HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

COMMUNITY SERVICES

Thursday, April 20, 2006

Committee Room 1

Crosbie House Society, Addiction Program

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COMMUNITY SERVICES COMMITTEE

Ms. Marilyn More (Chairman)
Dr. John Hamm
Mr. Ernest Fage
Mr. Peter Christie
Mr. Jerry Pye
Mr. Gordon Gosse
Mr. Stephen McNeil
Mr. Leo Glavine
Ms. Diana Whalen

[Mr. Peter Christie was replaced by Mr. Mark Parent.]

In Attendance:
Ms. Mora Stevens
Legislative Committee Clerk

WITNESSES

<u>Crosbie House Society</u>

Mr. Perry Boyd, President

Dr. Jan Goodwin, Contract Physician

Dr. Gen Campbell, Contract Physician

Mr. George Libby, Program Director

HALIFAX, THURSDAY, APRIL 20, 2006

STANDING COMMITTEE ON COMMUNITY SERVICES

2:00 P.M.

CHAIRMAN
Ms. Marilyn More

MADAM CHAIRMAN: I now call the Standing Committee on Community Services to order for April 20, 2006. We're delighted to have representatives of the Crosbie House Society with us this afternoon. We don't often get a chance to say "this afternoon". I think we'll start by introducing the members of the committee, and then we'll ask you to introduce yourselves.

[The committee members introduced themselves.]

MADAM CHAIRMAN: I understand we'll be joined shortly by Dr. Hamm. I also want to bring regrets from Jerry Pye, the member for Dartmouth North. Jerry is on his way back from Ottawa and he's not in the province yet.

Usually we ask our presenters to give a brief overview of the information they'd like to share with us, and then we open it up to the members of the committee for one or two rounds of questions and comments.

Perry, I think you're going to do the presentation. Do you want to introduce yourself and your colleagues.

MR. PERRY BOYD: I would just like to start by thanking everybody for inviting us here, in particular Mark, who has come to some of our meetings and has been very, very supportive, and Leo.

Today we have a very brief presentation. We'll do some introductions in a minute, we'll talk about our partners and our supporters behind this operation. George will talk to Crosbie House and what we're doing today, the new and improved Crosbie House.

MADAM CHAIRMAN: Could I just suggest that you hold the mic up a little closer to your mouth, we want to make sure we record everything for Hansard.

MR. BOYD: Dr. Campbell will talk about addiction and, really, demystifying addiction. Dr. Goodwin will follow up on that to show where Crosbie House sits in the addiction continuum or, in our case, the addiction pyramid, and positioning Crosbie House in relation to the government services. We'll wind up by talking about Crosbie House and its good for Nova Scotia, Nova Scotians, Nova Scotia communities, and Nova Scotia business. Then, at the end, I think we'll open it up to discussion and opportunities, if that's acceptable to you.

Let's start with the introductions. I'll turn that over to Dr. Goodwin. Dr. Goodwin, by the way, is our spokesperson, so if you ever hear us out on the street, media things . . .

DR. JAN GOODWIN: Talking to Bill Carr. (Interruptions) Thank you, sir.

Again, just to elaborate on what Perry has said, it's a delight to be here and have this opportunity to talk to you. I'd like to introduce our esteemed group here. Sir Perry Boyd, who has extensive business background in high management across Canada, he's our business brains. Walter Newton is a very respected lawyer in the Kentville area. He's not with us today, but he is our lawyer and our legal advice. Dr. Gen Campbell, to my right, is a family physician at the Woodlawn Clinic, where I also work as one of her colleagues. She also has a special competency, she has her certificate of competency in addiction medicine through the American and the Canadian boards, so she has a very special expertise.

Myself, I'm a family physician at Woodlawn Medical Clinic full-time. I also wear the hat of coordinator of the professional support program of Nova Scotia, which is a confidential program for physicians and residents, dentists and veterinarians, having problems with addiction, stress, depression, financial issues, family issues, et cetera.

Ray Beaudoin, who is not able to be here today, is our graphics expert. He has designed our Web site, he's our Web master, and he's also one of our business advisers. He has his business down in the Valley, as well.

Not leaving last, the most important guy here in some ways is George Libby, who is our program director. He will speak to our program down at Crosbie House. The house is now a beautiful spot down in New Minas.

MR. BOYD: Behind us are our partners and supporters. These are the people we've approached. We're not professional fundraisers, we never purported to be. When you go to banks and say you're a society, and you're lucky to get a cup of coffee. Business development monies are really not available to non-profit entities.

Over the last two and a half, three years, on a volunteer basis, we made about 35 or 40 presentations. We approach these various organizations and we talk about addiction in the workplace. It's a very serious issue, it's not confined to Nova Scotia. We looked at productivity of the addicted employee, we looked at absenteeism rates, we looked at quality issues in the workplace, work accidents, extended health care costs. We looked at theft in the workplace; one-third of people addicted to drugs, prescription or illegal, will steal at some point in time from their employers.

Also, addiction is a human rights issue. These companies and organizations have a duty to accommodate. If they fail that accommodation, they will have unjust dismissal suits which they will lose and it will be very expensive. It will generate grievances and it will generate arbitrations, which they will lose.

By partnering with us, they now have an option to give their employees. We are partnered with Crosbie House Society, we will have somebody here this afternoon to do an assessment with our occupational health people. It is a substantive offer, and if they come and they are successful, the company gets back productive, grateful employees and family - hopefully get the family back - because one of the things we point out is addiction, when it becomes obvious in the workplace, it has usually been there about 10 years, so they want abstinence-based addiction treatment.

[2:15 p.m.]

So, for them, it's a very persuasive argument. Their return on investment is less than 30 days. We go through all the calculations. The Auditor General in Ontario puts that number at 565 per cent in terms of total return investment with all numbers included. I have never gone through that, but very simply, an employee costs you $150 a day and he's out sick because of an addiction, he may end up on disability, you have to replace him at $150 a day, when we look at our cost at $6,500, it is a very, very attractive investment.

Many of these companies are sending their employees to out-of-province treatment facilities. The Ontario programs are costing around $22,000. I know the Department of National Defence, who we've worked with over the last three years - we had a commitment and all the players changed- but I know they're sending everyone to British Columbia now at $30,000 each.

DR. GEN CAMPBELL: There's no local after-care.

MR. BOYD: These people will talk about our very extensive after-care network and how we've positioned ourselves - very much customer/client orientated, we will actually do our assessments right in their premises. We get the phone call, we'll be there, we'll work with your occupational and human resource people. So they are tremendous people to work with, they understand addiction.

At that point, we'll move on to George Libby, and our mission, what we're doing.

MR. GEORGE LIBBY: Thank you, Perry. Our mission was to take the Crosbie House, it was in operation in Kentville for 24 years and did a great job - and make it better. One of the things that we've done to make it better is make it more available to people. Within 48 hours of the time somebody phones, we will see the client, whether it is at our place or their place. It doesn't matter. We will set up a pre-treatment agreement. If they need detox, we will send them; if they need to see a financial counsellor because of gambling debts, we will arrange that. In the meantime, they will have a contact person - somebody whom we know has years of sobriety - to lean on, to meet with, to have coffee with and to go to an AA, GA, or NA meeting. When they're ready, we will take them on program.

It is an abstinence-based, 12-step program; that is, abstinence from all chemicals. At the end of the program and during the whole course of the program, we work toward an after-care network. I like the word "network"because it means a number of different people in their life. Firstly, they will have a contact person whom we know will meet with them at least once every week for the next two years. We will phone them every two weeks. We have a little questionnaire we've developed. If we detect a problem, we bring them back and try to resolve that problem. We will report to the referring agent with the proper documentation, three, six and 12 months down the road. We feel if they do it on a mandatory basis for the first two years, they will do it because they want to after that. Abstinence is the answer.

We've been blessed with about 162 people, from every walk of life you can imagine, throughout this province and across Canada. Wherever they come from, we can arrange a contact person. That is the program.

MADAM CHAIRMAN: Thank you. Dr. Campbell.

DR. CAMPBELL: I think it is very important that we understand that addiction - not overuse, but addiction - is a disease. The American Society of Addiction Medicine newsletter from January/ February 2006, that is right now, announced the locations of one of the genes which is causative in alcoholism. They can look at children of alcoholics, find out whether their gene is the alcoholic side or the non-alcoholic side and predict their future problems with alcohol.

What the genetic disorder seems to be is twofold. One is a decrease in the ability to feel pleasure. It looks like addicts - alcohol, gambling, drug addicts - have an inability to feel the good stuff in life, so when they're exposed to something that floods their good stuff receptors, perhaps for the first time in their lives, whether that be a VLT or "a 40 of rye", or whether it be a hit of acid, they experience pleasure for the first time. For them this is a significant learning, and their brain takes that on, learns it and associates the relief of discomfort - the joy of a Spring day, anything - with the kind of pleasure that they got from this substance or process. This is a learning that bypasses the intellect, so once started with a drink or a drug the individual is out of control, seeking more and more and more, looking for this hit.

The other abnormality, and is the one where the gene was just discovered - on chromosome 10, by the way - is that these folks seem to be low- responders to the negative effects of alcohol. That means they don't have the funny head, they don't have the dysarthria, they don't have the swaying, except at a high level of use. So they actually have a ticket to use - they can use more, for longer, without the negative effects.

