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COMMITTEE

ON

COMMUNITY SERVICES

Tuesday, May 17, 2011

Committee Room 1

Community Homes Action Group

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COMMUNITY SERVICES COMMITTEE

Mr. Jim Morton (Chairman)
Mr. Gary Ramey (Vice-Chairman)
Mr. Sid Prest
Mr. Gary Burrill
Mr. Brian Skabar
Hon. Karen Casey
Mr. Geoff MacLellan
Mr. Alfie MacLeod
Mr. Keith Bain

In Attendance:

Ms. Kim Langille
Legislative Committee Clerk

WITNESSES

Community Homes Action Group

Ms. Wendy Lill,
Co-Chair

Dr. Brian Hennen,
Co-Chair

Dr. Mary Tomlinson,
Advocate for Mental Health

HALIFAX, TUESDAY, MAY 17, 2011

STANDING COMMITTEE ON COMMUNITY SERVICES

9:00 A.M.

CHAIRMAN
Mr. Jim Morton

MR. CHAIRMAN: Good morning everyone. I think we'll get started. I know that we are waiting for one witness, who is parking the car I think. That might be more complicated downtown than it would be in some other places.

I'm Jim Morton, and I'm the chairman of the Standing Committee on Community Services. I'd like to welcome everyone; we'll have introductions in a moment. As well, I'd like to welcome people who are observing this morning, and I'd like to particularly welcome to this committee Sid Prest, who is a new member of this committee, replacing Maurice Smith who has been reassigned. So welcome.

Maybe we can go around the table and have introductions, starting with Kim.

[The committee members introduced themselves.]

Our witnesses today are from the Community Homes Action Group. Wendy, if you could introduce yourself and your colleagues.

MS. WENDY LILL: I am Wendy Lill and I am co-chairman of the Community Homes Action Group. This empty seat is for Dr. Brian Hennen; he left me about two minutes ago to park the car down at the courthouse parking lot. He says there's never any trouble getting a parking spot there, but obviously that has not happened. He should be here very shortly; we know he's in the vicinity. With me is Dr. Mary Tomlinson; she is the Mental Health Advocate for the Community Homes Action Group.

Would you like me to start the presentation?

MR. CHAIRMAN**:** Yes, if you are prepared to start, that would be great. So the usual procedure would be that you will make your presentation and then everyone will have a chance for questions and discussion. Has everybody got a copy of the presentation? We have extra copies here.

MS. LILL: Thank you, Mr. Chairman, and members of the committee, thank you for giving us the opportunity to make a presentation to you today.

As I said, I am Wendy Lill, and I am here with Dr. Brian Hennen and Dr. Mary Tomlinson. Dr. Hennen is a family physician and co-chairman of the Independent Living Nova Scotia and works both locally and nationally in efforts to educate medical professionals around developmental disabilities. Dr. Mary Tomlinson is a psychiatrist with Capital Health, working specifically with persons with developmental disabilities within the Services for Persons with Disabilities program - that's the SPD.

Community Homes Action Group is a collection of concerned citizens, health care professionals, parents, and advocates who have come together to draw attention to the crisis in residential options for persons with developmental disabilities, and also to work with the provincial government to find solutions. I'm happy to see that we have other members of our group in the audience today - Dawn LeBlanc, Sherry Costa and Lois Miller.

We're here to draw attention to what appears to be a lack of urgency attached to meeting the needs of this vulnerable population waiting for residential options with the Services for Persons with Disabilities Program in the Department of Community Services. We've provided you with a written presentation already and this morning we'll provide you with some of the key points.

First of all, an important fact: over 650 individuals out of a population of around 5,000 persons with developmental disabilities are on waiting lists for services, many of them living in near-crisis situations while waiting for appropriate residential placements. Many others are living in types of supportive housing unsuitable for their needs and detrimental to their health.

The 2008 Report of Residential Services commissioned by the Department of Community Services identified serious systemic problems in our residential services programs. What exactly is this system and who does it serve? The SPD program provides residential and other supports to over 5,000 Nova Scotians, including 1,000 children under 19 years of age. Those presently receiving services include individuals with developmental disabilities, individuals with long-term mental illness, individuals with physical disabilities and individuals with dual diagnosis.

The range of services within this system includes small option homes, direct family support, alternate family support, and independent living support. The types of facilities within this system categorized as long-term care include residential care facilities, group homes, developmental residences, adult residential centres and regional rehabilitation centres.

For many years, there has been a freeze on small option homes in the community. The people requiring residential services have increased, but the community-based, independent living options available to them have not. So, the system is gridlocked, there's a traffic jam and no one is moving. That can be a huge problem if you are aging parents desperate to have your offspring settled in the community before you pass on, or, if you're a young adult who wants to move out of the house to start their own life, just like their brothers and sisters have done before them. People in their mid-20s definitely want to leave home; they want to go out and begin their own lives.

It's also a huge problem if you are an individual whose needs are changing rapidly and your condition is exacerbated by the place you are living and by other individuals you find yourself living with. Individuals supported by the SPD program stay with the program for long periods, many for a lifetime. The lack of capacity means that the individuals tend to remain where they are, even if the type of setting is no longer appropriate to their needs. We simply do not have the range or quality or quantity of residential options needed to meet the demand and the individuals in need of services are continuing to grow.

Dr. Hennen wants to provide some background on research that's being done in Nova Scotia with developmental disabilities and the problems which have been allowed to grow within the system over several decades now.

DR. BRIAN HENNEN: Good morning. I welcome the opportunity to make a few remarks over our group presentation that was circulated. We're grateful that our democratic process facilitates such a discussion.

The numbers of Nova Scotians with developmental disabilities who receive services from the Ministry of Community Services has changed minimally over 10 years. Accurate research on the numbers and their needs is scarce. Estimates can be made by applying national and international comparisons and from these we know there are at least as many with developmental disabilities not receiving support as there are receiving support, and the numbers are continuing to increase. The Nova Scotia Health Research Foundation recently funded the Intellectual Disability Service Needs Research Alliance to conduct a three-year study which has begun to look at needs. This study will be reported and discussed for the first time on May 30th.

Recent efforts by the Department of Community Services have developed a provincial baseline client profile of those on residential placement waiting lists. These efforts have extended licensing to more small option homes, they have supplemented funding of home supports - these are all modest steps forward. They do not fundamentally

change the gridlock and inherited approach of assigning persons who have developmental disabilities - too often in crisis mode - to whatever vacancies exist, unresponsive to the individual's particular needs and wishes.

In the last decade, no progress has been made in moving persons with developmental disabilities out of our largest institutions. Supplements to support those in family homes are insufficient and only catch up with inflationary demands to previously inadequate funding. The persistent gap between 21 hours per week of support offered through the Independent Living Program and full 24-hour, 7-day support in a residential placement - this gap is an outstanding example of a non-responsive, rigid approach.

