39.
[252] Book X, Tab 40.
[253] Testimony of Trish Murray, June 20, 2018.
[254] Book X, Tab 8, pg. 13/19, <u>JEB p. 7794</u>.
[255] Testimony of Trish Murray, June 20, 2018.
[256] Book X, Tab 45
[257] Book X, Tab 8, pgs. 13, 14/19, <u>JEB pp. 7793-7794</u>; Testimony of Trish Murray, June 20, 2018.

reassessment form to the hospital since he was "due" for one.[258] An assessment was completed in January 2015. The stated placement goal was "Placement in a community option that can provide level 5 support for Joey."[259]

164. Joey was offered a placement at Quest RRC in February 2015. This was the first placement offer that was made to Joey during his nearly five years on Emerald Hall. Ms. Murray testified that after years of not being able to reach Ms. Lattie, Ms. Murray was suddenly able to reach her by phone to get her consent for a Quest placement.[260] Ms. Murray wrote a case note which said that she had told Ms. Lattie that Quest has a rehabilitative function and that Joey would move onto a community placement from Quest if he was able.[261] On cross-examination Ms. Murray stated that she told Ms. Lattie that Quest would be a way for Joey to move into a small option home.[262]

165. Ms. Murray initially refused to acknowledge that it was inappropriate for Joey to live for five years in a hospital setting. After being taken to numerous government documents[263] referring to living in a hospital as inappropriate, she relented and agreed that it was "inappropriate" for Joey to live in Emerald Hall after he had been medically discharged.

166. Joey was at Quest from February 2015 until January 2017.[264] Tammy Delaney testified that she visited Joey while he was there. She found it was very similar to Emerald Hall. It's locked. It's loud. [265]

167. Joey's mother died on May 22, 2015. Tammy Delaney became his SDM for the purpose of placement offers. [266] On October 25, 2015 Tammy Delaney phoned Joey's new care

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[258] Book X, Tab 8, pg. 12/19, JEB p. 7792.
[259] Book X, Tab 49, JEB p. 8061.
[260] Testimony of Trish Murray, June 20, 2018.
[261] Book X, Tab 8, pgs. 11, 12/39, JEB pp. 7791-2.
[262] Testimony of Trish Murray, June 20, 2018.
[263] Book VI-B-3; Book VIII, Tab 6; Book VIII, Book VI-A-13; Book VIII-Tab 84.
[264] Book X. Tab 8, pgs. 6-10, JEB pp. 7786-7790.
[265] Testimony of Tammy Delaney, March 6, 2018.
[266] Book X, Tab 8, pg. 9/19, JEB p. 7789.

coordinator and requested that Joey move to a small option home or developmental residence.[267]

168. Joey was supposed to receive regularly scheduled ECT treatments while living at Quest. His appointments were frequently cancelled, and this was identified by his care coordinator as a barrier to his placement outside of Quest.[268] Joey was discharged from Quest because he was experiencing "increased vocalizations and agitation which was disturbing other clients."[269]

169. He was discharged to the Dartmouth General Hospital. Emerald Hall was asked to re-admit him since he had nowhere to go after his discharge from Quest.[270]

170. Within days of his admission to Emerald Hall the staff identified that Joey had a kinked intestine.[271] This was treated and shortly afterwards the case notes record that Joey has "returned to baseline."[272] Joey continues to live on Emerald Hall to this day. Dr. Sulyman testified that his bowel issues are very much under control, he is now calm and content.[273]

The Nature and History of the Disability Supports Program

171. The Disability Support Program's current policy manual defines the program in the following terms:

> 1.1 The Disability Support Program (DSP) provides for assistance to persons in need under the mandate of the *Social Assistance Act*. It provides support to children, youth, and adults with disabilities through residential and at-home support programs. DSP Support Options range from supporting families who care for a family

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[267] Book X, Tab 8, pg. 8/19, JEB pp. 7788-7789.
[268] Book X, Tab 8, pg. 6, 7/19, JEB pp. 7786-7.
[269] Book X, Tab 53, pg. 8/31, JEB p. 8085.
[270] Testimony of Dr. Sulyman, March 14, 2018.
[271] Book X, Tab 8, pg. 6, JEB p. 7786.
[272] Book X, Tab 8, pg. 5, JEB p. 7785.
[273] Testimony of Dr. Sulyman, March 14, 2018.

> member with a disability in their own home, to supporting people with disabilities in a 24-hour residential support option. [274]

172. As Ms. Hartwell testified, "it is a program that provides support to people who need assistance with their daily activities, and who require particular residential supports in order to be able to be live the kind of quality lives that they want to live." [275]

173. Although the program is often referred to as offering residential supports, the DSP primarily provides staffing services to meet the support needs of persons with disabilities. To the extent that the DSP provides 'bricks and mortar' housing to persons with disabilities, this comprises a relatively small portion of the DSP annual budget. [276]

174. On cross-examination Ms. Hartwell agreed that the primary purpose of the DSP is the provision supports and services to persons with disabilities. This support may take the form of assistance with activities of daily living, assistance with recreation or employment, or necessary medical services, such as foot care. She testified that the labour required to provide supports and service forms "the most significant by far" expense in the DSP annual budget. She described the costs associated with actually providing physical housing for program participants as "nominal." Ms. Hartwell also agreed on cross-examination that many of the community-based homes in which DSP participants live are rented, rather than owned by the DSP. [277]

175. Finally, Ms. Hartwell agreed that the Province has no involvement in finding, creating, or operating the housing of persons supported through a number of DSP programs (Direct Family Support, Flex at Home, Flex Independent, Enhanced Family Support, Independent Living Support). In looking at Joint Exhibit Book III, Tab 17, she agreed that a "very high

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[274] Current DSP Policy Manual, Exhibit 58, Policy 1.1

[275] Testimony of Lynn Hartwell, August 9, 2018

[276] VI-A-18, "The majority of service provider costs in Nova Scotia are related to staffing, representing about 85 percent of the cost of the service", JEB p. 2529.

[277] Testimony of Lynn Hartwell, August 10, 2018

proportion" of DSP participants are supported through these programs. Ms. Hartwell acknowledged that the Province therefore has had no involvement in the creation or operation of the physical housing in which that a very high proportion of DSP participants live. [278] As of December 2017 the DSP provided residential supports to 5197 individuals. Approximately twenty percent of these people were residents of ARCs, RRCs, and RCFs, which Ms. Hartwell agreed were "large congregate care facilities" and not "community based options at all." [279]

176. Denise MacDonald Billard and Lynn Hartwell agreed that, prior to 2001, the *Social Assistance Act* governed both income assistance and the disability support program. In 2001 the *Employment Support and Income Assistance Act* was passed, it governs income assistance in the Province. [280] The DSP remains a statutory social assistance scheme under the *Social Assistance Act*. The *Social Assistance Act* requires the provision of social assistance to all eligible "persons in need." When the *ESIA* was introduced the definition of a person in need under the *Social Assistance Act* was simultaneously narrowed to a person "who requires financial assistance to provide for the person in a home for special care or a community based option." Regulations under the *Act* establish that the general standard for assistance provision is the provision of defined "items of basic requirement," including food, clothing, shelter, fuel, utilities, household supplies and personal requirements.[281]

177. The DCS' Annual Accountability Report from 2000-2001 showed that approximately 20% of the Departments' annual budget was devoted to the DSP. The same report reads "Over 90% of the Department's Services are legislated and under these Acts, the Department is required to provide services to those individuals and families who are eligible for

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[278] Testimony of Lynn Hartwell, August 10, 2018

[279] Book III-Tab 17, DCS Table of residential capacity by type of living situation (1989 through 2017) JEB pp. 640-641; Testimony of Lynn Hartwell, August 10, 2018.

[280] *Ibid*; Testimony of Denise MacDonald-Billard, June 18, 2018

[281] Testimony of Denise MacDonald-Billard, June 18, 2018; *Social Assistance Act,* RSNS 1989, c 432; Municipal Assistance Regulations, NS Reg. 76/81, Regulations 1 (i), 4 (1) and 4 (2).

assistance regardless of available funding."[282] Ms. Hartwell was shown this document on cross-examination. She agreed that the reference to "over 90%" of the services to refer to ESIA, the DSP, and Child Protection. However, she testified on cross-examination and on redirect examination that she did not understand to be a legislated service that the Province is required to provide, regardless of available resources. She agreed on cross-examination that the DSP is considered by the Province to be a "capped" program. She testified that all programs offered by the DSP are seen as "capped" by the Province, except Flex at Home and the Direct Family Support for Children program.[283] The Province believes it is not obligated to provide assistance to all eligible persons in need under the *Social Assistance Act*, and it is not in breach of the *Act* and its regulations to impose caps on the number of people who may access residential supports under the DSP. The DSP is also capped in the sense that there are financial parameters attached to the supports and services offered by the program. Persons may become ineligible for the DSP when the cost of their required supports exceed the Province's financial parameters.[284]

The Province is Responsible for the NSHA and DSP Service Providers in Nova Scotia

178. The Province is responsible for the funding , regulation, administration of community-based options and institutional facilities in this Province.[285] When deaths or cases of abuse have occurred in institutions, the Province has assumed responsibility for investigating and resolving the underlying issues.[286] The Province has also asserted its power and responsibility over DSP residential supports by repeatedly announcing its intention to

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[282] Exhibit 70, DCS – Annual Accountability Report, Fiscal Year 2000 – 2001, pgs. 6 and 34.

[283] Testimony of Lynn Hartwell, August 10, 2018

[284] Book IV-5-b, Memorandum from Joe Rudderham to Lorna MacPherson re Improved clarity to specific sections of the Level of Support Policy, September 19, 2014, JEB p. 942.

[285] Book VIII-Tab 12, August 19, 2009 LaPierre Ministerial Briefing Note re Community Homes v Small Option Homes (2), JEB p. 4261..

[286] Book VI-A-35 Paladin Security Report Re Quest, JEB p. 2955; Exhibit 54, Stylus Consulting Inc., Current State Assessment Report dated September 10, 2015; Book VI-A-42 Report on Riverview Home Corporation, JEB p. 3054; Book VI-A-26 Deloitte Touche Operational Review of Braemore Home, JEB p. 2706.

close institutions and open more community options. The Province also funds the Nova Scotia Health Authority and is responsible for its operations.

Institutionalization and De-Institutionalization in Nova Scotia

179. The institutionalization of persons with disabilities has its roots in the poor house model of social assistance provision.[287] The first poor houses were opened in Nova Scotia in the 1700s, and they housed impoverished people with and without disabilities. The abuses within these institutions are well-documented. The first separate asylums for people with mental illnesses were opened in the 19th century.[288] The poor house remained the primary vehicle for delivering social assistance to low-income people with and without disabilities until the mid-twentieth century. The Elizabethan poor house model of assistance provision for people without disabilities ended in 1958 with the passage of the *Social Assistance Act* was passed. The institutional model for provision of care remained in place for people with disabilities requiring financial assistance from the Province.[289] Lynn Hartwell acknowledged she was familiar with the historical roots of the institutional model of care for persons with disabilities in Nova Scotia.[290]

180. The *Social Assistance Act* governed social assistance for both people with disabilities and people without disabilities from 1958 until 2001. Municipalities remained responsible for the provision of social assistance under the *Social Assistance Act*.[291]

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[287] Exhibit 12, Dr. Bach's Expert Report, report pg. 5; Book VI-A-3, Moving Towards Deinstitutionalization: a Discussion Paper (DCS, February 1995), JEB p. 1715; Book VIII-Tab 111, Report of the Task Group on Homes for Special Care (DCS, June 1984), JEB p. 6481.

[288] Book VIII-Tab 111, Report of the Task Group on Homes for Special Care (DCS, June 1984), report JEB p. 6481.

[289] *Ibid*; Exhibit 12, Dr. Bach's Expert Report, report pages 7-12; Book VI-A-3, Moving Towards Deinstitutionalization: a Discussion Paper (DCS, February 1995), JEB p. 1715.

[290] Testimony of Lynn Hartwell, August 10, 2018.

[291] Exhibit 12, Dr. Bach's Expert Report, report pages 9-12.

181. The movement towards normalization emerged and became widespread in the 1960s and 1970s. As an internal memorandum from the Minister of Community Services to the provincial cabinet wrote in 1990:

> The 1960's and 1970's produced social change within the field of mentally handicapped as it did they did with most of society. The concept of normalization was born and developed in this period evolving a philosophical stance which stated that the mentally handicapped should be treated in the same fashion as the normal or average citizens in our society. They should go to school, live in the community, work, and recreate in the community. They should not be placed outside of the community, i.e., in institutions.[292]

182. Since 1984, the Province has repeatedly committed itself to implementing a program of deinstitutionalization.[293] Ms. Hartwell agreed on cross-examination that many of these documents identified the same issues with the DSP system as did the 2013 Roadmap report, and contained many of the same recommendations for a program of deinstitutionalization. She asserted that some of the documents were framed not as government commitments, but as policy statements or recommendations.[294]

183. Bev Wicks, Marty Wexler, Jim Fagan, and Carol Bethune all provided evidence about the creation of the network of community based options in Nova Scotia. The disability rights community began advocating for the closure of Mountain View institution in 1974. This was the first campaign of the deinstitutionalization movement in the Province. Mountainview was closed in the late 1970s. Service providers advocated for and organized the opening of the first group homes in Nova Scotia in the late 1970s.[295]

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[292] Book II-Tab 8, Memorandum to Cabinet MCS LeBlanc Nov 1990, JEB p. 362.

[293] Book VIII-Tab 111. Report of the Task Group on Homes for Special Care, 1984, JEB p. 6548; VI-A-1, The Mentally Disabled Population of the Halifax County Region: Needs and Direction- A Plan for the Future, 1989, JEB p. 1683; Book II-Tab 8, Memorandum to Cabinet MCS LeBlanc Nov 1990, JEB p. 362; VIII-71. Management Audit Report January 1994 Vol 1 JEB pp. 5766, 5772; VIII-33 Planning Document in Response to Management Audit, 1994, chapter 4-14, JEB p. 4756; VI-A-3. Moving Towards Deinstitutionalization: A Discussion Paper, 1995; Book VI-A-32. Choice, Equality and Good Lives, JEB p. 2857; Book VIII-Tab 26, DCS 2015-16 Accountability Report, JEB p. 4590.

[294] Testimony of Lynn Hartwell, August 10, 2018.

[295] Testimony of Marty Wexler, February 21, 2018; Testimony of Bev Wicks, June 5, 2018

184. RRSS began operating group homes and developmental residences in the late 1970s. By the early 1980s RRSS concluded that it was not beneficial to operate larger homes. Larger homes were not in keeping with the emerging literature about best practices to support people with disabilities, and people were expressing a desire for a smaller community-based home. In 1985 RRSS implemented a freeze on the creation of additional group homes. Ms. Wicks, the former Executive Director of RRSS, recalls expressing that RRSS was only interested in opening "smaller options." She began to hear the term "small option" to refer to community homes for 3 or fewer people in the mid-1980s.

185. The period from the mid- 1980s until 1995 was described by Bev Wicks as the "golden age" for the creation of community-based homes in Nova Scotia. Jim Fagan testified that RRSS opened more than thirty small option homes between 1986 and 1995. Marty Wexler also testified that the period from the mid-1980s until 1995 was a period of expansion for the his organization, Community Living Centres. The service providers would receive a referral, would conduct an assessment of the person's needs, design supports around their needs, and submit the funding proposals to municipalities. The service provider would negotiate with the municipality, and then begin service delivery. Per diem funding rates corresponded with individuals' needs.[296] Ms. Wicks testified that wait times from the date of referral to service delivery with RRSS could be up to a year, but most people were served within 6 months.[297]

186. Ms. Bethune agreed that prior to 1995, if someone eligible was seeking residential supports the municipality would create a placement around their needs. She testified that prior to 1995 care coordinators had more resources, a greater ability to be work creatively to meet clients' needs, and fewer controls over their work.[298]

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[296] Testimony of Marty Wexler, February 21, 2018; Testimony of Bev Wicks, June 5, 2018; Testimony of Jim Fagan, March 12, 2018

[297] Testimony of Bev Wicks, June 5, 2018

[298] Testimony of Carol Bethune, September 18, 2018

187. The funding for the "golden age" of small option home creation came from all three levels of government. Community based options were funded by the municipality under their "general assistance budget." The cost incurred by the municipalities were partially reimbursed by the Province. the rate of compensation varied between municipalities, but the average rate of compensation was 75%.[299] The Province was in turn compensated for 50% of its social assistance budget by the federal government under the Canada Assistance Plan.[300]

188. The Province closed institutions for children with disabilities in the mid-1990s.[301] The Roadmap document refers to these closures in the context of Nova Scotia being perceived at the time as a nationwide leader in deinstitutionalization initiatives.[302] Barb Horner testified about her experience advocating DCS to close these institutions alongside other parents of children who lived in these centres. Their major concern was the abuse children suffered there.[303] Ms. Hartwell testified during her direct examination that closing the Children's Training Centres was the right thing to do. Children should be with their families and not in facilities.[304]

189. In 1995 the Canada Assistance Plan was repealed and replaced with the Canada Health and Social Transfer. The Transfer is an open-ended block grant that gives provinces

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[299] *Municipal Assistance Regulations*, NS Reg. 76/81.

[300] Supplementary Exhibit Book, 4a, House of Assembly, April 18, 1995, Hansard pagination, pg. 2

[301] Book II-Tab 5, DCS News Release, April 11, 1994, JEB p. 298; Book II-Tab 9, Strategy for CTC implementation team report, JEB p. 366; Book II-Tab 11, Review of Children's Training Centres - R & R to Minister of Community Services Oct 1994, JEB p. 377; VI-A-62, Review of Reports on Disability Supports and Services in Nova Scotia: For Joint Government-Community Advisory Committee on Transforming the Services to Persons with Disabilities Program (IRIS), March 2013 (slide deck), JEB p. 3384.

[302] VI-A-32, Choice, Equality and Good Lives in Inclusive Communities: A Roadmap for Transforming the Nova Scotia Services to Persons with Disabilities Program (June 2013) [by The Nova Scotia Joint Community-Government summary on Transforming the Services to Persons with Disabilities (SPD) Program], JEB p. 2877.

[303] Testimony of Barb Horner, June 13, 2018. Ms. Horner's testified she motivated to advocate for the closure of the children's institutions due to her daughter's experience living there. Her daughter left the CTC after receiving second-degree burns. CTC's explanation of how she received the burns was not accepted by her daughter's doctor as plausible.

[304] Testimony of Lynn Hartwell, August 9, 2018.

complete discretion over its spending.[305] In 1995 the Province also assumed responsibility for funding one hundred percent of the cost of social assistance, including the cost of funding the DSP. The Province imposed its moratorium on the creation of new small option homes in June 1995.[306]

190. Carol Ann Brennan testified about the impact of the moratorium upon service providers. RRSS has only opened 5 homes since 1995. There of these homes were opened in 1996 to support people who had previously lived in the Children's training Centres. These homes had planned prior to 1996. The two remaining homes were opened in 2014/2015. They provide support to individuals whose parents had publicly advocated for their release from Quest (one of the individuals is Nichelle Benn, whose mother Brenda Hardiman testified before the tribunal about her advocacy).[307] Since the moratorium was imposed RRSS has approached DCS with proposals to break its larger group homes into small option homes but they have all been refused.[308]

191. DCS Marty Wexler testified that the moratorium has created greater rigidity in the way Community Living Centres supports individuals. Prior to the moratorium CLC moved people between houses when it was desired. When appropriate and desired, they moved people from small option homes into more independent arrangements. The moratorium has made it difficult to move people internally within service providers, since they must be wait on the Province's central list prior to the move.[309]

192. The Department of Community Services tracked deinstitutionalization as a positive measure of its performance in its 2001-2002 Accountability Report. It dropped this

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[305] Testimony of Neil MacDonald, June 19, 2018.

[306] Book VI-A-6, *Report of the Review of Small Options in Nova Scotia*, JEB p. 1768; Book III-Tab 4, JEB p. 565.

[307] Testimony of Carol Ann Brennan, June 6, 2018.

[308] *Ibid*

[309] Testimony of Marty Wexler, February 21, 2018.

performance metric in 2002 after the closure of the Cole Harbour Rehabilitation Centre and the Scotia ARC, explaining it had no plans to further deinstitutionalize the Province.[310]

193. The Board received extensive evidence about the Province's most recent commitment to deinstitutionalization, the 2013 Roadmap document. The committee which authored the Roadmap document had a number of representatives from the Province, the disability rights advocacy community, service providers.[311] The committee functioned on a consensus basis.[312] It was explicitly informed by the UN Convention on the Rights of Persons with Disabilities.[313] The Roadmap also cites the guarantee under the Charter of Rights and Freedoms, and the Nova Scotia Human Rights Act of "equal rights, respect, and dignity in all aspects of life without discrimination on the basis of disability." [314]

194. The Roadmap contains a five-year plan for deinstitutionalizing people with disabilities and implementing a person-centered, community-based model of residential supports. Wendy Lill, the community co-chair on the committee, testified that the five-year time frame was accepted as a reasonable timeframe for implementation by all the committee members, including government representatives.[315]

195. Ms. Hartwell testified on her direct exam that the commitment to "reduce reliance on institutions" was "the big one" of the report's recommendations. She was asked about what the intent behind the phrasing "reduce reliance." Did it mean institutions would be closed? Ms. Hartwell confirmed that it did. She "certainly" didn't take from it that it was in anyway a softening of the desire to close large facilities. The intent behind the

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[310] VI-A-56 DCS Accountability Report 2001-2002, JEB p. 3238; VI-A-57 Accountability Report 2002-2003, JEB p. 3278; VI-A-58 Business Plan 2003-2004, JEB p. 3314.

[311] VI-A-32, Choice, Equality, and Good Lives, Appendix A, JEB p. 2913.

[312] Testimony of Lynn Hartwell, August 10, 2018; Testimony of Michael Bach, February 13, 2018.

[313] Testimony of Lynn Hartwell, August 10, 2018; Book VI-A-Tab 32, Choice, Equality and Good Lives in Inclusive Communities: A Roadmap for Transforming the Nova Scotia Services to Persons with Disabilities Program (June 2013), JEB pp. 2860, 2861.

[314] VI-A-32, Choice, Equality, and Good Lives, JEB p. 2862.

[315] Testimony of Wendy Lill, June 7, 2018

recommendation was for the Province to say “out loud” “we will be closing larger facilities.” [316]

196. The Roadmap was released prior to the provincial election of 2013. The Liberal government endorsed the Roadmap after the election.[317] On Ms. Hartwell’s re-direct examination she confirmed that the government remains committed to implementing the Roadmap, closing institutions, and opening community-based options.[318]

With the Proper Supports, all Persons Can Be Supported to Live in the Community

197. All people can be supported to live in community. This fundamental assumption was shared by the drafters of the Roadmap document.[319] Ms. Hartwell testified on direct examination that the government believed that statement to mean “what it says. A belief that all people with the right supports and a-available, can be supported to live in a community.”[320]

198. When asked specifically about how the government intended the word community to be interpreted, she stated that the government wasn’t being “coy” about its use. The government was using the way it’s used by disability rights advocates, to mean “smaller options-community based options, not facility-based care.” [321] She confirmed that the Province continues to believe this fundamental Roadmap assumption to be true. [322]

199. Further, on cross-examination Ms. Hartwell affirmed that a very similar statement of principle was contained in the Province’s 1995 “Moving Towards Deinstitutionalization”

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[316] Testimony of Lynn Hartwell, August 10, 2018.

[317] VII-1 Advice and Briefing Memo MCS Transformation Pelham and MacPherson November 2013, JEB p. 3920; VI-A-64, DCS DSP Standing Committee, September 15, 2015, JEB p. 3476; VIII-41 December 16, 2016, JEB p. 5069.

[318] Testimony of Lynn Hartwell, August 10, 2018.

[319] VI-A-32, Choice, Equality and Good Lives in Inclusive Communities Roadmap for Transforming SPD, JEB p. 2862.

[320] Testimony of Lynn Hartwell, August 9, 2018.

[321] *Ibid*

[322] *Ibid*

document.[323] Denise MacDonald-Billard agreed unequivocally with the fundamental assumption that all persons can be supported to live in community contained in these documents.[324] Carol Bethune also concurred "in principle" with the fundamental assumption that all persons can be supported to live in community contained in these documents. [325]

200. Marty Wexler, the founder and former Executive Director of Community Living Centres, testified that his organization had supported a lot of people with "very difficult backgrounds." As long as the proper supports were in place and there was adequate staffing, there was no one his organization would not or could not support. [326]

201. Jim Fagan, the long-time Director of Resident Services with RRSS, testified that RRSS is the largest service provider in the Province. RRSS has supported people with very complex needs since it began operating in the late 1970s. It has supported approximately 300 people to live in the community since this time. RRSS believes that all people can be supported to live in the community. [327]

202. The Board heard evidence from health professionals who work with the COAST team, which provides supports and services to people with disabilities living outside of acute care settings. Shonagh Parker is a registered nurse who works full-time with the COAST team. The service is based in Halifax but serves over 200 people around the Province. It provides assessments, short-term treatment, education and collaborative care support to individuals and their caregivers. The COAST team has two part-time psychiatrists, two nurses, one board-certified behavioral analyst, and a part-time social worker. People

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[323] Testimony of Lynn Hartwell, August 10, 2018; the statement of principle was "The Department believes that not only do all Nova Scotians have the right to live in the community, it believes the community is the natural setting for individual growth and fulfillment" at VI-A-3, JEB p. 1718.

[324] Testimony of Denise-MacDonald Billard, June 18, 2018.

[325] Testimony of Carol Bethune, September 18, 2018.

[326] Testimony of Marty Wexler, February 21, 2018

[327] Testimony of Jim Fagan, March 12, 2018.

discharged from Emerald Hall are followed by the COAST team. Ms. Parker testified that most people discharged from Emerald Hall are doing well. The COAST team receives positive feedback about the support it provides to people with dual diagnoses. [328]

The Moratorium

203. In April 1995 the Department of Community Services assumed control of the operation of the Community Based Option program. In June of that year the Province imposed a moratorium on the opening of new Community Based Option homes. The Province justified the moratorium by claiming that it needed a period of time to create an action plan for deinstitutionalization and the creation of standards for the operation of small option homes.[329] Interim Standards that all operators of small option homes were required to comply with were in place by November 1996.[330] The moratorium nonetheless remained in place.

204. On May 1, 1997 a thorough explanation of the mechanics of the moratorium was provided in the House of Assembly by the Minister of Community Services at the time, Mr. John MacEachern. He clarified that the moratorium imposed a cap on the number of people supported in small option homes. Some exceptions to the cap could be made-for instance some small option homes were built for former residents of Children's Training Centres upon their closure. Otherwise, the only way someone could begin living in a small option home is if an existing resident leaves the home and creates a vacancy. He affirmed that the moratorium remained in effect as of the date of the exchange. He acknowledged that the moratorium was likely responsible for the creation of a backlog of demand for small option homes, but he was not aware if a "formal waiting list" for the service existed. [331]

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[328] Testimony of Shonagh Parker, March 8, 2018.

[329] Book III-Tab 1, Community Based Action Plan Small Options Component 1996, JEB p. 546; VI-A-6, Report of the Review of Small Option Homes, JEB p. 1755.

[330] VI-A-6, Report of the Review of Small Option Homes, JEB p. 1755.

