Valley View Centre

Transition Planning

Recommendations to the

Minister of Social Services

Presented to:

The Honourable June Draude
Minister of Social Services
Province of Saskatchewan

Prepared by:

The Transition Steering Committee
May 2013

Government of Saskatchewan
Ministry of Social Services

VALLEY VIEW CENTRE FAMILY GROUP

Saskatchewan Association for Community Living

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May 2013

The Honourable June Draude
Minister, Saskatchewan Social Services
Room 303, Legislative Building
2405 Legislative Drive
Regina SK, S4S 0B3

Dear Minister Draude:

As Chair of the Valley View Centre (VVC) Transition Steering Committee I am pleased to provide you with the full report of the progress of VVC Transition Planning. The attached report includes the committee's findings and recommendations based on best practices from research the VVC Transition Team conducted. The purpose of this report is to identify how to ensure a successful transition to community-based services and supports for every individual living in VVC.

The committee is confident that if the recommendations identified in this report are followed then the individuals who currently live in VVC will receive supports equal to or that exceed the support they are currently receiving. Our end goal is to ensure the transition is a positive one, made up of experiences leading toward a higher quality of life. There is an opportunity to enrich the lives of the residents through intentional engagement, life skills development, participation in the process, and ultimately through community living and inclusion.

If acted upon, these recommendations will give individuals greater choice in their lives. In order to have choice, there needs to be multiple options and supports available and accessible. It is recognized that supplemental resources are needed to provide ancillary supports, crisis supports, and to develop community capacity and knowledge. In addition community-based employment, recreation, leisure, and therapeutic activities should be further developed to meet the unique needs and preferences of VVC residents. The committee's recommendations will ensure that there are choices by supporting existing agencies, encouraging the development of new programs and services, and focusing on individualized and person-centred planning.

We recognize the importance of fostering existing relationships as well as having new ones. There needs to be opportunities for relationships with staff and friends at VVC to be maintained after the transition. The recommendations also identify the importance of developing natural supports for residents in their new home. Every individual should have the opportunity to develop and access a support network of friends and community members that evolves with them.

We know this has been a time of fear for families and residents. VVC has been many of the residents' home for a majority of their lives. The transition process to date therefore has been incremental to ensure that each family and resident has time to participate, and voice their concerns and future expectations. The VVC Family Group (VVCFG) and the Saskatchewan Association for Community Living (SACL) are available to support families and residents throughout the transition. It is also the SACL's privilege to be available to continue to support the VVC residents in their new home.

We would like to thank you for giving us adequate time to recommend a successful transition plan and follow a process that involves community. It is a timeframe and process respectful to VVC residents and has allowed for critical research to be done, families to be involved and options to be explored. Most importantly, it gives the residents the time needed to consider and express what is important for them to have in their new homes, as well as providing them with an opportunity to identify where they will choose to live.

The VVC Transition Steering Committee looks forward to the continued development of a Made-in-Saskatchewan transition, which will meet the unique needs of all 197 VVC residents.

Sincerely,

Doug Conn

Chair, Valley View Centre Transition Steering Committee

Table of Contents

Executive Summary

In setting a four-year window to close VVC a commitment has been made by government to allow for authentic engagement and participation in the closure. At the direction of the Transition Steering Committee (TSC) a diverse team of professionals and stakeholders have been working diligently to develop the foundation for a thorough and thoughtful transition for the residents of VVC. While there are many factors necessary to establish a successful transition, the unique partnership between families (through the VVC Family Group leadership), advocates (through the Saskatchewan Association for Community Living), and VVC and the Ministry of Social Services (through VVC staff and management and Community Living Service Delivery) is critical in guiding the process.

This report will provide highlights about the research conducted and the information compiled throughout the transition planning to date. It will provide some insight into who the residents of VVC are and what some of their needs might be. It provides some information about processes that have been underway to support the transition planning. And it will discuss key components and considerations that have been made through planning.

The 14 recommendations and their sub-components outline the work necessary to support the residents and their families through the upcoming change in service delivery. They are not hierarchical in order, however, they do paint a picture of the activities required to facilitate a successful process. They identify that future services should be community-based and if followed provide the framework for person-centred planning to be used. They also identify critical considerations including the continuity of service delivery, ancillary support needs, and the importance of relationships. The recommendations provide a framework that will allow government to set the direction for the transition of the residents.

A great deal of preliminary work has been completed in the last year, most of which is usually done by government with the individuals and families in private, prior to announcing something as bold as a closure. In choosing to work in a unique and collaborative manner there has been an opportunity to create a meaningful and transparent process, and to develop a Made-In-Saskatchewan approach. As a result, it may appear as though planning is moving slowly, but the intention is to do it properly rather than quickly.

This report and the recommendations here-in represent the outcomes of that diligent process.

Recommendations Summary

The following is a summary list of the 14 recommendations being made to the Minister of Social Services for the planned transition of VVC to residential services and for successfully moving the residents to new homes. These recommendations are based on best practices identified through research in institutional closure and will inform the Made-In-Saskatchewan approach being developed.

RECOMMENDATION # 1: TRANSITION VALLEY VIEW CENTRE SERVICES TO COMMUNITY-BASED SERVICES

RECOMMENDATION # 2: PROVIDE THE RESIDENTS OF VVC WITH THE OPPORTUNITY TO LIVE IN ORDINARY HOMES, IN REGULAR NEIGHBOURHOODS, AND IN THE COMMUNITY OF THEIR CHOICE

RECOMMENDATION # 3: ENSURE EACH VVC RESIDENT HAS A PERSON-CENTRED TRANSITION PLAN

RECOMMENDATION # 4: EXPAND THE RANGE OF RESIDENTIAL SERVICES AND FUNDING OPTIONS AVAILABLE CREATING INNOVATION IN SERVICE DELIVERY

RECOMMENDATION # 5: ENSURE THERE IS CONTINUITY OF SERVICES FOR VVC RESIDENTS

RECOMMENDATION # 6: FACILITATE THE CONTINUATION AND DEVELOPMENT OF NATURAL RELATIONSHIPS

RECOMMENDATION # 7: ENSURE VVC RESIDENTS CONTINUE TO HAVE ACCESS TO ANCILLARY SERVICES

RECOMMENDATION # 8: EXPAND AND ENHANCE CRISIS PREVENTION AND SUPPORT SERVICE CAPACITY

RECOMMENDATION #9: EXPAND RESPITE SERVICES

RECOMMENDATION # 10: ENSURE EACH RESIDENT HAS ACCESS TO INDIVIDUALIZED ACTIVITIES OF CHOICE

RECOMMENDATION # 11: ENSURE FUNDING IS AVAILABLE TO SUPPORT INDIVIDUALS THROUGH TRANSITION

RECOMMENDATION # 12: DEVELOP AN ACTION PLAN TO IMPLEMENT THESE RECOMMENDATIONS

RECOMMENDATION # 13: DEVELOP AN EVALUATION FRAMEWORK

RECOMMENDATION #14: INCREASE PUBLIC AWARENESS REGARDING COMMUNITY INCLUSION

Preface

On February 24, 2012 the Minister of Social Services, the Honourable June Draude, announced that the Government of Saskatchewan would be starting consultations on improved services for the residents of VVC. Based on that announcement, the TSC and Transitions Planning Team have been moving forward with the following objectives:

1. Develop transition plans to determine the services required to meet each person's unique needs.
2. Align Saskatchewan with best practices in service provision for the residents of VVC.
3. Develop services that better support the inclusion of people with disabilities in our communities.
4. Enhance the array of services available to Saskatchewan people.
5. Transition the residents of VVC into new services.
6. Discontinue the use of VVC.