The range of residential resources available is not equitably distributed from region to region, so for the needs of an individual to be met, she or he may have to be wait-listed to move to another region or to accept a residential option less suitable to their requirements. Nova Scotia is not keeping up with other provinces in developing a place they call home for its citizens with developmental disabilities, and while we commend the federal and provincial governments for supporting the United Nations Convention on the Rights of Persons with Disabilities, Nova Scotia is some distance from meeting that chartered benchmark.

There have been recent reports of institutions failing to provide adequate and safe home environments for this vulnerable population. Reviews have been done and are being done, and yet we have not seen a constructive, sensible and sensitive strategy presented for the renewal of residential home provision. We do commend the minister on determining that the Braemore investigation would be done by an external review. Discussions of a comprehensive disability strategy for the province are encouraging though slow, but a specific renewal plan for residential homes is nowhere apparent.

There is no teeth in the legislation, or operational accountability. We cannot assure that family members or self-advocates are included in local or regional boards, or that support staff are adequately trained and updated for their frequently difficult tasks, or that there are transition plans in place to support youth moving from their child-based care systems to the adult systems of care. We cannot ensure that there is a comprehensive accreditation process for residential homes, or that there is a human resource plan to ensure that adequate numbers of professionals are being educated to meet the service needs of this growing population.

The Community Homes Action Group members are prepared to contribute their time and expertise in developing a program that does ensure these things. We want to be part of the solution. As a province, we will be judged according to how effectively we include citizens with developmental disability in our lives and allow them to achieve independence. This begins with ensuring they have a comfortable and safe place to live in and can proudly state 'this is my home'.

Dr. Tomlinson, who speaks next, has worked as the premier psychiatrist of persons with developmental disabilities throughout the province for over 25 years. She is based at Emerald Hall at the Nova Scotia Psychiatric Hospital and is the psychiatrist for the COAST outreach team. Mary has a caseload of over 500 clients, a few of which she'll now tell you about.

DR. MARY TOMLINSON: Thank you, Dr. Hennen. It's actually only 15 years with this population, but I have been at the Nova Scotia Hospital for nearly 30 years. I think I can put a human face on these figures because I actually travel all over the province and I meet my patients at home, certainly for the first assessment. I have been in almost all institutions in Nova Scotia; I regularly visit some of them. I go to group homes, I go to people's family homes, I go to small option homes - all sorts of places.

I'm mostly asked to see people because they've become aggressive or they are aggressive, sometimes to themselves - they beat themselves up. I see people with horrible scars and swollen heads because it feels better to bang your head than to experience something that they're experiencing in their head. They're also aggressive to other people - to their caregivers, to each other - and that's mostly why I'm asked to see them, and usually the problem has been growing for a long time.

I would say about a third of those people's behaviour is either caused by or made worse by the situation they're living in. If you can't speak and you're oppressed by noise, or by a lot of people, or by somebody taking your stuff or by the fact that people aren't listening to you, you want a drink of water and they're too busy or you don't know how to ask for it - what do you do? You might hit your head, you might hit the person who comes to bath you or that kind of thing. They call me and they expect me to give them medication, so I'm trying to treat behaviour that is being caused by horrible situations.

An awful lot of the people I see in these institutions have been there most of their lives. They come from a time when parents were told, oh, put him away in an institution and get on with your lives, and people used to do that so I'll meet a 70-year-old who's been at the Nova Scotia Youth Training Centre and then some kind of residential facility. Families are not going to put up with that anymore. They are going to want something decent for their people. They want enough attention, they want some kind of a life, they want a place where instead of being one toilet for 14 people - people sitting on the toilet and there is only a curtain and there are people coming in and out.

Most of the staff are really good, they're kind, they're doing this work because they love it and they love the people. You hear them talking about somebody who's hitting them and they say, oh, well, Charlie, he's always been a bit like that. You can see that they love them, but there aren't enough of them, they're not properly trained and they have awful facilities to work in. It breaks my heart, actually, seeing this kind of stuff and being expected to fix it with pills - you can't do that.

It's not the only reason I see people. Some of the people are actually mentally ill and they have been on inappropriate medication for years, and I can do something about that. Most of them have reasonable access to physical health care, but there's often not enough recognition that - again, if you can't speak and you've got a toothache you might be agitated, upset, whacking yourself, and your toothache becomes an abscess, you become very ill, this kind of stuff. People who can't speak need an awful lot of very careful attention to their physical health as well as their mental health.

I often hear the words "attention seeking" - he's doing it for attention. Well, he needs attention so give him some attention, but there might be three staff for 20 people. It's a full-time job just keeping people fed and clean and keeping their clothes on. Another thing people do is strip their clothes off when they're upset - well, nobody likes that, so they're constantly being told to or helped to dress again, this kind of stuff. I have to stress, again, most of the staff are good and kind and doing their best and they hate seeing what they see day by day, having to deal with it.

Then I turn to the families who have somebody at home who might be 40 and they're getting nearly 80. I know one family where Dad would hold the young man's hands while Mother washed him because if you didn't hold his hands he'd be hitting either himself or Dad, and this had been going on for years and years. He only got housed when his mother got sick. Where did he get sent to? A large institution, and then his hitting himself really crescendoed. He is with us now at the hospital. Well, he's doing really great but I don't know where we're going to send him.

A so-called system where somebody leaves home when mother is too sick to look after them anymore and gets sent to an institution that might be 500 kilometres away, away from family, being looked after by very stressed, overworked strangers - that is a very bad system. I think Nova Scotia can do better than that.

I think if ordinary people in Nova Scotia knew what was going on, they'd want a better life for our folks. They are citizens and they have rights. They might not be able to talk or they might be talking just to make you happy; you see that a lot. I ask somebody something and you can see them say, what am I supposed to say to that? They are not used to being heard and being allowed to say what's really important to them and often they actually can't say what is important to them. They are trying to please you and they break my heart.

The families, the elderly parents ask, what's going to happen to him? I can't say, oh well, Community Services will find a nice home near you, so that he can settle before you die or get too sick to look after him. I can't say that because it's not going to happen. There are years and years and years and years of waiting lists and when the person comes to the top of the list, it is because Mom is too sick to look after him anymore, and it isn't right. That's all I have to say.

MS. LILL: Thank you, Mary, for putting a human face on statistics.

We've talked about the systemic problems and Dr. Tomlinson has talked about the problems they're having on individuals trapped within the gridlocked system. So where do we go from here? We need a continuum of residential options to meet the wide range and needs of this population. In consultation with individuals with disabilities, their families and communities, the Government of Nova Scotia needs to move forward immediately with an action plan to increase the quantity, quality and range of residential options for persons with developmental disabilities.

We have to stress that this is not a problem specific to the Department of Community Services. We have, in fact, many departments and many parts of our government involved in this challenge, and that includes the Health and Wellness Department, Education, housing, Justice. All departments really need to work closely on developing a plan for this.