[331] Supplementary Book of Exhibits, Tab 4-F, May 1, 1997 Committee of the Whole House, Hansard pages 468-470

205. The ongoing operation of the moratorium is evidenced through a number of documents contained in the Joint Exhibit Book.[332]

206. Ms. Hartwell testified to the moratorium's existence. She agreed that a quantitative expression of the moratorium is contained in the table of small option capacity in the Joint Exhibit Book, which shows stability in the number of small option homes over the course of a number of years.[333]

207. Although she denied ever having seen an internal government document announcing the moratorium, she confirmed in her cross-examination that such a significant policy decision would have required ministerial approval. Moreover, Ms. Hartwell agreed that the decision to maintain was effectively made each year since its imposition through the creation of the Province's annual budget. *Ad hoc* exceptions to the moratorium were made since she began with the Department of Community Services in 2004. She agreed that exceptions to the moratorium were made by the Province in response to two circumstances. First, some small option homes were created after the closure of some institutions, such as the Halifax County Rehab Centre. Second, exceptions have been made for high-profile cases that have attracted media attention or the involvement of very senior government officials. She is aware of approximately twelve such exceptional,

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[332] Supplementary Book of Exhibits, Tab 4 c, Hansard Committee of the Whole House May 9, 1996 Hansard pages 330-332; Supplementary Book of Exhibits, Tab 4 d, Hansard Committee of the Whole House May 10, 1996 Hansard pages 371 and 372; VI-A-6, Report of the Review of Small Option Homes, Jeb p. 1768; Book III, Tab 1, Community Based Option Program Small Option Home Component, JEB p. 545 Book III-Tab 3, Letter MacEachern Hamm Re Housing Supports 1997, JEB p. 554; Book 3-Tab 4, NS Dept. Audits DCS 1998 Ch. 5, JEB p. 565; Book III-Tab 5, Letter MCS Christie to Thompson 2000; Book III-Tab 8, Small Option Homes Moratorium Feb 2007; Book III-Tab 9, Advice to Minister of Community Services, Briefing Note, Small Option Homes Moratorium Termination Act; Book III-Tab 10, Memo in Response to Small Options Moratorium Termination Private Members Bill 2007, JEB p. 616; Book III-Tab 12, DCS Ministerial Briefing Note Re Lack of Small Option Homes by Judy LaPierre Feb 2008; Book III-Tab 13, DCS Web Page Re Moratorium Nova Scotia Permits Directory; Book III-Tab 14, Web Page April 12, 2004 DCS Moratorium; Book III-Tab 15, Advice to Minister of Community Services, Residential Community Homes v Small Options Homes, Judy LaPierre, March 8, 2012 [DOJ Disclosure, Nov 6 2015, 19(iv)]

[333] Testimony of Lynn Hartwell, August 10, 2018, when presented with Book III-Tab 17, DCS Table of Residential Capacity, by type of living situation (1989 through 2017), JEB pp. 640-641.

high profile individual cases that have occurred during the course of her career including one that was resolved after Brand & Hardiman met with the Premier.[334]

208. Ms. Hartwell stated that a "clear signal" the moratorium had been lifted came two provincial budgets ago, which contained money to open several new small option homes. She agreed that this was the first time in fifteen years that the government planned the opening of new small option homes.[335] She acknowledged on cross-examination that while calling it a "clear signal" the government did not issue any kind of announcement about the end of the moratorium.[336]

209. Ms. Bethune testified from a care coordinator's perspective that the practical effect of the moratorium was that a vacancy had to open in order for a participant to be offered a placement in a small option home. Further, she agreed on cross-examination that the resulting backlog of demand for small option homes spread to other residential options offered by the DSP.[337] Waitlists are a practical expression of the moratorium. Now, waitlists exist for every DSP residential option except is Flex At Home.[338] Ms. Bethune would have us add Residential Care Facilities to this list, but this contention contradicts both clear wording of this internal provincial document, and the testimony of Ms. Hartwell. [339]

210. Although the Province's moratorium on small option homes remained in place, it remained receptive to proposals to open larger Group Homes. The Province also pursued a policy of expanding three-bed small option homes to four-bed small option homes.[340]

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[334] Testimony of Lynn Hartwell, August 9 and 10, 2018

[335] Testimony of Lynn Hartwell, August 10, 2018, when presented with Exhibit 56, Hansard Debate, October 10, 2017, document page 37/49.

[336] Testimony of Lynn Hartwell, August 10, 2018.

[337] Testimony of Carol Bethune, September 18, 2018.

[338] VI-A-66 [REPLACED BY STAND-ALONE DOCUMENT], DSP Transformation, Adult Service Array Design, (slide deck), December 16, 2016, Slide 52.

[339] Testimony of Lynn Hartwell, August 10, 2018.

[340] Book VIII-12, August 19, 2009 LaPierre Ministerial Briefing Note re Community Homes v Small Option Homes (2), JEB p. 4261.

The Waitlist

211. The waitlist for residential supports has grown steadily since the moratorium on small option homes was imposed by the Province in June 1995.[341] These are not parallel facts. They are intersecting facts. There was no waitlist for small option homes before the Province assumed responsibility for these homes in 1995.[342] The waitlist has grown exponentially because the moratorium was imposed in 1995 and renewed for many years thereafter. It exists because the government has failed to provide the resources necessary to provide residential supports to the waitlist people with disabilities. [343]

212. Everybody on the waitlist for residential services with the DSP has been determined to be an eligible "person in need." Further, everyone on the waitlist has also been found eligible for residential supports.[344] Waitlists were maintained by region until 2010, when the Province collapsed these separate waitlists into one waitlist for the entire Province. [345] As of November 2017 there were 1490 people on the waitlist for DSP services. Of these 1490 people, 433 were receiving no residential supports from the DSP. The remaining 1057 people were receiving residential supports but wanted a different support option. Of the 1490 people on the waitlist, 1028 listed a small option home as their first, second, or third preferred support option.[346]

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[341] VII-3, DCS Briefing Note SPD Wait List for Adults with Disabilities LaPierre Oct 2007, JEB p. 4010; VII-8, Advice to Minister SPD Wait Lists by J LaPierre April 3, 2012, JEB p. 4025; VII-9, Advice to Minister re SPD Program Wait List and Placement Pressures -L. MacPherson March 11, 2013, JEB 4029; VII-18, Briefing Memo SPD Waitlist, Jessome Nov 2013, JEB p. 4167; VI-A-64, DCS Presentation to the NS legislature's Standing Committee on Community Services re the Disability Support Program, September 15, 2015, JEB p. 3474.

[342] Testimony of Lynn Hartwell, August 10, 2018; Testimony of Carol Bethune, September 18, 2018.

[343] Testimony of Carol Bethune, September 18, 2018.

[344] *Ibid;* Exhibit 58, Current DSP Policy, section 5.4.1; VI-A-66, DSP [REPLACED BY STAND-ALONE DOCUMENT],Transformation, Adult Service Array Design, (slide deck), December 16, 2016, slide 186.

[345] Testimony of Lynn Hartwell, August 10, 2018.

[346] Exhibit 45, November 27, 2017 DCS DSP Waitlist Info

213. People waitlisted but receiving no DSP residential support may live at home, in a hospital, in a shelter, in jail, in a nursing home, or in a children's residential facility.[347] Many people with disabilities remain waitlisted for residential supports for years. As of September 15, 2015, one person had been on the waitlist for 19 years.[348]

214. The Department of Community Services actively screens applicants for residential supports with the DSP. Care coordinators are required under their current policy manual to inform applicants during intake calls about the existence of the waitlist and the approximate length of time they could expect to wait for various services. [349] Although Ms. Bethune has not had responsibility for performing intake conversations since 2011, she testified that a similar screening practice was in place within the DSP prior to that year. She stated that she would inform people it would be a "really long wait" for a small option home or an RRC. She admitted on cross-examination that she would steer applicants towards residential options for which there was a shorter expected wait time.[350]

215. On September 15, 2015 Ms. Hartwell stated in the House of Assembly that the waitlist for DSP services is likely "artificially small."[351] She agreed on cross-examination that the waitlist was likely artificially small due to the intake screening care coordinators are required by DCS to perform. [352]

216. Priority of placement on the waitlist has no predictive value of how long a person will wait for a placement. Ms. Bethune testified that she is frequently asked by participants or their families how long they will wait for a placement. She has no way of providing

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[347] Book VIII-Tab 70, June 2013 Services for Persons with Disabilities - Waitlist (slide Deck), JEB p. 5731.
[348] VII-14, DSP Waitlist – by length of wait time, September 2015, JEB p. 4121; VII-15, DCS Average wait times August 31, 2015.
[349] Exhibit 58, Current DSP Policy, Section 6.1
[350] Testimony of Carol Bethune, September 19, 2018.
[351] VI-A-65, Hansard DCS DSP Transformation, September 15, 2015, JEB p. 3522.
[352] Testimony of Lynn Hartwell, August 10, 2018

them that information. She can ask the waitlist coordinator for the person's place on the waitlist, but that does not translate into an answer about how long they might wait for a place to live.[353]

217. People waitlisted for DSP are living in inappropriate settings. Ms. Hartwell agreed that waitlisted persons are being neglected by the Province, they are not receiving the supports they need. She stated further that this was "the whole reason" the Province was "focused on trying to change the system."[354] For this reason, DCS has tracked waitlist growth as a negative performance indicator in its annual accountability reports.[355]

Moving Far from the Community of Choice to Access Residential Supports

218. Ms. Hartwell testified that people seeking residential support under the DSP are required to move far away from their community of choice to receive the assistance to which they are statutorily entitled.[356] The Directory of licensed Residential support options catalogues the uneven geographic availability of residential supports the Province offers.[357] As Joanne Pushie testified, there are no small option homes in the Prestons, Lincolnville, Sunnyville, or any other predominantly African Nova Scotian communities.[358] The DCS Table of Residential Capacity similarly bears witness to the issue. As of December 2017 818 people were clustered into several large RRCs and ARCs located in Waterville, Bridgetown, Pugwash, Sydney, Dayspring, Yarmouth, Sackville and Stellarton.[359] Presumably, many of these persons had to move from their community of choice in order to receive necessary services in these facilities.

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[353] Testimony of Carol Bethune, September 18, 2018.

[354] Testimony of Lynn Hartwell, August 10, 2018.

[355] *Ibid*; VIII-27, DCS 2015-16 Statement of Mandate, JEB p. 4612; VIII-25, DCS 2014-15 Statement of Mandate, JEB p. 4569.

[356] Testimony of Lynn Hartwell, August 10, 2018.

[357] VIII-107, DCS Directory-Licensed Residential Support Options

[358] Testimony of Joanne Pushie, February 20, 2018

[359] VI-A-67 DCS DSP Transformation ARC RRC Current State Overview, JEB p. 3595; III-17, DCS Table of Residential Capacity By Type of Living Situation (1989 through 2017), JEB p. 641.

219. The scale of the systemic issue was illustrated in the hearing through individuals' experiences. Betty Rich, one of the Province's witness, has "always lived" in New Waterford, Cape Breton. Her son, Joey, has received residential supports in Halifax county for decades.[360] Richard Rector testified that he accepted a placement on Windsor in order to leave the Community Transition program. [361] He now lives about forty minutes from his mother and an hour and forty-five minutes from his father.[362] Beth entered Kings as a fourteen-year old girl and was far from her family for much of her time there.[363] Sheila Livingstone's statutory decision maker was offered one placement option outside of Emerald Hall. As a result, Sheila lived her final years in Yarmouth, hundreds of kilometres from her family.[364]

The Province's Assessment and Classification are Invalid

220. The classification tools used by the Province have been criticized repeatedly as unreliable, invalid, and arbitrary. [365]

221. The Province used an assessment tool which classified individuals in accordance with the facility that corresponded to their level of care. This system was in place from 1993 until 2014. This assessment tool was replaced with the "level of support" assessment system in 2014.[366] It was accepted by numerous witnesses that neither the facility-designation

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[360] Testimony of Betty Rich, August 7, 2018.

[361] Testimony of Richard Rector, June 12, 2018

[362] Testimony of Leslie Lowther, June 7, 2018

[363] IX Tab 6, November 2000 Kings RRC Discharge Summary, JEB p. 7191.

[364] Testimony of Olga Cain and Jackie McCabe-Sieliakus, March 6 and 7, 2018.

[365] VI-A-9, An Independent Evaluation of the Nova Scotia Community Based Options Community Residential Service System [aka "the Kendrick Report") (Commissioned by DCS) (January 29, 2001) JEB p. 2153; Exhibit 78, SPD Renewal Project: Assessment Instrument Pilot Project Report and Recommendation, Judy LaPierre, June 21, 2005 at p. 3; Book V-Tab 2, Office of the Attorney General Departmental Audit, November 2010, point 3.23; JEB p. 1609; Book VIII-Tab 41, DSP Transformation, Adult Service Array Design, December 16, 2016 Item 3 & 4 (b) at JEB pp. 5183-5187; Exhibit 71, Dr. John Agosta, Individual Data-Based Assessment, Separation, and Supports Planning, Slide 7/52.

[366] Testimony of Lynn Hartwell, August 10, 2018.

nor the level of support dictated where someone had to live. All classified persons could be supported in any residential program, including small option homes.[367]

222. The facility-based assessment tool used by the Province was critiqued by Michael Kendrick in his influential 2001 report as "institutionally-derived." It was designed to "fit people into categories of service rather than designing services to fit the needs of people."[368] Ms. Hartwell acknowledged on cross-examination that she was aware that Dr. Kendrick was critical of this aspect of the assessment tool. [369]

223. Despite Dr. Kendrick's critique, the same assessment tool remained in use by the Department. A report issued as part of the 2005 DSP renewal initiative condemned the same assessment tool in no uncertain terms:

> The current assessment process is a non-standardized narrative approach to assessing clients. It does not allow for data collection or trend analysis; it is not reliable or valid, nor does it allow for comparisons of services between care settings. Most importantly, it is not compatible with the assessment approach used in the Department of Health (D0H) Continuing Care Division.[370]

224. Ms. Hartwell was involved in the 2005 renewal project. She was aware that the initiative involved an attempt to replace the assessment tool then in use by the department because it was recognized the tool was defective.[371]

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[367] Testimony of Carol Bethune, September 6, 2018; Testimony of Renee Lockhart Singer, August 8, 2018; Testimony of Trish Murray, June 19, 2018; Exhibit 63, slide 35, 37.

[368] VI-A-9, JEB p. 2153. An Independent Evaluation of the Nova Scotia Community Based Options Community Residential Service System [aka "the Kendrick Report") (Commissioned by DCS) (January 29, 2001).

[369] Testimony of Lynn Hartwell, August 10, 2018.

[370] Exhibit 78, SPD Renewal Project: Assessment Instrument Pilot Project Report and Recommendation, Judy LaPierre, June 21, 2005 at, p. 3

[371] Testimony of Lynn Hartwell, August 10, 2018.

225. In a 2010 report the Office of the Auditor General criticized the same assessment tool as "outdated" and in need of replacement. [372] Again, Ms. Hartwell acknowledged that she was aware of the critique of the assessment tool contained in that report. [373]

226. The assessment tool criticized in these 2001, 2005 and 2010 reports was finally replaced by the Province in 2014 by a new assessment tool. [374] This tool, like its predecessor, has been criticized internally and externally as unreliable and invalid.

227. A 2016 government presentation identifies the lack of correlation between the assigned "level of support" and the "total assessment score" as a significant problem with the current assessment tool. This lack of correlation led the government to conclude that it "cannot use our existing IASP and LOS framework to fairly allocate support budgets," and more bluntly, that the IASP was "not valid."[375]

228. Dr. John Agosta, an external consultant hired by the provincial government, has highlighted the "weak relationship between individuals' needs and the amount of supports they receive" and "a lack of tools to support service planning and service use consistent with community integration and self-direction" as "policy concerns" raised by the DSP's current assessment processes. [376]

229. Ms. Hartwell agreed that the current assessment tool is unreliable and in need of replacement. It can result in people being denied the services they require and their placement in situations that are unresponsive to their needs. Indeed, when an assessment was performed of peoples' levels of supports and their living situation, the Province found many people with low levels of supports living in very restrictive

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[372] Book V, Tab 2, NS Auditor General's Report, November 2010, JEB p. 1609.

[373] Testimony of Lynn Hartwell, August 10, 2018.

[374] *Ibid*

[375] Book VIII-Tab 41, DSP Transformation, Adult Service Array Design, December 16, 2016 Item 3 & 4 (b), JEB pp. 5186-87.

[376] Exhibit 71, Dr. John Agosta, Individual Data-Based Assessment, Separation, and Supports Planning, Slide 7/52.

environments like RRCs and ARCs. The Province recognizes the flaws with its assessment system and is seeking a new assessment tool. [377]

Complex Cases

230. The Complex Case Committee has been in existence since at least 2006.[378] It serves people with disabilities who have been denied necessary supports and services by the Province.[379] The Committee was born of a recognition that the Province could not hospitalize people unnecessarily indefinitely, nor could DCS maintain its position that it was not responsible for providing services to persons it deemed unclassifiable. [380]

231. Ms. Bethune has been working part time as the only complex care coordinator for Central Region since 2011. She agreed on cross-examination that the Committee was created due to pressure on the Department of Community Services from the Department of Health to move people out of the hospital who had been medically discharged but who required residential supports.[381] Ms. Bethune acknowledged that, since at least 2007, the Committee has been guided by the Committee partners' acknowledgement of their collective responsibility to resolve complex cases. [382]

232. Ms. Bethune testified that the 'complexity' of the case refers to the client's disabilities and their 'behavioural issues.' She agreed that her clients' perceived "behavioural issues,"

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[377] Testimony of Lynn Hartwell, August 10, 2018; Book VIII-Tab 41, DSP Transformation, Adult Service Array Design, December 16, 2016 Item 3 & 4 (b), JEB p. 5044.

[378] Testimony of Renee Lockhart-Singer; Exhibit 66, 2006-2008 Complex Case Management Team Minutes and Memoranda.

[379] Testimony of Lynn Hartwell, August 10, 2018.

[380] *Ibid*

[381] Testimony of Carol Bethune, September 19, 2018.

[382] She agreed with this after being taken to VIII, V4, Tab 124, September 2008 DCS and Health Complex Case Report, JEB p. 7055. An additional source that acknowledges joint departmental responsibility for resolving complex cases is VIII-6, April 4, 2012 Phase 1 Report and Recommendations, JEB p. 4237.

were related to their disabilities.[383] Ms. Bethune readily acknowledged that, while many complex case clients are considered ineligible or "unclassifiable" for residential supports, the complex case committee does not serve everyone considered ineligible for residential supports through the current DSP. Indeed, she agreed that it serves a small portion of the people who are considered "unclassifiable" for residential supports by the DSP. [384]

233. She testified that she currently has about twenty complex case clients. The committee does not have its own budget. To receive funding for complex case clients the committee members must request a joint funding package from the Department of Community Services, the Department of Health, and/or the IWK. She agreed that it can take years to resolve a complex case. However, the Committee does not keep statistics about the average time someone considered a complex case waits for a placement. She stated that the only way to speed up the resolution of cases is to provide new funding to meet someone's needs. However, she agreed that it is only exceptional cases in which new funding is provided to a person, and that such cases are few and far between. She acknowledged that the Committee has no authorization to create new spaces within the residential supports system to accommodate complex case clients. Many people considered "complex cases" are not waitlisted for DSP residential options due to their ineligibility for the same.[385]

234. There was a period of time in which DCS was not involved in the complex case committee in June 2009 due to "resource issues."[386] Ms. Bethune is aware that there was a gap in DCS' participation in the Committee in between when her predecessor, Donna Pettipas, left the committee and when she began her role in 2011. She does not know the length of time that DCS resiled from its work with the Committee.[387]

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[383] *Ibid*

[384] Testimony of Carol Bethune, September 19, 2018.

[385] *Ibid*

[386] Exhibit 79, EH Progress Note June 26, 2009

[387] *Ibid*

"Unclassifiability:" Persons Considered Ineligible for Residential Supports Due to the Nature of their Disabilities

235. The Province draws a distinction between eligibility for the DSP and eligibility for residential supports offered by the DSP. It maintains it is entitled to find persons eligible for the DSP at the same time as they are ineligible for the residential supports they require.[388]

236. The Classification Policy manual used by the Province from 1993 to 2013 listed twenty-two reasons why someone might be considered unclassifiable by the DSP and therefore ineligible for residential supports. The reasons for finding someone ineligible for residential supports ranged from being on a new medication, to needing blood work more than once or twice a week, to those "requiring a considerable amount of restraint." "Alcoholics whose alcoholism is causing disruptive behavior" were unclassifiable, however, if "alcoholism is secondary to a physical or mental problem, alcoholics may be acceptable." The final listed reason for finding someone unclassifiable was a discretionary catch-all category, "such other person who, in the opinion of the classification committee, are not appropriate persons for admission to Homes for Special Care." [389]

237. Ms. Bethune acknowledged on cross-examination that many of the reasons why people were found unclassifiable under this policy manual were tied to their health and disability needs. Persons who were considered unclassifiable were not provided residential supports and were not on the waitlist. [390] A policy directive was issued in 2009 which required care coordinators to interpret the 1993 manual more flexibly to prevent evictions for health issues that could be treated with health resources generally available

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[388] Exhibit 58, Current DSP Policy Manual, Section 10.0.

[389] Book 1, Tab 3, pp. 93-96.

[390] Testimony of Carol Bethune, September 18 and 19, 2018.

in the community. [391] Ms. Bethune testified she was not aware of the policy directive and could not interpret it. [392]

238. In 2012, the Ombuds' Office issued a report which concluded that the DSP's practice of finding some individuals "unclassifiable" or ineligible for residential supports was resulting in the incarceration of persons with mental health diagnoses and/or intellectual disabilities. [393]

239. Ms. Bethune agreed that the term "unclassifiable" is no longer used by the DSP. However, there remains a category of persons considered ineligible for residential supports. Ms. Bethune agreed on cross-examination that persons who require health services that typically aren't provided in the community will likely be ineligible for residential supports with the DSP. She acknowledged that people may therefore be ineligible for DSP residential supports by virtue of their health condition or disability. "Ineligible" people receive no residential supports and are not on the waitlist for DSP services. Not everyone found ineligible is referred to the complex case committee. The DSP may try and refer someone considered ineligible for DSP to Adult Protection or the Mobile Crisis Team.[394]

240. Ms. Hartwell and Ms. Bethune's testimony conflicted about the existence of a category of people who are currently considered ineligible for DSP residential supports. Ms. Hartwell acknowledged during her direct examination that the label "unclassifiable" was previously used to refer to people who didn't meet the DSP's eligibility criteria for residential supports. She rejected the term as "no longer valid" today. She identified the problem of someone falling through the cracks of program eligibility with DCS and DOH

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[391] Book 1, Tab 3, Memo to SPD Specialists re policy directive on classifications Lorna MacPherson September 16, 2009, pp. 23-25.

[392] Testimony of Carol Bethune, September 19, 2018.

[393] Book V-Tab 1, An Own Motion Review pursuant to Section 11 of the Ombudsman Act involving Services for Persons with Disabilities, Department of Community Services 2012, Report pp. 1583, 1596.

[394] Testimony of Carol Bethune, September 19, 2018.

as "one of the reasons" that DCS was committed to transforming the DSP. [395] Ms. Hartwell denied that some people may presently fall outside the scope of the DSP. Today, she testified, DCS and DOH both recognize that they are responsible for providing appropriate supports and services for people with disabilities to live in the community and are committed to doing so. [396]

The Definition of Institutions

241. An institution is any living environment where residents are isolated from the broader community, lack control over activities of daily living, and where the requirements of the institution itself take precedence over the needs of the individual residents. [397] It is not defined merely by the number of residents. Dr. Michael Bach testified that the UN *Convention on the Rights of Persons with Disabilities* does not define an institution with reference to the number of its residents, but with reference to segregation and isolation from the broader community its residents experience and the lack of choice and autonomy they exercise over their daily lives. [398]

242. He testified that the qualitative approach to defining an institution is more widely accepted amongst professionals working in the field of disability studies than the quantitative approach. While it may be theoretically possible to have a large facility that is not an institution because it under the control of residents, Dr. Bach has never seen such an arrangement in practice. He testified that large facilities by their nature do not afford individual residents choice and opportunity. [399]

243. Dr. Bach testified about the link between institutionalization and funding DSP participants' residential supports in the form of a "*per diem*" to a service provider. Under

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[395] Testimony of Lynn Hartwell, August 9, 2018.

[396] Testimony of Lynn Hartwell, August 9 and 10, 2018.

[397] Dr. Michael Bach Expert Report, Exhibit 12, pages 22, 23.

[398] Testimony of Michael Bach, February 13, 2018.

[399] Testimony of Michael Bach, February 14, 2018.

the "*per diem*" model, the funding flows from the Province to the service-provider to fund the resident's "bed." This model does not afford the resident the right to leave the arrangement, find an alternative place to live, and take their funding with them. Power under this model therefore rests with the institution, not the individual. As such, the "*per diem*" funding model is an aspect of an institutional arrangement. Meaningful deinstitutionalization involves both closing large facilities and shifting resources towards individual participant control. [400]

244. Dr. Frazee echoed Dr. Bach's definition of an institution. She testified that size is a marker of an institution, but it is not decisive. The determinative factor is control. If the paramount concern is the efficiency of administration and not the aspirations of individuals who live there, that is an institution. [401]

245. The Province did not call its own expert to testify about the definition or characteristics of an institution.

The Harms of Institutionalization

246. The Province has repeatedly admitted that people with disabilities are disadvantaged through institutionalization.

247. In a 1984 report of a task group Homes for Special Care program to the Minister of Social Services, the authors recognized that institutionalization was contrary to the Province's embrace of normalization and concluded:

> For the past decade, in Nova Scotia and across North America, the development of residential and support services for the mentally handicapped has been guided by the principle of normalization. Normalization has the following emphasis: "the integration of the mentally handicapped into a variety of community living settings; the provision of a broad array of community—based support

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[400] Testimony of Michael Bach, February 13 and 14, 2018.

[401] Testimony of Dr. Frazee, June 4, 2018.

> services; a gradual policy of deinstitutionalization of mentally handicapped persons from large, often remote, institutional facilities; and a rehabilitative rather than custodial orientation within institutions to ensure that persons are moved as quickly as possible to community alternatives." [402]

248. In November 1990 an internal memorandum to from the Minister of Community Services to the Cabinet Committee on Policy and Planning stated:

> Most other jurisdictions in Canada have clearly stated that mentally handicapped persons should be encouraged and enabled to live and participate as fully as possible in community life. While there are and will continue to be differences amongst families, advocates and professionals as to what types of service models best constitute full participation in community life, the placement of mentally handicapped children and adults in large, segregated and often isolated institutional environments is clearly beyond the parameters of this philosophy. [403]

249. In a similar tone, the Province's "Putting People First" document concluded that:

> There can be no doubt that the legacy of an era of residential facilities where occupants were treated more like inmates than residents lingers still...There is strong agreement that any facility-based model which clusters people with disabilities for administrative convenience, or segregates them for lack of inclusive community-based options, is not person-centered and must be rejected. [404]

250. The 2016 Terms of Reference for a DCS "Health System Alignment Working Group" document stated it even more baldly:

> Institutionalization is no longer considered an acceptable way to deliver supports to clients...It is also believed that there are clients in NSHA facilities (e.g. Alternative Level of Care beds, acute care beds) that should be in a DSP placement-the current lack of capacity/waitlists often prevents this from occurring which means that clients are often in a level of care that is not suited to their

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[402] Book VIII-Tab 111. Report of the Task Group on Homes for Special Care, 1984 at JEB p. 6547.

[403] Book II-Tab 8, Memorandum to Cabinet MCS LeBlanc Nov 1990, JEB, p. 363.

[404] VI-A-29, Putting People First: What we Heard, JEB p. 2772.

> needs. In all cases, clients are in placements that do not support their health and social outcomes." [405]

251. Similarly, a 2016 DCS presentation about the DSP Transformation stated that:

> Young participants desire to live in the community or with family/friends-they do not talk about wanting to live in institutions, group homes, or large settings...There is a lack of opportunity for skill building in our residential centres. ARC/RRCs are not fulfilling their rehabilitative mandate have evolved to "LTC type supports".[406]

252. Ms. Hartwell agreed that institutionalization is harmful to people who don't need to be there. She explained that this harm was one of the reasons why the Province is engaging in the process of transforming the DSP.[407] Trish Murray, a DCS employee, also agreed on cross-examination that hospitals are inappropriate environments for people to live in. [408]

253. The complainants called three medical experts who testified to the harms inflicted on institutionalized persons, Dr. Sulyman, Dr. Theriault, and Nicole Robinson.

254. Dr. Sulyman is one of the psychiatrists on Emerald Hall. She testified that remaining on a unit like Emerald Hall after stabilization where others are acutely unwell can be distressing and can trigger relapses of an illness. Institutionalization can also lead to a loss of independence and a sense of responsibility. As such, it can lead to a loss of a sense of self, self-esteem and confidence. Patients tend to withdraw into themselves and become passive. People with intellectual disabilities have deficits in their life skills. Adequate recreation opportunities and individualized attention are necessary to maintain or enhance their skills. Skills deficits are worsened when institutionalized in a place like Emerald Hall where adequate recreation opportunities are not provided and there are frequent staff changes. There is a high volume of staff on Emerald Hall, which can be very

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[405] VIII-Tab 84, March 25, 2016 DSP and Health Realignment Terms of Reference, JEB pp. 6059-6060.