Addicts, therefore, require abstinence as the first step in recovery. To initiate use at a social level activates that learning that they have made, which bypasses the thinking brain and starts the whole cycle again. It's also required to know that addiction is a disease because, for years, they have been using and beating on themselves, and beating on themselves predisposes to using again. They feel awful, so they use. They get stuck in a vicious cycle. So they need the education to know that addiction is a disease. The third thing they need is they need a new source for positives in their lives. Perhaps a spiritual outlet, perhaps a sense of helping others, certainly the support of other people who are in the same situation as they are, on a daily basis, to remind them that they have a disorder. This, unfortunately, cannot happen in a cut-down program.

MR. BOYD: Dr. Goodwin is going to position Crosbie House in relation to the general population and the services that are out there now.

DR. GOODWIN: Thanks, Perry. I think that the addiction pyramid is a good way to explain where we fit in the whole model of addiction care. I think it's important for us all to recognize, as Dr. Campbell has said, that this is a disease, that these people cannot get this to stop despite whatever intellect they have, and there are a lot of very bright, very successful people who struggle with addiction and do well when they get into recovery. I think that it's important that we recognize there's more than one way to treat addiction, just as there's more than one way to treat or more than one drug to treat hypertension or diabetes, there are different approaches, and this really ties it all together.

Approximately 50 per cent of the population are social users of whatever. They can go out for dinner, have a glass or two of wine, that's the end of the story. They may go to a casino, say let's spend $20. They spend their $20 and out they go - no issue. About 30 per cent to 40 per cent of the population are getting into problem behaviour,

and that varies with the definition. If you've already started using a bit of cocaine, which is an illegal substance, you've got a big problem, regardless of whether you're using it once a week or every day of the week, you've got a big problem. You're involved with illegal issues, not only the medical issues, but the legal issues as well.

People who are into problem use can benefit a great deal from a harm reduction model of care. In those programs and, of course, here we have the core program with drug dependency, we have Middleton - you are very familiar with them all, I'm sure - those people can learn to cut back. They can learn to understand what the potential is if they continue to escalate their use and if, for example, they have the genetic component which Dr. Campbell has alluded to, they can learn that maybe they need to rethink their whole use completely. Maybe they can't cut down, maybe they should look at stopping. So education is a tremendous component of those harm reduction models of care.

There are some tremendous programs as well, weekend workshops on women's health and addiction, on gambling specific to those entities. Another example would be kids, young teenagers who are starting to use marijuana, which everybody thinks is so innocuous. Basically, we consider it a gateway drug. So people start on that and then they kind of think, well, that's kind of fun but there has to be something else that gives me a better buzz. Let's try a bit of cocaine, let's try a little bit of ecstasy. Someone at one of the addiction medicine conferences referred to marijuana as the cheap drug that gives you the dumb high. Those kids can learn that maybe I've got a problem, maybe I better pay attention here. So those programs are excellent programs.

The people we are concerned about and are part of this continuum- and I stress again continuum of care because, again, we have different treatment models for different levels of need - are the, at least, 10 per cent to 15 per cent. This is 7 per cent to 10 per cent. It's actually higher than that. If you attend any of the addiction medicine conferences, some of them will talk about 15 per cent to 18 per cent of the general population have what we call addictive use. They can't make that stop. They're at a VLT machine, the dopamine receptors are loaded and firing. They are just into that machine - it's the lights, it's the sounds. It's not going to the ATM machine to get more money to play the VLT, they have to keep that machine going, it's the dopamine that's flooding their receptors in their brain. Those people cannot learn to cut down.

I can't tell someone in my practice, either with professional support or in my office in Woodlawn, you have to just limit your use, you cannot use more than $20, because that VLT user, if they're an addict, will intend to spend only $20, but that's not where it will end. We know the stories -if you want some personal stories, we have lots of them here. The same thing with someone who's an alcoholic, an addict - they can't just have one glass of beer or one glass of wine, because even though that's what they intend to do, because of how their brain responds - she has discussed that for you - that's not where it's going to go for those people.

Those are the people we are worried sick about, and that's why we've worked so hard for the last three years to get a program for those people. Those people will not do well in a harm reduction program. We know that alcoholism and other addictions, if not treated, are fatal. These people die in car accidents, they die in suicides, they die in overdoses, they die of heart disease, strokes, GI bleeds - they occupy a lot of our hospital beds, and sometimes for extended periods of time. We're talking about a major problem here.

These are the people we say have crossed the pickle line - we have some Valley people here, from agricultural country, and the analogy is if I take a cucumber and I pickle it, there's a chemical change that has occurred within that cucumber and I cannot turn that pickle now into a cucumber. There's a chemical change within that structure in the same way someone who is an addict has had a chemical change in their brain. I cannot get those people back over that line. Those people, as Gen has said, need abstinence. Those people may die if they try to reduce their use. They have to learn they cannot use and they cannot risk using anything that they might become cross-addicted to.

So if I have an alcoholic, they need to also understand you cannot be using benzodiazepine because they work in the same site in the brain, they work on the gabba receptors. So we get the same response with benzos, the Valium, the Ativans, clonzapine, as we do with alcohol. They need to learn that they have a disease, and they need to learn that they can live in recovery and live really happily without any of those drugs in their system.

That's where we are coming on board here. We take these people, and we'll talk about sort of who we're currently bringing in. We've had a few people go through. They are so hungry for information and for help. I'm going to read you just one thank you that we got.

[2:30 p.m.]

MR. BOYD: Jan just picked a letter up last night.

DR. GOODWIN: It's a thank you from a young woman who just went through Crosbie House in New Minas a few weeks ago. I think that her thank you kind of says it all. It's dated April 7, 2006.

"Dear Everyone,

> It is difficult to find the proper words to Thank You all - You have saved my life, all of our lives. I never truly believed I would ever kick my unhealthy habits, it just seemed out of reach. However, when I arrived, I was scared I wouldn't make it through without screwing up, but because of your unflinching support and your non-judgemental ways, I

discovered the truth. I am a person, I count and people do care. I will never forget any of you, you've all helped give me back my life, heart & soul . . .

P.S. Nothing tops the feeling of freedom! I have that freedom now."

That's the new life without the drugs that she's talking about.

Again, we are part of the continuum of care. Abstinence isn't for everyone, not everybody needs it. Harm reduction will not work for certain people. It's the people at the top of this pyramid that we feel we need to reach. I'm getting tired of having to send people out of province, at $22,000 for one month, to Homewood or Bellwood, where they also don't have their family support. Those are excellent programs, the same model of care as we have. I'm tired of sending them away. They come back and they say so, what do I do now? It was a fantastic program, but now what do I do?

Crosbie is here; it's an hour's drive from Halifax; it's reachable for anybody from Nova Scotia. We're also getting some calls from out of the province and from the States. The big thing is, as we've talked about, that after-care support. Recovery doesn't mean you go through 28 days and you get a pin and a certificate and now you're done - it's the start of a new beginning. Recovery is a lifelong process. We are a big part of that continuum of care.

Thanks. Sorry I got carried away.

MR. BOYD: You can put your toonie in the pot.

Just a summary of the benefits for Nova Scotia that Crosbie House brings with it, and I think this has become obvious. Families, careers and lives are saved. Crosbie House results were, as Dr. Campbell likes to say, the gold standard. Simplified, three out of four people who went through Crosbie stayed abstinent after a year.

Our target is going to be 100 per cent, but it is a tremendous program. It supports Nova Scotia industries' competitive position - industry has told us, we need you, we want healthy employees who are going to show up for work on a regular basis with all their faculties and give us a good day's work.

It keeps treatment dollars in Nova Scotia. Dr. Goodwin talked about people going down the road, and there are a lot of them. On the flip side of that, we're getting calls from outside the province to bring money into the province because there aren't too many abstinence-based treatment centres within Atlantic Canada. There's the potential for bringing revenue in.

New job creation. These are not seasonal jobs, these are year-round, sustainable jobs in a rural community. They're incremental, they're new, they're replacing

anything. There are health care savings, there are a lot of very direct and some are indirect. The direct savings are if people are paying us, they aren't going to the government programs. The other side of it is, where they don't have anywhere to go, they end up in hospital beds and psych wards and multiple trips to detox. If they go through Crosbie and they find abstinence in a program and a new life, there are significant savings because we know hospitals cost about $800 to $1,000 a day.

DR. CAMPBELL: Could I add a couple of steps to that. I think one of the most important ones is 80 per cent of children in foster homes come from families where addiction was a factor in placement in a foster home. We're talking about huge social money and the lives of children here as well as the lives of the addicts themselves.

The other is, a third of the hospital in-patient stays are related directly or indirectly to the ravages of addiction - whether it's on the liver or on the esophagus or on the guy who beat him up or on the motor vehicle accident. One-third of hospital stays can be traced back to addiction.

MR. BOYD: This is where we open it. We are a new venture, we're not officially open. We are taking people in, it's word of mouth. We're waiting for our developmental agreement with Kings County to be finalized, which it will. Kings County has been very supportive. We will probably have a grand opening this Summer.