It's past time for real leadership and for action to be taken for these people. It's time that the place they call home provides them with a healthy and safe residence. A place that is staffed by caregivers, well prepared to meet their needs and located within communities that reach out to them and a province that shows it fully includes its most vulnerable constituents. That's a dream and a plan we all need to work together to realize. Thank you.

MR. CHAIRMAN: Thank you all for your presentation. I guess that brings us to an opportunity for questions and I have at this point two people on my list, Mr. MacLellan and Ms. Casey, Mr. MacLellan to begin.

MR. GEOFF MACLELLAN: Good morning and thank you very much for your presentation. I just have a comment, which leads into a question. We've seen reports of abuse and systemic problems, as you mentioned, at Braemore, Riverview and in Colchester in the last couple of years. I'm the Community Services critic so I sort of get in-depth with some of these situations that have been happening on the ground in the residential care facilities, and the issues that are inherent are very consistent.

You see clients who are - as you stated in the presentation - abusing themselves, abusing other clients and there's been extreme incidents of that, also some clients with high-level needs abusing staff. Again, the staff members do their absolute best but sometimes they don't have the training. They are certainly over-worked. I know that many of the staff members in Braemore have felt that there's such a breadth and depth of issues, that they struggle everyday to keep things as good as possible there.

What we've asked for, and I've spoken to the minister about in the Budget Estimates, is a comprehensive review. When you see a lot of these cases and they're repeating themselves, I think it points to problems in the system. The minister was certainly receptive to that option and what she had said in those estimates was that

Braemore, that report will be indicative of some of those wide ranging problems. That will be the benchmark to maybe launch into a comprehensive review.

That was going to be my question, if you thought that a comprehensive review was warranted but obviously I think you agree that it is. We're looking forward to that, certainly as one-off views, let's look at the whole system and identify those major problems.

All three of you talked about level of care for clients, staff training, one-on-one support, smaller more targeted facilities and community councils or an oversight group. I guess what I'm asking you is, in a nutshell, where you see this going? Does it tie directly into the report commissioned that was put together by Dr. Kendrick? Would that be fair to say? Are you familiar with that report and do you see that being sort of the foundation for residential care facilities moving forward?

DR. HENNAN: I think the Kendrick report is the baseline but it's a little bit outdated now. I think the report by the Services for Persons with Disabilities Program in 2008 made a lot of recommendations, most of which we agree with. If you're going to promote a comprehensive review, I would focus on implementation of action rather than a review again of more information. There's a lot of information available. Most people who have done it in the past have identified what the main issues are so I think the focus would be on, let's get something to happen. How we can organize the system differently to respond to these, because they've already been delineated.

MR. MACLELLAN: They aligned pretty closely with the Kendrick report? I haven't seen that report. I know that Dr. Kendrick has offered some updates to the original plan that was 10-years-old, he did that last year.

DR. HENNAN: There are some new things. There's some new stuff coming out from various national groups and local groups in other provinces that would be worth looking at, very much so. I just don't think we need another research kind of overview of what the problems are. That's all I'm saying.

MR. MACLELLAN: Yes, ok.

MR. CHAIRMAN: Thank you. Ms. Casey.

HON. KAREN CASEY: Thank you very much to all three presenters. I think you have been very successful in putting a real face on a population and a concern that many of us do not understand unless you have direct contact with either having a family member who is receiving care or should be receiving care or you're delivering the care. I would be safe in saying that most of us around this table heard things this morning that perhaps we have either turned a blind eye to or didn't have the information on. I want to thank you for putting a very real face on it.

I want to go to Dr. Tomlinson with a comment and a question; perhaps an explanation. When you were talking about you getting calls and you go into a facility and "they" are saying this person needs medication, can we get medication? Can you tell me, who the "they" are? Is it staff, is it family - who is calling you? When you get there, because of the behaviour that they are seeing, their last resort must be medication. But, who is the 'they'?

DR. TOMLINSON: It's mostly staff. Sadly, many of the people who live in the large number of long-term institutions here have been institutionalized for most of their lives; there isn't much family contact anymore. Yes, it's staff who sometimes recognize that a person is suffering or more commonly see that person causing suffering to other people - aggression.

MS. CASEY: If I could follow up, Mr. Chairman?

MR. CHAIRMAN: Yes.

MS. CASEY: So the medication they may talk to you about is medication, perhaps, for an illness that they think the patient may have or to control a behaviour that is hurting the patient or others. Would that be fair?

DR. TOMLINSON: Yes.

MS. CASEY: Do you find that most patients that you see have been medicated?

DR. TOMLINSON: Yes, nearly always, they're already on medication. Quite a lot of it is necessary, but quite a lot of it is a result of the conditions they're living in and if they were living in better conditions, they wouldn't need the medication that they're on or they wouldn't need anything like as much.

MS. CASEY: As a classroom teacher, I have seen over the number of years how people have tried to control students' behaviour with medication. Medication should be the last resort, I believe, in a lot of these situations. I'm not suggesting that these patients don't need medication, but I think maybe over the years, people have been too quick to medicate to control behaviour and perhaps it is not the best way to do it.

DR. TOMLINSON: Yes I agree.

MS. CASEY: So thank you for the picture you painted.

MR. CHAIRMAN: That takes us to Mr. Ramey.

MR. GARY RAMEY: Thank you for the presentation. The study that's being released on May 30th - does it have a name or a title?

DR. HENNAN: The meeting is called "Planning for the Future of Nova Scotians with an Intellectual Disability: A Needs Assessment of a Population at Risk." Basically it's a review of 150 people who have been intensively interviewed, most of them directly, personally, a few with interpreters and a few with other people speaking for them, but it's 150 people who have had in-depth interviews and it is going to identify some of the needs, specifically, of what we need to be looking at.

MR. RAMEY: I do appreciate that. As part of that, you interviewed some family members and some staff in some of the institutions as well?

DR. HENNAN: Staff weren't interviewed directly; they were only interviewed if they were helping somebody interpret. It was strictly a study that looked at people themselves.

MR. RAMEY: Correct me if I'm wrong, but somewhere during the presentation I heard about 650 people out of maybe 5,000 or something, currently on waiting lists. Do you have any breakdown of the age or the definitions of the population of that 650 people?

DR. HENNEN: We don't, but the Services for Persons With Disabilities Program has just established an overview of the whole population who are on the waiting list and they have a profile, so they could provide you with age, weight, particular problems and so forth.

MR. RAMEY: Finally - and this one will be brief - I think what you're telling us is the problem has been studied and identified. We know what needs to be done, we should do something, I think that's the message I'm sort of getting. I'm sure particularly you, Dr. Hennen, have probably looked at many jurisdictions across the country and at what they're doing. Who's doing the best job in this regard, based on what you know, across our country?

DR. HENNEN: I think those people who are doing some good things are not all in one package; different provinces are leading in different ways. Ontario, particularly, is leading in education of people, training programs for primary care providers in terms of health care. Newfoundland and Labrador was way ahead of declaring that they would not have any institutional placements at all, a number of years ago. I'm going to be visiting there in a month or so and I'll get more specifics of what they're doing, whether it's good or not.