VVC is one of the few remaining institutions of its kind in Canada. When it was opened in 1955 it was considered a state of the art facility, and was deemed the best way to provide care for people with intellectual disabilities. Today, the institutional model of care is an outdated way of providing support for people with intellectual disabilities, and there is an international movement toward closing facilities of this kind.

Recognizing this, it is important to move forward and provide new and appropriate supports for the residents of VVC while continuing to provide them with the best care possible. This report outlines recommendations to the Minister of Social Services about how to proceed with the development of replacement services for individuals currently residing at VVC and the transition of care and support of the VVC residents to those services. As VVC moves toward closure in 2016, there are many considerations to be made to ensure a successful process.

At the heart of the planned closure of VVC are the residents. The remaining 197 residents of VVC and their quality of life is the highest priority. VVC is their home, and in some cases has been the only home they have known. There is reasonable fear that a move of this nature will have a detrimental effect on them. Life changes on this scale, such as moving homes, are proven to have an impact on health and wellbeing. However, due to the long-term benefits of transitioning to community living research does not support the continuation of institutional care; but we clearly recognize that the transition to community needs to be planned carefully

and managed thoughtfully to minimize negative consequences.[1,2] The recommendations are intended to be viewed with a lens as to the outcomes for each of the residents as individuals and as full citizens of Saskatchewan.

In addition and very importantly, the physical plant and infrastructure of VVC is facing decline and increasing expense. With a population that is continuing to decline and no new admissions since 2002 a point will soon be reached where the care and safety of the residents will be compromised in this deteriorating setting. The buildings are old and require a major investment merely to maintain them operationally. Further, an additional major capital investment would be required to modify the site in order to deliver services in a manner that reflects best practices.

Investment in the physical structure at VVC is no longer a reasonable option, both philosophically or financially. It is clear that a great deal of resources must be dedicated to continue supporting the residents of VVC, and there are choices for where to allocate those resources that were not previously available. It is important to separate the physical and institutional structures of VVC from the care and support that the residents need in order to provide the best services possible. This will in all likelihood cost the government more than maintaining the status quo by investing at VVC, and is necessary to provide the best services possible.

There will of course be a disruption that will impact the daily lives of the residents of VVC. Throughout the transition the goal is to ensure that the impact is a positive one, made-up of experiences leading toward a higher quality of life. Rather than allowing the impact to be negative there is an opportunity to enrich the lives of the residents through intentional engagement, life skills development, participation in the process, and ultimately through community living and inclusion.

At present, the families are offered a certain amount of assurance that their loved one will be taken care of at VVC. This change is introducing a different model of support than many of the residents of VVC or their families have experienced, although some residents have had previous experiences with supports outside of

[1] Lemay, Richard (2009). Deinsitutionalization of People with Developmental Disabilities: A Review of the Literature." Canadian Journal of Mental Health. Vol 28. No. 1. Spring 2009. P. 181 – 194.
[2] Kozma, A., Mansell, J. and Beadle-Brown, J. (2009). "Outcomes in Different Residential Settings for People with Intellectual Disability: A Systematic Review." American Association on Intellectual and Developmental Disabilities. Vol 114. No. 3. May 2009. Pp. 193 – 222.

VVC. Reasonably, there are concerns about the future care, safety and security of the residents and those concerns are being taken seriously.

In response, several commitments have been made to the families. They have been promised that, where possible, quality of care will be maintained or improved. Families have been told that the individual residents will drive the transition process and resources will be put in place based on individual need. Families have been assured that the Government of Saskatchewan will still run some of the replacement services. And the families have been told that when possible residents will have access to the same staff. The goal of everyone involved is to honour those commitments.

The recommendations of this report are intended to assure families that their concerns have been listened to; and to instill in them the peace of mind that the quality of services they have received can be continued into the future, only delivered in a different way. Delivering services in community-based settings better reflects our understanding of how to support people with intellectual disabilities, provide for their needs and supporting them to live inclusive lives.

It is widely recognized that the institutional model of care is no longer the best practice in providing supports for people with intellectual disabilities. The institutional model by virtue of its structure is a barrier to inclusion, choice, and independent decision making. With the approaching closure of VVC the focus is now on providing a service delivery model that will be a leader in the country, and that is appropriate in providing supports to the residents of VVC as full and equal citizens of Saskatchewan.

The research indicates that the majority of individuals and families that have undergone this process in the past are satisfied with the new community-based supports after the transition, but it takes time to realize the benefits of community living. In the meantime a lot of trust is required.

As the development of the 197 individual transition plans moves forward, it is important to note that this report cannot discuss issues related to individuals and their personal planning. Information will be provided in the form of combined data. To protect the interests of the individual residents, personal information will not be shared.

As well, this will not include recommendations in two areas as they are outside of the scope of this report.

1. This report will not provide recommendations regarding specific details or sought outcomes of a human resources and/or labour relations plan beyond recognition that a plan is necessary to enable staff to support the successful transition of residents to new supports.
2. This report will address neither the repurposing of the land at VVC, nor will it make recommendations regarding the repurposing of the buildings or assets on the current VVC site.

This report is the result of the collaboration of stakeholders on the TSC[3] and the information gathered to date. The recommendations reflect the outcomes of research identifying best practices in institutional closure and in planning for the transitions of individuals with intellectual disabilities to new homes. In addition, this report reflects the development of a Made-In-Saskatchewan approach to the transition of residents from VVC in Moose Jaw to their new and future homes.

[3] Stakeholders on the TSC are the Valley View Centre Family Group, the Ministry of Social Services Community Living Service Delivery including Valley View Centre, and the Saskatchewan Association for Community Living.

Research

Research is being conducted in four ways on an ongoing basis to ensure that best practices are identified and engaged in service provision for the residents of VVC when designing replacement services for VVC.

1. Resident information is being systematically reviewed to ensure a comprehensive understanding of support requirements.
2. Grassroots knowledge is being explored including meetings with residents, family members, support networks, VVC staff, community-based agencies and service providers, representatives from local service systems (e.g. Health Regions), and stakeholders in the transition of VVC to closure.
3. Literature is being reviewed from a wide range of sources including government and academic sources in order to provide a thorough understanding of institutional closure.[4]
4. Best practices and the experiences of individuals who have moved out of institutions have been sought. Individuals, families and support networks, professionals who have participated in similar closures and agencies/people who support individuals who have transitioned out of institutions have all been consulted in order to provide practical knowledge about institutional closure.

As research is conducted and pre-planning comes to an end for the transition of the residents to new resources and the closure of VVC, the TSC and the transitions planning team is able to draw upon the information gathered to ensure that a thoughtful and successful transition happens.

The research indicates a few key findings that have informed the development of the recommendations.

Those key findings include:

1. Leadership and philosophy are critical to the success of supporting individuals with intellectual disabilities. In the home, the leadership of the staff providing support will set the tone for how those supports are delivered. The leadership creates the philosophy that will guide the organizational culture and set the standard for how supports and resources are directed to the individuals. When the leadership and philosophy embrace inclusion then the individuals receiving those supports thrive.

[4] Sources are local to Saskatchewan, but also come from sources from around the world.