However, what we have now, the dilemma we have, we have paying customers coming in, putting up the $6,500 and we will have and have had industry signing people at $6,500 - we have spare beds right now. We have people coming in and what I would like to do is open it up to the opportunities that you may be able to avail yourselves of in terms of Crosbie. We know out there that there are people who have gone through the government programs and have not been successful. We'd like an opportunity to treat those people because we don't want them back in detox and we don't want them in the graveyard or the hospitals.

The second opportunity would be there are long-term care facilities out there, such as the Marguerite Centre and Alcare. Excellent places. If the director deems that somebody would benefit from a 28-day program and possibly reduce their stay in that long-term care facility because many stay for six months and a year. I've been to both places and know the people there, that there's a significant return on investment there. Also, in the psychiatric wards. Physicians are telling us there are people with gambling addictions, they're suicidal, whatever, and we can treat the primary addiction.

Those are the types of opportunities we would like. What that does for us, number one, it gives us more of a predictable cash flow - that's the business side because we know it's going to take 12 to 18 months to ramp this thing up. It gives us diversity of people within the program, which is very important for the program because when you're in the program, you're unique and suddenly you find somebody of a different sex, different ethnic background with a different addiction telling your

story. Suddenly, that addiction becomes much clearer and that's all part of the recovery process. It helps from a program standpoint, and it helps from a financial standpoint. From a government standpoint, try us, there's no investment in you people, there's no investment in bricks and mortar, and if you don't like it, withdraw it. So we're saying give it a shot.

Now those are just some of our ideas how we can treat more Nova Scotians in need today. At that point, I think we're over our time. We appreciate your attention.

MADAM CHAIRMAN: Thank you very much. That was quite fascinating, actually. I'm sure there are lots of questions.

Mr. Parent.

MR. MARK PARENT: It has been a long journey, and I'm delighted to see you here, delighted that things are going forward. I thank Leo for the support he has given in this important venture. If I were a regular member of the committee I would be wanting to make a motion that we write to the Department of Health that they support this. Perhaps a regular member could make it.

I have a couple of questions. When the old Crosbie Centre was being phased out, the health authority at that time, what I kept getting back was harm reduction, harm reduction, harm reduction, as it seemed the only method of treatment for addiction that they thought, or the best method. I hear something different from the doctors who are here this afternoon, that harm reduction is good for a certain population, total abstinence is the model for another population base.

Is harm reduction the model that's being used across our addiction centres in the province, or do we have a menu of options that we can offer the people who suffer from addictions?

DR. CAMPBELL: In the province, at the moment, the philosophy is harm reduction. You can look at the brochures and you can see it written, you can interview, or, as Jan and I did, we went to Middleton and talked to the director and the area director. Understandably, with limited funds and a large population to treat, the middle portion of that triangle is the largest population portion. So if you can turn that group around, you're doing the most bang for your buck.

What we're looking at is a smaller population who kind of got left because of limited funds and the need to treat the larger group, the group they could do the most with, with the least funds. I think you'll find that the philosophy of the entire government-based service at this point is harm reduction.

MR. BOYD: Just one point there, I know in addiction services they do abstinence-based counselling for those people they know are addicts. The environment

they're in - and I can speak from first-hand experience - if you're addicted and somebody gives you safe- drinking guidelines, you're in denial, and it's an opportunity you do not want to put in front of the addict, just like responsible gambling guidelines. Excellent things to have, but once you've established that that person has crossed the line into addiction, that option should not be anywhere, it should not be on the table, and should not be in that treatment environment.

DR. CAMPBELL: Let me just add one more thing, which is, I do some work with drug dependency services. It's good work. They're a good group of people. There are counsellors there who have been there for years, through many, many directors and many, many philosophies, who understand abstinence is required. It's in the long-term programs and in the programming where the harm reduction philosophy seems to be the main philosophy. Sorry to interrupt.

MR. LIBBY: I have a problem as a professional, because when somebody comes to me with a problem of a use of chemicals or a process, I don't know where that pickle line is. If I were to even hint at the possibility that they could use safely and I'm wrong, they could lose a family, we could kill somebody on the highway, and so as a professional, when somebody has a problem serious enough to come to me, I have to assume that they're addicted and preach absence all the way.

DR. GOODWIN: What's the worst thing that happens?

MR. LIBBY: What is the worst thing that can happen if he buys my message and I'm wrong? He misses a party. It's better than killing somebody on the highway.

MR. PARENT: It's good to hear this because, you know, it's very frustrating - and George knows some of the frustrations I had, because it seemed that they bought into just the one model and, clearly, from our presentation there are various models that are needed. One of them is abstinence. The other thing about the abstinence model that I always saw as one of the benefits was its strong interrelationship with the community, with former addicts - well, with people who were recovering addicts, I guess, would be the more appropriate term, who were then support, and you've built that into the new Crosbie Centre in a very unique way it sounds like.

MR. LIBBY: You know, Mr. Parent, I worked at Crosbie House in Kentville for 24 years before it moved. I used to hear, all the time, people from the community referring to the Crosbie House as their program, it was owned by the community. I don't hear that anymore and I want that back. I want the people in New Minas to feel that this is theirs. We've even offered free services to anybody in New Minas who wants to come and talk to us about addiction in their family - or their own - at no cost to them whatsoever. We want it to belong to the community.

MR. PARENT: In terms of the new sort of addictive needs - you mentioned it in conversation beforehand, George, when we were chatting about gambling addiction

- crystal meth is a problem. One of the counsellors, who first alerted me to the problem that our society was having with gambling addiction and the effect it was having on people, has now come to me and said there's another addiction out there - and that's pornography - and that we're just seeing the tip of it with child pornography as a very powerful addiction. Any comments on that?

[2:45 p.m.]

MR. LIBBY: No, I haven't had any approaches by anybody about that yet, but it's coming.

MR. PARENT: And so we've got a growing addictive problem in society, a growing number of people suffering from various addictions?

MR. LIBBY: I feel the ones who are not being looked at right now are the people who chose to go on methadone - they're very costly by the way - there is no method in this province whatsoever to get people off methadone and live a life free of chemicals. I have one right now whose doctor, over a period of about three years, has been convincing him that it's time to wean off methadone and I've taken him on program. What a delightful man. This is a man who worked in the same job since 1982; he's a professional, and he's within a hair's width of losing that job, losing his wife and two daughters, and very possibly being involved with the law - I thank God he's with us right now.

Gambling is the other one. There's a lady from Yarmouth who came to me. Her husband and her stepdaughter and stepson in the last four years have all died, and the only thing keeping her alive right now is a 15-year-old son. She's involved with gambling and alcohol. She hasn't the money to come to treatment - it's hard to say I can't take you.

MR. PARENT: Well, I'm glad you're there because we criminalize these addictive problems, which are really diseases, and make them worse oftentimes, as you say. One question in terms of the new improved Crosbie Centre that I know I struggled with - and I raised it with the board when I met with you - was the whole public-private partnership has so much potential and certainly that's, as you listed, Perry, the businesses that see the economic benefit and yet, of course, we know that it also has a lot of public controversy surrounding it.

You're a non-profit society or a (Interruption) A non-profit society.

MR. LIBBY: A charity.

MR. PARENT: A charity, okay, contracting with private companies that then pay for their individuals to take the treatment? Is this a new model that has the potential

of being replicated, or is it just the way we had to go in order to get the Crosbie Centre up and running again?

MR. BOYD: I think what we did, and part of it was intentional and part of it was unintentional, I think we put four people at this table and threw in Walter Newton and whatever, and these ideas came forward and we said, when you, the government, closed Crosbie Centre - and we accept those things, I'm not going to go out and fight it. We have benefited from Crosbie House, and my personal opinion, something like this is like squeezing a balloon, and something is going to pop up somewhere else - that's us.

We looked at it and we said how can we position this to have value added? We weren't out just for charitable donations. How can we make this value added? How can we make the program better? If you look at our mission statement it says, "The Clients and the Treatment of the Addiction Always come First." Everybody in that program knows that, and George reinforces that. If a client comes to you and says I want to talk to you, Mr. Libby, George is not going to say I have a telephone call. He's not going to say I have a meeting, and he's not going to say I'm leaving for the day. The client comes first. Our target is 100 per cent.

So we took very much a customer service approach. Yes, George said to me, Perry, what happens if somebody phones from Sydney and they have a problem with an employee? I said we get on a plane, George, and we go, because he's in need. We will service your requirements, working with your occupational health people, your EAP people, your human resource people, your labour relations people.

Our next step. This is something very tangible that business says we need badly to stay competitive. Our next step in that is, Dr. Campbell has put together an excellent in-house orientation program. We've been to these businesses. We've been on the shop floors, but now we're going into something structured and we're going to talk to supervisors and employees and managers and say this is addiction, because supervisors - I used to have 1,200 employees in my last job and, trust me, supervisors do not like dealing with addiction. Sometimes it's, you're fired, and suddenly there are grievances and arbitration cases. So we're there to help them understand addiction and help them understand Crosbie House, and we're partnered with you and we're there to help, and don't be afraid of confronting an employee on addiction.