B.C. has had some leadership, but one of the things that happened in B.C. when they deinstitutionalized, the idea was that the money spent on the institutionalization would be transferred into the community but the next year or so after that, their budget to this population reduced between 15 per cent and 18 per cent.

People do see some savings if they do deinstitutionalize, but I think the truth is the broad cost of providing care to these people appropriately will improve a lot of things and I don't think the ultimate outcome will be an increase in costs. I mean, some of the money that's being spent now could be spent in different ways. The example would be, what is being spent on licensure here could be directed toward Accreditation Canada, which has just developed a brand new set of standards for developmental disabilities just published last November.

MR. RAMEY: Thank you very much and thank you for the liberty of asking three questions, I appreciate it.

MR. CHAIRMAN: Thank you, Mr. Ramey. Mr. MacLeod, then followed by Mr. Bain.

MR. ALFIE MACLEOD: Thank you, Mr. Chairman and thank you for your presentation. I'm just curious about the Community Homes Action Group. Is it a province-wide organization?

MS. LILL: We are a very unique little group of individuals who come together specifically around the issue of quantity, quality and range of options for persons with developmental disabilities. We've been in existence for 18 months. I think you could say we're an informal collection of people mainly in this area. I think you could say that we're a single-issue grouping. We will be very glad to dissolve once this problem has been corrected. We're not looking for existence beyond solving this problem.

At the present time we have members who are working provincially such as Dr. Tomlinson; she is working across the entire province with individuals in this situation. Dr. Hennen as well is working with individuals and with doctors around the province. Dawn LeBlanc is with Capital Health based at the IWK. Sherry Costa is the Executive Director of Independent Living Nova Scotia, so yes, we do have a provincial mandate. Lois Miller, who is in the yellow sweater there, is the former wonderful Director of Independent Living Nova Scotia. Ken Deal is living in Cheticamp and working also at McMaster University in Hamilton.

MR. MACLEOD: The reason I ask is, there's an organization in Cape Breton called Cape Breton Community Housing Association. They operate a number of homes plus supervised apartments and a homeless shelter. I've been on that board for the last 10 years and we've got some really great people who are doing some really good things there. I guess the reason for my question was that there may be some expertise there that could be added to your committee to strengthen what you want. I think one of the things as a board member there that we all strive for, is to make sure that the clients that we have are getting the best care and the best quality of life that we can offer them.

That would lead, partially, to the same question that Mr. Ramey had. In Nova Scotia, is there any particular area that seems to be leading the way in the types of things

that need to be done with the resources that are already in place? It's always a challenge whenever you're doing this. The resources are always going to be an issue, but there are some unique things taking place, as you said, across the country, but I'm wondering if there's anything in particular in the province that you've noticed that should be grown across the province from within.

DR. TOMLINSON: It's hard to say. There are some wonderful pockets of excellence in pretty poor organizations. There are an awful lot of for-profit organizations in this business, running small option homes, for example - bare bones - but inside that, if you've got the dedicated people they can give people a great life. It depends far too much on the individual initiative and the efforts of private individuals, particularly when you're getting the for-profit sector involved in this business. I think anybody who is trying to make a profit out of people who are so disabled is going to be exploiting both those people and their staff. Anyway, don't get me started on that one.

MR. CHAIRMAN: I know Lois Miller who is observing - are you interested in making a comment? Is the committee comfortable with that? Please take a chair, Lois, at the microphone just so your voice can be heard. Would you introduce yourself when you're seated?

MS. LOIS MILLER: Sure. I'm Lois Miller and I'm here today as vice-chairperson of Nova Scotia League for Equal Opportunities. We have affiliate groups all around the province. Some of you will have met our chairperson, David Mooney from Yarmouth, but David is not up in town today.

I just wanted to mention in response to Mr. MacLeod - you asked about the coalition and provincial presence, which is a really good point. I wonder if you might make sure someone in our group has - or you could send us contact information, you mentioned a group in Cape Breton because maybe we could get in touch with that group. If you could make sure that, perhaps - or you could trade cards, or something like that.

The Nova Scotia League for Equal Opportunities is a participating member of the Community Homes Action Group. We're trying to keep in touch with communities in other parts of Nova Scotia. Another group that is also represented with the Community Homes Action Group is the Disability Rights Coalition, which again has representation from around the province.

Many of us involved with the Community Homes Action Group are also involved with the Disability Strategy Working Group and that brings together about 30 different disability groups from around the province. We're trying, through all these networks, to keep in touch with persons with disabilities around the province. I just wanted to make sure that was clear. Thanks.

MR. CHAIRMAN: Thank you very much for adding that clarification, Ms. Miller. That will take us to Mr. Bain and then, just so we know the order of things, over to Mr. Burrill after that.

MR. KEITH BAIN: Thank you, Mr. Chairman and thank you very much for your presentation this morning. Mr. Ramey has basically touched on the questions I was going to ask: when you say it's time for action - we have reports, we have recommendations that are there; and whether or not there are any jurisdictions across the country that you are aware of that have programs that are working that we, as a government, could emulate.

I'm going to ask two questions and I'll just let you give the answers to them. The other on is, community-based housing and the challenges that are presented because of rural areas. You mentioned the goal is to try and keep the - can I say the client? - close to family and being in a totally rural constituency with Victoria-The Lakes, the challenges are there. I guess I'd like to hear, possibly, some of the ideas you might have as far as community-based housing in more remote, rural areas. Thank you.

DR. TOMLINSON: It's a problem because if you're going to run a nice home for a small handful of people with a disability, it isn't just the home - it's somewhere to go during the daytime, reasonable work, recreation. They need a life and it's hard enough for regular folks in isolated rural areas to lead a life, now that they're not farming all day. They need to get around, they need transportation and they need somewhere to go to. It is difficult in an isolated area to lead a fulfilling life, especially if you have a disability.

MR. BAIN: Mr. Chairman, if I could just - I guess another challenge would have to be the availability of caregivers in rural areas. So I guess that would sort of limit your choices, your opportunities, and therefore it would be more towards the more urban centres, am I correct?

DR. TOMLINSON: Yes, and of course historically it has been towards the institutions, which also tend to be in rather isolated rural areas, quite deliberately.

MS. LILL: Mary, are you going to talk about L'Arche, because that's a model that actually has been . . .

DR. TOMLINSON: Yes, there is L'Arche Canada, there is L'Arche Nova Scotia - I don't know if you guys know about L'Arche. It is an extremely successful model on the whole. It has to be supported by Community Services - it's not a rich organization, they have to use whatever resources there are locally. What they do is set up small residential options, sometimes in a community like Orangedale, for example. In Wolfville, there are a few houses around.