2. The best practice for supporting individuals with intellectual disabilities is in community-based options. As understanding about the rights and abilities of individuals with intellectual disabilities has grown it is widely accepted that institutional models of care are no longer the acceptable model of support.
3. Research about personal outcomes, quality of life outcomes, social wellbeing, relationships, health and wellbeing, complex and challenging behaviours, personal risk and mortality, and safety and security demonstrates that people with disabilities do better in community-based options. The research does not support the continuation of institutional models of care based on the support needs of the client.
4. Independence, choice, and decision-making opportunities are critical factors in personal development and personal satisfaction. Smaller and personalized support mechanisms are shown to generally support these factors better than larger congregate care facilities.
5. The best practice is to provide ancillary services through typical service delivery systems. However, practical experience indicates that those systems may not have the needed knowledge or capacity to support individuals with intellectual disabilities appropriately. In many cases ancillary service providers do not understand the citizenship rights of individuals with intellectual disabilities to access those services and may have policies in place that act as barriers to accessing supports. Service providers themselves noted the need for ancillary service provision to be cautiously supplemented by dedicated systems while capacity, knowledge, and understanding grow in the typical systems.
6. Ensure that there is the appropriate amount of time and resources to allow for a well-planned and thoughtful transition. Allow the needed time for pre-planning and development. Ensure that the time is allocated to develop the personalized and person-centred plans required to support the success of the individuals in their new homes. Ensure the required resources are in place throughout the process.
7. Involve the Individuals, families, advocates, staff and caregivers, and the community early in the planning process. Building a team around the individual early in the process helps to ensure that the individual receives all of the support and considerations required to have a successful transition, as well as success in the community following the transition.

Supporting the Residents of VVC

The following information will provide a glimpse of the support needs of the residents of VVC. This information is being used to develop a preliminary understanding of what resources will need to be developed to support the residents, and to support their individualized and person-centred plans.

The following data was collected in 2012 at VVC.

The Residents of VVC

To understand the needs of the residents of VVC it is important to have a general understanding of who they are. The residents are a diverse group of people with a wide range of personalities and needs.

The average resident age is 58.9 years, and 80.5% are over 50 years old. It is clear that the population is aging and it will be important to ensure that age related support needs are considered during planning.

Table 1: Resident Age, December 2012

Age group	Female	Male	Totals	Percent
18-30	0	0	0	0
31-40	4	2	6	3.0 %
41-50	10	23	33	16.5 %
51-60	34	52	86	43.0 %
61-70	21	34	55	27.5 %
71-80	7	10	17	8.5 %
81-90	2	1	3	1.5 %
91+	0	0	0	0
Totals	78	122	200	100 %
Percent	39 %	61 %		

The average length of time that the current residents have resided at the centre is 41.5 years. The least amount of time a current resident has resided at VVC is 11 years. The Centre has not had any new admissions since 2002.

Therapies at VVC

Professionals from the Therapies and the Leisure & Independence departments at VVC have provided information to describe the overall therapy needs of the residents. During person-centered planning a more detailed framework will be utilized to describe and capture therapy needs for each resident of VVC.
The following two tables provide an overview of the mobility of the residents of VVC and what therapies they are accessing.

Table 2: Mobility of the Residents of VVC, December 2012

Ambulatory	Ambulatory with support/ devices	Wheelchair (independent)	Wheelchair (with assistance)	Bed
90	20	8	78	4

There is only one designation for mobility for each resident. A large number of the residents are ambulatory and are able to move around independently. However, there are a number of residents who will require homes that can support their accessibility needs.

Table 3: Therapy Needs of the VVC Residents, December 2012

Occupational	Physical	Respiratory
110	153	31

Individuals could be receiving one or more of these therapy services.

The ongoing provision of therapies following the transition will be important to maintain the wellbeing of the residents.

Support Needs

Throughout the centre there are individuals with a variety of medical and behavioural support needs. There are also some residents who require little to no medical or behavioural support. Of the residents of VVC there are currently 77 individuals who are considered to have high medical needs.

Some of the medical issues the residents of VVC have include conditions such as epilepsy, diabetes, dysphasia and Hepatitis B. Some residents live with different levels of hearing and vision impairment, and some of the residents require supports that include gastrostomy tube feeding, indwelling catheters, and specialized diets.

There are also some residents who present some challenging behaviours that require careful management; some of those behaviours could be life threatening for them. The behaviours are understood and addressed, and will continue to be addressed through personal planning and supports in the community. The behaviours of the VVC residents are no different than behaviours already supported across the province for people who live outside of VVC.

In many cases these medical issues and behavioural support requirements do not occur in isolation and may co-occur adding to the complexity of supports required. All of the specific medical and behavioural support needs of the individual residents will be captured and addressed in their person-centred plans.

The Daily Living Support Assessment (DLSA)

The Daily Living Support Assessment (DLSA) is an assessment tool used by CLSD to help to identify the care and support needs of individuals with intellectual disabilities. The DLSA assesses the amount of support required in three major areas; dependence, behaviour and health. Assessment of all residents of the Centre using the DLSA was completed prior to the Needs Assessment Meetings.

The DLSA scores will help to inform both the comprehensive personal planning and support work, and the planning and budgeting for resource development. It is important to acknowledge that a DLSA score is not static. As ones needs change over time the DLSA can be revisited and a new score generated. Over time everyone's support needs may change and vary; this is also the case for the support needs of people with intellectual disabilities.

The following table illustrates that the range of DLSA scores for VVC residents is heavily weighted to the higher ranges. This is not typical when compared to the range of scores available for individuals in the community; this profile would look more like a classic bell curve.

Table 4 indicates 82% of the VVC residents score 3.5 or higher on the DLSA. In the community, and as would be seen in a classic a classic bell curve, the scores would be clustered around 3.

Table 4: Overall VVC Resident DLSA Score, 2012

DLSA Score	1	1.5	2	2.5	3	3.5	4	4.5	5
Total	0	1	2	8	25	39	66	44	15

Table 5 below illustrates the range of scores in each of the three major areas that are assessed with the DLSA tool. Notably, dependence is the most significant support requirement at levels 4 and 4.5.

Table 5: Breakdown of the VVC Resident DLSA Score, 2012

	1	1.5	2	2.5	3	3.5	4	4.5	5
Dependence	4	15	16	20	29	36	60	20	0
Behaviour	2	20	46	50	40	27	10	5	0
Health	6	19	43	39	32	35	10	14	2

The DLSA scores indicate that a larger proportion of the residents at VVC have higher support needs than are found in the community. This was expected given the history of residency and discharges at VVC and the context of service delivery in a facility like VVC.

While the proportion of people at VVC with high DLSA scores at VVC is greater than in community, it needs to be clearly stated that *the level of support required by the residents of VVC is no different than the level of support provided to people in community-based services*. The existing community-based service delivery system is successfully supporting individuals with similar support needs all across the province; and people with similar, and sometimes more complex support needs are being supported in community around the world.

Person-Centred Planning

Person-centred planning is a critical component of planning for the needs of people with intellectual disabilities. CLSD facilitates a process of person-centred planning as part of their Comprehensive Personal Planning and Support Policy (CPP & SP). Each resident will experience comprehensive personal planning with their Community Service Worker (social worker) and the team that is established around them as individuals. The process of person-centred planning identifies the support needs of the individual and identifies how those needs can be met.

Person-centred planning is a process through which all aspects of the participant's life are considered. The participant determines what is meaningful to him or herself. Decisions may range from day-to-day concerns such as what to have for breakfast to larger, more encompassing decisions such as where to live and work. The participant has the right to decide and direct the process.

Complex Needs Assessments

CLSD also uses a standard process of Complex Needs Assessments to identify individuals with more complex needs beyond what may be captured in the DLSA. Only individuals with the most serious, enduring, and persistent challenges will be designated as having complex needs in order to determine what supports can be put in place, beyond what can be established in the person-centred planning process to mitigate those additional challenges.