[406] VI – A-66, Side 56.

[407] Testimony of Lynn Hartwell, August 10, 2018.

[408] Testimony of Trish Murray, June 20, 2018.

frustrating to people on the unit who experience difficulties communicating and who require staff to be familiar with their communication patterns. Frequent changes in staff can therefore cause frustration, which can lead to negative behaviors which are often perceived as aggressive. [409]

255. Dr. Theriault, a psychiatrist who has worked in East Coast Forensic Hospital for 20 years and more broadly within the NSHA (and its predecessor) for almost as long, echoed Dr. Sulyman's views about the medical harms inflicted by institutionalization. Dr. Theriault testified to the sense of hopelessness that patients detained in ECFH after their conditional discharge experience. After experiencing hopelessness, behavior perceived as negative can emerge. People on ECFH are surrounded by people in acute crises and they may be exposed to violence. Little programming is available, and many patients are very bored as a result. [410]

256. Nicole Robinson is a board-certified behavioral analyst who works at Emerald Hall and with the COAST team. Ms. Robinson provided expert testimony that all behavior has a communicative purpose. For some people with disabilities communicative behavior can include actions like striking out, which is then often labelled by people around them as "aggression." Behavioural analysts identify 'environmental' triggers for communicative behaviors perceived as negative and teach positive replacement behaviors. She testified that motivation is very important to changing behavior.

257. Institutional 'environments' can trigger negative behaviors. Emerald Hall residents' lives are run on a rigid schedule. It's frequently chaotic, and residents are often surrounded by other residents and staff. This can be very frustrating. Institutionalization can also lead to a loss of motivation and, frequently, depression. Institutionalization can also foster a

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[409] Testimony of Dr. Sulyman, March 13, 2018

[410] Testimony of Dr. Theriault, June 11, 2018.

greater dependence on staff for help with activities of daily living ("learned helplessness" or "prompt dependence").

258. Ms. Robinson testified about the difficulty in working on the behavior of someone institutionalized in a setting like Emerald Hall. Teaching a positive replacement behavior requires individualized, focused attention from staff who understand a client's motivations. Large institutions have lots of staff, and not all staff will be well acquainted with all residents. Having large numbers of staff work with residents makes teaching positive behaviors difficult and can actually worsen residents' behavior.

259. Emerald Hall provides residents few opportunities for recreation. The Unit has one van, but there are 9 residents and 60 staff. There is a gym on site, but it is often occupied and inaccessible to Emerald Hall residents. Behavioural analysts work by teaching a skill in one setting, then generalizing it in other environments and with other people. It is hard to take residents off of the Unit in order to work on generalizing their behavioral skills.

260. She is unable to properly do her job on Emerald Hall. Hospitals are poor environments to teach new skills and behavior. She can teach the skill there, but since it isn't being practiced in more natural settings, the person loses motivation and the skill can't be taught to its fullest potential. Ms. Robinson testified that her behavioural work would be much more effective in a quieter community-based home where skills can be taught by staff working closely with residents and then easily generalized to other community settings.

261. Ms. Robinson is frequently involved in meetings with DCS care coordinators. In these meetings she will be told that a particular aspect of someone's behaviour is the barrier to the placement. She and the resident will then work hard to eliminate the behavior and present this information to DCS. The care coordinator will often then point to another issue that needs to be resolved prior to placement. Sometimes, care coordinators will be

forthright that there are no placements available. Ms. Robinson interpreted these demands from care coordinators as attempts to "buy time." The behaviors identified are sometimes not actual criteria for the person living in the community.

262. She testified that the disappointments suffered by residents after the prospect of a placement offer has faded can lead to social withdrawal. [411]

263. The complainants also presented several disability studies experts who testified to the harms of institutionalization, Dr. Bach, Dr. Griffiths, and Dr. Frazee.

264. Dr. Bach identified the major realms of disadvantage caused by institutionalization in his expert report and his testimony. A major consequence of institutionalization is a loss of autonomy and the inability to make decisions about one's own life. Institutionalized individuals often engage in self-abusive behavior. This behavior is often not interpreted properly as communicative, but instead is perceived as behavior justifying restraint. The use of restraint is then seen as a reason why they need the institution and could not be supported to live in the community. Privacy is hard to come by or impossible to access in institutions. Overcrowding, which the Canadian Mortgage and Housing Corporation defines as an adult sharing a room with someone with whom they are not in a conjugal relationship, is common. [412]

265. Dr. Dorothy Griffiths also testified about the harms of institutionalization, with a particular focus on Emerald Hall. Dr. Griffiths conducted an external review of the Emerald Hall unit of the Nova Scotia hospital in 2006.[413] Dr. Griffiths, was presented as an expert in the field of disability studies. Dr. Griffiths testified that she was retained by the

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[411] Testimony of Nicole Robinson, March 8, 2018.

[412] Testimony of Dr. Michael Bach, February 13, 2018; Exhibit 12, Book containing Mr. Michael Bach's reports and CV, report pgs. 24 and 25.

[413] Emerald Hall External Review, 2006, JEB VI B Tab 3, JEB pp. 3714-3755. Also referenced in the Complaint Exhibit 17, paragraph 147 and following.

Health Authority at the time to conduct an external review of the Emerald Hall Unit, an acute care unit specialising in 'dual diagnosis' patients. Dual diagnosis is defined as a person with both an intellectual disability as well as a mental illness and Dr. Griffiths testified that there is a higher prevalence of mental illness among people with intellectual disabilities than the population as a whole due in part to the impacts of stigmatisation of people with intellectual disabilities, life circumstances including abuse, and to being in inappropriate environments.

266. With respect to stigmatisation, she testified that there has been a long fight for inclusion of people with disabilities in the community and educational settings. One of the challenges in the case of people with a dual diagnosis is their need to coordinate both health and community services, but due to 'silos' and lack of communication, people with dual diagnosis often faced a 'catch 22', in that their need for health services lead to them losing or being found ineligible for community based services.[414] Dr. Griffiths' report also details how many Emerald Hall residents became caught by this 'catch 22' because their need for health services resulted in the loss of their place to live. [415]

267. Dr. Griffiths testified concerning the term 'behaviour' when applied to persons with disabilities. She testified that in institutional settings, where people have very little choice or autonomy, behaviour can be a way of taking control in a world where decisions are made by others. She testified concerning the development of an understanding of 'behaviour' as a way a person has of escaping something, or to communicate a need. She described this as a 'psycho-social model' of behaviour and contrasted it with the medical model it replaced, which identified deficits and relied on pharmacological responses to stop the behaviour, rather than building skills and treating the underlying reasons for the behaviour.

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[414] Testimony of Dr. Griffiths, March 15, 2018.

[415] VI-B-Tab 3, Emerald Hall external review, Griffiths and Stavrakaki (2006), JEB p. 3724.

268. Dr. Griffiths described her site visits to Emerald Hall, and her meetings with individuals who were living there. One man had been living there for 40 years.[416] She testified that the residents of Emerald Hall, like patients she had encountered in other institutional environments, had very little control over their lives. They were governed by a strict schedule. Many experienced a loss of motivation, a feeling of helplessness. [417]

269. Dr. Frazee, a Professor Emeritus in the field of Disability Studies at Ryerson and a former Chief Commissioner of the Ontario Human Rights Commission, authored a report and testified as an expert in the field of disability studies. Of the harms of institution she wrote:

> Small Option homes contrast dramatically with institutional arrangements. These latter facilities may have hundreds of residents, all of whom live in highly uniform, impersonal, and unnatural environments that offer little or no opportunity for the expression of individual preference or style. Daily routines are highly regimented and encounters with the "outside world" are minimal, except for the ubiquitous presence of television.[418]

270. In her evidence before the Board Dr. Frazee explained the isolation and segregation inherent in institutionalization and the harms that flow from these phenomena. Segregation and isolation, she explained, cause a "great degree of psychological and physical harm. They are stressful, depressing, and dehumanizing." This is well established in the academic literature on the issue, much of which was cited by Dr. Bach in his report.[419]

271. This Board heard from a number of first-voice witnesses with personal or family experience of institutionalization. Richard Rector lived in the Community Transition

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[416] The length of time was corroborated in later testimony from Carol Bethune, a Disability Supports worker who testified for the Respondent, who identified another individual who had been residing on Emerald Hall for a similar length of time.

[417] Testimony of Dr. Griffiths, March 15, 2018.

[418] Exhibit 37, Dr. Frazee's Report.

[419] Testimony of Dr. Frazee, June 4, 2018

Program ("**CTP**") and Quest for a combined total of nine years. Mr. Rector described his time there as "hellish." He lived at Quest first, which he described as "Alcatraz" and "pure boredom." He was forced to abide by the institution's schedule. The food was bad, his only choice surrounding his meals was "to eat or not." He could only leave to smoke or go for a walk if the workers weren't busy, but they were frequently busy. It smelled of feces. The windows were Plexiglas. Living surrounded by up to 24 people left him "no room for feelings, no room to worry about himself or his family." He was repeatedly assaulted by another resident. He was subjected to the therapeutic quiet room a number of times. He testified he was put there because he and a female resident were engaging in sexual activity. He described CTP as very similar to Quest. The resident who assaulted him while he was at Quest moved upstairs too, and resumed his frequent assaults on Mr. Rector. [420]

272. Mr. Rector's mother, Leslie Lowther, also testified before the Board. She testified that during his time at Quest she would receive phone calls from him, begging for her to get him out. He was deeply depressed when living there. They had conversations in which he expressed indifference to everything. She testified that he became "a shell." Quest punished him for behavior perceived as negative by denying him family time. His family was told he could not go home for a visit on Christmas. Ms. Lowther advocated strongly for a Christmas visit, Quest relented and allowed him one night away with his family. Since his parents are divorced, he had to choose between spending the holiday with his mother or father.

273. She was aware of his confinement in the therapeutic quiet room on a number of occasions. She testified that he disliked the food there and had no choice surrounding his meals. Due to his brain injury he is sensitive to noise, and other residents there would yell constantly, which was very distressing to him. He connected more with the staff than the

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[420] Testimony of Richard Rector, June 12, 2018

other residents there, but none of the staff had time to speak with him or provide him with attention.

274. She advocated to DCS and DOH for his release from Quest, and after five years he was offered a room upstairs at CTP. She was assured he would remain there 18 months, but he remained there for four years. It was very similar to Quest- many of the residents and staff were the same, as was the food, it also lacked programming and access to the outside world. He was repeatedly assaulted by a resident while in both CTP and Quest. Once while at CTP, he was choked by this resident. He was also assaulted by a staff member at CTP. The staff member grabbed his neck and yelled loudly enough to draw the attention of another staff member, who witnessed the incident. It was the subject of an investigation. He remained depressed while at CTP. While living there he once told him mom "I'm dead, I'm just dead." She continually pressed DCS to find him a place to live in the community. Finally, in the fall of 2016, she had what she described as a "meltdown," and shortly afterwards he was offered a place in a small option home. [421]

275. Brenda Hardiman's daughter Nichelle Benn lived for a number of years in an alternate family arrangement. Approximately 5 years ago, the family decided that they were no longer able to care for her within their own home they requested funding to create a small option home which Nichelle could live in and they could operate. DCS refused their request, citing the Moratorium. Nichelle was offered a placement at Quest. Ms. Hardiman advocated for a non-institutional placement for her daughter, but was told Nichelle's funding would be cut if the placement was not accepted. Nichelle was in Quest and CTP for a combined total of 2.5-3 years. While there she frequently called her mother, crying, asking for help to get out of the institution. She learned negative habits from other residents, including cutting herself. A resident died due to an assault when she was living there. The food was cold and staff were not authorized to heat it up. She was dragged

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[421] Testimony of Leslie Lowther, June 7, 2018

down a hallway by her arms and legs by staff. She was charged with assault for throwing a ‘foam letter’ and a shoe at a staff member. In an effort to get Nichelle out of Quest she publicized her plight in the media. She was an active member of an disability rights organization called “Advocating Parents of Nova Scotia.” She was granted a personal meeting with the Premier. Shortly afterwards Nichelle was offered a small option home with her choice of service provider. [422]

276. This Board also watched the documentary film “Freedom Tour” and heard testimony from the filmmaker, Brad Rivers. That video contains numerous interviews with Nova Scotians about their experiences in various institutions around the Province.

277. This Board also has before it evidence regarding issues in specific Nova Scotian institutions. Krista Spence was a developmental worker on Emerald Hall from 2011-2013. She testified to the shortage of recreation opportunities available there to residents. There were insufficient staff and resources for regularly-scheduled outings to occur. Planned outings were frequently cancelled so staff could attend to acute emergencies. She estimated that residents left the unit once per week, on average, for approximately two hours. She perceived residents to lose their important life skills and their ability to converse over the course of their time at Emerald Hall. [423]

278. Joanne Pushie, a former social worker on Emerald Hall, also testified to the decline she witnessed there in residents’ skills, including their social skills. Emerald Hall accepts patients from across the Province. Residents there for long periods of time experience separation from their families and friends and experience grief and loneliness as a result.[424]

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[422] Testimony of Brenda Hardiman, June 7, 2018.

[423] Testimony of Krista Spence, March 7, 2018.

[424] Testimony of Joanne Pushie, February 14, 2018.

279. Jennifer Gallant is a former charge nurse at CTP. She testified about the conditions in that institution. Most residents were in Emerald Hall or in Quest prior to their arrival at CTP. There were three security guards working there at all times. Food was brought upstairs from Quest's kitchen. Clients were exposed to many different staff over the course of a single day. There were frequent, almost daily, assaults on residents by other residents. She witnessed the therapeutic quiet room being used. The quality and frequency of recreational opportunities for residents on and off the unit varied significantly. Staff spent a lot of time in the nursing station interacting with each other. Residents stayed there for much longer than the 18 months that they were nominally supposed to stay in CTP. She raised this both with her manager, and with DCS care coordinators. She was told by both that the stays were being prolonged due to the shortage of available DSP housing.[425]

280. A recent DCS report provides some insight into conditions in Nova Scotia's ARCs and RRCs, as reported by their administrators. Several institutions (Sunset ARC, Kings RRC, and LaHave ARC) noted that their buildings are very old, and badly in need of repairs. Sunset ARC is over 120 years old, and the building "presents many challenges for people with disabilities."[426] Another significant issue highlighted by this report is the large number of institutionalized individuals who are not receiving regular assessments by the DSP. Of the residents in Kings', the author noted "Most are outdated except for those in Community Homes and a participant in ILS. 51 were updated in between 2013 and 2015. Some have not been updated since original assessment (1978 is oldest)." [427]

281. Issues of abuse have been documented within Nova Scotian institutions. An independent investigation into the Braemore home in Cape Breton made four findings of abuse pursuant to the *Protection of Persons in Care Act*, constituting a failure to provide

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[425] Testimony of Jennifer Gallant, June 12 and 13, 2018.

[426] VI-A-67, NS Department of Community Services DSP Transformation ARC RRC Current State Overview FINAL, undated, JEB pp. 3597-3636.

[427] *Ibid* at JEB p. 3633.

adequate care.[428] A report commissioned by the Province connected the resident abuse to deeply entrenched issues within the organization's culture, governance, and physical surroundings.[429] An investigation into the Riverview ARC indicated that RHC had a total of 22 founded cases of abuse/neglect of which nine were staff to client and 13 were client to client.[430]

Taking a View

282. The parties and the Board took views of several institutions central to the evidence in this case.

283. We visited Kings RRC, where Beth was institutionalized at age 14, and where countless others have lived since. The Kings RRC is located on Home County Road, Kings County, off the #1 Highway. Its closest neighbours are a Provincial Correctional Facility (NS Youth Facility), a fire station, and farmers' fields. At the time of our visit it held 175 residents ranging in age from 25-95. All but two of the 8 units were locked from the inside and outside, and most residents shared a bedroom with between 1 and 3 other residents. Unit bathrooms are shared. A single cafeteria provide the majority of the meals, although some residents were allowed to prepare their breakfast in a kitchen on the unit. Some residents go to the cafeteria for their meals, and some meals are delivered on trays to the units. It has some space for programming including a craft room and learning technology area. Some units are segregated by gender. The building is old. Residents spend much of their days in the common area, with few opportunities for recreational pursuits. It has therapeutic quiet rooms.

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[428] VI-A-26 Deloitte Touche Operational Review of Braemore Home at JEB p. 2709.

[429] *Ibid* at JEB pp. 2720-2725.

[430] VI-A-42, Report on Riverview Home Corporation at JEB p. 3081.

284. The Quest RRC is located in a similar manner at the end of a laneway, surrounded by a parking lot and bounded on two sides by elevated highways at the junction of the #101 and #102 Provincial Highways. It opened in September 2008 and has 24 beds. It closest neighbour is the Community Transition Program upstairs, opened in 2012, also a segregated institution for individuals with mental disabilities. Originally designed for 15 beds it now houses a maximum of 12 residents. Both institutions have 24/7 security guards inside the building employed by the private company Paladin Security. It is next to a busy highway and an overpass. It is not in a pedestrian-friendly area. The building is locked. The interiors of both institutions are spartan and sterile. They have therapeutic quiet rooms. Both Quest and CTP have a fenced outdoor space. Residents each have their own bedroom.

285. Emerald Hall is a locked acute care in-patient unit for ‘dual diagnosis’ (intellectual disability and mental illness) patients, housed in the Nova Scotia Hospital, a psychiatric hospital administered by the Province until 2001 and currently by the Nova Scotia Health Authority. The hospital itself is located on large grounds with parking areas, on the four lane Pleasant Street, adjacent to a wooded shoreline park area and the recently built Alderney campus of the Nova Scotia Community College. Emerald Hall has 15 beds but 9 patients at the time of the viewing, and a small common area next to the nursing station, a cafeteria and an outdoor fenced in courtyard. Patients have single rooms with a washroom, and share tub and bathrooms as well as a sensory room, dining/activity room.

The Province Has Repeatedly Acknowledged That Living an Integrated Life in the Community is a Human Right

286. For decades, the Province has recognized the benefits persons with disabilities derive from living integrated lives in the community on an equal basis with persons without disabilities.

287. As a result, the Province has repeatedly commitment itself to providing community-based residential supports since 1984.[431]

288. In its 1995 report "Moving Towards Deinstitutionalization" report the Province framed its commitment to providing community-based supports as a matter of respecting the human rights of persons with disabilities:

> The department believes that not only do all Nova Scotians have a right to live in the community, it believes the community is the natural setting for individual growth and fulfillment.[432]

289. Ms. Hartwell agreed on cross-examination that this 1995 statement about the right to community living is similar to statements made in the 2013 Roadmap. She further agreed that the Roadmap's commitment to community-based residential supports was guided by UN *Convention on the Rights of Persons with Disabilities*. [433]

290. In 2014, Nancy MacLellan, the Associate Deputy Minister of Community Services stated in the House of Assembly that "we will not lose sight of the reality that living independently and in inclusive communities is a basic human right for all persons." [434]

291. In April 2016 the Premier wrote to Marty Wexler in his capacity of Chair of the Disability Rights Coalition and stated:

> The UN Declaration on the Rights of Persons with Disabilities guides a number of my Government's ongoing initiatives...Our

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[431] Book VIII-Tab 111. Report of the Task Group on Homes for Special Care, 1984, JEB p. 6547; Book VI-A- Tab 1, The Mentally Disabled Population of the Halifax County Region: Needs and Direction- A Plan for the Future, 1989, report JEB p. 1683; Book II-Tab 8. Memorandum to Cabinet, November 1990, JEB p. 362-364; Book VIII-Tab 33 Planning Document in Response to Management Audit, 1994, see Chapter 4-14 De-Institutionalization, JEB pp. 4756-4757; VI-A-3. Moving Towards Deinstitutionalization: A Discussion Paper, 1995, JEB p. 1716; Book VI-A-33. Putting People First, JEB p. 2933.

[432] JEB VI-A-3, JEB p. 1718, para. 1.

[433] Testimony of Lynn Hartwell, August 10, 2018; Book VI-A-Tab 32, Choice, Equality and Good Lives in Inclusive Communities: A Roadmap for Transforming the Nova Scotia Services to Persons with Disabilities Program (June 2013), JEB p. 2860-2861.

[434] Book III-Tab 18, Hansard Community Services Standing Committees, Nova Scotia Legislature March 4, 2014, JEB p. 646.

> government believes persons with disabilities belong in their communities and have access to meaningful employment opportunities across the Province. [435]

292. The Board has heard extensive evidence from the complainants' witnesses about the benefits of community integration. Dr. Michael Bach was asked on cross-examination whether there was unanimous consensus amongst experts in the field that community-based supports for persons with disabilities were "the ideal." He replied that there was "near unanimous" consensus about this. Some outliers maintained that persons with significant mental health issues should remain institutionalized.[436]

293. Dr. Bach testified that, after a period of adjustment, deinstitutionalized individuals provided with proper community supports experience an increased quality of life. They gain greater control over their lives, stronger skills, and enhanced social connections. [437] Nicole Robinson, the Board-Certified Behavioral analyst, confirmed that a small community-based setting is the ideal setting for teaching positive behaviors to persons with disabilities. [438]

294. Community-based service providers also testified to the benefits of community-based living for the people they support. Mr. Wexler, the founder and former Executive Director of Community Living Centres, testified to the autonomy people living with his organization experience over all aspects of their lives. His organization helps introduce the people they support to the activities that they express an interest in. The staff then supports people while they pursue the recreational and employment opportunities they choose. The staff help introduce the people they support to the activities that they express an interest in.[439]

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[435] Book VI-A-Tab 55, JEB p. 3209, Letter April 18, 2016 Premier McNeil to Wexler.
[436] Testimony of Dr. Bach, February 14, 2018.
[437] Testimony of Dr. Bach, February 13, 2018.
[438] Testimony of Nicole Robinson, March 8, 2018.
[439] Testimony of Marty Wexler, February 21, 2018.

295. Jim Fagan, the Director of Resident Services at the Regional Rehabilitation Services Society ("**RRSS**"), testified that this organization makes a concerted effort to maintain consistency in staffing for the individuals they support. RRSS recognizes that it is important for the people they support to have strong, meaningful relationships with their staff. RRSS makes a lifelong commitment to support people. Some people have lived with RRSS for decades. Menus in RRSS home accord with the residents' preferences. Staff and residents collaborate in cooking meals and eat together as a house, when possible. There is no expectation that everyone eats the same meal. Residents choose their recreational and employment activities and are supported by RRSS staff to pursue their goals. There is no set schedule each day in an RRSS home- residents determine their own schedule and daily activities. [440]

296. Wendy Lill testified to the quality of life her son Sam enjoys living in a community-based setting. He thrives with living with housemates. He has held jobs working in restaurants and at Dalhousie's Sherrif Hall. He takes the bus around the community. The staff at his home check with his supervisor at work to make sure he arrived to work safely. He lives a short walk away from his parents. He is well known in the community. Friends and neighbours like to witness his independence and keep a watchful eye out for him. Ms. Lill testified that his independence is life-affirming for everyone. [441]

297. Brenda Hardiman favourably compared her daughter's experience in a small option home with RRSS to her experience at Quest. Now that she is in a small option home she has some privacy. She can prepare a meal if and when she wants it. She lives in a "regular family home." RRSS staff de-escalate her behavior appropriately without the use of force. She has good relationships with the staff. They work out at the gym together. She has had part-time employment in the community that pays the minimum wage. She is happy. [442]

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[440] Testimony of Jim Fagan, March 12, 2018

[441] Testimony of Wendy Lill, June 7, 2018.

[442] Testimony of Brenda Hardiman, June 7, 2018.

298. Leslie Lowther also spoke of improvements in her son's wellbeing she witnessed since he moved from CTP to a small option home. He sets his own schedule. He helps prepare meals and eats them with his house mate and staff. He has a part-time job at a foodbank and two other positions as well. His sense of humour has returned. His aggression has decreased. His behavior is de-escalated effectively by staff. Staff treat him like an adult. They go for walks, drives, and coffee in the community together. However, he would prefer to be on the Eastern Shore and not in Windsor. [443]

299. The Board and several of the parties visited a "small option" home in Dartmouth in midday, July 2016. The three bedroom home was located inconspicuously in a quiet residential neighbourhood. It had a front and back yard and deck and a driveway. Inside, the kitchen, dining room and living area was open plan and the furnishings and decorations resembled an ordinary home. The atmosphere was quiet, but for the sound from the TV. The home was decorated with photos, artwork and other personal items. There were two staff members employed by the Regional Residential Services Society (RRSS) and one of the residents was also present during the tour, although we were advised that three individuals resided in the home. Each of the residents had their own bedroom and appeared to have access to all areas of the home. In short, the experience at the home was one of familiarity and warmth/coziness.

Forcing People with Disabilities to Live at Home Indefinitely Causes Harm

300. In 2005, the Province began marking as a metric of positive performance the "Percentage of Adult Clients with Disabilities Receiving Support Services who Remain at Home with their Families." The stated rationale for so doing was that "the funding offered through this program enables families to support family members with a disability at home, preventing the need for an out-of-home placement."[444] The Province continued to use

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[443] Testimony of Leslie Lowther, June 7, 2018.

[444] Book VIII-Tab 19 2005-2006 Accountability Report, JEB 4419-4420.

this as a measure of positive performance until 2009, then resumed using it as a measure of positive performance in 2016/2017.[445]

301. Ms. Hartwell's testimony was clear that the only uncapped programs within the DSP are flex at home and direct family support for children. [446] The Foundational allowance under flex is $500. The intermediate funding level that may be provided is $2200. The maximum "enhanced" flex amount which may be provided is $3800/month. Respite allowances to families, over and above the $3800, may be awarded by a care coordinator, up to a maximum of 60 days per year. [447]

302. The Province acknowledges that flex is not appropriate for all persons DSP participants seeking residential supports. The government acknowledges that flex at home is

> ...intended to supplement the natural supports that a participant receives from their family/personal support network and through other standard community resources that are available to residents of Nova Scotia. [448]

303. Most participants are under the age of 30, "due to aging parents/waitlist."[449] Wendy Lill testified to the limitations of the flex program. She stated that during a Roadmap Advisory committee meeting the government provided a flex success story that involved 3 people in the flex program whose families bought a home so they can live together. Ms. Lill stated that these families paid $100,000 out of pocket to buy the home, and DCS provides no help with training or hiring staff or supervising the home.

304. She stated that the flex program "kicks the problem down the road-even families with resources will run out of them with age and time." Flex excludes those without a strong

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[445] Book VIII-Tab 20 Business Plan 2006-2007, JEB p. 4443; Book VIII-Tab 21 DCS 2008-2009 Accountability Plan, JEB p. 4484; VIII-28 Accountability Report 2016-2017, JEB p. 4628.

[446] Testimony of Lynn Hartwell, August 10, 2018.

[447] Testimony of Carol Bethune, September 19, 2018; IV-6-e-DSP Flex Individualized Funding Program, Section 8.3.2.

[448] Exhibit 63, VI-A-66 DSP Transformation Adult Service Array Design December 16, 2016, slide 15.

[449] *Ibid,* slide 14.

family support network possessing both administrative and financial resources necessary to run their loved one's small option home. She stated that it does not provide the solution to about 90% of people on the waitlist for DSP residential supports.[450]

305. Barb Horner and Jennifer MacDonald testified to the harm inflicted on individuals and their families by the Province's decision to offload its responsibilities for providing care to people with disabilities on families.

306. Jennifer MacDonald's son Sam has been on the waitlist for a small option home for about eleven years. Ms. MacDonald meet with Sam's DCS caseworker every year. Every year, she expresses a wish for him to live in a small option home close to the family's home in Bible Hill. Each year she has been told that it won't happen. She feels that he has grown too dependent on his family. He is 32 and it would now be difficult for him to ever live independently of his parents. At the same time, he is frustrated by living with his parents. Having Sam live with his parents well into adulthood has also caused harm to his parents. Their caregiving responsibilities interfere with the running of their small business out of their home. Finding and managing caregivers is a lot of work. He experiences frequent staff turnover. The family is concerned about what would happen to Sam if their health suddenly declines or if they pass away unexpectedly. They are attempting to buy a home with another family to find Sam a place to live. They will go into debt to do so. [451]

307. Barb Horner testified that she and her husband care for her daughter Mallory at home and have done so since they took her out of the Dartmouth CTC due to suspected abuse. Mallory has been waitlisted for a small option home for about 7 or 8 years. Four separate proposals made for Mallory's support outside the home have been rejected by DCS. She was offered a spot in an open small option home in May 2018, weeks before her scheduled testimony before the Board. Barb discussed the challenges of caring for an

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[450] Testimony on Wendy Lill, June 7, 2018.
[451] Testimony of Jennifer MacDonald, June 6, 2018.

adult child with disabilities at home: "caring for a child with disabilities takes a huge toll, it is financially, emotionally, exhausting. " She testified that she "just wants to be Mallory's mom," not her caregiver. Being forced to live with family well into adulthood also harms people with disabilities who experience a "lack of dignity, autonomy, being unable to live a full life...not being able to live a full life outside of families." [452]

Gridlock on Emerald Hall

308. Emerald Hall was intended to be an acute psychiatric unit for people with dual diagnoses of a mental illness and an intellectual disability. The original purpose of the unit was to admit patients for short-term stabilization during an acute crisis. [453] The unit is locked at all times. People from all over the Province may be admitted to Emerald Hall.