They tend to be much more inward looking than a lot of the good small homes that I've seen, in that there will be a group of homes and they maybe will have their own workshop. They're not so much - although they are changing in that way - centering

themselves on the lives of where they are. It is changing, they are much more kind of porous now to people coming in from outside and some of their people going to a workshop or a workplace in their general community. But it is an excellent model, if you're looking at highly motivated staff - they don't pay them enough, actually, but they certainly have a model staff, very dedicated to their folks. It's a model that we should be looking at more.

MR. CHAIRMAN: Thank you Mr. Bain. Mr. Burrill.

MR. GARY BURRILL: I feel quite embarrassed with how much of what you have said is new to me. I'm trying to make sure that I have grasped what you are putting across as the basic core of the problem here, that the core issue is the gridlock. Am I following you right that at the core of the gridlock, is the moratorium on the expansion of small options homes from some time ago? If that's a correct reading, then am I to understand that a significant expansion on this front is primarily the thing that is required?

DR. TOMLINSON: I would say yes, that would make a huge difference. I think there is always going to be a small group of people who are not going to survive in a small house. People who need to pace, they need a lot of space; people who do need an awful lot of physical help; people who, whatever anybody does, they're always going to be a bit aggressive, they're going to need more specialized care. They might need to be in, say, a small institution with maybe 12 people with specialized staff, that kind of thing. But nearly all the people that I see who live in the big old institutions would be much happier and much better off in a small place that was inside a town or village; real life.

MS. LILL: I would concur with that, I would say that we have a supply problem. We do not have enough residential options for people and I think there is a lot of interest and commitment on the part of people to make this happen. There are families who have their own ideas about housing possibilities and there are collections of individuals that want to come together and try different models of housing. There's going to have to be a very large collaborative effort on the part of a lot of people and a lot of departments to make this start working because we've left it too long. Many governments have gone by and have just allowed this to slide and the numbers have continued to grow. The numbers of individuals who need assistance, supportive living, continue to grow while the options do not continue to grow. It's pretty straightforward but the answers aren't too straightforward.

DR. HENNEN: Just to sort of combine two or three questions. The problem in rural areas can be helped if we target some of the health professionals and the social works of professionals that live in the rural areas. Family doctors are key and I'm a family doctor so I'm going to say that, but they are. Social workers, rurally, are really important, visiting nurses are extremely important and schools are very important in rural areas. The recent reduction in teaching assistants, that is a terrible way to start, so that's a problem.

We know people actually are moving urban because they think the facilities are better. There are people leaving the province to other provinces because they think they can get something better in Ontario or Alberta or somewhere else, so we're actually losing citizens because their kids aren't being served. There are young adult children; some of these parents are in their 80s looking after 40 year-olds.

I just wanted to make the point about, it's a local community challenge in a rural community, so you get together who have got most contact with these people, who might have some resources. You go to the teacher, the family doctor, the local social worker and the visiting nurse and maybe you've got a team that might get you something started.

MR. CHAIRMAN: Mr. Burrill, I think you had a follow-up.

MR. BURRILL: I'm just trying to think along the same vein to organize the complexity of the matter into the problem that suggested direction. This is a powerful phrase you've used - the problem is an inadequate sense of urgency, that the overall issue is being characterized by a lack of this kind of focus. If an adequate sense of urgency were brought to bear, what might this look like? It would include a significant expansion of small options homes and high on the list, what else?

DR. HENNEN: Cross ministry collaboration is absolutely essential. This isn't just a problem with Community Services.

DR. TOMLINSON: They would have to look at closing those institutions. It's not a good model for our folks. Some of the people there are quite happy, but not many of them and certainly our rising generation is not going to put up with those institutions, not now that people know what goes on in them. I actually quite like institutions and I went to boarding school, this kind of stuff, but I think I'm unusual in that. It's a bit inhuman. I think we should aim to close the institutions and replace them. In Cole Harbour, the Regional Rehabilitation Centre closed down - there has been nothing really adequate to replace it. There is the Cobequid Centre, which is not really suitable for its purpose - a collection of highly disturbed individuals with precious few resources.

MR. CHAIRMAN: Thank you, Mr. Burrill. Mr. Skabar.

MR. BRIAN SKABAR: Thank you very much for your presentation. Dr. Hennen, let me just go back a little bit. The organization of services to persons with disabilities was as much of an issue as anything in particular. When Mr. Ramey asked you a question, you mentioned that all in all, that if the amount of money in the system was organized in such a way to be more responsive to the real needs as opposed to just having bought into what we've done for a hundred years, I guess, we might be able to better address the system there.

So, to what extent can many of these shortcomings be mitigated by a reorganization of the system? If we're only providing, right now, half the level of services that might be

required - and I understood that from an earlier part of the presentation - would a cleaning up of the organization and the vision be able to address many of these?

DR. HENNEN: My own bias is that if we spent some of the money differently, we could improve the system, but if we're going to meet the needs of the people who are coming down the pike, there is going to have to be more money for that. If we looked at what the current system was and said, okay, the cost per person is about this much, we re-juggle what we're spending the money on, maybe we can improve the system substantially but there are more people coming down.

There has to be almost a cost-per-person formula so that when the increased numbers come down and people are living longer and they're still more complex, that's where the extra money is going to have to be spent. That's my bias.

MR. SKABAR: I did also appreciate your comment about almost, the analysis paralysis. We've looked at it and have studies and it's time to do something, by all means, but to that extent, is there something already done or on the shelf that kind of would address some of these organizational issues in the medium run, even?

DR. HENNEN: I think the Services for Persons with Disabilities, that part of the organization, has now established a baseline - they've got this profile of all the people who are on the waiting list. That would be a great place to start. There are some information bits that we can move into action by starting to respond to the needs of that population.

MR. SKABAR: But leaving the institutions as they are in the meantime, then?

DR. HENNEN: No, I don't think we want to advocate that, but there have to be steps taken in the plan and that's one of the problems - there isn't a plan.

MR. SKABAR: That's what I was asking. If we have enough studies out there and plans and we know what we kind of want to do conceptually - for lack of a better term, is there a master plan?

DR. TOMLINSON: Just an observation. Every institution I go to is having huge expensive renovations done. What does that mean?

MR. SKABAR: They expect to be there longer. So would that be a no then, in terms of we have nothing on the shelf for a plan to address some of these issues of which we speak?

DR. TOMLINSON: Whatever they say the plan is, that's what I see actually happening.

MS. LILL: I think just from a personal perspective, if you talk to hundreds of families who are waiting for a call from Community Services to say that a place has been found for their young adult or their middle-aged offspring, they would say there is no plan. They would just say, well, we understand we're 100th on a list for a small option home, we're 80th on a list for a group home. That is a very desperate place to be at when you are 60, 65, 70 and you've got a difficult individual who you've been caring for your entire life. Is there a plan? Well, tell those people, what is the plan because it's not sustainable. Their lives can't endure this much longer and obviously the system is not functioning if that kind of situation is in place.

MR. SKABAR: I was talking more of a plan holistically for the whole system which would, I'm thinking, eventually come down to the specific individual who needs help right now.