Taking that over there, we said, this is a nice niche to have, because our personal agenda is that we just want to see this program work for more people. We didn't want to see it die. Now that we're opening, we're saying we know for the first 18 months we will have some spare beds. We have people phoning. It's killing us because we know that it is progressive, it's terminal. We have the dilemma on one side putting paying and non-paying people in the same facility, but there are special- needs people out there who call it closer to the end of the line than others. You have to remember, all of us are on ground zero. We work with these people, we know these people, we work with

Alcare and Marguerite Centre and whatever, and they have needs for 28-day abstinence-based treatment, and maybe we can shorten the stay of somebody. The reintegration period will be shortened if they have the 28-day program. That benefits the government, that benefits us.

Gambling is a big issue. We would like to take a crack at that. Somebody in a psychiatric ward who has attempted suicide, send them to us. We have some unique abilities there and we're going to be building that as we go along.

MR. PARENT: That would be the gist of a motion I would make but I think Leo is probably going to work on it. One of the problems - and I'll use the example from education, we have Landmark East in Wolfville. There was, with legislation, that if the school board could not service a particular student that they would pay for the cost to the person going to Landmark East. So the legislation was there, but it was never used. They would say there was no student they couldn't service. Part of that was financial, because the full cost would have to be borne. It was very expensive at Landmark East. Part of that was simply, as a professional educator you never want to say I cannot treat this person. I think that may be part of the problem that one will be facing with the public system and your non-profit society.

How to get around that, I guess, is a difficult sort of thing, but a challenge that hopefully we can knit together so that the two can work co-operatively with each other, which is I know what your goal is. So I just want to mention challenges that I know you already are well aware of. I'm just excited you're here. I have to leave early, so I wanted to get my questions in. So all the best.

MR. LIBBY: There is a lady who has come to me and said that she wanted to start a fund for those people who couldn't afford.

MR. PARENT: A foundation?

MR. LIBBY: Yes, and what we thought, maybe trustees of that fund, and how somebody gets the money when they come through the door doesn't matter to me as long as they have the money. We have a guy right now, very limited in funds. He's there. He paid what he could. I really believe that he's so motivated that he will, when he gets his feet on the ground, finish paying for his treatment. I think everybody who comes should pay something.

MR. BOYD: The exception that we made in that case was just somebody seriously in need, and George and I talked about it, we took an amount and said if you can pay us that, we'll give you a loan. If you do not find recovery, it's a forgivable loan. If you do find recovery, we expect that money back. We will never chase him. It was a special- needs case and a very serious one. It's not something we want to make a habit of, but there are opportunities to do that. I don't like getting into means tests, you know.

DR. GOODWIN: I go down on Tuesday afternoons and do the doc talk for an hour with the clients and what a privilege that is to be part of, but this individual has had a job making about $75,000 a year. He got to the point where he was living in his car up North - known as the town bum, as you would refer to - and said that he didn't put money in the car to buy gasoline so he could turn on the heat because that would take money away from his drug purchases. So that tells you the depth of despair that people can get to, and I feel, as you do, this person, he's just lapping it up. He wants to get better, and he will. He will return that.

I think that it has to be said, and I'm going to say it, we talk about two-tier health care and, obviously, that's part of our concern here, is are we representing two-tier health care? The reality, Dr. Campbell and I, on the front lines in our offices already deal with two-tier health care every day. We deal with patients who either have access to physiotherapy privately, or through the hospital system. Would you say, Gen, it wouldn't be an exaggeration, most of the time if they go through the hospital system, unless they've had an acute fractured leg, by the time they get there for their care, their problem is resolved?

DR. CAMPBELL: One way or the other, yes.

DR. GOODWIN: Exactly, exactly. So we have struggled with this issue of two tier versus one tier. The flip way to look at that is, at the present time, because of what we have said about the need for a second form of care for people who are addicts where harm reduction is not going to work for those people, at the present time we don't really have the first tier of care for those people. So you can argue on either side, are we two tier, are we one tier? The bottom line is people are dying.

MR. BOYD: I think, technically, too, we don't have a hospital affiliation, we're not physician based, so it does not fall under the health care Act.

DR. CAMPBELL: There are a number of ways to interact. One is with the Drug Dependency Services counsellors who may find that a client of theirs would benefit from abstinence-based treatment. Another one, currently there is a psychiatrist who makes the determination who needs out-of-province care. Addictionists working with a psychiatrist might be more able to say who might benefit from an abstinence-based treatment. So there are a number of ways to work with this.

MR. BOYD: We recognize that residential addiction treatment is very expensive. We just feel that being private, not-for-profit, is an opportunity for all of us to treat some of the sickest people. Personally, everything I've looked at, the return on investment for the government is significant. Obviously, it's going to save lives and I think it's an option that should be open to those special needs Nova Scotians.

Your commitment is - you're not investing any more in salaries or bricks and mortar - join with us, we'll give it our best shot with you and, if you don't like it, walk

away. Give us some coaching, but we will be successful. It's a new operation, it will take us 12 to 18 months to get going. We'd like to see you there, we have a long partner list and it would be really nice to be able to say, and show, that we have government participation.

This has been really all party and when you look at the diversity of industries that we have here, we're all lining up - addiction is addiction is addiction. I mean, if you walk into the Catholic diocese or you walk into Michelin - same issues.

DR. GOODWIN: Or you walk into the Millbrook First Nations Band Council.

MR. BOYD: We walked into the First Nations and George was hugging everybody. They thought this was great, we got in front of their board and we were preaching to the converted.

MADAM CHAIRMAN: I have more questioners but, before we continue - Mark, I appreciate that you have to leave a little early - I think I would like to suggest that we stick to our regular practice of having motions later in the meeting, so we get as much information out on the table as possible and we've clarified exactly where we want to go as a committee. Thank you.

I have Leo and then Stephen.

[3:00 p.m.]

MR. LEO GLAVINE: Thank you for coming in today. Certainly, a very familiar group, for me, presenting today and I just want to go back very quickly to where my involvement started. I believe it may have been within the first four weeks of my being an MLA back in August, 2003. Mr. Libby called me up and asked if I would like to come for a coffee, he had a story to tell me, he had a journey he was about to embark on and was there some way I could help out. Just to cut it short, it has been quite a journey and I applaud each of you for the stick-to-it-iveness that you have had to get to where you are today.

That being said, there are a few pieces around government inaction in supporting you and I think it's time to put those cards on the table. You've alluded to this and presented this very well today, but there are many people - certainly I think right across the way in our Department of Health - who perhaps see you as being in competition with the current program. I just want to put this out for you - I know the answer, but I would like your clarification in terms of do you see an extension of what exists right now and what is that very clear role that you want Crosbie House to play?

DR. GOODWIN: I think if Perry wants to put the pyramid up again - as I've said before, we are part of the continuum of care so we are a complement to the programs that are already there that are doing very good work, that are effective for a

certain percentage of the population, but we are the complement that finishes, that kind of completes that pyramid. We are not in competition - there are enough people out there with addictions, nobody needs to compete. We need everybody.

MR. GLAVINE: I just want that to be so clear.

MR. BOYD: I think the outcomes that they will show will be, have stopped their use or reduced their use, and that's a consolidated figure. We have three measures and they're very, very simple: One, are you abstinent? Two, were you satisfied with the program? - and our target there is 99 per cent. Three, are you following a program?

If we have those three things in place, we are successful, we're all successful. We know the relationship with your grandmother will improve, we don't ask those other questions. There are some stats that we have here to show how it works.

MR. LIBBY: I think it should be noted too, Leo, that I have invited Mr. Morton, who runs a program in Kentville and has been to the centre, and we have agreed to co-operate fully with each other as far as what they do and what we do.

DR. CAMPBELL: Both Dr. Goodwin and I visited the facility in Middleton and spoke to John, the head nurse, and to Mr. Morton, who were most hospitable to us, and certainly their program is an excellent program, it just falls at a different place on the continuum of the pyramid and, certainly, we can work together, absolutely.

MR. GLAVINE: Thank you very much for that. Realizing and recognizing and very much aware of Crosbie House history and its importance to addiction services in the province and well beyond, George, are you currently the only continuity with the Crosbie House of the past and with the new Crosbie House?

MR. LIBBY: Definitely not.

MR. GLAVINE: Okay, there are others as well?

MR. LIBBY: When this first started, various people said would you give us back the program. I was so fortunate to have the staff who didn't go to Middleton, most ready. Now, most of us are grey-haired here, on pension, but we are passionate, and part of our mandate is not only to get this thing up and running but to train people to do it the way it was done all those years in Crosbie House.

I have Brian Hernon, who is a clinical therapist with many, many degrees, who worked at Crosbie House in Kentville. He's with us. Reg Brown is with me. He worked for many, many years in all aspects - detox, 28 day, and after care. Dennis Conway is a gift. He's a Newfie and he's a delightful person. All together, we have over 100 years of treating alcoholics, on staff. We've added some pretty special people. I have a chef whom everybody absolutely adores. I have a lady who used to work at Marguerite

Centre. She's so talented. She's a person who is capable of moving up the chain when one of us retires. So, yes, we have a wonderful staff.

MR. GLAVINE: I wasn't so much wanting to establish that, I was pretty well aware of that, but it is good that you did say it for all the MLAs and the committee today to bring us that. What I was really wondering, George, at any point along the way were you given an explanation as to why government, why the Department of Health, was no longer prepared to support the 28-day program?

MR. LIBBY: No.

MR. GLAVINE: You were just left stonewalled, in other words?