309. An external review of Emerald Hall was conducted in 2006 by Dr. Dorothy Griffiths and Dr. Chrissoula Stavrakaki. Dr. Griffiths testified before the Board that the report authors were asked to examine the issue of people being medically discharged from Emerald Hall but unable to leave due to a shortage of community placements. [454]

310. The authors of the resulting report found that Emerald Hall was not being used in accordance with its intended purpose:

> 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. These individuals are being confined without justification because no community options are available for them within the system...consequently, these individuals are living in a more restrictive environmental setting

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[452] Testimony of Barb Horner, June 13, 2018.

[453] VI-B-3, Emerald Hall external review, Griffiths and Stavrakaki (2006) at JEB, p. 3724; Testimony of Dr. Sulyman, March 13, 2018; Testimony of Nicole Robinson, March 8, 2018.

[454] Testimony of Dr. Griffiths, March 15, 2018.

> than is needed, appropriate, or advisable, because of a moratorium on placement development in the Department of Community Services.
> …
> Relative to the inpatient unit, the current bottleneck has created a situation where the natural flow-through of individuals in the acute care unit has ceased. This has created a feeling of hopelessness for the individuals who live in the unit and who have responded positively to treatment... [455]

311. Dr. Griffiths elaborated in her testimony about the causes for the "bottleneck" she referred to in her report. A common problem identified was that people would frequently have their community placement cancelled after their admission to Emerald Hall. Another prevalent issue was a person being re-classified while in Emerald Hall and being waitlisted for a different kind of support than they had previously been receiving. Both issues were symptomatic of a program which was insufficiently person-centered and community-oriented. [456]

312. Joanne Pushie testified that she began working on Emerald Hall in January 2011. At the time, 60-70% of the patients were medically discharged and waiting for the Province to provide them with housing outside the hospital. There was no legal reason for their detention. She was "astounded" at the very long delays patients were experiencing for discharge. Many people were waiting 3-5 years, and some had waited for more than a decade for discharge. She reviewed Griffiths' description of the bottleneck on Emerald Hall and felt that the problem remained unresolved during her tenure there. [457] She advocated to the director of the DSP on behalf of the clinical team at Emerald Hall for a resolution to the problem to no avail. The decision to seek a legal remedy to the situation was made collectively by the clinical team on Emerald Hall. [458]

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[455] VI-B-3, Emerald Hall external review, Griffiths and Stavrakaki (2006) at JEB p. 3716.
[456] Ibid at JEB p. 3717; Testimony of Dr. Griffiths, March 15, 2018.
[457] Testimony of Joanne Pushie, February 14, 2018.
[458] Book IX, volume 1 of 2, tab 68, page 7467

313. Dr. Sulyman is one of two psychiatrists currently working on Emerald Hall and with the COAST Team. Dr. Sulyman testified that the "bottleneck" of patients on Emerald Hall remains a pressing issue. She stated that the Unit is not functioning as an acute care unit, but as a holding unit. Clients enter for acute stabilization, but remain for lengthy periods of time once medically discharged because they have no place to go. As a result of this issue, the clinical team is actively trying to prevent admissions to the Unit, when possible. Emerald Hall staff now try to serve people in the community and provide their caregivers additional support to prevent hospitalization. She testified that there are 9 people on Emerald Hall, and 6 or 7 of them are stabilized, ready to live in the community, but without a place to go. One patient has been on Emerald Hall for over 40 years. [459]

314. Nicole Robinson is a certified behavioural analyst who also works at Emerald Hall and with the COAST Team. She also testified that only 2 of the 9 patients on Emerald Hall are acutely ill. The remaining 7 are medically stable and ready for discharge. She stated that most of these 7 patients had been waiting between 5 and 10 years for a placement. She echoed that one person had been there for 40 years. [460]

Post-Conditional Discharge Confinement at East Coast Forensic Hospital

315. Many people remain in East Coast Forensic Hospital ("**ECFH**") after they receive a conditional discharge because they are waitlisted for housing through the DSP. This group of individuals comprise another "stream" onto the waitlist of DSP residential supports.

316. Mr. Patryck Simon, the Manager of Intake, Registration, and Reporting of Mental Health and Addictions for the Nova Scotia Health Authority, testified under subpoena to the Board. He also provided an expert report, which is in the evidence as Exhibit 39. The data in his report was not tracked solely for the purpose of authoring the report, it is routinely

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[459] Testimony of Dr. Sulyman, March 13, 2018.

[460] Testimony of Nicole Robinson, March 8, 2018.

collected by the NSHA. Mr. Simon testified that his director regularly requests the data contained in his report in order to prepare for meetings with DCS and DOH. He is aware of at least one occasion on which his former director, Mr. Trevor Briggs, presented the data to the DCS. He was not provided feedback about the quality of the data presented as a result of his directors' meetings with DCS. He expressed a "good degree of confidence" in the accuracy of the data. [461]

317. His report examines the length of time people remained in ECFH after receiving a conditional discharge while awaiting either an assessment or a placement outside the ECFH through an external agency. Mr. Simon testified that the external agency in question include DOH and DCS, but he is aware that the majority of these people are awaiting assessment or placement for residential supports with DCS programs. The date of conditional discharge was chosen by staff at the NSHA and the ECFH as equivalent to the date on which the patient was medically discharged, or no longer needed to be a hospital in-patient. In other units within the NSHA, the date of medical discharge is referred to as a designation as Alternate Level of Care ("**ALC**").

318. Mr. Simon testified that his report does not include similar statistics from other institutions within the Nova Scotia Health Authority because the data necessary to author such a report was unavailable or of such poor quality it was unreliable. Unfortunately, in other NSHA units record keeping within the health authority about ALC designations has been inconsistent. Mr. Simon's report only provides ECFH data from March 2017 onwards because the necessary data was unavailable before that point. [462]

319. The data does not include anyone without a conditional discharge. Between March 2017 and April 2018, between 33 and 49% of the total number of people in ECFH have received a conditional discharge and are awaiting either an assessment or a placement from DCS.

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[461] Testimony of Patryck Simon, June 4 and 5, 2018.

[462] Testimony of Patryck Simon, June 4 and 5, 2018.

58% of these people were waiting more than one year for assessment or placement, and 40% of them were waiting for more than two years for assessment or placement.

320. The average time spent waiting for an assessment was 371 days. This figure does not include persons who are assessed by DCS within 30 days of the date of their conditional discharge. However, persons assessed within 30 days of conditional discharge are captured under the report's category of "waiting placement." The average time spent waiting for a placement once assessed was 878.7 days. As of April 2018, one person had waited more than 6 years for a placement outside the hospital through DCS.[463]

321. Dr. Theriault, a psychiatrist at ECFH, testified that no one is referred by the ECFH team for conditional discharge unless it is believed that they are ready to live in community with appropriate supports and services. He stated that there was a period of time earlier in ECFH's existence that the clinical team would refer patients for conditional discharge before they truly believed the person was ready to live in the community. However, their recommendation in these circumstances were frequently challenged by the Crown and the Criminal Code Review Board as premature. As a result, Dr. Theriault testified that the clinical team at ECFH has not recommended someone for conditional discharge who was not prepared for community living for a number of years. [464]

322. The issue of continued confinement at ECFH post-conditional discharge due to the Province's failure to provide community housing is not new. This issue was the subject of the East Coast Forensic staffs' submissions to the DSP Renewal Committee in 2003. The report was admitted into evidence. Ms. Bradley was its primary author, but she wrote on behalf of the whole ECFH clinical team. [465] The report reads:

> Regardless of whether Forensic Patients have or have not been part of the Community Based Options (CBO) system prior to their admittance there is a great deal of difficulty in entering or re-

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[463] *Ibid*

[464] Testimony of Dr. Scott Theriault, June 11, 2018.

[465] *Ibid*

> entering the CBO system upon discharge. Many obstacles impede placement: the classification process is itself problematic; bed shortages create long wait lists...[466]

323. The report also lists the length of time that people had remained in ECFH waiting for DSP housing post-conditional discharge. The charts show many people had waited hundreds of days for a place to live, most of whom were waiting for housing with DCS.[467] Ms. Bradley confirmed that the report was presented to DCS as part of the renewal committee process. As administrator of ECFH at the time, she had access to the file information necessary to calculate the wait times from conditional discharge up to the date the report was written. She identified that a shortage of placements available through DCS was the main issue that the report aimed to address. She also testified that the classification process used by DCS was cumbersome, and added to the length of time people were confined in ECFH. She referenced the Kendrick report in her submissions to DCS, because it was believed that implementing the report would benefit the patients. [468]

324. Dr. Theriault testified that the report did not have any practical impact on resolving the fundamental problem identified to the renewal committee. He has been a clinician at ECFH for twenty years, and the problem has been ongoing for the entire length of his employment there. [469]

325. The Province did not call an expert witness to rebut the evidence brought by the complainants. The only evidence that it raised regarding wait times post-conditional discharge in ECFH was Ms. Bethune's anecdotal evidence that it generally takes about four to six weeks for the DSP to assess people waiting in ECFH with conditional discharges. She had no documentation to support his assertion. She "couldn't think why" it would take, on average, 371 days for persons with conditional discharges to receive an

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[466] Exhibit 55, Capital Health Memo to DCS CSA Renewal Committee Names Redacted Oct 2003, report pg. 1.
[467] *Ibid*, pgs. 6-11; Testimony of Louise Bradley, June 11, 2018.
[468] Testimony of Louise Bradley, June 11, 2018.
[469] Testimony of Dr. Theriault, June 11, 2018.

assessment from the DSP. She did not explain why her impressions of the assessment period should be preferred to the data presented by a statistician for the NSHA.[470]

326. Ms. Bethune was not asked to speak to the post conditional discharge wait times for placement.

Gridlock in Other Institutions

327. The gridlock on Emerald Hall and ECFH is emblematic of a systemic issue across the healthcare system. Dr. Theriault testified that, throughout his experience as an administrator within the NSHA from the early 2000s onwards, it has been standard for approximately 30% of medically discharged patients on a unit. On specialized units, the rate can be even higher. The barrier to their discharge from the hospital is the lack of available DCS supportive housing. In speaking to the scale of the problem this presents for the health care system, he testified that he has met with Ministers of the Department of Health from various previous governments. When asked to identify the single most significant issue within the NSHA, he invariably answered it was the number of medically discharged patients waiting to be discharged. [471]

328. Dr. Theriault was taken to annual reports authored by the Psychiatric Facilities Review Board between 1998-2001 which identified that there had been an increase in detention in psychiatric facilities due to the lack of community-based housing provided by DCS. Dr. Theriault confirmed that the authors of the Board's reports were referring to the same problem which has existed on ECFH during his twenty years' experience as a clinician there. [472]

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[470] Testimony of Carol Bethune, August 8, 2018.

[471] Testimony of Dr. Theriault, June 11, 2018

[472] VI-B-9a, Psychiatric Facilities Review Board Annual Report, 1998-1999, JEB p. 3823-3826; VI-B-9b, Psychiatric Facilities Review Board Annual Report, 1999-2000, JEB pp. 3833-3835; VI-B-9-C, Psychiatric Facilities Review Board Annual Report, 2000-2001; VI-B-9-D, Psychiatric Facilities Review Board Annual Report, 2001-2002, JEB p. 3853; Testimony of Dr. Theriault, June 11, 2018.

329. Medically-discharged people waiting in hospitals for DCS housing was addressed as an issue in the House of Assembly by Mr. Joe Rudderham, the Executive Director of the DSP when he stated that there were "over 100" people living in acute care units within the NSHA who "could and should be living in the community." [473]

Income Assistance and the DSP Share Many Important Characteristics

330. Income assistance in Nova Scotia is governed by the Employment Support and *Income Assistance Act* ("**ESIA**"). Like the DSP, income assistance is provided to eligible "persons in need" under the Act. The determination of whether someone is a "person in need" of income assistance under the ESIA is made through a budget-deficit calculation. The same budget-deficit system determines eligibility for the DSP under the *Social Assistance Act* ("**SAA**") and is used for all social assistance schemes in the country. The budget deficit program compares the applicant's incomes and assets and compares it to their allowable expenses. The requirement to perform this budget-deficit analysis is mandated by both the SAA and the ESIA. Both the SAA and ESIA set out basic and special needs. The income assistance program under the ESIA has important accommodative features. For instance, it allows for special diet and shelter rates for recipients with disabilities. These accommodations are tailored to meet the needs of people with disabilities. The DSP special need policy is identical in many respects to the IA special needs policy. They both share the same exempt sources of income. The earnings clawback also works in the same way under both programs. The basic and special needs rates, the shelter allowances, and the personal allowances rates are identical under both programs. [474]

331. Ms. Hartwell testified that the Province intended for there to be a great degree of consistency between the programs. From a policy perspective, the same services should be available regardless of which program a person with disabilities was accessing. This

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[473] VI-A-65 Hansard September 15, 2015 at JEB p. 3513.

[474] Testimony of Lynn Hartwell, August 10, 2018; Testimony of Denise MacDonald-Billard, June 18, 2018; Book VIII-Tab 44, Employment Support and income Assistance Policy Manual; Exhibit 58, Current Disability Support Program Policy Manual.

desire for consistency is expressed in a number of ways. Someone in the DSP's Independent Living Support Program receives rates of assistance identical to that of income assistance recipients. Ms. Hartwell testified that a majority of people receiving income assistance have some form of disability. In fact, people may shift between receiving IA and receiving assistance through the DSP. Ms. Hartwell agreed that people should be able to transfer seamlessly between the programs. To that end, the appeal mechanism for both programs is identical. DSP appeals are actually addressed under the ESIA. The appeal process procedure is identical for both programs. [475]

332. There are some distinctions between Income Assistance and the DSP. While people without disabilities can receive Income Assistance, only persons with disabilities are eligible for the DSP. Eligible Income Assistance recipients begin receiving support within a week or two of their application. People on Income Assistance are not provided assistance in poor houses or in another segregated setting-they are provided it in their community of choice. The Province never requires an income assistance applicant to move to another part of the Province in order to receive assistance. There is no waitlist for Income Assistance. There is no cap or limit on the potential caseload.[476] There has never been such a limit or cap on the number of people who can access income assistance. If a large employer closed its operations the Province would be required to provide every eligible former employee with Income Assistance. There is no Departmental budget spending limit on Income Assistance.

333. Ms. Hartwell testified that there is, in contrast, all residential support programs other than Flex at Home and Direct Family Support for Children are capped (Ms. Hartwell preferred the term 'spending limit' to 'cap'). Demand for residential supports can rise, but the number of beds remain fixed. As a result, there is a waitlist for most residential

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[475] Testimony of Lynn Hartwell, August 10, 2018.

[476] Testimony of Denise MacDonald-Billard, June 18, 2018

supports under the ESIA. Persons who are eligible for DSP and eligible for residential supports are often waitlisted for these supports. [477]

Public Housing Not Similar to Social Assistance

334. Public housing is not a legislated social assistance program. It is not an entitlement-based program. The Province is not statutorily obligated to provide public housing to eligible "persons in need." There is a waitlist for admission into public housing, which Mr. Neil MacDonald acknowledged would not be possible if the Province was required to provide public housing to eligible applicants. The Province has discretion to provide public housing.[478] Unlike every social assistance scheme in Canada, eligibility for public housing is not based on a budget-deficit calculation.[479] There is no asset test for admission to public housing. The cost of disability supports a person may require are not accounted for in assessing financial eligibility for public housing.

335. Admission to the public housing system is based upon the Canada Mortgage and Housing Corporation's assessment of whether meets their definition of being in "core housing need," meaning they spend thirty percent or more of their household income on housing. A family in a three-bedroom apartment in Halifax can have an annual household income of fifty-one thousand and five hundred dollars and remain eligible for public housing. This household income limit is three to four times larger than the income at which someone becomes ineligible for social assistance in Nova Scotia.

336. Unlike social assistance programs, Nova Scotia's public housing system has no firm financial criteria for remaining in the program after admission. Once a person lives in the public housing system, their income could rise substantially. As long as they remain willing

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[477] Testimony of Lynn Hartwell, August 10, 2018.

[478] Testimony of Neil MacDonald, June 19, 2018.

[479] Testimony of Neil MacDonald, June 19, 2018; Testimony of Denise MacDonald-Billard, June 18, 2018.

to spend thirty percent of their income on rent, they can continue to live in public housing system.

337. Housing Nova Scotia also provides funding to the co-operative housing program, which provides subsidized housing but has absolutely no financial eligibility criteria. Co-operative housing corporations admit members at their discretion. Housing Nova Scotia does not require the corporations to have meet financial eligibility criteria to gain admission to the co-operative.

338. Unlike every social assistance program in the country, there is no statutory right to appeal a decision regarding public housing. Unlike the DSP, public housing is not a capped program. The Province could chose to clear its waitlist for public housing immediately through providing more rental supplements or public housing units. Another important distinction between the DSP and public housing is that waitlists for housing are regional. Applicants waitlist themselves for housing within the regional they wish to live. People on the Halifax waitlist are not told that they must move to Cape Breton in order to receive necessary support.

339. A final difference between public housing and the DSP is that the Province provides no programming or services within public housing. Persons receiving public housing receive bricks and mortar housing. The Province requires people living within public housing to live independently and to be able to evacuate without assistance in an emergency. Persons who require 24/7 support are therefore excluded from living in public housing.[480]

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[480] Testimony of Neil MacDonald, June 19, 2018.

Disputed Evidentiary Issues

Beth MacLean

Capacity

340. The Province disputes that Beth has always capacity to make decisions with respect to placement while somewhat confusing, it appears that Ms. Bethune contends that Beth has only possessed capacity to make decisions about placement decisions since 2016.

341. Of course, Beth was not offered a placement outside of King's from 1986-2000, nor was she offered a placement outside of the Nova Scotia Hospital from 2000 up until the point at which she was moved to the Community Transition Program (**CTP**) in June 2016. Her parents were not offered and never refused a placement offered on Beth's behalf during the time period that the Province argues Beth lacked capacity to make placement decisions. The question of whether Beth had capacity to make a decision that she was not provided the opportunity to make is therefore of marginal relevance.

342. It is the complainants' position that Beth had capacity to make placement decisions during the entire time period of the complaint. As such, her parents' views about where Beth should live are utterly irrelevant to the decision before the Board. The facts underlying the complainants' claim regarding capacity are therefore set out in this section. The legal argument on this point can be found in the "argument" section of the brief.

343. There is a legal presumption of capacity. This presumption can only be displaced by an assessment by a psychiatrist that the person lacks capacity. Capacity is decision-specific. Someone may possess capacity to make placement decisions, even if they lack capacity to make healthcare decisions. Only psychiatrists may perform capacity assessments.

344. There are two capacity decisions conducted by Dr. Sulyman before the Board. The first dates from June 2013. Beth was not Dr. Sulyman's patient. However, Dr. Sulyman was

requested by Dr. Riives to perform the assessment. Dr. Riives explained to Dr. Sulyman that she could not conduct the capacity assessment since she was not a psychiatrist. Dr. Sulyman concluded that it was "very clear" to her that Beth had capacity to make this decision.[481] She wrote that Beth has "capacity to instruct legal counsel/lawyer to help her look for a supported living accommodated in the community."

345. Dr. Sulyman testified that she conducted a review of Beth's medical file. There was no assessment of Beth's capacity to make placement decisions or instruct legal counsel anywhere in her file prior to the one she completed in June 2013.

346. Dr. Sulyman conducted a second capacity assessment of Beth in 2016 at the request of the NSHA's legal counsel. She concluded that Beth had capacity to make placement decisions. [482]

347. Ms. Bethune acknowledged that she did not see any earlier capacity decision on Beth's file. However, she maintained that one might have occurred, and might exist only in her medical file.

348. Carol Bethune testified on redirect that there would be supporting documentation on a client's file if the client was found by a psychiatrist to lack capacity. The issue of capacity to make placement decisions would not simply be addressed through an undocumented conversation between the care coordinator and medical staff. [483]

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[481] Testimony of Dr. Sulyman, March 13, 2018; Testimony of Dr. Sulyman, March 14, 2018.
[482] Book IX, Tab 98, JEB pp. 7639-7640; Testimony of Dr. Sulyman, March 13, 2018.
[483] Testimony of Carol Bethune, September 19.

Whether or not Beth could have been supported to live in the community for the entire period covered by the complaint

349. The Province repeatedly raised the issue of Beth's "aggression" and the impact it supposedly had upon her ability to live in the community.

350. Jim Fagan authored an expert report about whether or not RRSS could have supported Beth to live in the community. [484] He testified about his methodology in authoring the report. He had access to her file at Kings, her entire medical file from her entire time at the Nova Scotia Hospital, and her time at CTP. In total, he had thousands of pages of documents available to him. For most referrals, RRSS receives about 20-30 pages of documentation. He had met with Beth in 2014 to assess her for the opening at the Kincadrine home. He met with Beth again when he was writing the report. He met her care teams at Emerald Hall and at CTP. As was mentioned above, he also met with the KLR small option home staff. He then convened the RRSS Committee that makes all admission decisions. The opinion of the admissions committee was that RRSS could have supported her for the entire period in question. [485]

351. Ms. Bethune testified on cross examination that she has worked with Jim Fagan for decades. She stated that she has no reason not to trust his judgement. She said he does a "great job" of working with RRSS' existing clients. She also testified that she has "high regard" for RRSS' expertise. She puts stock in RRSS' views about whether or not they can support someone to live in the community. She trusts their views about who they can support and how they can support them.[486]

352. The Board should place similar trust in Mr. Fagan's claim that Beth could have been supported to live in the community for the entire time period of the claim.

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[484] Exhibit 27, Report Re Beth

[485] Testimony of Jim Fagan, March 12, 2018.

[486] Testimony of Carol Bethune, September 6, 2018.

Waitlisting Beth for Quest and Breton Ability Centre in January 2017

353. Beth MacLean and Ms. Bethune presented contradictory testimony about whose idea it was to waitlist Beth for Quest and Breton Ability Centre in February 2017. Beth testified that she informed Ms. Bethune upon her return from KLR that she still wanted to live in a one-level small option home in Halifax or Dartmouth. Beth testified that she was informed by Ms. Bethune that her only options were Quest or the Breton Ability Centre.[487] Ms. Bethune testified that Beth expressed a desire to live in these institutions. She acknowledged that she talked to Beth about those options. Ms. Bethune was asked if she spoke to Beth about her prospects for a small option home after her readmission to CTP. She stated that she couldn’t recall if they spoke about small option homes at that time.[488]

354. Beth has been very consistent in her stating her desire for a small option home for years. The references to all of her recorded statements on this topic are cited above, in the section about uncontested evidence regarding Beth.

Whether it was Wrong for Fourteen-Year Old Beth to be Institutionalized with Adults

355. Ms. Bethune refused to say that it is inappropriate for children to be institutionalized with adults. [489] This is in conflict with the evidence from Ms. Hartwell, who testified that “the closing of the children's training center was the right thing to do...Children should be with families they shouldn't be in – in facilities…” [490]

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[487] Testimony of Beth MacLean, March 6, 2018

[488] Testimony of Carol Bethune, September 18, 2018.

[489] Testimony of Ms. Bethune, September 6, 2018.

[490] Testimony of Ms. Hartwell, August 9, 2018

Sheila Livingstone

Preference for an Institutional Environment

356. Ms. Lockhart-Singer testified that Sheila was waitlisted exclusively for institutional environments for years because she seemed to respond better to an institutional setting. This is irrelevant, since Sheila had an SDM for placement decisions during the entire time period under discussion, which Ms. Lockhart-Singer acknowledged.[491] Her family members, who knew her best, testified that she was much happier in her small option home on Topsail Boulevard than she ever was on Emerald Hall or in another institution.[492]

The Province's Responsibility for Ending Her Funding to RRSS

357. Ms. Lockhart Singer testified that decisions about cutting people's funding to service providers are made collaboratively with the service provider. She insisted that Cathy Wood's decision to cut Sheila's funding would have been made collaboratively with RRSS. She acknowledged that she had no direct knowledge of this, and there was no documentation in Sheila's file to support her claim. [493]

358. Suzanne McConnell, a senior administrator with RRSS, testified that the decision to cut someone's funding rests with DCS, not RRSS. The decision about continuing funding is not RRSS' to make.[494] Cathy Wood's notes made at the time demonstrate that she considered herself to be the decision-maker about whether or not Sheila's funding would be continued.[495]

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[491] Testimony of Renee Lockhart Singer, August 7 and 8, 2018
[492] Testimony of Olga Cain.
[493] Testimony of Renee Lockhart Singer, August 8, 2018
[494] Testimony of Suzanne McConnell, March 12, 2018
[495] Book XI, Tab 4, Page 6/37, JEB p. 8159

Whether or not Sheila could have been supported to live in the community for the entire period covered by the complaint

359. The Province repeatedly raised the issues that Sheila's "aggression" and health issues impacted her ability to live in the community.

360. Jim Fagan authored an expert report about whether or not RRSS could have supported Sheila to live in the community. [496] He knew Sheila from her lengthy time living with RRSS. He testified about his methodology in authoring the report. He had access to her entire Emerald Hall file. He met with staff at Harbourside. For most referrals, RRSS receives about 20-30 pages of documentation. He then convened the RRSS committee that makes all admission decisions. The opinion of the admissions committee was that RRSS could have supported her for the entire period in question. [497]

361. Ms. Bethune testified on cross examination that she has worked with Jim Fagan for decades. She stated that she has no reason not to trust his judgement. She said he does a "great job" of working with RRSS' existing clients. She also testified that she has "high regard" for RRSS' expertise. She puts stock in RRSS' views about whether or not they can support someone to live in the community. She trusts their views about who they can support and how they can support them. [498]

362. The Board should place similar trust in Mr. Fagan's claim that Sheila could have been supported to live in the community for the entire time period of the claim.

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[496] Exhibit 27, Report Re Beth

[497] Testimony of Jim Fagan, March 12, 2018.

[498] Testimony of Carol Bethune, September 6, 2018.

Contested Evidence Regarding Joey

Whether Joey Preferred an Institutional Living Environment

363. Ms. Murray testified that DCS did not consider funding his support with RRSS once he was classified since he seemed to prefer a large, institutional setting. A small option home wasn’t considered to be appropriate for this reason.[499] This is irrelevant, since Joey had an SDM for placement decisions during the entire time period under discussion. Ms. Murray acknowledged on cross-examination that care coordinators are not supposed to make placement decisions for people lacking capacity to make placement decisions. That power rests with the SDM. Joey had an SDM for placement decisions during the entire time period of the complaint.[500]

The Number of Times that Joey was Home “On Passes” from the Hospital Before His RRSS Funding Was Cut

364. Ms. Murray testified that Joey went home on two passes from Emerald Hall and returned to the hospital before his funding was cut.[501] The case notes establish that one visit home occurred. A second one was planned, but there is no evidence that it actually occurred.[502]

Whether an Assessment was Performed on Joey in June 2010

365. Ms. Murray insisted that she did do or “would have done” an assessment of Joey in June of 2010 prior to his classification that month.[503] It was later agreed between the parties that, in fact, no assessment was performed in June 2010.

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[499] Testimony of Trish Murray, June 19, 2018.

[500] Testimony of Trish Murray, June 20, 2018.

[501] Testimony of June 20, 2018.

[502] Book X. Tab 8, JEB p. 7796.