MS. LILL: The housing report that was done in 2008 for the Department of Community Services said that there was a dire need for a plan, that there was a need for an increase in capacity. Many of the points that we've been making today are pretty much based on that report. I think the department would say they are working away at it, but the pace is far too slow and we're not seeing the solutions that need to be moving into place right now. We're just not seeing them.

MR. SKABAR: That's becoming apparent, yes. I mean it is for a long time . . .

DR. TOMLINSON: I was talking to the head of Services for Persons with Disabilities; we had a meeting yesterday at Nova Scotia Hospital. They're very happy because they have 50 new places, but they are in people's homes. That means that they're untrained, I don't know what kind of supervisory structure is going to happen. I have visited people who have been taken over, it's like sort of an adoption procedure but it's for adults and some of them are wonderful, but I don't know how supervised they're going to be. Those people have no training.

What tends to happen is that the person remains a child in many ways because the families - good families with the best of intentions - don't really know how to help a person to develop into an adult. That's not their training; they didn't have a training; they're families. Their own children have a drive to get out. My guys don't, they need a bit of a push, they need something to go to.

I don't think that's the solution. They're very happy about that because it's cheap - they don't pay these families very much and they don't train the family members. So I do not think that's the solution and that's the latest thing that I've heard from the Community Services about how they're hoping to solve this problem.

MR. SKABAR: I don't want to monopolize your time, but I'd just like to mention that I live in Amherst, and I don't know what the difference between what happens in New Brunswick compared to what happens in Nova Scotia but for whatever reason - and

cross-border issues are happening and all kinds of things - but with at least a couple of families, they seem to think services are better in Nova Scotia than in New Brunswick and have moved to Amherst to that end. I'm thinking that New Brunswick must be really bad, then.

DR. TOMLINSON: This is a good thing?

MR. CHAIRMAN: Thank you, I guess, Mr. Skabar. I think Ms. Casey is next on my list.

MS. CASEY: I have just one quick question. It goes back to the 650 who have been identified as on a wait list, and we talked about whether they were in family homes waiting to move into a residential home, or whether they are in an institution. Do you have that breakdown - how many of those 650 are still with being cared for by family, elderly parents, whatever, and are waiting, and how many are in an institution waiting. Do you have a breakdown of that 650?

DR. HENNEN: We don't, but SPD does. For example, of the 650 that they have on their waiting list, there are about 200 who would opt for a small options home. That's an example of the kind of information we've got.

DR. TOMLINSON: If you're in an institution, you're not on that waiting list - unless you are in my institution. If you are at the Nova Scotia Hospital and we fixed you, then you are on a waiting list. I have eight patients occupying acute care beds at the Nova Scotia Hospital who need placement and are on that list, who haven't moved for years and who are preventing us from bringing people in to treat their mental illness, and sending them home again.

MS. CASEY: Not unlike the problem we have with people awaiting long-term care facility placements who are housed in our hospitals. Thank you.

MR. CHAIRMAN: Thank you, Ms. Casey. Mr. Ramey.

MR. RAMEY: Yes, I'm just going back again to - sort of in line with what my colleague Ms. Casey was asking as well.

I could just picture as I become older, if I had a person I was caring for all my life and as I was getting older and probably less physically able to handle the issue - holding the hands or whatever it was I might have to do, and worrying about all that - and then, of course, worrying about what would happen when my wife or I, or both of us, moved on to the next dimension or something. I think what you said was when that starts to happen, depressing as it is to think about, people get jumped up to the top of the list because of sheer desperation. Is that what you said?

DR. TOMLINSON: Nearly all the placements are urgent placements nowadays.

MR. RAMEY: So that's the way - I don't want to say "gets handled" because I'm not saying it's really getting handled in any good way. But that is what happens when a person says, look, I'm going to be hospitalized now and I don't know if I'm coming back out or not, I'm in a desperate situation here, what are we going to do? Then that person is parachuted out of that home where they lived all their life, with people who loved them, and put somewhere else. Is that it?

DR. TOMLINSON: Yes.

MR. RAMEY: Well that's as depressing as I thought it was going to be for an answer, but I thought I had better ask that, so thank you.

MR. CHAIRMAN: Thank you, Mr. Ramey. As I said, I'm a social worker by training, and it occurs to me that I think I started practicing 35 or 36 years ago and that's how I saw people get into the system at that point. In some ways, things haven't changed.

Mr. Burrill.

MR. BURRILL: Thanks. I was wondering if I could get you to explain a little more, both Dr. Tomlinson and Dr. Hennen - you were speaking about concerns about adequacy of staff training and education. My sense of this world is that a big part of the education and training is provided through the Human Services program at NSCC. I was wondering what your thoughts were about the adequacy of where we are on providing adequately educated staff both in terms of numbers and in the capacities that are imparted through the training.

DR. HENNEN: I understand they're fairly short programs. The word that I hear is they're pretty well trained to do fairly basic supervision and care, but they certainly have limitations in terms of the skill set. The other staff training is just hobbledy-gobbledy.

Professional training is a huge issue. I did a review five or six years ago of the whole country and other countries, and the availability of training programs for nurses, doctors, social workers, occupational therapists and almost the whole gamut is very inadequate in terms of where this population is concerned. As a family physician and an academic family physician, we've struggled very hard to get two half-days in the new undergraduate medical curriculum and we now have some residency training for our second-year residents. We have one third-year position filled for the first time this year for someone who's done a whole year of training as a physician in developmental disabilities. But there's no permanent position to fill across that way.

MR. BURRILL: This was the dimension you were meaning to refer to then, I see, yes.

DR. TOMLINSON: The better non-profit agencies train their own staff, like RRSS in metro. They take it quite seriously and so does Gateway - my son worked for them for a couple of years - and they have a good model of training people but it's entirely up to the agency. Some of the agencies in town, I hate going there - untrained people, bare bones facilities. It's nasty.

MR. BURRILL: There are minimal requirements that people would need to have human services certification in our present small options system?

DR. TOMLINSON: Oh, minimal. I mean, they. . .

MR. BURRILL: Or zero?

DR. TOMLINSON: No, I mean my son did something about medication from Shoppers Drug Mart, he did CPR. There were a few things that he had to learn, but the real stuff he learned on the job with excellent staff and a good supervisor. He's now in computer science. (Laughter)

MR. CHAIRMAN: Thank you. Mr. Skabar has another question.

MR. SKABAR: Getting back to the operational accountability that we touched on, I still can't get it clear in my mind. I think I get the big picture, but this is the Queen Mary and it will take a little while to turn this ship around; 35 years already and it hasn't changed too much, apparently. What kind one or two degrees of a turn can we make to at least try and head us closer to the right direction? I know that's probably not a five minute answer, but is there anything - one or two things we can start, or that can be started, to start heading us in the right direction?