MR. LIBBY: Yes.

MR. GLAVINE: Yes, and there's no question about its need so, therefore, it was just basically dropped?

MR. LIBBY: Yes.

MR. GLAVINE: At the present time - I know you have only been operating a few weeks, a matter of weeks, but just for the record - have you had anybody come to you wanting to engage in a 28-day program who had already tried to be helped through the harm reduction program?

MR. LIBBY: Yes.

MR. GLAVINE: Gosh, this is sounding like an inquiry. So, in other words, what you have already stated is the reality that there is going to be a percentage that only such a program, if successful, is going to take them from perhaps death or some type of life trauma, obviously?

MR. LIBBY: I have contacted outpatient departments right across this province to let them know that we're back, and the reception we get is unbelievable. Thank God you're back, is what a lot of the people in the outpatient department are saying.

DR. CAMPBELL: That's the outpatient department of Addiction Prevention and Treatment Services.

MR. LIBBY: Yes, throughout the province.

MR. GLAVINE: So in many ways you could provide one of those real gaps that has been missing, and that is a program that we have been sending Nova Scotians for out of the province. Do you have any idea how many would be going out of the

province? Have you gathered any of those statistics, because I think, cost wise, the province should be knocking on your door?

MR. LIBBY: It's difficult for me - maybe through the Department of Health you can find it - but there are other people going out of the province. For instance, some of the Aboriginals are telling me that it cost an awful lot of money to send these people off to some treatment centre away from the province. The Catholic Diocese in Halifax has been sending people from their organization to the States for treatment. So to give you a number of the people who are being sent out would be impossible, but I know it's happening and it's happening often.

DR. CAMPBELL: I, as coordinator of the Physician Support Program, before Jan was coordinator, sent doctors, dentists and veterinarians out of province. Jan, I'm assuming that you continue that practice?

DR. GOODWIN: Yes, we've done the same.

DR. CAMPBELL: People who required abstinence-based treatment.

MR. BOYD: I know that I had a situation back in the 1990s where I applied to go out of province and it was turned down, so I took out my own money and went to Ontario and, again, it was after-care. It was a good program - don't get me wrong - I came back and ended up in Crosbie and it was a wonderful program, but I think it's hard to quantify all the people who are going out, but I know as a matter of course many of these companies are sending people for out of province. Government, very rightly, is reluctant to send people out of province because of the sheer cost - I mean that's just being responsible, but at the same time it's a high-risk venture to say no in some cases, and it's quite a lengthy bureaucratic process to get there.

MR. GLAVINE: So will the province then be offering that full measure of psychiatric services that are an important part of the whole therapeutic program, and so on, that is offered?

MR. LIBBY: Spiritual and psychiatric. Dr. Mulhall, Head of Psychiatry Services in the Valley would love to work with us and has accepted any consults that we want to send his way, sure.

MR. GLAVINE: I will stop there. My colleague may want to go further.

MADAM CHAIRMAN: Thank you very much, Leo.

Stephen.

MR. STEPHEN MCNEIL: Thank you, Madam Chairman, and thank you for the presentation.

You guys seem so surprised that George got all those hugs on the First Nations in Cape Breton. (Laughter) I can't expect a community where he would not get those hugs in the Valley. I'm sure, for many years, he has been the face that families who have been able to survive their addictions, that they have attached to him. So I bet there are lots of hugs still out there for you, George.

DR. GOODWIN: It's a huggy place.

MR. MCNEIL: Yes. What would be the capacity of the new Crosbie Centre?

MR. LIBBY: We have seven beds right now and we have the ability to put another one in, and we will take up to four day patients - so 12.

DR. CAMPBELL: Two rotate on a weekly basis, so it's a graduated program.

MR. MCNEIL: You had mentioned the 48-hour period, that you would be in contact with someone within a 48-hour period?

MR. LIBBY: Within 48 hours.

MR. MCNEIL: Right, and it's also stated here that you're not a detox centre?

MR. LIBBY: That's right.

MR. MCNEIL: So if somebody contacts you within that 48-hour period and you realize they need a detox centre, how easy is it to get someone in for treatment?

MR. LIBBY: It's not the easiest thing in the world, but if you're persistent and you do some phoning around - and we have a number of volunteers who would transport if necessary - if you call around the various treatment detoxes, you can usually find one within a period of time. We had a gentleman from Sydney who needed help, he couldn't get in, and we got him into South Shore. He spent time there and then he came to us afterwards. So it's not easy. That's one of the enhancements that we wanted to make for our 28-day program, to be there for them. For instance, Middleton right now, if the program is full you wait until it's not full, where we want to be open-ended, people coming every week and leaving every week, so we can be there for our partners.

MR. MCNEIL: If I were to contact you within that 48-hour period and you were to send me to - let's say you're fortunate enough to find a facility that would take me and I do my five- or seven- day program, however long it takes, and they release me and I'm unable to pay the $6,500, what happens to me?

MR. LIBBY: Well, we never turn anybody away. I may not be able to take you on program, but I will make available our after-care network. I'll give you a sober

contact person. I will take a look at what your needs are as an after- care and we'll give you as much support as we possibly can.

MR. MCNEIL: Through the Crosbie Centre, what is available for the spouses and children of a person suffering from addictions?

MR. LIBBY: Right now we're collecting the names of the families of the people who have gone through. We'll include supervisors from the various partners that we have. As soon as we get enough people, we'll run a family workshop, a two-day workshop. Brian Hernon, our clinical therapist, is already setting that program up. We have, I think, five different volunteers from the community. A family for instance, a man and his wife and daughter, it's an awesome presentation they make on what it is like to live with addiction and then live with recovery. That program is pretty well set up. The United Church in New Minas, which is across the road, has offered their space to run that, so we're ready to go as soon as we get the number of bodies.

MR. BOYD: We've got the space. We got the AA and NA . . .

MR. LIBBY: We have tremendous support from AA, NA, Al-Anon, the GA. They come in and make presentations.

MR. MCNEIL: How many people that you would see, or that you've seen before, do you think suffer from multiple addictions?

MR. LIBBY: Most of them. When I started in 1978, it was mostly "a pure alcoholic, 40 to 50 years old and male," and today it is multiple addiction, from any walk of life, male or female, young and old.

MR. MCNEIL: You had mentioned about a test that could be taken to see if you carried the gene?

DR. CAMPBELL: That's research. I've been looking at it since I got the ASAM bulletin about the gene and that's being done on a research level, to prove that indeed that is a gene, taking children of alcoholics and children of non-alcoholics and checking the DNA, and then watching them as they progress through life. So at this point it is a research tool only.

MR. MCNEIL: And it's showing that . . .

[3:15 p.m.]

DR. CAMPBELL: It's statistically significant, yes.

MR. MCNEIL: Leo had talked a little bit about a percentage - and maybe this is an unfair question for you - how many people do you think are in our correctional facilities because of an addiction?

MR. LIBBY: A few years ago, Judge Kimball came up and gave a talk to our ex-patient group and he said that, in a very quick review of the people he had faced, over 75 per cent of them were there, directly or indirectly, because of alcohol or drugs.

MR. MCNEIL: Do we provide them any treatment, do you know, when they're incarcerated?

DR. GOODWIN: It's AA that goes into the institutions and does presentations, programs, yes.

DR. CAMPBELL: We used to have people come out when they were ready for day parole and go into 28-day, and that would be a wonderful area to be able to offer that service.

MR. LIBBY: Some of the prosecutors in the Kentville area have come forward and said what they would like to do is make a donation to us, in lieu of fines, for anybody who would normally be fined for alcohol or drug problems.

MR. MCNEIL: I represent the riding of Annapolis, which has the Middleton facility you're talking about, and it is a wonderful facility. The problem with it - and the big challenge for us as government people - is you look at it and this one size fits all just doesn't work with addictions. I also have in my constituency the Rob White Recovery Centre, which the justice system and judges are saying, this person shouldn't be going to the correctional facility, we should be releasing him to the Rob White Recovery House for recovering from addictions, and we're saying, as government, we're going to treat you as a boarding house, we're not going to treat you as a recovery centre. So on both sides - as government one part of us is saying yes, we believe that to be the case, and another part is saying no, it isn't. So there is no money following with those people.

The real challenge and the thing that you face - and it is very much the same as you're facing - is those clients are at the end of the road. The system did not work. It will not work for them; they need that intensive treatment. To go in and ask someone, do you think you have a drinking problem? No, I don't. Then your treatment is over. For some people, you just cannot touch alcohol, or you cannot be in front of a VLT. The real challenge - there are times in this profession when you have powerful moments, when you have loved ones sitting in front of you looking for an answer and you just cannot provide it. It seems like we just can't be responsive at times, and this being one of them. I know you have a solution here, but you're going to cover a very small percentage of them; there is a huge percentage who also need that treatment that the Rob White Recovery Centre may cover.

Just as each one of us sitting around this table is different, so is the addiction different for each person. The addiction may be the same, but when it is with another person, it's different, and how you recover from it. Their home situation is different, and it's a challenge. If we don't adapt to the idea that the pigeon hole won't work, it needs to be much broader than that or we're going to fail an awful lot of people. It is at a frustrating point when you're sitting there saying - and you're the last line of defence, quite frankly.