[503] Testimony of Trish Murray, June 20, 2018

Whether Joey Could Have Been Supported to Live in the Community for the Entire Time Period of the Complaint

366. Jim Fagan testified that Joey could have been supported to live in the community with RRSS from the date of his medical discharge from Emerald Hall until the present. [504] He acknowledged that his expert report was based upon an understanding that Joey was medically discharged in the summer of 2011, and not in June 2010.[505] He clarified that RRSS could have resumed supporting Joey when he was medically stable and medically discharged in July 2010. [506]

367. Mr. Fagan knew Joey from his lengthy time living with RRSS. He testified about his methodology in authoring the report. He had access to his entire medical file. He met with staff on Emerald Hall and at Quest. For most referrals, RRSS receives about 20-30 pages of documentation. He then convened the RRSS committee that makes all admission decisions. The opinion of the admissions committee was that RRSS could have supported Joey when he was medically stabilized in July 2010.[507]

368. Ms. Bethune testified on cross examination that she has worked with Jim Fagan for decades. She stated that she has no reason not to trust his judgement. She said he does a “great job” of working with RRSS’ existing clients. She also testified that she has “high regard” for RRSS’ expertise. She puts stock in RRSS’ views about whether or not they can support someone to live in the community. She trusts their views about who they can support and how they can support them.[508]

369. The Board should place similar trust in Mr. Fagan’s claim that Joey could have been supported to live in the community for the entire time period of the claim.

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[504] Testimony of Jim Fagan, March 12, 2018.
[505] Exhibit 28
[506] Testimony of Jim Fagan, March 12, 2018.
[507] Testimony of Jim Fagan, March 12, 2018.
[508] Testimony of Carol Bethune, September 6, 2018.

Contested Systemic Evidence

370. There were several points of evidence in which the Province's evidence contradicted with the complainants', or the Province's evidence was internally contradictory.

The Percentage of Nova Scotians Currently Institutionalized

371. On Ms. Hartwell's direct examination she testified that 90% of DSP recipients are already living in community-based settings.[509] When confronted in cross-examination she conceded that her estimate of 90% didn't account for all people living in ARCs, RRCs, and RCFs. She conceded that RCFs were clearly identified in the Roadmap and DCS policy and documents as non-community based placements, facilities or institutions.[510] She clarified that the Province still considered RCFs to be institutions that will be closed, and that when the number of all people currently housed in RRCs, ARCs and RCFs is calculated, given the figures most recently available for 2017, the proportion is between 19-20% of all DSP recipients are currently living in one of those three types of facilities. [511]

Internal Knowledge Within DCS of the Moratorium

372. There were inconsistencies between the witnesses called by the respondent Province concerning the "moratorium" defined as a freeze on creation of new small options homes or placements. DCS employees Trish Murray, Denise MacDonald-Billard and Renee Lockhart-Singer all claimed to have little or no knowledge about the existence of the moratorium on the creation of new small option homes.[512] DCS employees Carol Bethune and Lynn Hartwell, on the other hand, readily acknowledged that they had knowledge of

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[509] Testimony of Lynn Harwell, August 9, 2018.

[510] Book VI-A-32, Choice, Equality, and Good Lives, JEB p. 2877.

[511] Testimony of Lynn Hartwell, August 10, 2018; cross examined concerning the numbers in government documents found at JEB III 17.

[512] Testimony of Denise MacDonald-Billard, June 18, 2018; Testimony of Trish Murray, June 20, 2018; Testimony of Renee Lockhart-Singer, August 8, 2018.

the moratorium and how it impacted the availability of residential options within the DSP.[513]

Hospitals as Inappropriate Places to Live

373. Carol Bethune and Denise-MacDonald Billard testified that it was “not ideal” for people to live in hospitals, but refused to acknowledge that unnecessary hospitalization was inappropriate or harmful. [514] Trish Murray initially refused to acknowledge that the hospital was an inappropriate place for Joey to spend years of his life, but after being taken to numerous documents about the inappropriateness of living in a hospital, she conceded this point.

374. None of the DCS employees who testified claimed to have any kind of medical expertise. As employees of the respondent, they also lacked independence and impartiality. In contrast, the medical professionals employed by the Nova Scotia Health Authority, Dr. Sulyman, Dr. Theriault and Nicole Robinson offered testimony that was objective, non-partisan, and specialised concerning the harms of institutionalization and ought to be granted substantial weight and preferred over the opinions of DCS employees about whether the complainants were harmed by the Province’s actions.

III. ARGUMENT

375. The broad outline of these submissions includes: a brief restatement of the governing law, a review of the evidence relevant to each of the Complainants and an application of the law to those facts.

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[513] Testimony of Lynn Hartwell, August 10, 2018; Testimony of Carol Bethune, September 18, 2018.

[514] Testimony of Carol Bethune, September 18, 2018; Testimony of Denise MacDonald-Billard, June 18, 2018.

The Law

376. There is no need to re-state the legal submissions set out in the Complainants' pre-hearing submissions (including the Reply submissions).

377. The present submissions will, however; apply the governing law to the evidence adduced at the hearing and refer to any additional legal sources that may be helpful.

The Discrimination test the same

378. A claim of systemic discrimination under human rights legislation in a group complaint is subject to the same test for discrimination as individual complaints, namely whether the complainant has suffered adverse effects based on a prohibited ground. As stated by the Supreme Court of Canada in *Moore*:

> The considerations and evidence at play in a group complaint may undoubtedly differ from those in an individual complaint, but the focus is always on whether the complainant has suffered arbitrary adverse effects based on a prohibited ground.[515]

379. In *Moore*, the SCC emphasized that the test for discrimination remains the same regardless of the number of people affected. Neither claim relies on proof of discriminatory intent, but rather on the adverse effects of government action or inaction in responding to the needs of persons with disabilities who require supports and services.

Interpretative Principles

380. In considering the legislative provisions relevant to this complaint in relation to disability and a service in the *Human Rights Act*, basic principles of statutory interpretation require

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[515] *Moore v BC (Education)* [2012] 3 SCR 360 at para 59

this board to take a liberal and purposive approach and to adopt an interpretation of the statute that best attains its purpose in preventing discrimination.[516]

381. The Supreme Court of Canada has repeatedly expressed that human rights legislation is not an ordinary law but has quasi-constitutional status, and should be considered part of the "fundamental law."[517]

382. The purposes of the *Human Rights Act* are as follows:

> **Purpose of Act**
> 2 The purpose of this Act is to
>
> (a) recognize the inherent dignity and the equal and inalienable rights of all members of the human family;
>
> (b) proclaim a common standard for achievement of basic human rights by all Nova Scotians;
>
> (c) recognize that human rights must be protected by the rule of law;
>
> (d) affirm the principle that every person is free and equal in dignity and rights;
>
> (e) recognize that **the government, all public agencies** and all persons in the Province have the responsibility to ensure that **every individual in the Province is afforded an equal opportunity to enjoy a full and productive life** and that failure to provide equality of opportunity threatens the status of all persons; and
> (f) extend the statute law relating to human rights and provide for its effective administration.
>
> [emphasis added]

383. The stated purpose of human rights in Nova Scotia is specifically to ensure that government and public agencies are accountable for ensuring that everyone has "an

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[516] *Action travail des femmes*, *supra*, para 24-35.; see also "*Meiorin" BC (Public Service) v BCGEU* [1999] 3 SCR 3, para 43
[517] *Ibid,* para 30; for additional recent sources, see *Reed et al v Nova Scotia* [2018] BOI para 108-109.

equal opportunity to enjoy a full and productive life." The Supreme Court of Canada commented on the meaning of "equal opportunity" as equivalent to "preventing all discriminatory practices," both intentional and, most importantly in this case, unintentional, or systemic, widespread forms of discrimination.[518]

384. Expert testimony in this proceeding from Professor Catherine Frazee underlined the importance of avoiding an 'ableist' mindset in approaching issues affecting persons with disabilities. This is none more true than in the interpretation of the test for discrimination.

385. The Supreme Court of Canada has commented repeatedly on the importance of avoiding mainstream assumptions and incorporating the perspective of those who are disadvantaged in achieving equality. An example of the ableist mindset in interpreting the test for discrimination is found in *Moore,* where the lower courts characterized the service as "special education programs." The SCC overruled those decisions on the basis that it was the education system as a whole that Jeffrey Moore had a right to – not the 'accommodative' program in the form of special education. It noted that the reasoning of the lower courts implied an acceptance of the now discredited "separate but equal" philosophy, that served as the justification for segregated schools and other systems of apartheid.

386. In *Moore,* the SCC also referenced its earlier decision in *Meiorin.* In *Meiorin*, a woman whose application to become a firefighter was rejected based a rule that imposed an aerobic capacity test as an eligibility requirement, based her discrimination claim on sex discrimination, despite the fact that the rule was neutral in that it applied generally to everyone, because it disproportionately excluded women. The BC Court of Appeal determined that it was not discrimination to impose a test on a job applicant that was shown to be necessary to the safety of the work. The SCC determined that the test, while

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[518] *Action travail des femmes*, para 27.

neutral on its face, violated the complainant’s rights, based on its adverse effect in disproportionately excluding women. In rejecting the now discredited ‘bifurcated approach’ to discrimination (“the conventional analysis” noted below) the Court noted the following:

> Although the practical result of the conventional analysis may be that individual claimants are accommodated and the particular discriminatory effect they experience may be alleviated, the larger import of the analysis cannot be ignored. It bars courts and tribunals from assessing the legitimacy of the standard itself. Referring to the distinction that the conventional analysis draws between the accepted neutral standard and the duty to accommodate those who are adversely affected by it, Day and Brodsky, *supra*, write at p. 462:
>
> > The difficulty with this paradigm is that it does not challenge the imbalances of power, or the discourses of dominance, such as racism, able-bodyism and sexism, which result in a society being designed well for some and not for others. It allows those who consider themselves “normal” to continue to construct institutions and relations in their image, as long as others, when they challenge this construction are “accommodated.”
> >
> > Accommodation, conceived this way, appears to be rooted in the formal model of equality. As a formula, different treatment for “different” people is merely the flip side of like treatment for likes. Accommodation does not go to the heart of the equality question, to the goal of transformation, to an examination of the way institutions and relations must be changed in order to make them available, accessible, meaningful and rewarding for the many diverse groups of which our society is composed. Accommodation seems to mean that we do not change procedures or services, we simply “accommodate” those who do not quite fit. We make some concessions to those who are “different,” rather than abandoning the idea of “normal” and working for genuine inclusiveness.
> >
> > In this way, accommodation seems to allow formal equality to be the dominant paradigm, as long as some adjustments

> > can be made, sometimes, to deal with unequal effects. Accommodation, conceived of in this way does not challenge deep-seated beliefs about the intrinsic superiority of such characteristics as mobility and sightedness. In short, accommodation is assimilationist. Its goal is to try to make “different” people fit into existing systems.
>
> I agree with the thrust of these observations. Interpreting human rights legislation primarily in terms of formal equality undermines its promise of substantive equality and prevents consideration of the effects of systemic discrimination, as this Court acknowledged in *Action Travail*, *supra*.[519]

387. The Court’s reasoning (including its reference to “able-bodyism” in the cited piece by Day and Brodsky), reinforces and recalls the evidence of Dr. Frazee concerning the significance of identifying ableist assumptions in approaching issues of disability. The SCC underlines that this involves an evaluation whether the treatment or rules in their operation are valid to start with, not simply whether the measures taken by the government are a ‘reasonable accommodation’.

388. This difference of approach can be seen in the positions taken by the parties in this case. For instance, in evaluating whether the government’s decision to provide persons with disabilities with institutional arrangements rather than community based supports and services, the complainants argue that the majority reasoning should be preferred. Whether people with disabilities ‘fit’ within a mainstream social assistance program is not the question. Instead, the Board must assess whether the social assistance program itself reflects and takes into account the differential needs of persons with disabilities.

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[519] *Meiorin*, *supra*, Note 516 at para 41.

389. To return to Ms. Frazee's analysis, the Complainants argue that the Province's decisions to create and maintain a 'moratorium' or freeze on the number of new small options homes and to create waitlists are expressions of ableism.

390. Another example can be found in the government policy of classification, and in particular the 'unclassifiable' category that consists of persons with disabilities whose needs are found to fall outside the confines of any government program. Starting in 2005 the Province's own documents establish that the classification or assessment tools used by government do not provide a reliable basis for evaluating people's needs.[520] The denial of supports and services on the basis of the Respondent's classification/assessment practices is discriminatory within the meaning of the Act.

391. It is the complainants' position that the overall system itself is discriminatory. At its root is the Province's failure to recognize and accommodate differential need. Under the government's classification system, the very thing that makes them eligible for supports and services– their disability and poverty – operates to exclude them from all government programs. While Lynn Hartwell testified that no person with disabilities is excluded, that evidence was contradicted by the historical record[521], and Carol Bethune who testified that there are still people who fall outside the classification system and the 'complex case' approach designed to assist those people.

392. The liberal and purposive approach to statutory interpretation, in the context of Nova Scotia *Human Rights Act* embraces an approach to substantive equality at the violation stage that seeks to achieve "equality of opportunity for a full and productive life" and rejects assumptions that reflect the 'separate but equal' approach that animates government responses to the differential needs of persons with disabilities.

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[520] See also Agosta Exhibit 71, LaPierre, JEB I -1 replaced by Exhibit 78.

[521] See for instance Griffiths and Stavrakaki, 2006, JEB VI-B-3; Bradley, Capital Health Memo to the DCS Renewal Committee, 2003, Exhibit 55; Complex Committee Reports, Exhibit 66, 72, 79, JEB VII-7, JEB VIII-30, JEB VIII – 42, JEB VIII – 68, JEB VIII – 124.

Authorities Supporting Community Based Supports and Services for Persons with Disabilities

393. 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.

394. As was stated in the complaint itself and the pre-hearing submissions, interpretation and application of section 5 of the *Act* should be carried out in a manner that is consistent with human rights instruments.

395. The *Human Rights Act* must be interpreted and applied in accordance with its purposes. Most importantly, this includes the principle of **substantive equality** cited frequently by the Supreme Court of Canada in its equality rights jurisprudence—both under s. 15 of the *Charter* and human rights statutes. In Nova Scotia, our Court of Appeal has referenced the SCC decision in *Quebec* v. *A* for the proposition that the right to substantive equality includes:

> "discriminatory activity, such as "unfair" group dominance or a denial of resources that are "basic or necessary for full participation in Canadian society".[522]

Section 36(1) of the *Constitution Act, 1982*

396. The Canadian constitution entrenches a 'joint commitment' by the governments of Canada and the Provinces to, *inter alia*, "providing essential public services of reasonable quality to all Canadians" (such as social assistance).[523] As Canadians who are intended to benefit under this constitutional commitment, interpretation and application of the ant-discrimination provision in s. 5 of the *Human Rights Act*, must be informed by relevant and overarching and constitutional provisions. Thus, it is relevant to the questions raised

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[522] *International Association of Fire Fighters, Local 268* v., 2016 NSCA 6 at paras. 64, 79 and 96 (emphasis added).

[523] Section 36(1)(c) of the *Constitution Act, 1982; Saskatchewan Federation of Labour* v. *Saskatchewan*, 2015 SCC 4 at paras. 119 and 168 (*per* Rothstein and Wagner, JJ. (dissenting, though not on this point) and *Federalism and Decentralization: Where Do We Stand?* (Ottawa: Supply and Services Canada) at p. 28.

in this case that the Constitution contemplates that Canadians will be provided with essential public services such as social assistance and that, qualitatively, those services will be ‘reasonable’. Conversely, it is submitted that acceptance of the Respondent’s position—upholding congregate care and institutionalization as non-discriminatory would leave the Province in breach of its constitutional ‘commitment’ under s. 36(1)(c) of the *Constitution Act, 1982*[524] and, in all likelihood, its obligations[525] under the United Nations *International Covenant on Civil and Political Rights* and the *Convention on the Rights of persons with Disabilities*.

International Human Rights

397. Without repeating the argumentation present in our pre-hearing submission, the Complainants refer the Board to paras. 86 through 89 of the Individual Complainants submissions which i) refer to the importance of tribunals and courts making interpretive use of international human rights law as a tool to assist their interpretation and application of legislation[526] and ii) the reference to the United Nations Human Rights Committee’s Concluding Observation on Canada (2005) at which point the Committee stated the following concern and remedial recommendation concerning the *intersecting* concerns impacting the ‘right to liberty and security of person’ (article 9 of the *International Covenant on Civil and Political Rights (‘ICCPR’*) <u>and</u> the right to be free from discrimination (article 26 of the *ICCPR*):

> 17. The Committee is concerned about information that, in some provinces and territories, people with mental disabilities or illness remain in detention because of the insufficient provision of community-based supportive housing (arts. 2, 9, 26).

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[524] See also: *Cape Breton* (*Regional Municipality*) v. *Nova Scotia* (*Attorney General*), 2009 NSCA 44.

[525] See *Sparks*, *supra*, at para. 50 where the Court included the Province as ‘duty bearers’ under Canada’s international human rights obligations.

[526] See the recent NS Court of Appeal judgment in *Sparks* v. *Department of Community Services*, 2017 NSCA 82 at paras. 50-52 and 60 where the Court of Appeal placed heavy reliance on international human rights law in the interpretation of legislation.

> **The State party, including all governments at the provincial and territorial level, should increase its efforts to ensure that sufficient and adequate community based housing is provided to people with mental disabilities, and ensure that the latter are not under continued detention when there is no longer a legally based medical reason for such detention.**
>
> [emphasis in original]

398. In this case, the Board is applying non-discrimination protections that also impact *liberty* interests. It is submitted that the Board should interpret and apply the equality provision in the *Act* in a manner that accords with Canada's international human rights obligations.

The Approach to Discrimination in *Moore*

399. The Supreme Court of Canada's 2012 in *Moore* sets out the law regarding the test for *prima facie* discrimination under human rights legislation. It does so in factual circumstances that are closely analogous to the present one inasmuch as both claims relate to discrimination by government in the provision of public services. *Moore* is very widely cited for the legal test for discrimination under human rights legislation. Accordingly, the discrimination analysis set out in *Moore* will be followed and applied here.

Moore: the facts

400. *Moore* concerned a young school boy (Jeffrey Moore) in British Columbia who has a disability (dyslexia). This disability meant that he required accommodation in the regular education program in order for him to benefit equally from his education; he had been recommended so-called 'special education' measures.

401. However, because of cutbacks to special education funding, school officials informed Moore's parents that his learning needs would not be able to be met by the regular public

school system and recommended a private school in the Vancouver area which was designed to meet the needs of students with learning disabilities. This advice was followed and Moore went on to perform well in the private school.

402. Moore's father filed a human rights complaint against the school district and the Province claiming that the failure to offer accommodative education to Jeffrey was discriminatory. He was successful before the BC Human Rights Tribunal.

403. The case advanced through the court system in BC--with Moore being unsuccessful at both the BC Supreme Court and Court of Appeal Level.

404. At the Supreme Court of Canada, Moore's appeal was allowed.

405. The Court ruled that the failure to offer an education program which accommodated Moore's disability related needs amounted to *prima facie* discrimination. From there, the Court addressed the Province's arguments that to accommodate Moore would have imposed undue hardship on it.

406. For present purposes, however, because the Board in this phase of the proceeding is only concerned with the question of whether the Complainants have established *prima facie* discrimination, the discussion and application of *Moore* will be similarly confined.

407. While the Province's pre-hearing submissions suggested that it was wrong for the Board to consider the possibly discriminatory treatment of the two groups within the Respondent's social assistance regime (the Respondent suggested, that the focus of the discrimination analysis ought to somehow compare 'persons in need' under the *Social Assistance Act* to applicants for public housing), it is unclear whether this is still a position that will be advanced. In any event, the Complainants will wait to review the Respondent's submissions and respond substantively once its current position is known.

The Elements of a *prima facie* Discrimination Claim

408. In *Moore*, the Court stated:

> ...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 <u>the service</u>; and that the protected characteristic was a factor in the adverse impact. Once a *prima facie* case has been established, the burden shifts to the respondent to justify the conduct or practice, within the framework of the exemptions available under human rights statutes. If it cannot be justified, discrimination will be found to occur.
>
> [emphasis added]

The 'Service'

409. In their complaint—indeed, throughout the many years of these proceedings—the Complainants have been clear in stating that the discrimination is rooted in the Province's provision of social assistance in Nova Scotia to two groups of 'persons in need'. Social assistance is the 'service' at issue.[527] In a narrow sense, as in *Moore*, the social assistance regime is discriminatory inasmuch as it fails to adequately meet the disability-related needs and accommodate the Complainants and those persons with disabilities with similar needs.

410. In *Moore*, there had been a dispute throughout the litigation as to what the 'service' was that was at the heart of the discrimination claim. Moore contended that it was a public school 'education'. The respondents argued that the service at issue was more narrow; 'special needs education' and the cuts thereto.

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[527] See the Complaint, <u>Exhibit 17</u>, filed August 1, 2014: re Beth MacLean at para. 39, re Sheila Livingstone at para. 77 and re Joey Delaney at para. 112.

411. Before the tribunal and, ultimately, at the Supreme Court of Canada, it was held that the 'service' properly scrutinized for discrimination was the provision of 'public education' not, as the lower courts had held, 'special needs' educational services.

412. In the end, the public education system was held to be *prima facie* discriminatory because of "the insufficiently intensive remediation" provided by the District for Jeffrey's learning disability in order for him to get access to the education he was entitled to."[528]

413. The Court observed that if the discrimination analysis were to have wrongly focused on 'special education services', it would have undermined the purposes of the equality rights protection. Because of the vital importance of this insight to the present case, an extended quotation from the Court's judgment in *Moore* is warranted:

> [29] Defining the service only as 'special education' would relieve the Province and District of their duty to ensure that no student is excluded from the benefit of the education system by virtue of their disability.
>
> [30] To define 'special education' as the service at issue also risks descending into the kind of "separate but equal" approach which was majestically discarded in *Brown* v. *Board of Education of Topeka*, 347 U.S. 483 (1954). Comparing Jeffrey only with other special needs students would mean that the District could cut all special needs programs and yet be immune from a claim of discrimination. It is not a question of who else is or is not experiencing similar barriers. This formalism was one of the potential dangers of comparator groups identified in *Withler* v. *Canada* (*Attorney Genera*l), [2011] 1 S.C.R. 396.
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> [31] If Jeffrey is compared only to other special needs students, full consideration cannot be given to whether he had *genuine*

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[528] *Moore*, supra, Note 515, at para. 40. Earlier in its judgment, the Court stated: "...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." (para. 26) and "....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." (para. 36).

> access to the education that all students in British Columbia are entitled to. This, as Rowles J.A. noted, “risks perpetuating the very disadvantage and exclusion from mainstream society the *Code* is intended to remedy” (see *Brooks* v. *Canada Safeway Ltd*., [1989] 1 S.C.R. 1219, at p. 1237; Gwen Brodsky, Shelagh Day and Yvonne Peters, *Accommodation in the 21st Century* (2012) (online), at p. 41).
>
> [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?

414. Again, all three of the individual Complainants have made clear that in their complaints that the Province’s response to their need for social assistance programming, specifically, the Province’s treatment of persons with disabilities requiring residential supports, has been dramatically inferior to the way that other social assistance recipients have been treated.[529] The *result* of this inferior treatment has been, *per* the Supreme Court in *Moore*, an “insufficiently intensive remediation” of the Complainants’ disability-related needs. The Province has failed to provide social assistance in a way that accommodates their needs as persons with disabilities.

415. It is important to remember that the obligation to accommodate is not a discretionary add-on that service providers may or may not choose to provide. It is a mandatory legal obligation on government flowing from human rights obligations. In the foundational and still leading Supreme Court of Canada equality-rights decision in *Andrews*, the Court stated: “[the] accommodation of differences . . . is the essence of true equality.”[530]

Social assistance for the poor generally and for those with disabilities requiring residential supports

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[529] See the Complaint filed August 1, 2014, Exhibit 17, : re Beth MacLean at para. 39, re Sheila Livingstone at para. 77 and re Joey Delaney at para. 112.

[530] Andrews v *British Columbia*, 1989 1 SCR 143 at 169 (the SCC has cited this passage on many occasions since).

416. The undisputed evidence from the hearing, much of it from the Respondent's own witnesses and documents, establishes what the Complainants set out in their pre-hearing submissions; from the 1970s through until 2001, social assistance for people with disabilities requiring residential supports and services, as well as people who were simply living in poverty and needing general assistance was authorized under the *Social Assistance Act* and *Municipal Assistance Regulations*. Both groups fell within the definition in the legislation as "persons in need".

417. Similarly, even after 2001, when the Respondent chose to keep the Disability Support Program in the *Social Assistance Ac*t while creating an essentially similar and parallel social assistance statute (the *Employment Support and Income Assistance Act*), the evidence clearly establishes that the two parallel regimes were not just conceptually and practically similar but were intentionally designed to be intertwined and "integrated" and "seamless" (to use the terms adopted by the Respondent's Deputy Minister of Community Services in her evidence).

418. Accordingly, there can be no real issue that where the claim is one of discrimination in the way that persons with disabilities requiring residential supports have been treated within the social assistance regime, the 'service' properly under scrutiny for discrimination, and the one explicitly cited in the Complaints, is the Respondent's social assistance regime.

Moore's Step #1*: *Characteristics protected under the NS Human Rights Act: Re Complainants MacLean, Livingstone and Delaney

419. The Complaint sets out two protected grounds of discrimination: 'the combined effect of the Complainants' disabilities and source of income; sections 5(1)(a) and/or (o) and/or (t) of the *Human Rights Act'*. It is noted that while 'disability' has been the focus for much of the hearing, this has all occurred within a context of poverty and, specifically being 'persons in need' of social assistance. Inclusion of the intersecting ground of 'source of

income', therefore, is a way of more fully and adequately capturing the Complainants' lived experience and bases of disadvantage.

420. It is understood that the Province is not challenging the claim that the Individual Complainants have 'mental disabilities' within the meaning of the *Act*. Similarly, the Complainants have all been shown to have been 'persons in need' and, thus, in receipt of social assistance. Accordingly, this protected ground, too, is not in issue.

Moore's Step #2: **'the complainant experienced an adverse impact with respect to the service'**
Re Beth Maclean's complaint

421. Again, in the context of Ms. MacLean's complaint, step #2 asks whether the Complainant had "meaningful access"[531] to the Province's social assistance regime intended to provide people with financial assistance to live in the community.

422. Beth Maclean's complaint dates from the inclusion of 'disability' as a protected ground of discrimination in the *Human Rights Act* in 1986 until January 2018 when the Province approved funding for her living arrangements. Because the complaint covers an extensive period of time, it is useful to segment it into several periods.

1986 through October 2000**:** ***the Kings RRC period***

423. In the Spring of 1986 when 'disability' became prohibited under the *Act*, Ms. MacLean had just been transferred from the Youth Treatment Wing of the NS Hospital to Kings Residential Rehabilitation Centre ("**Kings RRC**") in Waterville, Nova Scotia.

424. It is submitted that the evidence of adverse impact/failure to accommodate regarding Ms. MacLean's needs, compared to those 'in need', but not disabled, lies in the following:

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[531] "Meaningful access" to the service is the test imposed by the Supreme Court in *Moore, <u>supra</u>*, <u>Note 515</u>; see paras. 28, 32, 34 (where the SCC cites additional sources for the proposition), 36 and 48.

1) As a 14 year-old girl she was 'placed' in an institution away from family; and

2) She was not just institutionalized, but the institution was one for adults--thus, apparently requiring Ministerial approval.[532]

3) Despite being only 14 at the time of her admission, Ms. MacLean received no formal education while at Kings.

Institutionalization

Specifically, the expert evidence of Dr. Michael Bach and Dr. Frazee confirms the historical disadvantage visited upon persons with disabilities.[533]

425. The Province's own evidence and witnesses confirm that institutionalization generally and especially institutionalization of children was wrong and unacceptable.[534] Indeed, the Deputy Minister of Community Services testified on direct examination regarding the closure of the Children's institutions in the mid-1990s, stating that 'children should be with families, not in facilities'. This is also one of the starting assumptions in the Roadmap-- a document that all agree was informed by human rights principles: "Families should be supported to rear children at home".

426. There is no dispute that as a result of her life's experience resulting from the Province's chosen approach to supporting persons with disabilities, Ms. MacLean has become "institutionalized".[535] This not only has its own harmful impacts on Ms. MacLean and others in her situation but can also be expected to pose its own struggles for Ms. MacLean

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[532] See **Exhibit IX-90**, page 2 of document: "Kings Social Work Admission Notes", <u>JEB IX – 90, p. 7598.</u>

[533] Exhibit 12, Dr. Bach Expert Report; Testimony of Catharine Frazee, June 4, 2018; Exhibit 37, Dr. Frazee's Report.