MS. LILL: That a big question. I'll just start by saying I'm glad we're here today because I think we're putting a new light on this issue, and this population, for more people by doing this. I think there are many people in the Department of Community Services, I think the Minister of Community Services, and I know many people in this government and in Opposition care a great deal about this issue.

How do we move it in a time of restraint, in a time of trying to balance budgets? I certainly think that it starts with an honest assessment and a call-out to the community saying we are concerned, we know we have a big problem here and we want to start addressing it. I do not believe the disability community feels that, I know families don't feel that - they feel that this issue is just floundering and it is not being addressed. The money is not being allocated to new housing options, the community options are not being explored to the extent that they need to be. Families are not being consulted to the extent that they need to be. So I think first of all, we need to see a commitment and that's got to look like something. It's got to be real it can't just simply be more words. Maybe you can tell us what it would like.

MR. SKABAR: Would look like what - that's what I'm thinking. I don't know what that might look like in my own mind even.

DR. HENNEN: There would be a family member on every board; that's not hard to arrange if you enforce it, the boards that are running the various regional community agencies, whatever they are, and they are all different. The organization of services in the community was a municipal responsibility 15 years ago and the province took it over and the province is still struggling with the inherited attitudes, beliefs and ways of doing things that the municipalities had established so that's a real challenge.

Get a family member on every board, get the self-advocates or family members. Identify the issues around support staff training and it might not be they have to take a four month program or whatever it is but they need an ongoing updating opportunity. It can be very focused on the needs that they have with their particular clients in that particular facility. They just need to have the opportunity to go somewhere and talk to somebody who knows what to do and give them a workshop or whatever; that kind of ongoing training. That's not hard to do.

MR. SKABAR: Doesn't sound like too much to ask.

DR. HENNEN: The transition from youth to adult systems, there's no model of transition of health care for all the people in the IWK system who are becoming 16-, 17- and 18-years-old. There is not a plan for what happens to them when they transfer into the adult system. They probably don't need a whole lot more resources - they need a plan. They need an agreement that certain specialists, sub specialists and various people in professions and from different departments, will work together to make that transition into the adult care system a smooth one.

The accreditation process - the licensing process looks very well after safety and the physical surrounding and all that minimal requirements but it doesn't talk about how many training programs there are, how updated the staff is, what are the requirements for the people who are hired, how families are engaged in the decisions about their family members. The licensing doesn't deal with that but an accreditation process would, so we could transfer to a better accreditation process. These are components that could happen.

MR. CHAIRMAN: I have a couple more people on my list but I think maybe it's time for me to ask a question. I was struck, Dr. Tomlinson, by your description of individuals whose health and emotional needs - I know the word that came to my mind was actually "languish". You're called to maybe visit and have a look at some of those things but I guess I'm interested on where those individuals live. Is it in a range of settings and particular kinds of settings? Is it more likely that somebody's health may languish in one type of setting than another? Could you comment on that a little bit?

DR. TOMLINSON: Yes, I see people in the large institutions, I see people in family homes. I see people in small option homes, sometimes people having a hard time in

very good small option homes because they're mentally ill. I see people in every setting there is really, for our folks and not all of their problems are directly related to where they live, although the recognition and the treatment of those problems often depends on where they live.

If somebody is autistic and can't speak, has epilepsy, and is developing some kind of neurological problem on top of that - often they don't get diagnosed because they might be very quiet about it. In fact, they're more likely to get diagnosed if they start hitting people because at least then they'll see me and I'll say, well I really don't think this guy is actually mentally ill, I think he might have a stomach ulcer because he hits people at mealtimes and at no other times - this kind of stuff.

Yes, I see people everywhere and I have to say some people are happy in their institutions. They've been there since they were 16 and before that they were in another institution, they don't know any better. They are having a life and the staff are good staff, they're doing their best. Usually very nice people work with our population, but they don't know enough. They don't have enough training, there aren't enough of them. They don't recognize that hitting your head might be something you do when you have a pain somewhere.

In the little small option homes, sometimes I see that they are hounding somebody to death for the sort of behaviour that I do all the time. They need a sense of proportion and we have people who go in and talk to staff about reasonable expectations; these people do not need to be programmed to death. We all do stupid things sometimes. On the whole, the small settings work better. In the large settings, an awful lot of the behaviour which is seen as bad or ill, is just a way of surviving when there aren't enough people to look after you.

MR. CHAIRMAN: Thank you. Mr. Bain had an additional question.

MR. BAIN: Thank you, Mr. Chairman. I think Dr. Hennen pretty much summed it up when we're talking about the training. We've been talking about housing options but I think the key to the whole thing, rather than just have housing options, they're not much good if we don't have staff that are trained sufficiently. I think that's probably the first step we all need to take if we sit back and look at this. If we're going to be looking at the small option homes becoming the norm, can I say, we have to make sure we have sufficient staff trained to work in those homes. I think that's something that could be started immediately but it is to define what sufficient training is, too. I don't know if you'd like to comment on that or not.

DR. HENNEN: I think these things have to happen in parallel because otherwise you'll have an unemployed workforce, there'll be no place for them to work and there needs to be homes.

MR. CHAIRMAN: Thank you. I think Mr. Ramey has another question and as far as I understand, that might be our final question, unless somebody else has one.

MR. RAMEY: Okay, just a short one, in reference to something Ms. Lill said about being glad to be here today - we're glad that you're here, too. You also referenced the fact that all members of the House - no matter what the Party - all care about this issue, which I think is obvious. We know that's the truth, we just want the best. We were talking about a multi-department approach and that totally makes sense. At least Community Services, Health and Education are three that I'm thinking of and there's probably more, maybe Justice is in there somewhere, for all I know.

It goes back to something that Mr. Bain said, again, I don't want to flog a dead horse here about the training - and I know it has to move in parallel, I agree, I mean you don't train people for places they can't work; that's just not such a good idea.

In terms of that training, let's assume that the small option thing did move ahead, which I think is the preferred mode, and then we did need people to work there, well-trained people. I don't want to put words in anybody's mouth, but I think we're talking about people trained at probably several different levels, like a Community Services-sort of training, maybe university-type training, too. So there would be a degree program of some sort that would be part of this, there would be a community college diploma part that would be part of this, there would be a private training part that would be part of this. Am I getting that totally wrong or is that the way you would envision the people who need to be trained, being trained?

DR. HENNEN: I think there needs to be again, a wide range of options, but I think the support staff in the small options home would be the number one people to prioritize. The professional training just needs a little prodding, it needs a little bit of will to say we're going to put more in the curriculum for these kinds of things. There are people being trained around the issues of people with developmental disabilities, but the career paths aren't there. To go into developmental disabilities full time as a family physician, that's what you're going to be doing. There's no career path for nurses who are interested in developmental disabilities - there's not one PhD program in Canada that trains nurses for developmental disabilities.