The Complex Needs Designation process involves the collection and evaluation of specific information to assess if someone would satisfy the criteria used for this designation, and a recommendation for a designation. The recommendation is further assessed and reviewed by the Specialized Programs Unit of CLSD and if it is deemed appropriate the designation is granted.

The process is time intensive and requires some rigour. Initial screening of all residents for this designation process has been completed by VVC staff. Nursing staff have prepared information regarding a number of individuals with high medical needs who may meet the criteria for complex needs. Staff from the Specialized Programs Unit is leading the development of information regarding individuals with high behavior support needs. It is anticipate that fewer than half of the VVC residents will have a complex needs designation.

Research Tours

A research team consisting of members of the VVC Transition Planning Team with members from the Ministry of Social Services Community Living Service Delivery, the VVC Family Group, and the Saskatchewan Association for Community Living toured Western Canada.

There were three goals to the tour:

1. To identify the best practices used in institutional closures across the west.
2. To learn from the practical experiences of individuals, families, support-workers, and government during those closures.
3. To meet with agencies and support-workers providing services to individuals who had transitioned out of institutions in these jurisdictions.

On these tours a great deal of information was collected and has been thematically organized to provide foundational information to establish the direction of the planned transition of the residents of VVC.

Pre-Planning and Preparation

As a matter of course Community Living Service Delivery has processes in place that, when implemented, meet the requirement for individualized and personalized planning. A holistic approach to the individuals should be taken, recognizing people as more than their diagnosis, medical condition, or behaviour. It is important that during the planning process individuals are not classified and categorized based on one or more traits that they may or may not have.

No two individuals are the same, and as a result no two homes or plans should be the same.

From the outset it is necessary to resource the project properly. The development of new capital resources and expanding the capacity of the existing service delivery system will require additional resources to accommodate individuals transitioning to the community.

Given the higher than usual dependence found in individuals residing in institutions, it is important to ensure that transitional resources are in place beyond what would typically be available to individuals within the

existing community-based service system. To ensure a successful transition these resources must be flexible, specialized, personalized, and created based on individual support needs and preferences.

It is critical that family and community be involved in the transition from the outset. Ongoing family engagement and input is necessary to put the right supports in place to facilitate success in community. Family and community engagement is critical to the development of natural supports which are required in lieu of specialized and professional supports found at VVC.

Consideration of the full continuum of supports will be required to ensure successful transitions for the individuals.

A. Residential housing
B. Vocational/Daytime
C. Complex medical needs
D. Complex behavioural supports
E. Aging

In the case of VVC residents, particular attention needs to be given to providing the medical and behavioural supports required for success, and also, of the effects of aging on the individuals' support requirements. In regions that have undergone institutional closure, it is the closure that has stimulated innovation and creativity in the community sector.

Across all of the regions visited on the tour, it was noted that existing ancillary support systems may not have the capacity or knowledge to support individuals with intellectual disabilities, and that challenge is exacerbated when attempting to support individuals leaving institutions. To offset these issues it is necessary to engage ancillary systems to grow their capacity and provide the necessary knowledge to do so. These systems may not understand the inherent citizenship rights that individuals with intellectual disabilities have as members of society.

However, it is important to balance support needs with choice in order to ensure a lack of immediate or direct access to these supports does not infringe upon community living. This is of particular importance when planning for individuals who have identified rural or remote areas as their new community of choice; particularly where access to one of the supports required may not be easy to or possible.

During the process it is important to acknowledge that the attitudes and skills of both the current care staff and the community-based staff can influence the transition of individuals to the community. Leadership and philosophy will have a noticeable impact on the outcomes. As in any process, an expectation of failure may have great potential to become self-fulfilling, while positive attitudes and strong leadership have the potential to develop the innovative and creative solutions required for success. It is important to provide information and opportunities in the form of values based training to alleviate these pressures.

Transitioning Individuals to Community

The planning for the transition of residents needs to begin prior to the applied approach to transition. There are existing systems, policies and supports in place to facilitate the approach to transition, however, within that planned approach there must be flexibility that ensures the transition process fits the individual, rather than the individual being led through a process that may not be appropriate.

When transitioning individuals, timing and an understanding of the individual will be critical to successful transition. There is no magic formula that will develop a specific transition process. Some individuals will succeed with rapid transitions moving from one place to the next immediately, while others will require long and well-formulated plans. In either case, following a model of person-centred planning and supported decision making will identify what the individual requires.

It was identified, primarily in British Columbia after the closure of their institutions, that the relocation of individuals within the institution should be minimized during transition to closure. Throughout the closure process it may be economically prudent to close homes and reduce expenditures, and therefore tempting to move people around as the population size is reduced. This practice is ill advised as it creates a situation where individuals are undergoing unnecessary stress and turmoil that may jeopardize the successful transition to community.

Community inclusion is critical to the development of natural and community-based supports, and has been shown to greatly improve the quality of life of individuals. The needs and wants of individuals should be balanced with community inclusion to establish the best possible supports.

No two residents are the same and no two residents will have the same support needs. When planning for individuals it may appear as though it would make sense to plan for individuals with similar support needs

together; people with high medical support requirements with high medical, and high behavioural support requirements with high behavioural, as it may be possible to gain some specialization and economies of scale by doing so. It was recommended that this is not the best practice and the result, instead, is the potential concentration of a high and stressing workload on front line staff and agencies. We therefore should support individual needs and diversity within the planning process, and find connections such as friendship and similar interests that support the whole individual instead.

Within VVC there is generally direct and immediate access to ancillary services. In the community, access to these services regardless of level of ability can be challenging. It is important that ancillary services are coordinated prior to transitioning an individual. However, access to ancillary support needs should be balanced with personal outcomes, and lack of access should not be a barrier to community inclusion, independent choice, or decision-making.

Individuals with needs similar to the individuals residing in VVC are being supported, to differing levels of success, in community-based residential options across Western Canada, including in Saskatchewan.

Community-based Supports

The continuum of residential options for individuals with intellectual disabilities ranges from no supports (homelessness) at one end to market based housing at the other end (Ownership). Options for supports can range from complete independence to 24 hour a day support. In any service delivery model there are limited options, leaving gaps in the types of supports people are able to access. There is an opportunity to fill those gaps and provide a greater ability to respond to the needs of individuals across the province.

VVC staff has a great deal of specialized knowledge in supporting the needs of the residents. That knowledge can be transferred to the community to ensure that there is continuity of supports throughout the transition and into the future. Beyond the knowledge about the specific residents, there will be professional knowledge that should also be transferred to community including: therapies, medical supports, behavioural supports, and overall support strategies.

In other regions, prior to transition to community a number of residents and families indicated a desire to develop new institutions rather than move to community-based supports. It can be easy to assume that residents are accustomed to living within VVC and that they require the congregate model of support.

However, it was identified during the research in other jurisdictions that even though the development of a new institution may have been the preference prior to institutional closure, once individuals move to community the satisfaction is high and the institutional model of support is no longer the preferred option. Individuals that have left institutions across the country who are living in community-based settings are thriving.

All of the stakeholders met with during the research tours identified independent living as the best practice, but allowing for choice and economic realities, three or four individuals living together could work, regardless of support needs.

Existing service providers, supports, and resources will have a key role in the long-term viability of supporting individuals in community after transition. While VVC staff have specialized knowledge of supporting residents in the VVC setting, community-based supports have specialized knowledge in supporting individuals in community. Engaging both systems to look for solutions and to develop resources that work in community will support the transition process.

Successful community-based living is dependent on relationships. Individuals must have relationships with professionals that they will be accessing in community, but more importantly, natural relationships must be supported and encouraged.