DR. GOODWIN: I think, too, when we look at the economic issues, as we say, there isn't enough money to provide the care that each of these facilities has the potential to provide. If we look at the greater picture, if we invested that money and helped those people get out of that cycle of criminal behaviour and repeat offending and back in the prison, whatever, in the long run we would be much further ahead as a society. We're getting into philosophical.

MR. MCNEIL: You are also getting into a point where, you know, money should not - unfortunately it always is, and it is a challenge to governments - money's always a front-line issue. There are certain issues, this being one, domestic abuse is another, quite frankly, money should not be the first reason. It has to be considered, obviously, but it can't be the first line of why you don't provide that support. There's a human need of each of us, there is a human part of each of us that needs to respond. We are treating them, and it's wonderful to hear the fact that there is something for families, because we are treating the person with the addiction, but there are many, many people who love that individual who suffer from that addiction who don't get the treatment they need because we have not responded properly.

MR. LIBBY: I'll share something very quickly with you. Talk about responding to the needs. A father called me after his son completed our program in mid-April and wanted to meet with me. The only time he had was Sunday afternoon, so I met with him. I got a beautiful card - thank you for saving my son's life. I spent probably two and a half hours with his mom and dad at Crosbie House and set them up with contact people, also family members who had also gone through this same mess, they're going to meetings just as well as their son is. So here you have a whole family recovering together, and not still continuing to fight.

MR. MCNEIL: Those of us who are fortunate enough not to suffer from an addiction should take in a meeting once in awhile.

MR. LIBBY: Nobody knows the value of sobriety until you lose it.

MR. MCNEIL: I've had the good fortune of going to them as a support. You leave with hope, quite frankly. (Interruption) I know where they're at, when you follow a loved one around you know where they're at, trust me.

MR. LIBBY: I have some pictures of the new Crosbie House here, before and after. We did some rough calculations and it looks like about $200,000 worth of volunteer work from recovering people who put this together.

MR. MCNEIL: It's interesting, as you were making your presentation you were talking about something replaces it, whether it be the need to help somebody else, as each of us have been exposed to somebody who has an addiction, you see those characteristics show up in people once they have the ability to try to find that recovery. You can see that in their everyday life.

DR. CAMPBELL: I just wanted to respond to something you said. I think going through Crosbie House, one of the most wonderful things, as a physician, is learning from a street person, or a convict, or a fisherman. They experience the same thing coming back they share with the physician, they are the same, they suffer from the same disease. That's a huge recovery for every one of those people, be it someone who has been in prison, or someone who has been through the third grade or somebody who has had 12 years post-grad education, to learn that we are all the same, we suffer from the same thing, and we can recover together. You support me, I'll support him.

MR. BOYD: Very powerful.

DR. CAMPBELL: That is found at the Crosbie House. Diversity . . .

MR. BOYD: Diversity within the group.

DR. CAMPBELL: . . . is terribly important.

MR. MCNEIL: Thank you very much for coming in. I've had the good fortune of seeing your presentation before, and you are providing hope to people who desperately are seeking it. So thank you very much.

MADAM CHAIRMAN: Thank you, Stephen.

Diana.

MS. DIANA WHALEN: One of the things going through my mind, and I'm hearing your message today that you have eight beds and they're not all filled and we need to work together to fully utilize the skills and the staff that you have available, the program that you've developed that's so successful. I know it will soon - as you say, you have 12 to 18 months at which time you expect that you'll be fully utilized. I am looking at your figures and it says 8,000 addicts. I think that's just gambling addicts. We haven't talked about - that was in one of your things.

So we have thousands and thousands of Nova Scotians, one in 10 have an addiction, is that what I'm reading? Here we have a program that's needed by so many,

and I'm feeling like we need at least two Crosbie Houses somewhere, and I know you've all worked like mad. (Interruption)

Not yet, because we're not full. I mean, you have worked so hard to get one up and running. It strikes me that with that demand you should be swamped. You shouldn't be worrying at all about filling eight beds. You will be swamped, I'm certain.

As Stephen said, a lot of the time, sure, almost every family has had experience with addiction within our own families. I am thinking back to a sibling of mine. The impact on family is extremely difficult. I know parents are desperate to find some help for children. It's bad enough when it's an adult who is perhaps the decision maker, but what about parents who are trying to help children. I can't imagine that there aren't hundreds of them right here in Nova Scotia who are looking for help.

So the cost is obviously a big concern. It was a little unclear how we were talking about the public/private. I guess my question, too, are you 100 per cent private and you can't take people in other than trying to make some arrangements with people for future financing?

MR. LIBBY: Yes.

MS. WHALEN: Is that an obligation you have to your other partners?

DR. CAMPBELL: We have had no choice except to set it up that way.

MS. WHALEN: So, again, your previous model was a government-funded centre, and the ideal thing, would you agree, is a blended model?

MR. BOYD: We would like the opportunity to treat some of those people. It just means, for us, the money should be transparent, it's coming from somewhere else for special- needs situations, and that's the opportunity. I think it's an opportunity for gambling addicts, special-care people, the people in the psych wards, people on current care facilities. Remember, we said the sickest people, the population may be that big, but we have to start somewhere and that's where Crosbie House is very effective.

DR. GOODWIN: I was going to say that the other thing we want to discuss is how we want to approach it and, as Gen says, we were forced to kind of go this route. Yes, it would be nice to have several Crosbie Houses down the road, but we started here and we've kept that passion for the last three years. I think the other issue is keeping autonomy with the program, so what decisions are made about the program, about who comes in, et cetera, are not controlled by some external force or body. We have an accountable professional board, and several of us are on that. So there's a transparency, as Perry was saying, and an accountability, and we want to maintain that. We don't want to sort of get lost in the other issues that can distract from our goal and our purpose, which is, the client comes first.

MR. BOYD: Just to follow up on that, we may be private but our meetings are open. Leo has come to our meetings. If anybody in this room said, look, I would like to show up at one of your meetings, you're more than welcome. We have no secrets and for us it's the collective effort.

DR. GOODWIN: The other thing that we've been surprised with so far is several of the clients who have come through have paid privately and they have not really had much objection to it. They have said, please, my son needs this treatment, we've tried everything else; or please, I need this, yes, I'll pay, can I pay it in two payments, or whatever. That surprised us. Only one of our clients so far has come through one of our partners, which is Michelin. The others have all been doing it privately and it's all through word of mouth because, right now, until we're officially rezoned, we can't advertise.

MR. BOYD: The partner side of it, what happens there is right now Michelin will say, well, you need to go for addiction treatment, we know you have a problem. He goes and he gets detoxed, and he sits at home waiting to get into a program. He might do some counselling and, suddenly, one day, he thinks he's cured and he comes back to the workplace, because he hasn't been using that period of time. We know he will relapse, he has no programs, no skills, he doesn't have the foundation. Now, what does Michelin do? They have to go through that whole progressive discipline and they start all over again and they have a high-risk employee back in their workplace. So they want to be able to, with us, say you have an issue, we have a partner, it works and to be able to send him to us.

DR. GOODWIN: Or, say you have a police officer in HRM - we've done a presentation to HRM and they have prepaid treatment modules - if you have a police officer who's down because of his addiction, the sooner you can get him into appropriate care, the better. He's back in recovery, the benefits are multi.

MS. WHALEN: I think the economic benefit is without a doubt unquestionable. It's going to be very valuable. We've talked a lot here at the Legislature and in these committees about the need for employees, our skill shortages, the importance of making opportunity for all Nova Scotians. If they're prevented from working because of addictions, then that's something we need to address and help the companies that are also relying on the workforce. It's a good partnership.

[3:30 p.m.]

MR. LIBBY: On the 5th of the month, supervisors from HRM will visit the Crosbie House. It's already set up for them to come down and see the place.

MS. WHALEN: So there would be thousands everywhere. I'm wondering again about young people, because they have different social needs and whatnot, how

do they fit in if you're talking about teenagers or very young adults? You mentioned you have all ages and stages, I wonder if they need something special or if they fit in.

MR. LIBBY: Personally, I don't believe in specialized programs. Addiction is addiction is addiction. We all have something to bring to the table, and it's really unique to see relationships between different members of the group - young people and old people, for instance.

For the young person to feel accepted by an adult is a big, big, big thing, instead of being a kid all the time. The after-care part of it may definitely need to be specialized. There are women's issues you may have to deal with in the after-care, but a 28-day program for addiction, we treat everybody together and don't specialize.

MR. BOYD: Youth is a component of that.

MR. LIBBY: It's beautiful to see a young person come in and just start to blossom, to be accepted and not treated as a kid anymore. It's nice to see that senior citizen who thinks their life is over and all of a sudden a relationship develops with a young person like that, the stories, it's just gorgeous to see that. It's very powerful.

MS. WHALEN: So you're telling me the intergenerational aspect of it is actually positive and not a problem for young people.

MR. LIBBY: We celebrate the sameness of men and women instead of separating them and saying you're different.

MS. WHALEN: Just one question now, finally, on domestic violence that we touched on briefly, there was a figure I read recently saying that women who were involved with drugs and alcohol statistically had a much higher chance of being murdered - involved in domestic violence and they actually said even a higher chance of murder. We've seen cases here in Nova Scotia very recently where that's the case. I'm wondering if domestic violence is often an issue around the families you're helping, and maybe if you have any suggestions that go beyond your borders.