MR. RAMEY: Let's just say for the sake of argument, there was a program at the community college - I'll just pick that one piece - called community services special homes option worker or something like that, where there was a branch of community services training, maybe there's one on drug addiction, maybe there's one of this, maybe there's one on that. There's one called special home options and that person who's taking that program is specifically trained to work with the populations that we're describing here in small homes and it was designed by people like yourselves - people like you and other people who work in the field would design the curriculum. They'd say, you have to get this in there, this in there, this in there and then that program would be offered. Would that be reasonable? Would that be something that would be desirable?

DR. HENNEN: That's something to start with, but the whole attitude has to be there. This person is going to have continuing training throughout their life and the five or six people in that group home, or the three people in the small options home across the street, might have quite different needs than the one you're living in now. There has to be that adaptability, that continuing training opportunity built onto a core training. So it has to be a comprehensive thing, it can't be just, well, we'll give them a certificate and they're ready to go.

MR. RAMEY: Sure, understood.

MR. CHAIRMAN: I think that brings us to the end of our questions. Do you have any summary comments that you would like to make, either that you've prepared or any of you would like to close with?

MS. LILL: I would just like to say something that was said to me about a year ago by a residential services agency person. I did put this in the document, but I think it bears repeating:

> "I admire the courage of persons with disabilities who get up every morning and withstand the insults, the frustrations, the stares, the rejections and humiliation. For them, life is very challenging. Isn't it the height of injustice that at the end of the day, many of them return to the place they live - the place they call home - only to find another trial to endured?"

I guess that really sums up the emotional core of this issue to me; it just lives very deeply in me and I'd like people to hold that thought. I hope we can hold that thought collectively and we can move forward collectively in trying to figure this out, figure out a big issue that we have in many ways created, but now we have it on our plate and we need to deal with it. That's really my final remark. Thank you for listening to us.

MR. CHAIRMAN: Thank you, very much for being here and for your presentation and the quality of the discussion. Thank you, everybody on the committee, for your questions that helped with that process.

We have a little bit more committee business to do, so we'll take a five minute recess so our guests can move out of the room and we will then resume.

[10:24 a.m. The committee recessed.]

[10:29 a.m. The committee reconvened.]

MR. CHAIRMAN: Let's call this meeting back to order. We do have just a couple of pieces of business to look at, I think. I didn't ask at the beginning if there was anything else that anybody wished to add to the agenda this morning.

AN HON. MEMBER: Gary wants to get out of the House.

MR. CHAIRMAN: Several of us do, probably,

I guess the first piece of committee business I'd like to refer to is correspondence. We have received a letter, which I think all of you have seen, from Ms. Wendy Keen, who is the executive director of New Start, which is a men's intervention program. She had a request to appear before our committee.

The group that she is associated with, which is a provincial association, had some concerns about funding. One of the things that I did when I saw that letter was talk with Ms Keen, who I know from some previous professional associations, and did some work to arrange for her to meet with the Minister of Community Services and the Minister of Justice, which hasn't occurred yet. A meeting was set up and because of some of the issues in the House, it wasn't possible to get both ministers in the room at the same time. So that meeting will happen.

My thought would be, and I'll throw this out, that it might be useful for Ms. Keen and her associates to have that meeting with the ministers involved, as a preliminary step, and then see if they're still interested in meeting. I think it might be useful for them to try and resolve their issues if they can. Is that an acceptable - and we will follow up to see if that is satisfactory to them, if they still want to meet.

MR. MACLEOD: Very good idea.

MS. CASEY: Will we put anything in writing to her to say that we will await the outcome of that meeting, or do we just let that meeting take place, if it's going to happen fairly quickly.

MR. CHAIRMAN: It was going to happen fairly quickly. I have spoken with her about it, but certainly we could let her know in writing that . . .

MS. CASEY: Just so she doesn't think that we've ignored the letter.

MR. CHAIRMAN: Absolutely, I think that would be helpful, yes. But just so you are aware, I did have a conversation with her and she seemed comfortable with that arrangement. So we will follow up by letter, just to confirm that we have received hers and that we will communicate to see if there's some closure to the process.

Our next item - well I guess maybe I'll go to the September meeting because our practice has been to take a recess during the summer. Is that to be continued as an appropriate arrangement? I don't see any opposition at all.

That means our next meeting date might be - I had a calendar in front of me - September 6th is the first Tuesday of September, which this year is the day after Labour Day. So I think the question might be, is that an appropriate day for us to meet?

Mr. Bain.

MR. BAIN: Could I suggest, Mr. Chairman, that we meet on the 13th of September?

MR. CHAIRMAN: Kim.

MS. KIM LANGILLE: There's another committee meeting that day. Now they do meet in the morning. We meet in the afternoon, normally.

MR. BAIN: Normally we meet in the afternoon.

MR. CHAIRMAN: I heard the 13th at one o'clock being proposed as an alternative, if that will work from a space point of view.

MS. LANGILLE: It should, as far as I know.

MR. CHAIRMAN: Does that sound like an acceptable arrangement to everybody?

MR. RAMEY: Not to disagree with that - are we meeting on the 7th of June?

MR. CHAIRMAN: Yes, I will return to that.

MR. RAMEY: Okay, sorry.

MR. CHAIRMAN: I'm forecasting a little bit before we get back, sorry.

MR. RAMEY: I'm good with the first proposal there.

MR. CHAIRMAN: Then we have agreement that our September meeting will be the 13th at 1:00 p.m.

I know I'm leaping forward but in the package of materials - sorry, I was only given that. I have a list of topics that we've covered, a few that are upcoming, and just a few that we have proposed in the past but have not yet addressed, I'm referring to that because it might be worthwhile to look at that document again but to use the September meeting as an agenda planning meeting, just to suggest that.

MR. MACLEOD: Maybe if we thought about doing the agenda planning on the 7th of June, that way we'd have the summer to work out the potential list of visitors who would be coming in September, October, November; just give them lots of notice.

MR. CHAIRMAN: That's a possibility. So let me take us back to June 7th, we do have witnesses - the Nova Scotia Participatory Food Costing Project, some folks from Mount Saint Vincent will be here, led by Dr. Patty Williams. That is a good suggestion, so maybe we could come prepared to think about future witnesses and we'll see if we can create enough time to make that possible.

MR. BAIN: Could the list that you have with the outstanding ones be provided to the caucuses so that when we come on June 7th we could be prepared?

MR. CHAIRMAN: Yes, we will do that.

MS. CASEY: I gave him that question to ask. Thanks Mr. Bain. (Laughter)

MR. BAIN: I read your mind. (Laughter)

MR. CHAIRMAN: Any other business that we should be addressing? We do need to talk about the time we're meeting on June 7th; I'm assuming we will be meeting in the afternoon at 1:00 p.m. That's acceptable and space is available for that.

MR. BURRILL: The Mount Saint Vincent people?

MR. CHAIRMAN: Yes.

MR. CHAIRMAN: So I think we've concluded our business. The next meeting will be on June 7th at 1:00 p.m. with our witnesses from Mount Saint Vincent. Thank you. We are adjourned.

[The committee adjourned at 10:36 a.m.]