Complex Medical and Behavioural Support Needs

Access to specialized services and supports is required at a level not easily attainable in community-based services. If access to services and supports is diminished, then there is potential for individuals to deteriorate in community. There needs to be bridging mechanisms and/or parallel service delivery systems in place until community-based services can be developed to maintain the existing levels of support.

Within community the typical response to crisis can be slow and reactive. Crisis response needs to be supported through a zero-rejection policy that will enable quick and effective supports being put in place to allow stabilization after crisis. This service can be provided either through government-funded community-based agencies or through government-run programs.

There are capacity issues within many existing community-based supports and barriers to accessing ancillary services that could impact quality of life. There is a lack of understanding of disability, the citizenship rights of

individuals with disabilities, and how to support individuals with disabilities within many of these systems. There needs to be a concerted effort to grow the capacity in community, and to provide the knowledge required to remove these barriers and create sustainable supports.

Innovation and New Community Resources

In the different jurisdictions visited, institutional closure was identified as an opportunity to support the creation of new and innovative resources in the community. The different medical and behavioural support requirements of residents leaving the institution can facilitate the use of new models including self-directed funding and community-based programming in place of congregate resources. Throughout the research tour congregate services were not recommended. Homes should have three or four residents, and in extenuating circumstances six residents at most.

In the case of long-term care facilities following the Eden™ philosophy, it was recommended that there be a maximum of 10 people per home/ward.

It was questioned if government should be involved in the ongoing provision of direct services to individuals or strictly be a funding body for services. Across the research tour it was recommended that community-based agencies (through traditional block funding models) or individuals (through forms of individualized funding) be funded to provide ongoing community-based supports and that the role of government in the direct provision of services be minimal.

Over the past 40 years the role of government in direct service provision has been largely displaced by community-based services. In Saskatchewan there are now approximately 4,100 people being served in community, and only 200 in government delivered care. The role of government in the direct provision of support should be reduced over time, although there is still a role at this time.

New services and supports should be flexible and responsive to the needs of individuals. Funding should be easily tailored to suit the needs of individuals, and models should be based on individual support needs and person-centred planning. Many of the individuals transitioning out of VVC may require transitional services and supports over and above what is typical in the community-based system. New services, funding, and models, need to accommodate this greater need, provide for the bridging of supports and for temporary

support needs in order to support individuals to live successfully in community. Existing resources may not have the ability to do this.

Traditional Service Delivery Models

The closure of institutions in other jurisdictions facilitated the development of new service models, and served to support existing service providers to strengthen their programs and services. There is an opportunity to support community-based agencies to expand and further the supports they are offering.

Funding needs to be flexible and support the individuals leaving the institution. Funding should be attached to individuals to provide sustainable support in the long-term. If funding is not attached, individuals entering the existing service delivery system may become displaced, and obligations made during closure for continuation of level and quality of support may not be met.

In all areas visited, recruitment and retention of staff is an issue. Many agencies offered solutions including higher wages; however, training and benefits were cited as critical factors in staff retention.

Access to Ancillary Services

In community there is ongoing difficulty in accessing ancillary supports. Levels of support available within VVC must be maintained to ensure the wellbeing of the residents.

In order to continue to provide the current level of support, access to ancillary supports needs to be supplemented in the community. Typical community-based systems may not have the knowledge, capacity, or expertise to support the ancillary needs of individuals transitioning out of VVC. Capacity in the traditional ancillary support sectors needs to be developed and cannot be expected to exist at the time of closure. Ancillary supports need to be bridged, in order to allow community capacity the time it needs to grow.

The development of supplemental resources, to provide ancillary supports, crisis supports, and to develop community capacity and knowledge is recommended.

It is important to discuss the impact of the closure of VVC with community service stakeholders early in the process. The impact on community-based stakeholders can be large, and needs to be accommodated and planned for. In many sectors community capacity does not exist to support large numbers of people leaving VVC. It is important to develop capacity over time through education and knowledge transfer, and to not

expect capacity to immediately and organically exist. This is particularly important to be aware of in the community of Moose Jaw where there will be the largest influx of VVC residents to the community, and therefore the largest impact on services; however there will be similar effects in many of the communities that VVC residents prefer.

Congregate Care

Individuals with intellectual disabilities, including those with complex medical and behavioural support needs, are being supported in community-based residential options.

The use of long-term care facilities should only be considered when it would be the typical community-based support offered to any other citizen and should be inclusive in nature and design, not solely for the support of people with intellectual disabilities. In other regions it was noted that the best outcomes for quality of life including health outcomes, occur in inclusive community settings.

Facilities that follow the Eden™ Model of Care were visited on the Saskatchewan research tour as they were indicated as a best practice in the provision of long-term care. While they do provide a high quality of life for the individuals who reside there, this model does not focus on establishing community inclusion, natural support networks, and community living but instead focuses on the creation of internal community development and engagement in order to combat loneliness, helplessness and boredom. As a result the model meets its goal and has strong outcomes, but is not necessarily suitable for people with intellectual disabilities based solely on disability.

Throughout the research tour it was indicated that, for people with intellectual disabilities, it is the best practice for individuals to live as independently as possible, not in congregate care settings. Three or four individuals living together would be acceptable and at most six. In an Eden™ facilities visited it was indicated that there should be no more than eight to ten people living in a home.

The development of facilities specifically to support individuals with complex medical or behavioural support needs was not recommended. They hinder the growth of community capacity to provide the needed supports. Instead, it was recommended to provide support in community, provide the needed specializations in community, and take the opportunity to develop community capacity over time with the specialized knowledge of existing institutional staff.

The development of a congregate care facility or large scale project dedicated to residents leaving the VVC would not be inclusive or meet obligations for inclusion and would not meet commitments to follow Article 19 of the Convention on the Rights of Persons with Disabilities.

Needs Assessments

Following the February 24, 2012 announcement of the VVC Transition Initiative, all families were contacted by Ministry of Social Services Community Living Service Delivery staff assigned to the VVC Transition Planning Team. A basic template was developed and used to guide the initial conversation.

This preliminary contact was intended to provide basic information about the announcement, to enquire about the family's willingness and ability to participate in needs assessment meetings regarding their family member, and to capture some initial feedback from families regarding any preferences they may have regarding a future geographic location.

Subsequently, a team was formed to complete needs assessment for all of the residents of VVC. The team was tasked with planning and organizing the needs assessment meetings, and any preliminary work required to support the transition of the residents to new homes.

Specific tasks included:

- Determining what assessment tools/processes to use for the initial needs assessment.
- Organizing the completion of any "formal" assessments.
- Developing an agenda for conducting the needs assessment meetings for each resident.
- Developing templates to guide the collection of information.
- Contacting individuals, families, caregivers and other significant staff, and coordinate scheduling of meetings on behalf of each individual.
- Preparing summaries of the information collected to share with families regarding their family member.

All needs assessment meetings were completed by December 2012. All next of kin were contacted and encouraged to participate in the needs assessment meetings. Led by Ministry of Social Services CLSD staff the meetings were held with the residents, VVC staff from various departments and SACL Transition Plan Advocates for individuals who did not have family representation or with families who chose to have SACL participation.

Families participated in 75% of the meetings and SACL Transition Plan Advocates in 48% of the meetings. Summaries of the discussion from meetings were distributed to individual families. See Appendix 1 for a copy of the Needs Assessment Meeting Agenda, which was used as a format for each meeting.

The purpose of the meetings was to focus on sharing the information prepared by staff prior to the meetings with participants at each meeting;

- to discuss significant concerns, services and therapies received and quality of life features important to each resident,
- to provide an opportunity for families to share their hopes and fears about the closure and preferences for geographic location, and,
- to add any additional information provided by individuals, families or staff, and to answer questions about the process.