[534] Book VIII-Tab 111, <u>pp. 6483, 6547-56</u>; Book II-Tab 8, <u>p. 363, para 4</u>, Memorandum to Cabinet MCS LeBlanc Nov 1990, report page 3, para 4; Exhibit 50, Community Services – Discussion Papers Released, February 10, 1995; ; VI-A-29<u>, p. 2763</u>, Putting People First: What we Heard; VIII-Tab 84, <u>p. 6059</u>, March 25, 2016 DSP and Health Realignment Terms of Reference

[535] This was agreed to by Carole Bethune whose evidence is consistent with Dr. Sulyman, Nicole Robinson and the staff at the Community Treatment Program (see CTP Care Plan: **JEB IX Tab 100**, page 1, JEB 7645).

in her desperate attempts to experience equality—this is, have a normal life in the community.

427. Ms. Maclean testified that she was offered no schooling while at Kings RRC.

428. She testified that her days there, her life there was routinized and often scary.

429. Ms. Maclean testified that she hated it at Kings, didn't want to be there, and wanted to leave.

430. Once while at Kings, she had visited someone at a Small Options home for a birthday party. She looked around the place and liked it.[536] The Kings RRC notes also confirm that staff there, too, had a visit to a Small Options home as part of their agenda for Beth.[537]

431. The documentation from Kings makes clear that Ms. MacLean was acutely unhappy and wanted to leave the institution.[538] It is clear that no 'Choices'[539] appeared to have been offered to her.

432. In light of the extensive evidence, indeed much of it is undisputed evidence and/or from the Province's own witnesses (e.g., Deputy Minister Hartwell testified: 'large congregate settings' (i.e., institutions) are 'not in the best interests of persons with disabilities….., no longer acceptable to families[540] ….. 'not always getting the outcomes that we hoped to be getting.'[541]

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[536] Testimony of Beth MacLean, March 6, 2018.
[537] Book IX, Tab 6, pg. 2444/2792
[538] See JEB IX-6, p. 7172, 'Discharge Summary Report by Alan Warner, Ph. D. Psychologist'
[539] This is , of course the more formal title of 'the Roadmap' document: 'Choice, Equality and Good Lives in Inclusive Communities', JEB VI-A-32.
[540] See also **JEB Exhibit VIII-84,** p. 6059, 'DSP and Health Realignment Terms of Reference' (March 25, 2016)
[541] Testimony of Lynn Hartwell, August 9, 2018

433. Finally, what is one of the most troubling features of Ms. MacLean's time at Kings is that she was simply 'placed' there starting at age 14 and for the next 14 years without any independent review by the Province's care coordinators. The Province's own Care Coordinator for Beth Maclean was obviously alarmed and troubled that, on Ms. MacLean coming onto her caseload when she was admitted to the NS Hospital in October 2000, she realized that there had been and was **no** independent assessment--by someone without a vested interest in keeping her there--as to the suitability of the Kings placement, as to whether Beth ought to even be there or would have been better off in another setting, for example, a community-based living situation. Ms. Pynch wrote:

> These Block funded clients at KRRC were not traditionally monitored by the municipalities as they were not municipally funded. I feel that regardless of how the client is funded (per diem by district offices or block funded) they are still a responsibility or the Province. Therefore, should be case managed no differently than other clients of Community Supports for Adults. <u>In Beth's case it seems that the was no impartial representative from the Department for the service provider, family or client to consult on an on-going basis</u>. As most of my experience in Homes has been CBO's I see a great benefit to annual IPP meetings. Now that l am case managing clients in licensed homes, I reel that a lot of crisis can be prevented through this process however none of the licensed homes have had annual IPPs In place, so when I actually think of this process it is not Just the Block funded clients it also includes clients in other licensed facilities. We have created a system whereas clients in CBO's have IPPs via Interim Standards but not In the Homes for Special Care Act so it seems that this need to be brought forward In any future legislation.[542]

434. As a child with disabilities, Ms. Maclean was segregated from the rest of society with all that that means as we know from the evidence.

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[542] See **JEB IX -9** "November 28, 2000 'DCS Pynch email to Brian Taylor'

435. Beth was 14 years old when she first went to Kings and 29 years old when she left in October 2000. Despite her enshrined right to equality, there is no evidence that Beth was offered an opportunity to live a non-segregated and supported life in the community. In her testimony, Deputy Hartwell on at least two occasions agreed with the characterization of large institutions as "segregating" people with disabilities from living in community.[543]

436. In comparison with the experience of persons who had been in receipt of social assistance under the same *Act* (i.e., the *Social Assistance Act),* and who either had, for example, either no disabilities or ones not requiring residential supports, not only would they have been completely free to live in whatever community in Nova Scotia they chose but, as importantly, they would NOT have had to live in an institution in order to receive received financial assistance--all agreed at the hearings that the days of the Nova Scotia Poor House have been long gone for decades. The disparities in treatment--and the results of those disparities e.g., decades of institutionalization resulting in the resulting gap in social skills and ability to live in community, are sharply and personally traumatic for Beth MacLean.

437. All of this evidence and for the reasons presented, establishes that Ms. MacLean was adversely affected and disadvantaged compared to the supports and services provided to non-disabled low-income people.

Maritime Hall, Emerald Hall and the Community Transition Program (CTP): 2000 -2018

438. Beth Maclean was, essentially discharged from Kings in October 2000 after an incident with Kings RRC staff who invariably described her behavior toward the end as a

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[543] Testimony of Lynn Hartwell, August 9, 2018; Testimony of Lynn Hartwell, August 10, 2018

misconceived *cri de coeur* for a person who had been effectively forced to live away from family in an institution for over 14 years.[544]

439. Of all places, why was she ‘transferred’ to an acute care ward of the NS Psychiatric Hospital--especially one not set up to meet the needs of a person with Intellectual Disabilities? The evidence is unclear, particularly because she had not been diagnosed as having a mental illness. The Province chose not to call evidence to explain that decision but, what is clear, is that an agreement was made between the Province's Departments of Community Services and Health that the latter would ‘take her’ for a one year term allowing the former to make longer term arrangements.[545]

440. We now know that those agreements between the Respondent’s officials were never complied with and, instead, Beth MacLean remained institutionalized for more than a decade and a half--even though the evidence -not to mention the Province’s stated policy position—is that, as a person with disabilities, Beth Maclean could have been supported to live in the community; “the community is the natural setting for individual growth and fulfillment”.[546]

441. In the early stages of MacLean’s hospitalization in an acute care unit, physicians at the Maritime Hall unit of the NSH were unable to identify any mental illness that would warrant her continued treatment there and recommended that planning for her discharge should be underway.[547] Care Coordinator Christine Pynch emailed other DCS staff members in March 2001: “...it is established that Beth does not have any diagnosable

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[544] See Kings RRC discharge notes: JEB IX-6, pg. 2429/2792.

[545] JEB IX-3, page 7152, first paragraph (entry for October 23, 2000).

[546] See JEB **Exhibit VI-A-3** “Moving Towards Deinstitutionalization, A Discussion Paper” (February 1995) at JEB page 1718.

[547] See **JEB IX-5,** p. 7160, and **IX-14,** p. 7221. “November 9, 2001 Confidential Meeting Notes”

psychiatric illness. Therefore Beth is inappropriately placed."[548] Tellingly, Pynch openly wondered, apart from Kings RRC, what "resources" might be available to meet her needs.

442. Given what we tragically now know, there is no need to spend an extended period discussing the outcome of the 'one year arrangement' between these two Provincial departments. Despite increasingly urgent pleas by staff at the NS Hospital[549] and sometimes earnest replies by DCS staff, Beth MacLean was left to languish in the lurch. She was no longer in a DCS facility and, on the evidence before the Board, that appeared to be 'good enough' to the Province's Department of Community Services. Substantively, Maritime and Emerald Hall were in many ways, just as institutional as the Kings RRC where DCS had previously housed her.

The NS Hospital Period: 16 years

443. It is submitted that the evidence does establish several things very clearly about what has to be seen as a staggeringly long period of unnecessary hospitalization.

444. **First**, at the time (e.g. 2002[550]), the Respondent's own Department of Community Services was *itself* saying that she was eligible for its program and could have been supported to live in the community.[551] While subsequent DCS classifications sometimes varied, it is worthwhile observing that had the Province supported Ms. MacLean in a timely way to live outside in the community, she would likely *not* have ended up spending ***all*** of her adult life needlessly institutionalized.

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[548] See **JEB IX-1**0 Pynch email to DCS staff

[549] See JEB IX-15 "March 11, 2002 email from Maritime Hall staff to John Campbell", IX-16 Faulkner to NSH staff and IX-17 NS Hospital letter to DCS (March 20, 2002)

[550] See: JEB IX-23 "May 28, 2002 DCS Classification re Beth MacLean DIII"

[551] Again, the evidence is undisputed that regardless of what DCS 'classification' was assigned to a person, they could be supported in the community in, for example, a Small Option home-- with appropriate supports and services.

445. **Second**, expert evidence from Jim Fagan, the RRSS Director of Resident Services, made clear that, after an extraordinary review of Ms. MacLean's extensive DCS files and NS Hospital charts, multiple meetings with clinical treatment teams, and after consultation with the RRSS admissions committee, his opinion, indeed, the RRSS opinion, was that Ms. MacLean could have been supported throughout the entirety of the period by RRSS.[552] While cross-examined by the Province, regarding so-called aggressive behaviours, Mr. Fagan indicated awareness of the incidents and testified, as well, that RRSS has supported others with behavioural challenges that were at least as challenging.[553]

446. **Third**, bolstering Mr. Fagan's opinion regarding the ability to support Beth MacLean during the period, are the following:

a. In the *Roadmap*,[554] (the Province and community representatives plan for the way forward for supporting people with disabilities) itself set out their joint starting assumptions for what followed:

> - The *Canadian Charter of Rights and Freedoms*, the Nova Scotia *Human Rights 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.
>
> - <u>All individuals have a unique developmental path, and may require unique interventions and supports to enable equality of outcome – full participation and inclusion</u>.
>
> - <u>All people can be supported to live in community</u>.
>
> - <u>Families should be supported to rear children at home</u>.
>
> [underlining added]

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[552] Mr. Fagan's expert written opinion regarding Beth was entered as **Exhibit 27**.

[553] Testimony of Jim Fagan, March 13, 2018.

[554] See JEB **Exhibit VI-A-32** "Choice, Equality and Good Lives in Inclusive Communities Roadmap for Transforming SPD" (June 2013), at **JEB page** 2862.

b. Indeed, as was brought to light during the hearing, the Department Community Services had, in 1995, published a report in which the Department's <u>*own*</u> position was stated in the following terms:

> The Department believes that not only do all Nova Scotians have a right to live in the community, it believes the community is the natural setting for individual growth and fulfillment.[555]

c. The Province's own witnesses (Carol Bethune and Lynn Hartwell) both testified on their opinion regarding RRSS' reputation. Deputy Minister Hartwell gave evidence that the Province had reached out to RRSS to resolve certain 'high profile' cases that have been "escalated" to her attention. She agreed that DCS had high regard for RRSS' work: "They have in the past been able to provide placements for some very complex behaviours." In fact, Hartwell testified, RRSS Executive Director, Carol Ann Brennan, who testified in the proceeding had been seconded by DCS to work on the Roadmap process precisely because she had 'lots of experience in some of the challenges' that DCS staff had been facing in their work.[556] DCS Care Coordinator, Carol Bethune, also testified that she knew Jim Fagan and the work of RRSS and held them both in high regard.[557]

d. Significantly, the Province chose not to adduce its own evidence to rebut the expert evidence of Mr. Fagan. Given the Roadmap's 'starting assumptions', (i.e., the principle that 'everyone can be supported to live in community'), one might speculate why that decision was made. But, the fact is that Mr. Fagan's evidence has gone unrebutted.

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[555] See JEB **Exhibit VI-A-3** "Moving Towards Deinstitutionalization, A Discussion Paper" (February 1995) at JEB page 1718. See the accompanying DCS media Release (February 10, 1995) "Community Services--Discussion Papers Released" **Exhibit 50**.
[556] Testimony of Lynn Hartwell, August 10, 2018.
[557] Testimony of Carol Bethune, September 6, 2018.

How does DCS 'Unclassifiable' decision for Beth MacLean in late 2002 and 2005 relate to the discrimination analysis?

447. While DCS ruled that Ms. MacLean was 'unclassifiable' in 2005, it is submitted that vis-a-vis the determinations that the Board must make regarding the adverse impact of *classification* on the access to the service, this is in no way determinative of that quite separate issue. This is the case for the following reasons:

(i) Had Ms. MacLean been provided community supports in May 2002 when DCS, itself, had found her to be eligible for their program, it is reasonably likely that Ms. MacLean would have been living in the community with there being no need for follow-up classification decisions.

(ii) **Second**, the expert evidence from the Emerald Hall clinicians (Dr. Sulyman and Behaviour Analyst, Nicole Robinson) both explained under oath that as time passes for a person who has become institutionalized on a long term basis, they lose hope/motivation and it is not surprising if negative 'behaviours' are manifested in an institutional setting.[558] One of the adverse effects of the Province's failure to provide timely access to Community Based Options to Beth MacLean was the negative impact on her psychiatric health which, in turn, led to behavioural issues. The circularity of this dynamic will be appreciated.

By the same token, if the Respondent Province were to rely on such behaviours in an effort to justify its having found Ms. MacLean ineligible for supports, such an approach would countenance the Respondent's complete failure to create adequate capacity for persons with disabilities; the continued institutionalization would *per se* make more likely further findings of unclassifiability.

(iii) **Third**, DCS' own internal critiques of the assessment tool which it was using undermines whatever significance classification decisions might have carried. Thus, in **June 2005**, DCS was reviewing the suitability of its own assessment

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[558] Testimony of Dr. Sulyman, March 13, 2018; Testimony of Nicole Robinson, March 8, 2018.

methodology--as part of the overall DSP program review being carried out at that time. Its own internal review observed that the then (2005) current assessment tool was:

> The renewal project team, with feedback from DCS staff, clients, service providers, and clients' families, concluded that the current assessment process and classification method of determining eligibility and supports was inadequate. The current assessment process is a non-standardized narrative approach to assessing clients. It does not allow for data collection or trend analysis; it is not reliable or valid, nor does it allow for comparisons of services between care settings. Most importantly, it is not compatible with the assessment approach used in the Department of Health (D0H) Continuing Care Division.[559]

The same Report notes that Lynn Hartwell, who testified in these proceedings, was then in the role of "SPD Renewal Project Manager" and a member of the 'work group' that conducted the pilot project to replace the flawed assessment tool. Accordingly, that tool--used by DCS to find Ms. MacLean "unclassifiable" was--in the same time period properly seen as seriously flawed: it is "not reliable or valid." (see quotation above)

(iv) **Fourth**, 'unclassifiable' as a concept is quite likely discriminatory itself. That is, in its concept, it discriminatorily excludes a subset of persons with disabilities as a result of their disability. Indeed, as is argued elsewhere in these submissions, Deputy Minister Hartwell's testimony was explicitly critical of the notion that a person with a disability would be 'unclassifiable' i.e., ineligible for supports from any government entity.[560]

(v) The key, of course, is the realization that 'unclassifiability' is, in any event, not synonymous with non-discriminatory within the meaning of the *Human Rights*

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[559] See: **Exhibit 78**, "SPD Renewal Project: Assessment Instrument Pilot Project Report and Recommendation, Judy LaPierre, June 21, 2005 at document page 3

[560] Testimony of Lynn Hartwell, August 9, 2018.

Act. That is, irrespective of which department or agency of the Province might have responsibility to provide supports for people to live in community, it simply cannot be the case that a person who is otherwise ‘in need’ financially and no longer requiring treatment in a locked acute care ward, can be turned away for supports and left to languish. It is not done elsewhere in Canada[561] and is unacceptable under Nova Scotia’s *Human Rights Act*.

448. ‘Unclassifiability’, as noted above, is *per se* contrary to what we can properly characterize as the human rights-compliant and inclusive ‘starting assumptions’ of the *Roadmap*, particularly that: “All people can be supported to live in community.”

The question of whether Beth MacLean lacked capacity to make decisions about her living circumstances.

449. It is difficult and, possibly, unhelpful at this stage for the Complainants to anticipate and address issues that the Respondents will make in their submissions, however the question of ‘Ms. MacLean’s capacity’ seems to be one that may usefully be addressed at this point.

450. While the Board may recall that, toward the end of the hearing, the Province stated on the record that it’s position was that Ms. MacLean did not have capacity to make decisions regarding placement, it is important to bear in mind that--regardless of whether Ms. MacLean--or he or anyone else--had capacity to make these decisions, at **NO** point during the time period that the Province appears to argue that Ms. MacLean lacked capacity to make placement decisions (i.e., apparently from August 2012 through to June 2016) was she **ever,** in fact, offered a placement outside of the Nova Scotia Hospital.

451. Therefore, the question of whether she had capacity to make a decision that she was never faced with making is of very limited relevance. The Province at no point from August 2012 through to June 2016 actually made a placement offer to Beth or anyone

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[561] Exhibit 12, Dr. Bach’s Expert Report, pg. 16; Testimony of Dr. Griffiths, March 15, 2018.

they considered to be her SDM.[562] Stated simply, any effort by the Province to challenge Ms. MacLean's capacity is ultimately irrelevant to the decisions that the Board will need to make--whether Ms. MacLean was treated in a discriminatory way in her request for accommodative supports and services by way of social assistance to enable her to live in the community.

452. Having said that, it is submitted that the relevant evidence and applicable law drives one to the overwhelming conclusion that throughout the relevant period, Beth MacLean had capacity to make her own decisions regarding where she would like to live.

The Law on Capacity

453. While a psychiatrist and not a lawyer, Dr. Sulyman testified correctly that the law presumes capacity in all persons--including persons with disabilities.[563] Respondent's witness, Carole Bethune, testified likewise.[564] The law is beyond dispute; because of the way the common law has incorporated the value of autonomy throughout the law on consent (and more generally, respect for decision-making), a person, including a person with disabilities, is presumed to have capacity absent medical evidence to the contrary. To approach the matter with any other *suspicion* or *hunch* regarding capacity, is, as Dr. Sulyman testified, the product of stereotypical thinking.

454. In light of the legal presumption, in order for it to be displaced, there must be a capacity assessment stating that the person lacks capacity to make a *<u>specific</u>* decision.

455. In her expert testimony, Dr. Sulyman discussed her June 2013 written capacity assessment regarding Ms. Maclean.[565] As part of that evidence, she was asked if she had

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[562] Carole Bethune, Ms. MacLean's Care Coordinator, agreed to this in her cross- examination evidence. It is also confirmed from a review of the Care Coordinator's case notes **JEB IX-9, Tab 3, JEB pages 7134-7137**

[563] See, for example: *Crewe* (*Re*), 2007 NSSC 322 which, in turn cites the leading case of *Fleming* v. *Reid.*

[564] Testimony of Carol Bethune, September 19, 2018.

[565] See JEB Exhibit IX-78

conducted a thorough review of Ms. MacLean's hospital chart to determine whether there had been any previous capacity assessments <u>regarding Ms. MacLean's capacity to make decisions regarding where she wanted to live</u>. She said that she had conducted such a review and there were <u>no</u> such assessments.[566]

456. Moreover, in her recent cross-examination evidence, Carol Bethune agreed that the actual Case Note that she was relying on (referencing Beth MacLean needing a "Statutory Decision Maker"), was ambiguous as to what kind of decision-making issue was actually being referred-to in the note. It wasn't at all apparent that it even referred to decision-making regarding placement.[567] In fact, on re-direct, Bethune went further and stated 'that there would be supporting documentation on a client's file if the client was found by a psychiatrist to lack capacity. The issue of capacity to make placement decisions would not simply be addressed through an undocumented conversation between the care coordinator and medical staff.' [568]

457. It is submitted that the Province has not come close to having adduced evidence that displaces the presumption of Ms. MacLean's capacity.

458. Indeed, when Ms. Bethune admitted on cross-examination that neither she nor, on the evidence, her predecessor (Christine Pynch) had made any inquiries to clarify Ms. MacLean's mental capacity--in light of receipt of a copy of Dr. Sulyman's June 2013 assessment in early March 2014,[569] one can reasonably conclude that the DCS was no longer paying due respect to Ms. MacLean's equality rights.

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[566] Book IX, Tab 98; Testimony of Dr. Sulyman, March 13, 2018

[567] Testimony of Carol Bethune, September 18, 2018

[568] Testimony of Carol Bethune, September 19, 2018

[569] See: **JEB Exhibit IX-83,** <u>p. 7547</u> "March 6, 2014 Pushie fax to Pynch w Beth Medical Assessment"

Waiting for social assistance that met her needs

459. Ms. MacLean has waited a shockingly long time for her entitlement to social assistance that accommodates her needs.

460. Indeed, even under DCS's own unfairly restrictive program terms, Ms. MacLean was continuously eligible for supports since March 2009.[570] This is undisputed.

The Community Treatment Program

461. In June of 2016, an opening came up at the CTP and, after 16 years in the NS Hospital, Beth was transferred to CTP.[571] This is a facility managed jointly by the Departments of Health and Community Services. The evidence was that, in broad terms, CTP was like Emerald Hall in many respects; it was institutional in design and living arrangements, with little autonomy around the basics being left to the individual.

462. When Beth agreed to be transferred there, it was made explicit that she was doing so solely to get out of the Hospital and on the understanding that she continued to want a community-based living situation.[572]

463. It appears that shortly after the transfer to CTP, a possible opening at a Small Options home became known to the Respondent's DCS and CTP staff. Despite Ms. MacLean's counsel having requested in writing that possible placements be conveyed through counsel to permit the benefit of his advice, this request by Ms. MacLean was ignored.[573] In the end, counsel learned of the move in December 2016, after it had taken place.[574]

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[570] See **JEB IX-50,** p. 7381, "March 18, 2009 Beth MacLean Classification"(DIII) and also, **JEB IX-70** "Wait list printouts from 2012 to 2015" at **JEB page 7482**.

[571] Book IX, Tab 3, p. 7134.

[572] Book IX, Tab 102.

[573] Testimony of Carol Bethune, September 18, 2018.

[574] Testimony of Carol Bethune, September 18, 2018; Book IX, Tab 3, p. 7133, pg. 2/22

464. In the end, the placement was unsuccessful. There appears to be no dispute in the evidence that the staff at the Small Options placement were ill-trained, not aware of the availability or use of a PRN. In short, a dispute over Ms. MacLean's yogurt being available to her was allowed to escalate without the protocol having been followed.[575]

465. Ms. MacLean returned to CTP in early January 2017 where she has remains to the present.[576]

466. Finally, as the hearing of the matter was getting underway in January 2018, the Respondent decided to offer to fund a Small Options placement for Ms. MacLean which RRSS is in the process of arranging.

Conclusion re Moore's Step #2: 'the complainant experienced an adverse impact with respect to the service'

467. The evidence confirms that Ms. MacLean's inferior treatment, since 1986, in obtaining the required accommodative supports, compared with people eligible for social assistance, but not requiring the accommodation offered, is both stark and manifest in a variety of ways. The range of 'adverse impacts' experienced by Ms. MacLean are presented in summary form below.

468. **First [Institutionalization]**, in the Kings RRC period (from 1986 through 2000), through the Maritime and Emerald Hall periods and while in the Community Transition Program (2016-2018) 'persons in need', and in receipt of general assistance under the *Social Assistance Act*, would **not** have been forced to live in congregate care facilities (as they were in the days of the Nova Scotia Poor House) in order to receive social assistance from the Province. Ms. MacLean's experience was tragically different.

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[575] Testimony of Jim Fagan, March 12, 2018; Testimony of Carol Bethune, September 18, 2018.

[576] Book IX. Tab 3. Pg. 2/22

469. The institutionalization and segregation of Ms. MacLean, and the disabled poor more generally, represented a dramatically inferior--and harmful--treatment at the hands of the Province.

470. The Province chose to only assist Ms. MacLean in the Kings institution which the Board and all counsel saw/experienced when we took a view on the 11th of January 2018. Ms. Maclean was 'placed' there as a 14-year old and remained there **for 14 years** until October 2000.

471. The thought of a child being institutionalized with adults, and being effectively forced to remain there during some of the most important years of her life in order to receive assistance--all because of the Province's decision to support people with disabilities in this way--verges, it is submitted, on the unspeakable.

472. The location and institutional form of the assistance provided to persons with disabilities was not somehow, 'separate but equal' with that provided by way of general social assistance but was segregating, isolating from community and downright harmful.[577] It deprived Ms. MacLean of the critically valuable human right to participate as equals and be a member of the community":

> "...the Department has done some work in talking with clients who actually helped us shape a view of what community means, and for them it's a place to feel safe, it's a place to feel included, it's a place where they get to make some choices; that, you know, real, basic human rights. They want friends and they want opportunities. So – so yes, it's the belief that everyone can live in a community."[578]

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[577] Book VIII-Tab 111, pp. 6483, 6547-56. Report of the Task Group on Homes for Special Care, 1984 at report page pg. 56; Book II-Tab 8, p. 363, Memorandum to Cabinet MCS LeBlanc Nov 1990, report page 3, para 4; VIII-Tab 84, pp. 6059-6060, March 25, 2016 DSP and Health Realignment Terms of Reference; VI-A-29, p. 2763, Putting People First: What we Heard, pg. 10; Testimony of Lynn Hartwell, August 10, 2018.

[578] Deputy Minister, Lynn Hartwell, in responding to a question by counsel for the Province who asked her to make clear what was meant by 'community' in the *Roadmap's* starting assumptions: "...when we wrote this we weren't being coy about the use of the word "community." We were using the word "community" in the sense that, I believe, it's accepted by many in the advocacy community, which is smaller – smaller options – community-based options, not facility-based care."

473. **Second: [Waitlist]**, In the NS Hospital period (October 2000 through June 2016), Ms. Maclean was on various occasions found to be eligible for social assistance under the *Social Assistance Act*. She was found eligible in May 2002 and, continuously since March 2009.

474. Therefore, while the evidence is undisputed that a 'person in need' requiring social assistance and who has either no disabilities or none requiring residential supports, would receive that social assistance virtually **immediately** upon being found eligible,[579] in contrast, Complainant Beth Maclean has **waited** for almost two decades to receive social assistance that accommodates and meets her needs so that she, too, can live in the community. For much of this period, the Respondent itself agreed that she has been eligible as a person in need meeting all eligibility criteria.

475. There can be no real question that the chronic and extraordinarily long wait that the Complainant faced, is distinctly inferior to the virtually immediate provision of social assistance to person without disabilities. This is dramatically adverse treatment with the consequential adverse impacts on the Complaint about which the Board he repeatedly during the hearing.

476. By definition, a wait of this length for accommodative supports and services is a profound failure in the government's statutory and human rights obligations in the provision of a "service."

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[579] See the evidence of Respondent's witness, Denise MacDonald-Billard who testified about the workings of the general social assistance system, both during the municipal system (under the *Social Assistance Act*) and, since 2001, under the Province's *Employment Support and Income Assistance Act* regime (Testimony of Denise MacDonald-Billard, June 18, 2018). Also, see the evidence of Deputy Minister Lynn Hartwell who agreed that persons found to be eligible for social assistance under the *Employment Support and Income Assistance Act* are assisted immediately upon being found eligible; no one is put on a waitlist for social assistance. Testimony of Lynn Hartwell, August 10, 2018; Testimony of Denise MacDonald-Billard, June 18, 2018.

477. **Third (entitlement to accommodative assistance]**, the remarkably different way that the Province treats *Social Assistance Act* recipients depending upon whether they are persons with disabilities or able-bodied (or disabled but not requiring residential supports) is, one more, testament to the cavalier way in which the complainant's rights--and those of all in the situation were treated. To apply Prof Frazee's words, this is a manifestly 'ableist' approach to the rights of those with disabilities. Meeting the needs of people with disabilities is far from the epicentre of ableist priorities.

478. People without disabilities (or disabled but not requiring residential supports) have been and are provided with social assistance immediately upon being found eligible. While the former have their entitlement under the *Social Assistance Act* treated as an obligation with urgency, people with disabilities are treated as though it is a benefit provided on a discretionary basis.

479. Thus, while both were equally 'persons in need' under *the same statute and regulations*[580] during the 1986 until August 2001 period, persons with disabilities were and continue to be treated by the Province as though their social assistance needs is quasi-charitable and discretionary.