MR. LIBBY: Yes. We try to deal with those issues. We try to set up after-care that helps deal with both issues. Yes, it is always something you have to look for when you get people in - child abuse and domestic violence.

MS. WHALEN: I know so many of these things are linked, it's very complex. I will say I'm very supportive, and thrilled that you're operating again.

I wonder if you would like to tell us about the zoning issue. You mentioned that you're not allowed to advertise, so, in effect, you can't really get the word out to the extent you'd like to until you have your zoning issue solved.

MR. LIBBY: About a year ago, we started working with Kings County Council to rezone to an institutional; right now, it's R2. We found out you couldn't do that in New Minas. So it was necessary to enter into a development agreement. The bylaws in New Minas didn't quite fit for a development agreement. So we've gone through the process of changing the bylaws. There was a mistake made. In fact, I talked to Warden Whalen, just yesterday and he said if they have a problem tell them to call me. Right now what we're doing is utilizing the space. We are zoned R2. We are allowed to bring people in and rent a room to them. He said, you do what you have to do because it's our mistake, you should have been up and operating at least two months ago. On the 27th of this month, next Thursday, hopefully, will be the final - they're having an emergency meeting after a public meeting and they will courier the passed legislation to Halifax for final approval.

MS. WHALEN: So it's within days.

MR. LIBBY: Within days, yes.

MS. WHALEN: Okay, that's good to hear. I didn't want to think that was going to go on. Thank you.

MR. LIBBY: I should say the support that we're getting from the council is just awesome, and the planning department has been just wonderful.

MS. WHALEN: That's good to hear.

DR. GOODWIN: We've done public presentations in New Minas and in Kentville with just overwhelming support. It's nice to see.

MS. WHALEN: Good.

MADAM CHAIRMAN: Thank you, Diana. I just want to say we have three people left on round one of questioning and, if there is time, Leo would like to start round two.

Dr. Hamm.

DR. JOHN HAMM: Thank you for being here. I was interested in your comment about the changing face of addiction, because I watched that over my lifetime, and it certainly has changed. The 28-day program, with which I am most familiar, is the one that started a number of years ago in Monastery, which is a slightly different model but achieved some results, and I witnessed some of those results. Outside of yourselves today, how many 28-day programs are available?

MR. LIBBY: Jim Stewart from Recovery House, I work with him a lot. I like the staff down there, they're good people. We are the only one, Dr. Hamm, that is operating a 28-day abstinence-based program with a strong after-care.

DR. GOODWIN: So, what does Recovery House run?

MR. LIBBY: Recovery House runs a 28-day abstinence-based program, but they really don't have the recovery, the facilities that we have to refer people on to the community. The network isn't there. We developed that network over 24 years.

DR. HAMM: You mentioned drugs, alcohol and gambling. The gambling is perhaps the latest addition to the three. Are you getting a handle on how you deal with gambling addictions? I know you made a very correct observation that it's hard to find a gambling addict who doesn't have other addictions. You probably haven't met one yet. Are you getting a handle in terms of the specific approach to gambling addiction and how that treatment is different from the treatment of somebody with an alcohol or drug addiction without the gambling addiction?

MR. LIBBY: It is very interesting that you asked that question, because if you looked at the DSM, the diagnostic manual in mental health, and if you looked at the criteria for diagnosing substance abuse or gambling, you would be stunned at the similarities between the two lists. They're almost identical. Our approach is to treat them as addicted people, share that, because when you get two people sharing, as Perry Boyd told you a few moments ago, one is a gambler, one is an alcoholic, all of a sudden the gambler is telling the alcoholic story and you're sitting in the same room, gee, you've been there too. Lying, hiding their booze or hiding money, all the issues are there, so we treat them as addicted people. After-care is a little different. Right now we have a difficult situation in trying to find good GA meetings, and we are positioning ourselves in New Minas to set up a really good GA meeting, hopefully, that will expand out.

Luckily, most of the people are dually addicted and we can convince them to use Alcoholics Anonymous or Narcotics Anonymous, and they do that.

MR. BOYD: Right now, just to put it in perspective, there are 74 AA meetings in Halifax a week. There are four GA meetings a week, which is pretty sad considering what we think the need is. So George has taken the initiative to - put it this way, facilitate opening up some more meetings in the Valley area and I think that will be very, very positive.

One other element - Dr. Goodwin and I were in a seminar by Bellwood, and some interesting dynamics on gambling addiction that were terrifying actually to watch, and the fact that denial is very much a part of the disease in that suddenly you have that win - I mean, what's everybody talking about, I don't have an issue, you know, and the wins prolong the addiction and keeps feeding the denial and the person

keeps on betting and the lies get worse and worse and worse. I think what she told us was they have to do a daily honesty inventory and then they leave the facility and, unlike the alcoholic or the drug addict, physically there are no changes.

With a lot of people in our society today, you come out of a treatment centre and they say good for you, we're proud of you, that type of thing, and they tend not to do that with the gambling addict, because they're $50,000 in debt. They have probably lied to a lot of their friends; they owe a lot of money to a lot of people; they're $50,000 in debt and they have maxed out all their credit cards - it's a really tough road for those people to climb back up.

DR. GOODWIN: Yes, one of the points that Pat Bell made, who runs the gambling program there, coordinates it, was that the difference between the other addictions - and certainly an addiction is an addiction - and with the gamblers is, one, that they lose hope when they come into recovery, because now they don't have that chance to win back what they've lost and, secondly, their suicide risk is 20 times the average population and, comparably, alcoholics have six times the risk. So they often present an acute crisis, a suicide attempt. They are the silent addiction - nobody has smelled anything on them, and family is often completely unaware of what has gone on until they have lost a lot. So they're all the same, but their approach is a little different in terms of the after-care, as George is saying.

The other thing that was interesting is in Toronto they have a couple of GA meetings, and some people long time in recovery from gambling, near the Bellwood facility, and one of the things that they address quickly with those clients coming is do you owe any money to any loan sharks - because it's extremely common that they've gotten to that depth, that they're in trouble with underworld kind of characters. So there are some subtle differences, but addiction is addiction.

MR. LIBBY: We talk about abstinence. Sometimes you'll get people who have never had a substance problem in their life and they get involved with the VLTs. If we don't preach abstinence - in other words, if we allow them to continue using alcohol, guess where they use alcohol, and guess what's right there? The VLTs. So they have to live a life totally free of alcohol and not go to places where the VLTs are.

DR. HAMM: A quick question, and this could relate back to the old Crosbie House, what was the recidivist rate?

MR. LIBBY: Low. Over the years I could probably count on my hands the number of people who went through the 28-day program the second time. Not that relapse isn't there, but often if relapse is used properly - in other words you get somebody back into detox, and I remember a policeman from town who said he had an awful problem after he left the 28-day program. He got back into detox, when he came to see me, I put him in a detox unit. He said, I guess my tool kit fell off the car on the

way back to Halifax, I thought I was cured. It was just everything that we told him would happen did. So it was a very valuable part of his recovery process.

MR. BOYD: He's an EAP coordinator today.

MR. LIBBY: Yes, he is.

MADAM CHAIRMAN: Gordie.

MR. GORDON GOSSE: Again I say thank you for coming in today. As I'm living on the other end of the province, in Cape Breton, I was not too familiar with the actual Crosbie solution until I read the handout that was given to us before we came here, but I do remember the closing of the 28-day program, because it did happen in Cape Breton and I'm just wondering maybe your opinion on the 28-day program versus the day program that's now offered?

MR. LIBBY: In many, many cases you need to remove the individual from their present lifestyle because they're being judged by families, they're being judged by employers, they're being judged by the community, as addicted people. There's no opportunity as a day program to really reflect on, I have a disease and I'm a worthwhile human being, to deal with the guilt and shame that they're already feeling. Residential takes them away from that area and gives them a chance to sit down and really reflect on who they are and where they're heading from here. Some people can benefit greatly from day programs, but the majority of the ones I have dealt with really need the residential.

MR. GOSSE: Have there been any stats since the 28-day programs have been shut down and the day programs are now offered by the DHAs, are there any statistics available to the committee or anybody?

DR. CAMPBELL: Yes, there are statistics. However, they're all less or no use. There are no statistics for abstinence as opposed to decrease. They're all lumped into one. So it's very difficult to compare those statistics with the statistics that came out of Crosbie originally which were based on abstinence.

MR. BOYD: We have a pamphlet somewhere.

DR. GOODWIN: But the statistics that were run recently, as Gen says, by Drug Dependency, the bar graphs are showing either less use or no use, you cannot lump those together. You either are pregnant or you're not pregnant. You either are not drinking and abstinent or you're not. So we found it difficult to sort of find that very scientific, because you can't lump the two things together.

[3:45 p.m.]

MR. GOSSE: Also, an interesting statistic that you said earlier - and I'm going to finish up early - is that 80 per cent of children in foster care come from addicted parents or guardians?

DR. CAMPBELL: Yes, that's a U.S. statistic and it's from Hazelden.

MR. GOSSE: A U.S. statistic, okay.