The information gathered at the needs assessment meetings was fairly high level in nature, and when person-centered planning proceeds more detailed information will be compiled.

A needs assessment template was created based on quality of life domains that were used to guide the discussion at the meetings. VVC staff completed the templates prior to each meeting for each resident. The template addresses the following areas:

- Social Participation including interpersonal relationships (friendships, social networks and social activities) and social inclusion (involvement in the community outside VVC).
- Well-being including emotional well-being (positive experiences, safety and security), physical well-being (positive health indicators, physical abilities) and material well-being (income and possessions).
- Independence including personal development (skills and adaptive behaviours) and self-determination (choices, autonomy and control).

Additional information discussed at the meeting was added to the templates. Please see Appendix 2 for a copy of the template.

During the needs assessment meetings a great deal of information was gathered. Basic information regarding the residents was compiled, concerns were brought forward and discussed, and preferred locations for new services and homes were identified. As well, services and supports required were brought to the attention of the team.

Families Concerns

There are a number of concerns that have come to the forefront of conversation during the needs assessments. As they are brought forward the team had the opportunity to address them and to ensure that they are considered as planning advances.

Some of the concerns brought forward during the meetings include:

Confidence in community to serve people with this level of need.

Some families and VVC staff expressed concern that many of the individuals residing at VVC have complex and sensitive medical and behavioural support needs. Families expressed concern that community-based organizations have non-professional staff who are not paid as well as staff at VVC, that agencies experience significant turn over of staff, and that there is inexperience dealing with people with very challenging needs in the community.

Access, including immediate access, to ancillary health services.

A number of families and VVC staff expressed the benefit of having all health services under one roof and the importance of immediate access to these services. Occupational Therapy, Physiotherapy, Respiratory Therapy, Nursing, Dental, Doctor are all available on site or through dedicated services at VVC.

Emotional times/fear of unknown.

Many of the families and staff who participated in the meetings expressed emotions and expounded on a fear of the unknown. Some families shared grief for past decisions; a significant number shared a worry about the future.

Safety & security.

Many meeting participants expressed concern that VVC has been a protected environment where individuals did not need to learn about street safety and hazards like hot stoves. There is a fear that people will not be protected to the same extent out in the community; they like the notion of having locked facilities where risk is eliminated.

During the meetings participants were assured that these issues are being considered in planning.These concerns are being addressed in the recommendations being brought forward and are greatly impacting the transition process.

Location of Choice

At the needs assessment meetings, individuals and families were asked to identify a location of choice for a future home. Some families found this to be a challenge as they are not aware of the array of residential options available in the community. Some families identified they wanted VVC to remain open or have a new facility that offered the exact same level of service. Other families took this opportunity to express their desire to have their family member move closer to them, so that they could reconnect and become a larger participant in the individual's life.

Table 6 on the following page provides a summary of the preferred locations that were identified at the needs assessment meetings. This table also includes a summary of the locations that were identified during the initial contact with families following the announcement.

When discussing the preferred location of services, and where people would like to live additional detail was made clear. It was not specifically asked, but 47 families indicated VVC as their initial preferred choice for services, however, since VVC was not going to be a choice they were still asked to provide their location preferences. The 26 who identified as "Undecided or No Preference" during the needs assessment includes meetings without families where the individual was not able to declare a location of preference for him/herself, and families who expressed they did not have a preference.

Table 6: Preference for Location of New Services, 2012

City	Initial Contact	Needs Assessment Meeting
Undecided or No Preference	32	26
Moose Jaw	62	129
Regina	16	12
Saskatoon	17	16
Prince Albert	4	8
North East	2	1
North West	3	1
South East	2	2
South West	7	1
Out of Province	3	4
Total	116	174

Please see Appendix 3 for a list of the specific communities for the locations noted as regions.

64.5% of the individuals and their families expressed Moose Jaw as their first choice, and an additional 7% identified Moose Jaw as their second choice. Moose Jaw was overwhelmingly indicated as a preference because, even if VVC was no longer going to be an option, the community of Moose Jaw is where the residents call home. By remaining in Moose Jaw there is hope that relationships will be able to be maintained.

Mental Illness and Disability

In the community at larger there is some confusion between mental illness and intellectual disability. The confusion can lead to misunderstandings about the services provided for people with intellectual disabilities, and who receives these services. Individuals with intellectual disabilities and mental illness both require similar services and supports, and as a result when resources are being planned communities have confused and mixed reactions including NIMBY-ism[5] and negative attitudes.

CLSD's mandate is to support individuals with intellectual disabilities. The criteria for receiving services from CLSD are:

- Significantly sub-average intellectual functioning: Defined as approximate IQ of 70 or below on standardized measures of intelligence. This limit is intended as a guideline; it could be extended upward through to IQ of 75 or more, depending on the reliability of the intelligence test used.
- Impairments in adaptive behaviour: Defined as significant limitations in an individual's effectiveness in meeting the standards of maturation, learning, personal independence, and/or social responsibility that are expected for his or her age level and cultural group.
- Manifested during the development period: Defined as the period of time between conception and the 18th birthday.

However more broadly intellectual disability is defined by:

- Thoughts being limited in cognitive understanding and ability.
- Being life-long and not dissipating.
- Onset occurring before the age of 18.
- Medication is unable to restore cognitive ability.
- Being assessed by a psychologist.

Mental illness is defined differently than intellectual disability.

[5] NIMBY-ism: Not In My Back Yard – the response of community members who do not want a service or support offered in their community out of fear of the impact that it will have on the community.

Mental illness is a disease of the mind that affects the psychological state of a person with emotional or behavioural problems serious enough to require a psychiatric intervention.[6]

Mental illness can be characterized by:

- Disturbances in thought processes and perception. Individuals may experience hallucinations and delusions.
- May be temporary, cyclical, or episodic.
- Onset can occur at any age.
- Medication can be prescribed to control the symptoms.
- Diagnosis by a psychiatrist.

Intellectual disability and mental illness are different from each other. However, it is important to understand that many of the supports required are similar, but when controlled with medication or supports, individuals with mental illness can live symptom-free, where there is no cure for people with intellectual disabilities.

It is however possible for individuals to have a dual diagnosis – the co-occurrence of an intellectual disability with a mental illness. The two are not mutually exclusive.

[6] WordNet (2013). WordNet Search – 3.1. "Mental Illness". Princeton.
Retrieved from: http://wordnetweb.princeton.edu/perl/webwn?s=mental%20illness

Seniors with Intellectual Disabilities

There are a growing number of people with intellectual disabilities who are aging, both in VVC and in the community. Due to advances in medical technology the life expectancy of people with intellectual disabilities has increased, however people with intellectual disabilities tend to experience age related illnesses earlier than people without disabilities. This has brought about the need to provide age-related supports to people with intellectual disabilities where it was not previously needed.

There is a lack of understanding of aging in the disability sector, and of disability in the seniors care sector. There are differences in principles and values where in the disability sector concepts such as person-centred planning are prioritized, and in the seniors sector the focus is on the provision of services to address specific needs. There is also a great deal of hesitation for the different service providers to share resources and responsibilities given perceptions of abundant resources in both systems and the reality of resource constraints in both.

Recognizing the citizenship rights of people with intellectual disabilities, it is necessary to plan for people with disabilities when planning for an aging population. Individuals with intellectual disabilities will also require access to the same age related supports as everyone else. However there are gaps in policy and service capacity that do not specifically address the needs of seniors with intellectual disabilities.