480. This inferior treatment by the Province of social assistance obligations to this group occurs despite the fact that being found to be a 'person in need' **entitles** that person to social assistance per s. 9 of the *Social Assistance Act*:

> **Duty of committee to assist person in need**
> **9(1)** Subject to this Act and the regulations the social services committee shall furnish assistance to all persons in need, as defined by the social services committee, who reside in the municipal unit.

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[580] The fact that both groups of 'persons in need' were assisted under the same statute was the case from at least as far back as the mid-1960s and certainly from the start of Ms. MacLean's Complaint in 1986 and continued to be the case until general social assistance ('Income Assistance) was transferred to the *Employment Support and Income Assistance Act* in August 2001.

481. The Superior Courts in Nova Scotia have confirmed for decades that the *Social Assistance Act* creates a mandatory legal obligation on officials to provide financial assistance to qualified 'persons in need'. There is no residual discretion vested in staff to decide whether or when to provide assistance to those having been determined to be eligible 'persons in need'.[581]

482. Similarly, since August 2001, general social assistance ('Income Assistance') is provided under the *Employment Support and Income Assistance Act* and, as under the *Social Assistance Act*, the legislation creates a legal obligation to provide assistance to 'persons in need'. Recently, in her evidence, the Deputy Minister of Community Services confirmed that her Department regards persons found eligible under the *ESIA* as having have a legal right; it is, she testified, 'an entitlement program'. [582]

483. The upshot, of course is that while there is absolutely no question that assistance to 'persons in needs' under the *Social Assistance Act* (both pre- and post-2001 given that the legislation has not changed), has been determined to be mandatory and provided as of right,[583] the Respondent Province has decided to limit it in the case of persons with disabilities requiring residential supports; treating it as though it is a discretionary benefit.

484. This is not simply the Superior Courts view of the statute but one which was evidently shared by the Respondent's Department of Community in its annual Reports. Even though the statements in these reports have no legal significance regarding the status of the legal obligations on the Respondent to provide assistance to persons in need, they *do* go to

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[581] See: *DeWolf, DeWolf and Johnston* v. *City of Halifax and Welfare Committee of City of Halifax,* [1979] N.S.J. No. 711 *per* Morrison J; *Woodard* v. *Social Assistance Appeal Board* (1983), 64 NSR (2d) 429 NSSC *per* Hallett J. (followed by the Nova Scotia Court of Appeal in *Carvery v. SAAB* (1993) Q.L.); *McInnis* v. *Halifax (City) Social Planning Department, Director*] (1990), 70 D.L.R. (4th) 296 (N.S.C.A.) *per* Jones J.A.; and, most recently, *Nova Scotia (Community Services)* v. *Boudreau*, 2011 NSSC 126.

[582] Testimony of Lynn Hartwell, August 10, 2018.

[583] This is not simply the Superior Courts view of the statute but one which was shared by the Respondent's Department of Community in its Annual Reports.

establish the Respondent’s awareness and recognition of those obligations, Thus, the Deputy Minister agreed on cross-examination that the DCS *Annual Accountability Report 2000-2001*[584] was impliedly including reference to the Community Supports Program (the predecessor to the current DSP) when it stated:

> Over 90% of the Department's services are legislated and under these Acts, the Department is required to provide services to those individuals and families who are eligible for assistance regardless of available program funding.

485. It may also be recalled that the Respondent sought, on re-direct, to minimize both these statements in the Report and the Deputy Minister’s testimony on cross-examination. The Report, of course, obviously speaks for itself regarding the awareness of the legal entitlement to these programs. Moreover, it is worth noting that versions of the Department’s subsequent *Annual Accountability Report* continued to highlight the undeniable legal reality:

> Over 90% of these services are legislated which means if an individual qualifies for a service it must be provided.[585]

486. To be clear, for purposes of **Step #2** of the discrimination claim, the adverse effect experienced by Ms. MacLean is that, in the face of the legal obligation to provide assistance in the *Social Assistance Act*, the discrimination lies in the fact that the Province has chosen to treat both its statutory and its Human Rights duties to provide accommodative social assistance to persons with disabilities as a matter of discretion compared to the rigorous entitlement approach that it takes to the provision of assistance under the *ESIA* for people who either have no disabilities or, if they do, do not require residential supports and services.

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[584] Exhibit 70, DCS – Annual Accountability Report, Fiscal Year 2000 – 2001, pgs. 6 and 34; Testimony of Lynn Hartwell, August 10, 2018.

[585] See **JEB VI-A-56**, “DCS 2001-02 Accountability Report”, **JEB page 3217** and, as well, see: **JEB: VI-A-58** “DCS 2003-04 Business Plan” at **JEB page 3304**.

487. In short, persons in need with disabilities requiring accommodation are given lesser regard and dignity in their entitlement to social assistance. As Prof. Frazee testified, in this context, the Complainants have been subject to an 'ableist' diminishment' of their needs and interests. The Province's approach sends a message to the complainant that her social assistance needs are of lesser importance than those of persons in need who have no disabilities.

488. Apart from the failure to provide the actual assistance, the Courts have confirmed that government recognition of one's legal right to the service is itself a component of equality. In *Egan*, the Supreme Court of Canada dealt with a similar government approach in circumstances where federal old age security benefits had been denied to a homosexual couple while having been accorded to heterosexual couples. The government argued that there was no disadvantage because the denial did not result in a lower net income when the couple's receipt of provincial social assistance was taken into account. The Supreme Court responded in a way that is no less applicable here in terms of the message that is sent to people with disabilities by the Province's decision to ignore its legal duties to provide accommodative supports and services:

> [T]he concept of equal benefit of the law should not be restricted to a simple calculation of economic profit or loss. The equality right set out in s.15(1) is not phrased as guaranteeing an *equal right to a benefit* but, rather, it is expressed as guaranteeing equal *benefit of the law*. The manner of expression is significant and furthers the aim of this section to foster respect for the innate dignity of every individual...and…. The law confers a significant benefit by providing state recognition of the legitimacy of a particular status. The denial of that recognition may have a serious detrimental effect upon the sense of self-worth and dignity of members of a group because *it stigmatizes them even through no economic loss is occasioned*... *This benefit of the law is very significant.* Its importance can be seen by considering what the result might be if, for example, the benefit were to be denied to couples because the individuals were of different races or different religions. The public outcry would, I think, be immediate and well merited. Such legislation would

> clearly infringe s.15(1) because its provisions would indicate that the excluded groups were inferior and *less deserving* of benefits.[586]
> [emphasis added]

***Moore's Step #3*: 'the protected characteristic was a factor in the adverse impact'**

489. There are several additional facts that are relevant to the analysis of this issue:

Each of the 'adverse effects' discussed in **Step #2** above: i) the **remote Institutionalization**, ii) the **Waitlist**, and iii) the treatment of accommodative social assistance as **a discretionary benefit not an entitlement,** were all visited upon Beth MacLean as a person with a disability but, as was argued, were **NOT** imposed on persons without disabilities or whose disabilities did not require accommodation by way of residential supports and services.

490. More generally, the following broad points are not only undisputed in the evidence but serve to further establish the link between the disadvantage suffered and the Province's treatment of persons with disabilities:

a. <u>All</u> of the 'persons in need' within the Disability Support Program are persons with disabilities, typically very profound disabilities. Conversely, people without disabilities are simply not categorically eligible for the program.587 For the reasons related to Ms. MacLean's particular treatment together with the design flaws in the DSP more generally, it is apparent that the Province has created a flawed and comparatively unfavourable program when it comes to accommodating the needs of person with disabilities.

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[586] See Egan v. Canada, [1995] 2 S.C.R. 513 *per* Cory J. for the majority at paras. 158 and 161 and *per* L'Heureux-Dubé at para. 86

[587] This was stated by many witnesses during the hearing but Deputy Minister Hartwell testified squarely to this on cross-examination. See also the Disability Support Program Policy Manual: **Exhibit 58**, Section 4.1 "Disability Requirement".

b. The Province chose to 'cap' the DSP program (with the recent exception of one of its sub-programs588), unlike its treatment of the Income Assistance program under the *Employment Support and Income Assistance Act* which has no 'cap' for its caseload, the number of people to be assisted or the total amount of social assistance that can be provided.[589]

c. In 1995, during the Provincial-Municipal service exchange, the Province imposed a Moratorium (discussed at length elsewhere in these submissions) on the approval/creation of new Small Option homes for persons with disabilities under the *Social Assistance Act*. Conversely, during the same time frame, the Respondent Province's takeover of what had been municipal social assistance not only involved no cap imposition on general social assistance caseloads, total amounts spent or social assistance rates for person in need. Nor, were there any wait times for persons in need of general social assistance.

491. In fact, as the Province stated, in 1995 and again in 1998, it has actually increased general social assistance rates as it took over responsibility from the municipalities.[590]

Conclusion regarding Step #3 of the Moore test

492. In *Stewart* v. *Elk Valley Coal Corp.,*591 the Supreme Court confirmed that the relationship between the disadvantages suffered and the grounds of discrimination need only be that of 'a factor'.

493. Here, for the reasons cited above, it will be clear that, as in *Moore*, the adverse impacts suffered by Ms. MacLean are due, at least in part, to her being a person with a disability.

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[588] That is, the *Enhanced Family Support Program*.

[589] See the evidence of the Respondent's witnesses, Denice MacDonald-Billard and Lynn Hartwell.

[590] See **Exhibit 49**: DCS Media Release: "Community Services--Metro Social Service Delivery" (March 20, 1996) and **Exhibit 46**: DCS Media Release "Provincial Record of Continued Improvements" (December 7, 1998)

[591] *Stewart v. Elk Valley Coal Corp., 2017 SCC 30* was cited by the Complainants in their pre-hearing submissions.

In answer to the question; 'who is subject to these adverse impacts endured by Ms. MacLean and others in her situation?', the answer is: it is poor persons in need of supports and services from the Province. All of the disadvantages cited and argued above are exclusively experienced by persons with disabilities in receiving social assistance that accommodates their needs.

Conclusion regarding *prima facie* case re Beth MacLean

494. The Complainant has met her burden to show *prima facie* discrimination: i) possessing one or more protected grounds of discrimination, ii) experienced harm or adverse effects in comparison to others regarding the service in question (here, 'social assistance'), and iii) the protected characteristics were 'a factor' in the adverse impact experienced.

Re Sheila Livingstone's complaint

Moore's Step #1: Protected characteristics

495. Again, as stated in connection with Ms. MacLean's complaint, step #2 asks whether the Complainant had "meaningful access"[592] to the Province's social assistance regime intended to allow people to live in the community.

Re Sheila Livingstone's complaint

496. Ms. Livingstone's complaint dates from 2004 and ran until her death in October 2016.

497. As outlined In her Complaint, Ms. Livingstone's family was from Pictou, Nova Scotia where she lived until about the age of 12. At that point, her sister, Olga Cain testified, the family

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[592] "Meaningful access" to the service is the test imposed by the Supreme Court in *Moore*; see paras. 28, 32, 34 (where the SCC cites additional sources for the proposition), 36 and 48.

was experiencing difficulties in meeting Sheila’s need sin the home and, as a result, the Province proposed that she move to the Children's Training Centre in Truro.[593]

498. At about age 16, Sheila was transferred to the ‘Halifax Mental Hospital’ where she lived for approximately 2-3 years. From there, in October 1966, Sheila was, once again, transferred to the Abbie Lane Hospital where she lived for almost 15 years.[594]

499. In January of 1982, Ms. Livingstone was transferred to the Cole Harbour RRC where she remained until May 1986.[595]

500. In May 1986, Ms. Livingstone moved into a Small Options home managed by RRSS.[596] She lived at two different RRSS homes for 18 years (July 2004),[597] coming to an end, when she was admitted to Emerald Hall where, tragically, she remained for a decade.[598]

501. Even though Ms. Livingstone had been medically discharged within months of having lost her home as a result of her medical condition needing prolonged treatment,[599] remained on Emerald Hall for almost a decade after her medical discharge, even though she had , been found to be a person in need and met the eligibility criteria of the Province's program for accommodating people with disabilities.[600]

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[593] Testimony of Olga Cain, March 6, 2018.
[594] Book XI, Tab 8; Testimony of Jim Fagan, March 12, 2018
[595] *Ibid*
[596] *Ibid*
[597] Book XI, Tab 84, p. 8646.
[598] *Ibid*
[599] Book XI, Tab 31
[600] Testimony of Renee Lockhart-Singer, August 7, 2018

502. Sheila was considered unclassifiable by both DCS and DOH for portions of her time living in Emerald Hall.[601] The category of "unclassifiable" was deemed "no longer valid" by Ms. Hartwell in her testimony.[602]

503. At the end of January, 2014, Ms. Livingstone was 'transferred' to an Adult Residential Centre, an institution located in Yarmouth Nova Scotia.[603]

Moore's Step #2: **'the complainant experienced an adverse impact with respect to the service'**

504. Again, in the context of Ms. Livingstone's complaint, step #2 asks whether the Complainant had "meaningful access"[604] to the Province's social assistance regime intended to provide people with financial assistance to live in the community.

505. A review of Ms. Livingstone's complaint (especially, para. 77) makes clear that her claim is very similar to that made by Beth MacLean: i) year after year of **waiting** for the supports she was found to be eligible for-- amounting to a failure to provide required supports and services ii) harmful institutionalization in Emerald Hall rather than the provision of supports and services to be able to live in the community, iii) being **forced to live hundreds of kilometres from family** in order to receive the required supports in a safe environment and iv) the harms and lost opportunities of living in **institutions** (Emerald Hall and, Harbourside Lodge) rather than being able to return to a Small Option home in community as she had done for the previous 18 years.

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[601] Book XI, Tab 4, pp. 8158-61; Book XI, Tab 4, p. 57; Book XI, Tab 52, pg. 8613; Book XI, Tab 52, 8616; Book XI, Tab 57

[602] Testimony of Lynn Hartwell, August 9, 2018.

[603] Book XI, Tab 84 , p. 8646.

[604] "Meaningful access" to the service is the test imposed by the Supreme Court in *Moore*; see paras. 28, 32, 34 (where the SCC cites additional sources for the proposition), 36 and 48.

Fagan Expert Evidence

506. As with the Beth MacLean complaint, the Board has the written expert report of Jim Fagan of RRSS who was, essentially asked to answer the following question: could RRSS have supported Ms. Livingstone from the time of her admission to Emerald Hall in 2004 through to her discharge and transfer to Harbourside Lodge in Yarmouth up until her death in October 2016.[605]

507. Again, Mr. Fagan had reviewed all the relevant DCS and NS Hospital charts and met with Emerald Hall clinical treatment team. He had also met with Ms. Livingstone and staff at Harbourside Lodge in Yarmouth.[606]

508. In coming to his conclusion, Mr. Fagan was clear in explaining that, in contrast to his report on Ms. MacLean, his understanding of Ms. Livingstone's needs and RRSS' ability to meet them were informed by the 18 years of experience that had been gained in supporting her in a Small Option home.[607]

509. Counsel will not repeat the additional points regarding the Fagan report presented in the context of discussing Beth MacLean's complaint but they are equally applicable here:

   a. The Province's own admissions, no, commitment in the *Roadmap* that 'all persons can be supported to live in the community;

   b. That Mr. Fagan and RRSS more generally are held in high regard and have been relied on in the past to support people with 'very complex' behaviours and,

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[605] <u>Report of Jim Fagan re Sheila Livingstone</u>, Exhibit 29

[606] Testimony of Jim Fagan, March 12, 2018.

[607] *Ibid*

c. For reasons that may well have to do with a) immediately above, the Province has chosen not to adduce rebuttal evidence, to suggest that the Board should not accept Mr. Fagan's report.

Sheila Livingstone Medical evidence

510. It will be recalled that Ms. Livingstone experienced significant medical challenges.[608] She was, as well, ping-ponged between the Department of Community Services and Health--with neither willing to take responsibility and each proposing that the other should accommodate her needs.[609] In the end, she ended up languishing in Emerald Hall for 10 years. [610]

511. This situation, Ms. Livingstone's situation, is a textbook example of the combined effect of the 'silo effect' phenomenon that several of the witnesses discussed **and** the 'unclassifiable'' attitude or practice that Ms. Bethune's evidence clearly demonstrated--despite the efforts of Deputy Minister Hartwell to assert these practices are over or, were wrong.

512. Human rights analyses are effects-based and, therefore, attempts by one Department to blame the other, are, in the end, irrelevant to the fundamental question of what was the effect on Sheila Livingstone of the finger pointing, the moratorium or, indeed, the fact that for a four-year period, there was not a single DCS assessment done to determine whether DCS could support her in the community. On this last point, it will be regarded that at least two care coordinators testified that 'they didn't have assessments done unless they got a call from the hospital.'

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[608] Book XI, Tab 8, pages 8234 and 8235

[609] Book XI, Tab 4, pp. 8159-8161; Book XI, Tab 60

[610] Book XI, Tab 84

513. Similarly, it will be recalled that counsel for the Province asked its own Care Coordinators the following question: 'Does the fact that a DSP applicant has been medically discharged mean that DCS has to automatically accept them?' This question, presumably arose from the following wording of a DCS DSP 'Classifications and Assessments Manual" which was used between 1993 and 2010:

> THE FACT THAT A PERSON IS DISCHARGED OR ABOUT TO BE DISCHARGED FROM A HOSPITAL DOES NOT MEAN THAT THE INDIVIDUAL AUTOMATICALLY BECOMES THE RESPONSIBILITY OF THE DEPARTMENT OF COMMUNITY SERVICES OR THAT THE INDIVIDUAL SHOULD BE ACCEPTED FOR ADMISSION TO A HOME FOR SPECIAL CARE.[611] (underlining and capitalization in original)

514. It will be appreciated that, from the complainant's perspective, it was/is completely irrelevant which branch of the Respondent Province is responsible for the failure to provide the accommodation required to live in community. Indeed, this is, in part, why 'the Province' was chosen as Respondent--precisely to avoid any need to sort out inter-departmental squabbles.

Reasonable Accommodation: Placement in Yarmouth

515. It will be recalled that for the last 2.5 years of Sheila's life she lived, not near family and loved ones in the Sackville or Truro area, but a long drive away in an institution in Yarmouth.

516. To be clear, the point is the distance from loved ones. This was unacceptable to her sister and her niece (Olga Cain and Jackie McCabe) and, not in Ms. Livingstone's best interest. Ms. Cain testified that she agreed to this 'placement' as an undesirable one but the only

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[611] JEB I, Tab 4, Classifications and Assessments Manual (DCS 1993) at p. 48.

way to have her sister leave Emerald Hall where she had been subject to increasingly severe and frequent assaults by other patients.[612]

517. The Board will recall the evidence of Denise MacDonald-Billard who confirmed the unsurprising point regarding eligibility for social assistance (both during the *Social Assistance Act* era and, since, 2001, under the *Employment Support and Income Assistance Act*); general social assistance recipients were never and are not now ever asked to move to either distant or remote communities as a condition of receiving social assistance.[613]

518. For persons with disabilities, and for Sheila Livingstone in particular, that prospect has become part of the practice; one where the needs of persons and their families are deprioritized to the priority of whichever institution happens to have an open 'bed'.

519. In the same way that it would be unacceptable to direct a social assistance recipient as to where they must live in order to receive support, it is discriminatory to impose this on person with disabilities who also are in need of assistance.

Conclusion re Moore's Step #2: 'the complainant experienced an adverse impact with respect to the service'

520. As in the case of the MacLean complaint, it is submitted that several examples of elements of adverse effects/failure to accommodate Ms. Livingstone have been established--indeed are not in dispute:
    a. The fact that Ms. Livingstone waited for almost 10 years to leave Emerald Hall
    b. the fact that she was, as a result, institutionalized as a result of the Province's choice to not provide supports and services to her--indeed, the evidence is that at

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[612] See a selection of the Emerald Hall Progress Notes from 2004-2014 in which hospital staff document the assaults: JEB XI, Tab 17

[613] August 10, 2018; Testimony of Denise MacDonald-Billard, June 18, 2018

no point was any assessment made as to the cost of arranging a Small Option home setting for her.

c. The fact that for several years, the Province pointed to medical health reasons for refusing to assist her;[614]

d. The fact that the Province's decisions not to increase the capacity of community-based options meant that Sheila Livingstone was ultimately 'transferred' to Yarmouth as the only option left in order to leave Emerald Hall.

***Moore's Step #3*: 'the protected characteristic was a factor in the adverse impact'**

521. There is no need to repeat the argumentation from the argument section regarding Beth in this part of the *Moore* test. All of the disadvantages/adverse effects presented above regarding Sheila Livingstone are patently linked to her being a person with a disability. Indeed, they are inherently linked to having lived her life as a disabled person. Conversely, none of the adverse effects highlighted here would be even conceivably visited upon a non-disabled person who is reliant on Provincial assistance in order to live in the community.

Conclusion regarding *prima facie* case re Sheila Livingstone

522. The Complainant, Sheila Livingstone, has met her burden to show *prima facie* discrimination: i) possessing one or more protected grounds of discrimination, ii) experienced several serious harms or adverse effects in comparison to others regarding obtaining the service in question (here, 'social assistance'), and iii) the protected characteristics were 'a factor' in the adverse impact experienced.

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[614] JEB XI, Tab 4, pp.8160-61; Book XI, Tab 4, pg. 8161

Re Joey Delaney's complaint

Moore's Step #1: Protected characteristics

523. As with the Complaints of Beth MacLean and Sheila Livingstone, it is understood that the Province is not challenging the claim that the Complainant **Joey Delaney** had 'mental disabilities' within the meaning of the *Act*. Similarly, the Complainants have all been shown to have been 'persons in need' and, thus, in receipt of social assistance. Accordingly, this protected ground, too, is not in issue and the discrimination analysis will proceed to the second step of the *Moore* test.

Moore's Step #2: **'the complainant experienced an adverse impact with respect to the service'**

524. Again, as stated in connection with the complaints of Ms. MacLean and Ms. Livingstone, step #2 asks whether the Complainant had "meaningful access"[615] to the Province's social assistance regime intended to provide people with financial assistance to live in the community.

525. It will be recalled that Mr. Delaney was admitted to Emerald Hall in January of 2010 as a result of a deterioration of his health.[616]

526. On June 9, 2010, the Province informed his service provider that because he would need continued treatment in Emerald Hall, the service provider should no longer hold his bed for him to return.[617]

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[615] "Meaningful access" to the service is the test imposed by the Supreme Court in *Moore*; see paras. 28, 32, 34 (where the SCC cites additional sources for the proposition), 36 and 48.

[616] Book X, Tab 18

[617] See JEB X-20: "June 9, 2010 Emerald Hall Social Work notes of conversation with Murray and MacKinnon

527. In fact, within two days (i.e., on June 11, 2010618), DCS had classified Joey again. That is, DCS had determined him to be eligible for the DSP program.

528. Despite having been accepted by the Province into its DSP program, Joey Delaney languished on Emerald Hall for many years before being transferred, in 2015 to Quest where he remained until January 2017 when, due to a bowel problem, he was discharged from Quest and ended up being treated in the dual diagnosis unit of Emerald Hall.[619] Until the Small Option home which the Respondent (in January 2018) asked RRSS to arrange is ready to receive him, Joey will remain at Emerald Hall.

529. A review of Mr. Delaney's complaint (especially, para. 112) makes clear that his claim regarding adverse impacts/disadvantages is very similar to those made by Beth MacLean and Sheila Livingstone. That is, the Province's failure to accommodate his needs is evidenced in several ways: he suffered: i) year after year of **waiting** for the supports he was found to be eligible for continuously since June 2010. This was to a failure to provide required supports and services in a reasonable time frame, ii) the resulting harms of **institutionalization** in Emerald Hall, and iii) the treatment of accommodative social assistance as **a discretionary benefit not an entitlement.**

Waiting to Return to community

530. Despite the fact that the Province had accepted Joey into its Disability Supports Program on June 11, 2010, he actually began a wait in Emerald Hall that went on for about five years.

531. In addition, the evidence is also clear from the testimony of his sister and the cross-examination of the DCS Care Coordinator, Patricia Murray, that the Province made virtually no effort to re-settle Joey in the community.

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[618] See: DCS Classification Document re Joey Delaney JEB X-21 (June 11, 2010)

[619] JEB X. Tab 8, pp. 7786-7799; JEB X, Tab 53, p.8111; Testimony of Dr. Sulyman, March 14, 2018.

532. DCS had been advised that Joey's SDM, Susan Latte was anxious that Joey return to living in a Small Option home as he had done successfully for 14 years.

Institutionalization

533. As a result of this wait, the evidence is that Joey had become institutionalized.[620]

534. The harms of that phenomenon, including loss of skills, combined with the loss of opportunity to live in community result in a major loss for Joey.

Social Assistance as a discretionary benefit not an entitlement

535. Joey Delaney's case is a good example of a person with a disability who had been accepted into the Province's statutory entitlement social assistance program but this fact alone seemed to make absolutely no difference in terms of his receiving the required assistance.

536. One irony, of course, is that despite the evidence of DCS witnesses insisting on a threshold difference between classifiability (i.e., eligibility) and 'unclassifiability' (i.e., ineligibility) for its supports and services, the evidence of Mr. Delaney's experience on the waitlist is that the real difference was/is at best notional.

537. Thus, while he was classified in June 2010, nothing whatsoever happened, placement-wise, for over 4.5 years.

538. Thus, the Emerald Hall social worker, Jo-Anne Pushie wrote to DCS in November 2012 reminding the Care Coordinator of Joey having been accepted by DCS and asking about placement for Joey as "he has remained on Emerald Hall for over two years."[621]

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[620] Testimony of Dr. Sulyman, March 14, 2018.

[621] See JEB X-45, pp. 8018-19: "Letter from Pushie to Trisha Murray" (November 28, 2012)

539. In this context, the expert evidence and written report of Jim Fagan concerning Joey Delaney becomes extremely poignant.[622] That is, it becomes crystal clear with the benefit of Mr. Fagan's Report and evidence that Mr. Delaney **could** have been supported in the community since 2010. The problem, therefore, was clearly ***neither*** anything to do with Mr. Delaney's health nor the availability of a service provider which was willing to support him. Rather, it was the Province's fundamental decision to **not** create capacity for him; the decision to **not** accommodate Mr. Delaney in its provision of social assistance. What prevented this from happening?

540. For purposes of this part, an aspect of the disadvantage/adverse effect experienced by Mr. Delaney is that, despite his statutory entitlement to social assistance623 and to assistance that accommodated his needs, the Respondent Province treated his rights and interests as something that created no obligation on it. If it chose to assist Mr. Delaney this was not because of a legal obligation to do so.

Conclusion re Moore's Step #2: 'the complainant experienced an adverse impact with respect to the service'

541. Each of the 'adverse effects' discussed in **Step #2** above: i) the **Waiting**, ii) the **Institutionalization**, and iii) the treatment of accommodative social assistance as **a discretionary benefit not an entitlement,** were all experienced by Mr. Delaney in the same way as the other complainants as persons with disabilities but, as was argued, these disadvantages were **NOT** experienced by persons without disabilities or whose disabilities did not require accommodation by way of residential supports and services.

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[622] See Exhibit 28: "Report of Jim Fagan re: Joey Delaney" (dated November 10, 2017)

[623] See the case law and authorities presented above in conjunction with the Beth MacLean complaint.

Moore's Step #3: 'the protected characteristic was a factor in the adverse impact'

542. There Is no need to repeat the argumentation from the argument section regarding Ms. MacLean on this part of the *Moore* test. All of the disadvantages/adverse effects presented above regarding Joey Delaney are patently linked to him being a person with a disability. Indeed, they are inherently linked to having lived his life as a disabled person. Conversely, none of the adverse effects highlighted here would be even conceivably visited upon a non-disabled person who is reliant on Provincial assistance in order to live in the community.

Conclusion regarding Step #3 of the Moore test

543. In *Stewart* v*. Elk Valley Coal Corp.,*624 the Supreme Court confirmed that the relationship between the disadvantages suffered and the grounds of discrimination need only be that of 'a factor'.

544. Here, for the reasons cited above, it will be clear that, as in *Moore*, the adverse impacts suffered by Mr. Delaney are due, at least in part, to his being a person with a disability. In answer to the question; 'who is subject to these adverse impacts endured by Joey Delaney and others in his situation, the answer is: it is poor persons in need of supports and services from the Province. All of the disadvantages cited regarding Step #2 above, are exclusively experienced by persons with disabilities in their struggle to obtain social assistance that accommodates their needs.