MR. LIBBY: I can tell you from personal experience because when I retired from Crosbie earlier, I started my own little business and I dealt a lot with Children and Family Services. It is so sad that most of the people working in that field know nothing about addictions and they're dealing with kids who have been taken away from addicted parents. For instance, a worker saying to an addicted person, I want you to sign this piece of paper saying you will never drink again, but not offering them any option, or treatment, it's a sad situation.

MR. GOSSE: So were any of these children ever tested within care for fetal alcohol syndrome?

MR. LIBBY: Our statistics are worse than that. Our statistics tell us that there's an 86 per cent chance because this is a family disease and those kids are already addicted and waiting for their first drink.

MR. GOSSE: Again, I say thank you for coming in. It was a nice presentation and I've learned a bit.

MADAM CHAIRMAN: Thank you, Gordie. We didn't plan this, but actually my questions - oh, that was a good bridge into my topic. You've mentioned several times the Department of Health and I'm wondering if you've had any discussions with the Department of Community Services because it appears to me, after hearing more details about your program, that there are a lot of clients of the Department of Community Services who would really benefit from the 28-day program and the follow-up care in the community.

I was going to mention, as well, the parents of children who eventually end up in the foster care system because I would think - and I think the department would agree with me - that the first sort of line of defence is to support the parents who are giving care in the first place to be able to do that in a more effective manner and, obviously, if one of the parents has an addiction problem - we now realize it's more of a disease - then intervention at that level, in the most successful way possible, would certainly benefit the children, keep them out of the child welfare system, be in their best interests, and save the government considerable money.

The other area where I'm thinking Community Services would benefit is the hard-to-house emergency shelters. I mean they spend considerable money and I don't remember the figure, but I'm suspecting it's like $100 to $150 a day for Pendleton Place and some of those others when we know that a number of the residents in the emergency shelters suffer from addictions and mental health problems.

I'm also thinking of the low-income people, people getting social assistance. If they have addictions, how do they possibly access programs they need? I'm sure when Leo comes up, I know he probably has a motion, but I'm not entirely clear from what I've heard today what you're asking of the Department of Health. Is it to actually refer people who would benefit from your program to you and cover their costs and, if that's so, are you also looking at the Department of Community Services? I'm sure there's an equal number of people who are clients of that department who would definitely benefit from the program that you're offering.

MR. BOYD: What we're saying is we have a very targeted program to deal with the sickest people. We are willing to open our doors in partnership or participation, call it what you want. Use us to meet your needs and establish a process. We will welcome these people with open arms because our position is that we just want to save lives. It will enhance our program. One of the things we've talked about is that there should be some sort of clearing agency through some sort of an assessment by an addictionist.

DR. CAMPBELL: In conjunction with psychiatry.

MR. BOYD: In conjunction with psychiatry. We do our own assessment at intake to make sure the person sincerely wants to pursue abstinence. People can use you for varying reasons, but George and his staff are very good at identifying those people who really want recovery.

So what we're saying is we have the beds, process will definitely be a medical assessment, maybe by an addictionologist and a psychiatrist, and feed it into us. Give us a year, some funding for a year, eighteen months, to take those types of people, and if you don't like us - or we will build on that. Sit down and do an evaluation - hopefully it won't be an autopsy - but sit down and do an evaluation at that point in time, because this may be an opportunity for something bigger. You will not have invested any money in new salaries bringing on indeterminate staff, no more bricks and mortar. Basically, we provide that service.

MADAM CHAIRMAN: So you're suggesting for those who would benefit, any department of the government could refer one of their clients to you as an option for either health or social reasons. I assume you have asked and this has not been forthcoming.

MR. LIBBY: We did meet with social services. We did meet with the Minister of Health and made a presentation.

DR. GOODWIN: The previous minister.

MR. LIBBY: The previous Minister of Health, and we got no response. We didn't get a yes or a no. So we just left it at that, especially when we start hearing the industry said, where have you been? Michelin Tire said where have you been, and gave us $35,000, and they didn't know us. We're just a bunch of people with an idea. Well, they knew us from reputation and working before. It just expanded from there, and so that's why we positioned ourselves there.

MR. BOYD: We went to a very similar proposal. We went to the Gaming Foundation and we made a proposal, and I have the documentation here. It was non-productive. The people who sat on that board - and I'm not throwing any stones, all I know is I put an awful lot of time into that. They refused to see us. The people who did the evaluation were the same people who closed Crosbie Centre. We just left it and said we're not going back.

Marie Mullally came to us - she is somebody who understands addiction - and said we want you to go back. We hired a Ph.D. student who knows about addiction, had done some work for Addiction Services, and a freelance journalist who was also in communications with the Buchanan Government. We produced about a 300- page document. We handed that in, it was non-productive. That was a counterproductive exercise, because we invested money and we invested time. We're not here to complain and bitch about that, we just get on with it. The mandate changed and things got fuzzy, and whatever - I do know that we put a very professional presentation together.

So we're here today to say something similar. Help us be successful, because we know we can help people with serious addictions out there. The process being, all we ask for is that we do our own assessment, and we're suggesting that on your side there is an assessment by an addictionist and psychiatrist, either-or. For us, it would be wonderful for our program, and we think we can give you tremendous return on investment, and you're helping a group that is creating jobs and putting new salaries in, will be injecting $0.5 million, up to $1 million worth, into the local economy. I think it's a win-win for everybody.

MADAM CHAIRMAN: So you're proven in terms of the programming that you're using, you're proven in terms of the personnel you're working with, you're getting at the root cause rather than just treating, again and again, the symptoms, it's cost effective - and the door is still being closed in your faces.

DR. GOODWIN: I think we could say that we would certainly be receptive to meeting with the Progressive Conservative caucus perhaps, and possibly with the Minister of Health - there has been a change there - to look at that again. We didn't

have an opportunity when the presentation was made to Mr. MacIsaac. There was a limited number of people who could be present. There were two of them, and one of them has kind of backed away into the background right now. We, as a group, did not have an opportunity to do this type of presentation to him and, certainly, we would be interested and willing to visit that again if that was felt to be appropriate.

MADAM CHAIRMAN: Leo.

MR. GLAVINE: I guess with the time being very short - there's no question, today we have heard, once again, a very compelling story from Crosbie House of what you have accomplished in the past and what you will go on to accomplish now. I would like to say that I hope all of us on this committee would like to remove some of the doubt about some of the challenges of going forward and jeopardize the future of Crosbie House.

With that, I would like to make a motion that the provincial government and Crosbie House meet to work out financial support and a system of encouraging patients to go to Crosbie House rather than out of province for the next 18 months, to give you that hand up to move forward.

MADAM CHAIRMAN: Is there a seconder?

MR. MCNEIL: I'll second that.

MADAM CHAIRMAN: Is there any discussion? Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

We're running a little behind, but I would like to give you two or three minutes to just sum up, if there's anything else you want us to know before you leave.

MR. BOYD: I think everybody has said it has been an amazing - we've run into so many obstacles, every one has made us stronger, and we've met some wonderful people in our travels, and we've learned a lot. Our motivation - we're all volunteers on that board, we've never asked for a penny, most of us are out-of-pocket - it's something we sincerely believe in, and the passion in the staff and the depth in the staff. Honestly, maybe this is the businessman in me, but we want success. We want abstinence, we want somebody following the program, we want somebody to have a new life. Some of us have benefited going through that process.

It is a horrible but wonderful journey. The addicted person today costs us enormous amounts of money, in society, in community services, in business, et cetera. Crosbie House wants to be able to go in and look at our partners and see multi-party support behind us. If we make mistakes, let's say let's work on this together. Maybe

I'm being a little bit naive, but let's work on this together. There may be other opportunities here, some that don't work, and some that do work. We're open and we're transparent. You can talk to us, you can come to our meetings. There are no hidden agendas on our side. Anybody in this room who wants to talk to any one of us about addiction, in your own family or whatever, or you want to refer somebody to us just for an assessment, we'll talk to them and there is no charge. We're here. That's what we do, and we think we're a good thing for Nova Scotia - business thinks so, and many organizations think so. If I was an MLA, I think I would opt to go to Crosbie House, if I had an addiction issue, rather than go to a government program, and maybe within the Civil Service there are opportunities there. We have wonderful partners. These people care about their employees and we're pretty proud about that too.

MADAM CHAIRMAN: We would like to thank you all for taking so much time out of your schedule today to come before us. You've told us an incredible story. We admire the passion and commitment that you are giving to people living with addictions, and we thank you for that. I think we are all inspired by the fact that you haven't given up when the operational funding for Crosbie disappeared. You just soldiered on, and we respect that very much, and hopefully our motion will encourage government to continue discussions with you and there will be a positive outcome. So thank you for all you are doing and thank you for coming today.

MR. LIBBY: We would like to invite members of the committee, and anybody else from the Legislature, who would like to come to New Minas and see the house, just give us a call. We would love to have you there. We're very proud of what they've done.

MADAM CHAIRMAN: Thank you.

Before the committee departs, could I suggest that we postpone the election of a vice-chairman, and our deliberations on the Forum on Poverty, until our next meeting? We will add those to the agenda.

MR. GLAVINE: So moved.

MADAM CHAIRMAN: Do we have a motion to adjourn?

MS. WHALEN: Yes, so moved.

MADAM CHAIRMAN: The committee is adjourned.

[The committee adjourned at 4:00 p.m.]