Discussion

There are 197 residents of VVC who require individualized and person-centred transition planning. The focus of the TSC is on developing 197 successful transition plans, based on the needs of the people who currently live at VVC in order to have successful transitions to new services in the community. Each resident of VVC is unique and has individual needs, wants, preferences, and personalities. By following the CPP & SP process of CLSD the outcome should be plans that work for the individuals, meeting their individual needs and establishing mechanisms to provide the necessary supports and resources for successful community living.

Over time the model of care and support for people with intellectual disabilities has changed. In the 1950's, when VVC was opened it was the best model of care available for people with intellectual disabilities. At the time there were no suitable community-based options for families to choose, and moving loved ones to facilities like VVC was what families did on the advice of the medical and social services community, and based on the social norms of the time.

The alternative was to keep their children with an intellectual disability in the family home and to rely on personal resources to create the supports. Families did choose this option, and many aging parents still support their children in the family home. The SACL supports families who made this decision, and are available to support them in order to alleviate the pressure on aging parents and siblings to provide supports.

Beginning in the 1960s with families seeking alternate options for their loved ones, the inclusion movement started to see resources developed in the community. Starting with the development of inclusive schools and community living options, the standard of how to best support people with intellectual disabilities began shifting from a model of congregated and segregated care in institutions like VVC to community-based resources. The most commonly known forms of services to arise out of this shift is the group home model for living and day programs with sheltered workshops for activities; both very prolific models in Saskatchewan.

As our knowledge of supporting people with disabilities has grown, so has the range of options for supporting people with disabilities. Globally, there has been a shift in policy and programming that is seeing institutions closed in favour of supporting people in an inclusive manner, recognizing people with intellectual disabilities as individuals with full citizenship rights including the right to live in community. Institutions in and of themselves are not necessarily bad places. However, in the case of providing supports for people with

intellectual disabilities, institutional care is no-longer an appropriate model. Deinstitutionalization is now a dominant social policy, and can be seen across Canada as institutions have been closing nationally.

But what is an institution? The People First of Canada & the Canadian Association for Community Living joint task force on the Right to Live in Community identifies an institution as "…any place in which people who have been labelled as having an intellectual disability are isolated, segregated and/or congregated. An institution is any place in which people do not have, or are not allowed to exercise control over their lives and their day to day decisions. An institution is not defined merely by its size."[7] This identifies the basics of an institution, but there is a need to add further detail to this to clearly identify what an institution is in order to avoid inadvertently creating new ones.

Institutions have characteristics beyond isolation, segregation, and congregation that are not typical to the homes of people living in the community. The following represent the primary concerns that have surfaced regarding the attributes of institutions that are undesirable.

Institutions are not about the people that they are intended to serve – although they may provide the needed care to varying degrees of success. In the administration and ongoing operations of institutions the focus is on the facility as a workplace and as an employer and how to manage those components of service. The concern of administrators becomes human resources and labour relations, and how to provide the services. In this hierarchy of service delivery the person receiving the services is usually at the bottom with limited options for choice and decision making. In this way institutions are about staff.

By their nature institutions look for efficiencies in how services are delivered. Institutions tend to be scheduled based on the operational needs of the facility, the required tasks of the staff, and how to minimize costs rather than on the choice, preferences, and self-determination of the residents. Activities of daily living are scheduled and timed based on the need for efficiencies in time management and the delivery of supports. A typical example of this would be meal schedules – where a specific meal occurs at a specific time within a set time period in order to allow the next activity to proceed. On the surface this may seem reasonable, and in the institutional setting, it is. But when coordinating a facility with a large number of people a set meal time has implications for the schedule for the entire day that continues to affect the independent choice and decision

[7] People First of Canada (2006). Deinstitutionalization. Retrieved from: http://www.peoplefirstofcanada.ca/deinstitutionalization_en.php

making of the individuals. It is more efficient to provide scheduled and limited options to everyone at the same time than to provide for individual choice.

Institutional living creates limitations on the ability of people to choose where to live, and with whom. Instead the focus is on facilities management as a form of organizing people rather than on supporting choice and decision making for individuals. Institutions typically have openings in beds and people are placed in those openings. Varying levels of care can be undertaken to ensure that the placement is a good one; however in the congregate model of care institutions tend to categorize, sort, and place people with limited regard for the choice of the individual. In this manner, institutions are about spaces and placements rather than on the development of the personal plan for the individual and how best to meet the outcomes of that plan.

Historically, large institutions have operated on a ward model of service delivery where larger numbers of people live in a larger congregate care setting. At VVC there were periods in its history where as many as 60 people lived together, sleeping in a dorm together, eating together, and spending their days together. Currently VVC operates with approximately 20 people living together and strives for individual bedrooms, smaller numbers of people sharing accommodations, and enabling choice in the lives of the residents. The reality is that regardless of the intention of staff and management, the institutional model is not able to support independence and choice for the residents to the extent that community-based models can.

Institutions focus on the delivery of safe and secure care for the people who live within them. The environment contains the individuals and shelters them from the outside world. There is an inclination to shelter individuals with intellectual disabilities from harm or from experiencing the challenges of day-to-day life. In institutions individuals are sheltered, behaviours are managed, and ‘everything is taken care of,’ but there is a dignity associated with risk that is a part of treating people as capable adults in community. Dignity of risk is the right of people to take some risk while engaging in life experiences. In taking risks people are able to grow and change, and are challenged in ways that lead to having a meaningful life. Through supported decision making and with the right supports risk is not reckless or dangerous, but empowering and engaging.

When moving forward in planning for the residents of VVC there are a number of attributes that are desirable to support. The models developed in the future cannot lead to isolation or segregation. They should be based in the community and be developed in a manner that fosters engagement with the community. To lead full and inclusive lives people need to be full and active participants in their community.

Smaller is better and the models developed should not be congregate models of care. This does not necessarily mean living alone, which can also lead to social isolation and a different form of segregation. A balance must be struck between independent choice and decision making in choosing how one's life looks and the need to provide services to 197 people. The smaller the setting the more personalized supports can be, the more tailored activities can be, and the more opportunity there is for active participation in the household.

The number of people that any one place serves is not necessarily a deciding factor on if it is an institution. Large is not in itself a deciding factor. A household of one person that creates isolation and segregation, and prioritizes the administration of support over providing the supports to an individual can be an institution. However, large congregate care facilities tend to develop systems and supports that undermine inclusion, choice, and independent decision-making to a greater degree than community-based options. The larger the facility the more institutional forms of support are likely to happen.

As services are developed, it is important to be wary of institutional creep. As the number of people increases in the service delivery model, or as services are delivered in closer proximity to medical and systems based supports, the more likely it is that institutional creep will occur. Simply put, as the home grows the more likely that the focus will become about the administration of the home rather than on the support of the person in that home. When the focus shifts from prioritizing the individual to prioritizing delivery of care to that individual in this way, the model is shifting towards an institutional model.

Resources that are developed, whether they are residential options or supports, need to focus on the person as an individual. Inclusive community living shifts the priority from the facility to the person. Processes such as person-centred planning, supported decision making, and the development of support networks around people enable individuals to live full and meaningful lives.

Inclusive community-based models become less about the administration and operations of support, and how to apply them to people, and become more about a model of service deliver for a person that requires administration and operationalization. It reverses the institutional model. In an institutional setting a program or service is developed and it is applied to the person, in this model the person is planned for and the service is delivered.

The community-based model is about creating a home, and choice within that home. Choosing where to live, who to live with, and what happens in the home is fundamental to support basic dignity; which leads to high quality of life outcomes. Home can support the whole individual, and in community-based models the home is about more than the delivery of specific services, but about supporting the whole person. Living at home should be the first priority, and receiving supports, services, and care should be secondary.