Conclusion regarding *prima facie* case re Joey Delaney

545. The Complainant has met his burden to show *prima facie* discrimination: i) it is undisputed that he possesses one or more protected grounds of discrimination, ii) he experienced

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[624] *Stewart v. Elk Valley Coal Corp., 2017 SCC 30* was cited by the Complainants in their pre-hearing submissions.

disadvantages or adverse effects in comparison to others regarding the service in question (here, 'social assistance'), and iii) the protected characteristics were 'a factor' in the adverse impact experienced.

Conclusion Regarding the individual Complainants and this phase of the proceeding.

546. It is submitted that should the Board accept our submissions that the individual complainants have established a *prima facie* violation of s. 5 of the *Human Rights Act*, pursuant to the agreement of all parties and the Board, the matter should be adjourned for the phase of the proceeding related to the Province's positions vis-a-vis section 6 of the *Act*.

Systemic Discrimination: Step 1

Grounds or Characteristics

547. The relevant provisions of the *Human Rights Act* provide a very broad definition of 'disability.' Based on the evidence, the individual claimants are all individuals eligible for, or actually in receipt of social assistance from the Province, as "persons in need" under social assistance legislation.

548. As noted, the DRC's complaint is being pursued on the basis that it's priorities and goals make it an "aggrieved person" able to pursue a complaint under s, 29(1)(a) of the *Act*. The complaint proceeded before the Nova Scotia Human Rights Commissions based on a Consent Order from the NSSC that set aside the Commission's initial refusal to accept the complaint from the DRC and recognized it as an "aggrieved party." The Order provided generally that the Commission "shall accept and process complaints made by groups" without the requirement that the group itself is a victim of discrimination.[625]

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[625] Consent Order filed November 12, 2014; Enclosed herewith.

549. In the Complaint, the DRC states:

> Specifically, the DRC complains against the Respondent that from 1986 through to the present and continuing, the Respondent ("the Province") has and continues to act and/or fails to act in a manner that aggrieves the DRC with respect to the social services provided to people with disabilities because of the combined effect of their disabilities and their source of income (social assistance). (Complaint para. 128)

550. In relation to the ground, it is clear that those affected are persons with disabilities, including but not limited to intellectual disabilities, sometimes referred to in the evidence as "developmental disability" or simply mental disability. A disproportionate number of those with intellectual disability also experience some form of mental illness, estimated to be in the range of 30%, and are sometimes referred to as persons with a "dual diagnosis."[626] In addition to intellectual disability, the Board heard direct evidence from those who experience other forms of mental disability as well as physical disability.[627]

Systemic Discrimination Step 2: Adverse impact with respect to the service

551. The non-provision of "financial assistance" and related supports and services in the community to persons in need 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*.

552. The DRC alleges that all of the Respondent's actions or inactions described above demonstrate that the Respondent has failed to accommodate poor people with disabilities in its provision of social assistance and/or social services. The provision of social assistance to "persons in need" discriminates between the disabled and non-disabled by enabling the latter, but frequently not the former, to live in the community.

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[626] Testimony of Dorothy Griffiths

[627] See for instance the testimony of Richard Rector and Leslie Lowther concerning the impact of brain injury and physical disability.

This failure to accommodate the needs of persons with disabilities is a failure to take account of their differential need, i.e. a failure to account for the fact that many persons with disabilities need supports to be able to live in the community which non-disabled persons do not need. This failure to accommodate the needs of persons with disabilities violates s. 5(1)(a), (o) and/or (t) of the *Human Rights Act* on the basis of poverty (their source of income being receipt of assistance from the Province as "persons in need") and disability.

The respondent Province is responsible for the required 'services' at issue in this complaint Under s. 5(1)(a), discrimination is prohibited in the provision of 'services'

553. The "service" consists of social assistance and related supportive services for persons with disabilities, including both residential and non-residential options.

554. Currently, the Province provides the necessary supports and services for people with disabilities to live in community through its overall social assistance scheme.[628] In particular, the Province has created a Disability Supports Program as the vehicle to intended to provide social assistance in a way that accommodates the needs of 'persons in need' requiring residential supports.

555. Social assistance programs in Nova Scotia, including income assistance and services for persons with disabilities, are mandated by provincial legislation. For instance, under the *Social Assistance Act*, persons requiring residential supports, are entitled to "assistance"

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[628] Up until 2001, the *Social Assistance Act* authorized both general social assistance and the supports and services to support persons with disabilities. Since 2001, general social assistance is provided under the *Employment Support and Income Assistance Act* , S.N.S. 2000, c. 27. See also, the statement in Hansard when the Minister of Community Services introduced the change: Exhibit 59 "NS Legislature Hansard 1st session 58th Assembly Fall 2000 pages 7595-7597"

which, *per* the *Municipal Assistance Regulations* is comprehensively set out and include a wide array of required supports and services.[629]

Residential Services

556. Currently, in terms of residential options, the Province is responsible for 100% of the funding, regulation and program standards for both institutional settings (RRCs, RCFs, and ARCs) as well as community based options such as small options.

Small Options

557. Prior to 2012, small options fell outside the regulatory framework of the *Homes for Special Care Act.* Until 1995, municipally provided supports and services were regulated under the *Social Assistance Act* and Municipal Assistance Regulations and , as well, they were cost-shared with the Province.[630] However, from 1995 until now, the Province has been responsible for 100% of the funding and approval of supports and services provided by service providers in small options homes settings. Program standards have been in place for small options since the DCS approval of the 1996 Interim Standards. Prior to 1995, the Province bore the primary budgetary responsibility for small options, shared with the municipalities.

Non Residential Services

558. Since 1995, the Province has been responsible for providing non-residential programs, including assistance to families and independent living supports programs. Prior to 1995, those programs, such as they existed, were cost shared with the municipalities.

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[629] See *Municipal Assistance Regulations,* made pursuant to s. 18 of the *Social Assistance Act,* R.S.N.S. 1989, c. 432, section 1(d).

[630] In the evidence, the proportion was said to be 75% in the case of Halifax area municipalities.

559. While the DRC suggests that in the case of residential options, the respondent Province's involvement is more than simply funding, and includes regulatory oversight, it is significant that the Canadian Human Rights Tribunal has found that government funding to a service provider itself can itself constitute a service under human rights legislation.[631]

560. With respect to the Respondent's regulatory role in residential options, and the setting of program standards, the facts are analogous to cases where Nova Scotia Court of Appeal has confirmed that the Province is providing a service through the Worker Compensation Board, and the administration of a pension plan, as well as the administration and enforcement of Food Safety Regulations.[632]

561. One of the 'inappropriate' settings in which persons with disabilities have been warehoused, is the hospital. Any hospital of course is the appropriate place to receive in-patient medical care –is in order to meet medical needs. However, as the evidence in this proceeding shows, many individuals with disabilities, primarily mental disabilities and mental illness, have found themselves 'stuck' or warehoused in hospitals following a medical discharge where there are no medical reasons to be in hospital, because they have no place to go. To reiterate, this complaint is not about hospitals, however, unnecessary institutionalisation in hospital, especially acute care, or forensic psychiatric treatment facilities, does constitute an adverse impact of the Respondent's failure to provide services, in the form of social assistance, that addresses the differential needs of people with disabilities.

562. The overwhelming weight of the evidence demonstrates that the respondent Province's practices and policies have had an adverse effect on people with disabilities in their access to social services starting in 1986. The individual complainants' experiences are not

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[631] CHRT *First Nations Caring Society*, 2016 CHRT 2, p 11, 35.

[632] *Reed et al v NS* [2018] NS BOI File NO 51000-30-H16-1629, para 131, 139 administration and enforcement of Food Safety Regulations is a service, citing N.S. v *Hodder,* 1998 CanLii 5962 NSCA *(*administration of pension plan a service); *O'Quinn* v N.S.[1995] 131 DLR 4th 318 NSCA

different or separate from the systemic claim; they serve to illustrate and are emblematic of those systemic failures.

563. The adverse effects of the service itself, for those persons with disabilities who were able to access service, or in the denial or delay in receiving services, will be outlined below.

564. It is admitted that not all persons with disabilities were adversely affected, as there were some who received access to community based supports and services. In the case of Joey Delaney and Sheila Livingstone, there were periods of time outside of the periods forming the complaint when they were receiving appropriate supports in the community in their small options homes.

565. In addition, the systemic failures are those of the Province as a whole: they are not directed towards a particular government department or entity. But to the extent that the Respondent has relied exclusively upon Department of Community Services programs and services to respond to this discrimination claim, those provincial government programs, including the Community Supports for Adults Program, the Services for Persons with Disabilities Program, and the current Disability Supports Program, serve as the government's response to the needs of persons with disabilities requiring supports and services to live in the community.

566. The Respondent Province admits that all persons can be supported to live in the community. The issue before this Board of Inquiry is whether the Province's actions or inaction in 1) providing the access to a service (in the case of institutional settings) or, 2) withholding or delaying access to the service, contributed to an adverse effect on persons with disabilities in their enjoyment of the services.

567. The evidence of adverse effect can be seen in the following:

1. Institutionalization and the harms/disadvantages of institutionalization
2. Moratorium on Small Option Homes as a withdrawal of services which adversely effected persons needing community-based supports and services.
3. The impacts of waitlists and delays in receiving services
4. The provincial classification systems used in determining access to services including the group of persons with disabilities labelled as "unclassifiable".

568. Each of these adverse effects will be dealt with in turn, but the cumulative effects can be seen in the experiences of persons with disabilities many of whom may have experienced one or all of these adverse effects over the course of their lifetime.

Institutionalisation

569. There is overwhelming evidence that for at least the last 20 years, patients at the East Coast Forensic Hospital, with mental disabilities, have been detained in that institution far longer than their circumstances required because of delays and in some cases denials of community based supports and services.[633] A similar conclusion can be made of other acute care units in psychiatric hospitals such as Emerald Hall.[634] Those circumstances continue to the present day.[635]

570. In addition, given the Province's admission that all persons can be supported to live in the community, the continued institutionalisation of persons with disabilities in Nova Scotia in provincially funded and regulated, large, segregated congregate care facilities such as the Regional Rehabilitation Centres (**RRCs**), the Adult Residential Centres, and Residential Care Facilities (**RCFs**) is unnecessary and discriminatory.

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[633] Memorandum of Louise Bradley & Staff of East Coast Forensic Hospital dated (October 24, 2003) Exhibit 55

[634] VI-B-3, pp. 3714-3727, Griffiths and Stavrakaki, Dr. Sulyman testimony, VI-A-33, pp. 2923-2933, 2936-37, Putting People First

[635] Exhibit 39, Expert Report of Simon, Testimony of Patryk Simon

571. The adverse impacts of institutionalization for persons with disabilities are well documented and the Board heard evidence from a number of witnesses concerning actual harms. Such treatment results in diminished opportunities to "enjoy a full and productive life."[636]

572. The complainants have relied upon the *Olmstead* case in previous submissions.[637] In a case dealing with discrimination under the Americans with Disabilities Act, the US Supreme Court found that unnecessary institutionalisation of persons with disabilities constitutes a form of discrimination. In a case remarkably similar on its facts to the circumstances of Ms. McLean, Mr. Delaney and Ms. Livingstone, the US Supreme Court found that the claimants as voluntary patients were in fact forced to remain in hospital longer than was medically necessary because of the State's failure to provide access to the necessary supports and services in the community. Justice Ginsburg stated that:

> Recognition that unjustified institutional isolation of persons with disabilities is a form of discrimination reflects two evident judgments. First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life...Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.[638]

573. The adverse impacts of isolation and segregation on persons with disabilities in *Olmstead* is no less true of institutions in Nova Scotia. Dr. Sulyman, Dr. Theriault, Dr. Griffiths and Nicole Robinson all testified concerning similarly negative impacts in relation to family relations, social supports, and work options. Repeatedly, witnesses testified that institutions deprived persons with disabilities of choice and privacy, the chance to

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[636] NS *Human Rights Act* s 2(e)

[637] See DRC pre hearing brief dated January 15, 2018, and Reply brief dated February 2, 2018.

[638] *Olmstead, ibid,* at 2187.

develop skills, and contributed to feelings of hopelessness. In addition to the individual complainants, the Board heard testimony from other persons with disabilities and their families including Richard Rector and Leslie Lowther, who testified concerning the overwhelming negative impacts of his institutionalisation in the RRC ins Sackville over a period of nine years, likening it to the experience of being imprisoned. Brenda Hardiman echoed those same concerns in the harms her daughter experienced as a result of being unnecessarily institutionalized first in the RRC, followed by the Community Transition Program. The expert evidence underlined the negative impacts of institutionalisation on persons with disabilities.

574. In her decision in *Eaton*, an equality rights case involving access to educational supports for a child with disabilities in a regular classroom, a decision that was overturned on other grounds by the SCC, Justice Arbour examines the harm and adverse effects of segregation and exclusion:

> The history of discrimination against disabled persons, which the Charter sought to redress and prevent, is a history of exclusion….

575. Deinstitutionalization was the first step towards full community integration, which has been the primary objective of the disability movement….

> In all areas of communal life, the goal pursued by and on behalf of disabled persons in the last few decades has been integration and inclusion. In the social context, inclusion is so obviously an important factor in the acquisition of skills necessary for each of us to operate effectively as members of the group that we treat it as a given. Isolation by choice is not necessarily a disadvantage. People often choose to live on the margin of the group, for their better personal fulfilment. But forced exclusion is hardly ever considered an advantage. Indeed, as a society, we use it as a form of punishment. Exile and banishment, even without more, would be viewed by most as an extremely severe form of punishment. Imprisonment, quite apart from its component of deprivation of

> liberty, is a form of punishment by exclusion, by segregation from the mainstream.[639]

576. The analysis of the harm or adverse effect of exclusion and segregation in Eaton in remarkably similar to the reasoning of the US Supreme Court in Olmstead.

577. It is the complainants’ position that the institutionalization of persons with disabilities is discriminatory and can only be justified on the same basis as for the non-disabled – when it is necessary for health treatment. Just as for the non-disabled, institutionalisation is otherwise justifiably regarded as a form of punishment. The rationalisation in favour of providing institutional arrangements and facilities for persons with disabilities depends upon an ableist construct of “separate but equal” treatment, the rejection of which was remembered in Moore. The Province’s continued reliance on institutions as residential options for persons with disabilities, results in a society based on “mainstream” attributes where persons with disabilities are segregated and arbitrarily grouped based on their perceived “otherness” or disabilities. This form of segregation itself is a form of discrimination.

“Moratorium” as a withdrawal of services

578. The evidence is clear that from 1986 until 1995, persons with disabilities in the Halifax area had access to community based options, in the form of “small options homes.”[640] The municipal system of supports for persons with disabilities was evolving away from larger congregate settings, in favour of smaller, more natural homes. During the same period, the Province instituted the closure of all institutions for children with disabilities in the Province, a process which was completed in 1996.

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[639] *Eaton v. Brant County Board of Education*, 1995 CanLII 980 (ON CA) Arbour, JA, at para 35, 36 38-40, overturned on other grounds at *Eaton v. Brant County Board of Education*, *ibid* [1997] 1 S.C.R. 241

[640] See testimony of Bev Wicks, CarolAnn Brennan, Marty Wexler, and Carole Bethune

579. In 1995, the Province assumed full administrative and financial responsibility for social assistance from the municipalities. Shortly after the Province imposed a “moratorium” on the creation of new small option homes; effectively imposing a freeze on this service, a service that had been a key part of the municipalities response to the needs of persons with disabilities who required supports and services.[641] The freeze can be justifiably seen as a cutback or withdrawal of services to persons with disabilities—especially for persons who weren’t then already using the service. It meant that their needs for accommodative social services would have to wait. As in *Moore,* where the services for students with disabilities were cut back, this withdrawal of services had an adverse impact on persons with disabilities who could not live in the community without these services.

The impacts of waitlists and delays in receiving services

580. Prof. Frazee commented on the phenomenon of the waitlist for supports and services for persons with disabilities in her report as follows:

> What begins as a faulty characterization of human need as undue burden, repeated with every new application for support, soon becomes a ghetto -- individuals are dehumanised as numbers on list, dormant case files, and institutional *bed fillers.* The larger the group becomes, the more its framing as the site of the problem is reinforced - when likes are grouped together what makes them alike is emphasized. Individuality is lost and the ableist presumption that created the group affirms itself.[642]

581. The cap, first on the number of small options placements, soon expanded and affected both residential and non-residential programs for persons with disabilities who needed supports and services to live in the community, with the exception of those who were living with family or alternate family members. Backlogs of people waiting for small

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[641] See testimony of Bev Wicks, Carol Ann Brennan, Marty Wexler

[642] Exhibit 37, Dr. Frazee Report, pg. 5

options homes, began almost immediately.[643] Eventually, people who were waiting for services were told they could join a waitlist for services, although a centralised waitlist system was not instituted until 2010, some 15 years after the original moratorium that created the backlog. Applicants for services are actually cautioned about the significant wait times.[644]

582. According to the most recent statistics available there are currently almost 1500 people on the waitlist for DSP services.[645] Even today the waitlist system is not transparent. Where someone is on a waitlist, how many people are in front or behind, how long it will take to access services are unknown.[646] It is apparent that many people wait years to get access to services. Everyone on the waitlist is eligible and has been assessed as requiring DSP services and supports.

583. Where are people while they are waiting for access to DSP services? More than 400 people on the current waitlist are categorised as receiving no services. Ms. Bethune testified that they could be living on the streets, in a homeless shelter, in prison or some other setting. Some of those continue to be detained in the forensic hospital, with significant restrictions on their liberty, for years. The harm of being placed on waitlist is clearly evident. While a waitlist is not a denial of service, the lengthy delays, in terms of years that people wait to receive services is tantamount to a denial.

584. Even those who are receiving services may be living in vastly inappropriate settings, or with inadequate access to the supports and services they need. Some of those individuals may be in their parent's home, or living on their own in the community.

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[643] See remarks of the Minister of Community Services in Hansard concerning the likely 'backlog' that could be expected as a result of the imposition of the Moratorium. "Supplementary Documents for Joint Book of Exhibits", Tab 4(f), May 1, 1997, Hansard pagination pp. 467-470; Tab 4(c), Hansard pagination 330-332; Exhibits", Tab 4(d), May 10, 1996, Hansard pagination pp. 371-375; Tab 4(c), April 29, 1997, Hansard pagination 388-389.

[644] "Disability Support Program Policy Manual", Exhibit, section 6.1.

[645] DCS DSP Waitlist Statistics, November 27, 2017, Exhibit 45.

[646] See the evidence of DCS Care Coordinator Carole Bethune.

The provincial classification systems used in determining access to services including the class known as "unclassifiable"

585. Since 1995 the province has assumed responsibility for funding and administering programs for persons with disabilities. As part of the program for persons with disabilities, the province has maintained a system of classification/assessment that purports to fit people within an 'array' of DSP services. Since the 2001 Independent evaluation by Michael Kendrick, the Province has been aware of significant deficiencies in the classification system.[647] While the classification/assessment tool was changed in 2014, the province admits that outcomes do not ensure that people's needs are appropriately met. A classification/assessment policy which results in people being denied access to the services they need has an obvious adverse effect.

586. The other aspect of the classification/assessment tool is the category of 'unclassifiable' applicants, consisting of those persons with disabilities who are eligible but do not fit within what are currently described as the 'level of care' categories.[648] Those who fall outside the classification policy, are similar to the women who were unable to meet the aerobic capacity requirement in *Meiorin*. Both represent criteria that appear neutral on their face. In the case of the classification/assessment tool, persons with disabilities are excluded from access to services. It is submitted that at the violation stage, the classification system has an adverse impact on access to services by persons with disabilities.

587. Where are people living who are deemed to be unclassifiable or a "complex case" while they wait for access to supports and services? Ms. Bethune testified that they could be in homeless shelters, prisons, forensic institutions, psychiatric hospitals or their parent's

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[647] There have been a number of critiques of the classification system starting with the Kendrick Report, DCS Pilot Project Report, and most recently the report of John Agosta. See Kendrick Report, JEB VI-A- 9, pages 2153-55, Agosta, Exhibit 71, p4. 7; LaPierre, JEB I -1 replaced by Exhibit 78, page 3, 2nd para.

[648] In an earlier form of the classification policy, what are now "levels of care" were designated based on the care provided in certain institutional settings; i.e. RRC, ARC, RCF, Developmental Home etc.

home. Currently, they may or may not be on the DSP waitlist, according to Ms. Bethune but historically it is clear that prior to 2012, those who were 'unclassifiable' were not permitted on the DSP waitlist.[649] The harm of being labelled unclassifiable was to be denied access to supports and services. Even today, those persons with disabilities who fall outside the pale of the assessment policy are labeled as complex cases, and clearly face long delays in accessing appropriate supports and services. At its worse, the 'unclassifiable' label resulted in the nature of the disability itself serving as a basis for exclusion or denial of access to supports and services. The adverse impacts of institutionalisation as well could lead to the development of 'behaviours' that would serve to disqualify a persons with disabilities from receiving the community based supports and services that could rectify the harms of institutionalisation.

Step #3: Substantive equality and systemic discrimination; 'was the protected characteristic a factor in the adverse impact'

588. As previously established, there is no real dispute that the persons affected possess the characteristics of disability and source of income (social assistance). The Respondent has responded to the claim through evidence of the programs offered uniquely to persons with disabilities provided by the Department of Community Services.

589. Each of the individual complainant's stories, provide searing illustrations of the manner in which their protected characteristic – disability – is a factor in the adverse impacts of the Respondent's policies and practices towards persons with disabilities who require supports and services to live in the community.

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[649] Ombuds Report JEB V-1, pp. 1583, 1596, Report of Complex Case Committee 2007, Complex Committee Reports, Exhibit 66, 72, 79, JEB VII-7, JEB VIII-30, JEB VIII – 42, JEB VIII – 68, JEB VIII – 124.

590. In addressing the issue of substantive equality in this case, the Board must determine whether people with disabilities have an "equal opportunity" to others in accessing social assistance, or in the words of the statute "financial assistance," in a manner that recognises their differential need, and accommodates their disability. Principles of substantive equality have held that equality is not about treating everyone the same and that identical treatment may frequently produce discriminatory results.

591. A purposive analysis that takes into account the social and historical context of the treatment of persons with disabilities in Nova Scotia is necessary in determining whether there has been discrimination in the substantive sense. Such an approach is necessary in order to avoid perpetuating the historical disadvantages experienced by persons with disabilities. Particularly keeping in mind the history of institutionalisation, the Board must determine whether the Province's practices and policies towards persons with disabilities widen rather than narrow the gap between persons with disabilities and others in our society.

Historical pattern of institutionalisation

592. In approaching any claim of discrimination, courts and tribunals have taken care to consider the claim in its proper historical and social context. [650]

593. As the testimony and evidence of Michael Bach and Dr. Catherine Frazee demonstrates, there is a clearly demonstrable pattern of both intentional and systemic forms of discrimination over time against persons with disabilities generally and in particular individuals with intellectual disabilities. This history of discrimination is not unique to Nova Scotia.

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[650] *First Nations Child and Family Caring Society of Canada et al*. v. *Attorney General of Canada* (*for the Minister of Indian and Northern Affairs Canada*), 2016 CHRT 2

594. An important dimension of the discriminatory treatment experienced historically by persons with disabilities is their segregation in institutional settings where they were grouped with other people with disabilities, and segregated from the community at large.

595. More recently, as part of its 'transformation' process the Department of Community Service commissioned the preparation of ARC/RRC Current State Overview, which found that:

> There is a heavy reliance on facility-based care with over 1,000 Nova Scotians living in Adult Rehabilitation Centres (ARCs) and Regional Rehabilitation Centre (RRCs) as well acute care facilities and tong-term care homes. These facilities are not fully able to meet the unique and diverse needs of residents and the right services and supports are not available to support community based living for these residents.[651]

596. That pattern of institutionalisation has continued until very recent times, with the Province having invested heavily in the creation of a new institution, in the form of the Regional Rehabilitation Center (RRC) in Sackville, Nova Scotia run by the service provider "Quest" in 2008.[652] According to DCS sources, the new 24 bed RRC was designed to meet the needs of 13 clients who were in "inappropriate settings such as hospitals" as well as 11 clients from the former Halifax County RRC, who had been living 'temporarily' in Sunrise Manor, also waiting for a suitable placement.[653]

597. The picture emerges of many people with disabilities being warehoused in inappropriate settings. Instead of addressing the waitlist for community based options in the early 2000s, the government supported the creation of a further institutional setting, which itself rapidly became subject to waitlists.

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[651] JEB VI-A-67, p. 3592.

[652] Exhibit 54 (Replacing JEB VI-A-37) Stylus Quest RRC Current State Assessment Report, (September 2015), page 2

[653] JEB VII-4, pp. 4013-4014, DCS Briefing Memo Cobequid LaPierre and Colburne 2007.

598. In the *Caring Society* decision, the Canadian Human Rights Tribunal reviewed in detail the history and impact of residential schools on First Nations in determining that a link existed between inadequate funding of child welfare services, and the protected characteristic of race/national or ethnic origin. [654] It found that the inadequate funding of child welfare services perpetuated the historical disadvantages experienced by First Nations people mainly through the residential school experience.[655]

599. In the case of institutionalisation, the segregation itself forms the basis of a finding that disability was a factor in the disadvantageous treatment experienced by people with disabilities. In other words, this type of treatment is unthinkable among the non-disabled population.

600. Similarly, the moratorium and consequent waitlist, arbitrary and highly discretionary classification/assessment practices, years-long delays in accessing services, denial of services based on the label ‘unclassifiable’ are disadvantages experienced by persons with disabilities precisely because they require supports and services to live in the community. This is highlighted when we compare the treatment of persons with disabilities who are persons in need and therefore eligible for social assistance, with non- disabled ‘persons in need’.

601. These practices and policies had a disproportionate if not exclusive effect on a particular subset of persons with disabilities based on their different need for supports and services to live in the community. The evidence unequivocally establishes a sufficient link between disability and the adverse impacts in this case.

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[654] *Caring Society,* para 405

[655] *ibid,* para 44.

IV. CONCLUDING STATEMENT OF *HUMAN RIGHTS ACT* VIOLATIONS

602. The Province discriminated against the individual complainants as ’persons in need’ in its statutory and human rights obligations to provide social assistance in Nova Scotia. It did so by failing to take into account and accommodate:

   a. Beth MacLean’s needs for “financial assistance” under the *Social Assistance Act* from 2010 until January 2018;

   b. Sheila Livingstone’s needs for “financial assistance” under the *Social Assistance Act* from 2004 until her death in October 2016; and

   c. Joey Delaney’s needs for “financial assistance” under the *Social Assistance Act* from 2010 until January 2018.

603. The Province’s failure to provide assistance in a non-discriminatory manner to the individual Complainants was a violation of their rights during the above periods under sections 5(1)(a), (o) and/or (t) of the *Human Rights Act*.

604. In particular, since 1986 to the present, the following practices by the Respondent, and adverse effects experienced by the Complainants and persons with disabilities who require supports and services to live in the community, violate section 5 of the *Human Rights Act*:

   1 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*; and

   2 The impact of the Province’s practices and policies that have resulted in unreasonable wait times for persons with disabilities, including the individual complainants who require supports and services to live in the community, is *prima facie* discriminatory and a violation of section 5 of the *Human Rights Act*; and

   3 The **delay** in providing appropriate supports and services results in adverse effects not just on individuals who are unnecessarily

institutionalised such in forensic hospitals, prisons, acute care psychiatric hospitals, and long term residential facilities such as RRCs, ARCs and RCFs, but also on those who find themselves in inappropriate settings in the community, such as homelessness, homeless shelters, or inadequately supported in their own homes. These delays are *prima facie* discriminatory and a violation of section 5 of the *Human Rights Act*;

4. The Province's **failure to provide supports and services** to the Complainants and other persons with disabilities **in the community of their choice**; while limiting supports and services to locations that are at an unreasonable distance from their homes and family, friends or other loved ones is *prima facie* discriminatory; and a violation of Section 5 of the *Human Rights Act*; and

5. The **denial** of supports and services to eligible persons with disabilities based on the Province's classification/assessment tool;

6. The Province's provision of supports and services to the Complainants and other persons with disabilities on a **discretionary basis**, rather than an 'as of right' or entitlement basis is *prima facie* discriminatory and a violation of Section 5 of the *Human Rights Act*.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

DATED at Halifax, Nova Scotia, this 5th day of October, 2018

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