A critical factor in all service models is relationships. In the institutional model of care relationships are typically developed within the environment. Relationships are formed with peers and the support staff in the facility. There is generally limited opportunity for natural relationships to develop outside of the constraints of the facility. In community-based models similar relationships also form with peers and the staff that support the individuals, however in community there is enhanced opportunity for additional natural relationships to be formed. Neighbours, community members, and local businesspeople become a part of the natural support network around the individual and become a natural safety net.

The institutional model and the community-based model can both provide a home for people with intellectual disabilities. A home can be defined in any number of ways, and has a great deal to do with how you personally feel about it and relate to it. A home is what you know and how you feel about it. A home is defined by family and the feelings that you have about it. The most important notion is that following transition quality of life outcomes, safety, and personal satisfaction are improved in the community-based model.

Recommendations

In keeping with best practices for providing services to adults with intellectual disabilities, the following recommendations are being presented to the Government of Saskatchewan to support the development of a Made-in-Saskatchewan approach to the transition of the residents of VVC to new services.

RECOMMENDATION # 1: TRANSITION VALLEY VIEW CENTRE SERVICES TO COMMUNITY-BASED SERVICES

Accessing community-based services is shown to provide better quality of life conditions and experiences, as well as improvements in adaptive behaviours and health than accessing services in institutional care.

1.1 Government should be the funder, regulator and supporter of the service system

Best practice in service provision is that government not be the direct provider of services. Service delivery that supports inclusion and community-based supports for individuals with intellectual disabilities has better outcomes when provided through community-based services. Government should continue to fund the provision of services for individuals with intellectual disabilities in the community.

There is a necessary role for government in the ongoing provision of ancillary, outreach, and crisis supports.

These include:

- Services when personal safety is compromised.
- The provision of a zero-rejection resource.
- The ongoing provision of ancillary supports.

During the transition of residents to new services there may be a need for overlap between government and community delivered services in a limited way. But government should adopt the vision of getting out of the business of direct service provision.

Not everyone living at VVC requires the level of support provided in government delivered services. Government delivered services are only required by a small number of people and tends to only be for limited periods of time.

1.2 Develop new agencies in consultation with individuals, family, and VVC staff to provide new residential supports

Provide access to the needed expertise and resources required to develop new agencies. This might include individuals with skills in organizational development (governance and administration), project management, municipal affairs, and housing developers.

New agencies will be required to provide for the residential and support needs of the residents of VVC as they move to community. Agencies are typically formed by individuals and their family, and in the case of the residents of VVC the staff may have a critical role in the development of resources that meet the needs of VVC residents. For the success and stability of new development, access to the relevant experts is necessary.

1.3 Support existing agencies to adapt to the inclusion of VVC residents into their services through additional transitional resources

Provide training and professional development opportunities. In order to strengthen the service delivery system opportunities should be presented to agencies to adapt to include residents of VVC and to strengthen their programming.

1.4 Ensure there is close monitoring of individuals following moves to the community

Ensure that great care is taken during transition. People, regardless of ability, are generally more susceptible to disease and death following major life changes, such as moving. All of the stakeholders are quite sensitive to this reality. This was one of the key reasons that a four year approach was taken.

During and in the period immediately following transition provide planned and comprehensive monitoring of the residents.

1.5 Address recruitment and retention issues in service delivery

Staff and family have both brought forward concerns regarding the recruitment and retentions of staff in the delivery of services in the future. There are many issues that affect the successful recruitment and retention of staff to provide supports and services in the community sector. These can include salary, professional development, training, and benefits. Continue to look for solutions to recruitment and retention issues that are evident in the delivery of community-based services.

RECOMMENDATION # 2: PROVIDE THE RESIDENTS OF VVC WITH THE OPPORTUNITY TO LIVE IN ORDINARY HOMES, IN REGULAR NEIGHBOURHOODS, AND IN THE COMMUNITY OF THEIR CHOICE

Some VVC resident's family members and VVC staff expressed limited confidence in the community service delivery system to be able to meet the needs of current VVC residents. However, evidence and decades of practice has proven that all individuals, no matter their ability or disability can live safe, meaningful, and inclusive lives in the community. Adults with intellectual disabilities should have access to living arrangements and everyday routines that closely resemble the rest of society including options to live alone, with one's family, or in a small group with their peers; in an ordinary home and in a regular neighbourhood.

Individuals should be provided with the opportunity to live as independently as is possible. Living independently does not necessarily mean alone. Independence is supported by choice and decision making – choosing who one lives with and in what location. Household size should be based on individual preference rather than on notions of economies of scale, the provision of special supports, and the particular needs of any one cohort of people.

2.1 Housing and supports should be dispersed across the community rather than in a congregated setting

Best practice indicates that housing should be provided in typical settings in typical neighbourhoods. Housing that is dispersed across communities maximizes individuals integration into the community, reduces stigma, and facilitates community inclusion. Dispersed housing has shown to have better outcomes for an individual's quality of life while congregated residential settings tend to inhibit choice and independence while reinforcing segregation and isolation of the residents.

2.2 Homes should be developed with no more than four (4) individuals living together*

Best practice indicates that homes with 3-4 people living in them are the maximum of an ideal living situation. The fewer people living together the more individualized supports can be. As house size grows service provision can quickly become about household operations, managing the home, and human resources rather than focusing on service delivery and the provision of supports for the people who live there. The larger the number of people who live together the greater likelihood independence, choice, and inclusion are eroded.

** There are exceptions to this best practice that relate back to personal choice, preference, and the outcomes of personal planning, however they should be considered with caution.*

2.3 Homes should be indistinguishable from other homes in the neighbourhood

Homes should look and feel just like any other home on the street. A home should be a place that the people who live there are proud of. When a home is noticeably distinguishable as a place that provides a service it can become stigmatized and lead to social isolation.

2.4 Identify opportunities to be included in housing projects that may be under development across the province

Look for opportunities in typical housing to support the residents of VVC. Partnerships with other government agencies providing affordable housing and working with property developers outside of the project can lead to innovative options and secure housing by experts in the field of housing.

- Work in partnership with private developers to build new homes when appropriate.
- Work with SaskHousing Corporation for the creation of homes based on the existing relationships with CLSD, and their expertise in providing affordable housing.
- Identify other opportunities that may support the development of new housing.

Over the past four years, the government has invested significantly in expanding residential services in the community. The planning, design, and development of these new homes has been supported by experts in the housing field including the Saskatchewan Housing Corporation (SHC), a facility planner with the Saskatchewan Association of Rehabilitation Centres (SARC), and local developers. Further expansion and development of housing and other related capital projects resulting from the VVC Transition will need to continue to rely on experts to support these projects.

RECOMMENDATION # 3: ENSURE EACH VVC RESIDENT HAS A PERSON-CENTRED TRANSITION PLAN

VVC residents, family members, staff and advocates expressed similar opinions, that the needs of the VVC residents must be considered first when developing transition plans to a new home. Residents should experience similar to or improved service delivery once they move from VVC.

The following principles should guide planning:

- Actions reflect equal worth of all people.
- Each person has unique intellectual, spiritual, social and physical needs.
- All interactions convey respect for the value and gifts of each individual.
- The individual is provided the choice of varied opportunities for optimal learning and growth.
- Opportunities for each individual are consistent with the range of what is seen and experienced by others in the community.
- Optimum learning, growth and change take place in enriched environments with people who respect and value the individuals.

Nobody should move without an individualized transition plan.

3.1 Provide the necessary resources and the mandate to begin individualized transition planning

To date, the focus has been on research and pre-planning for the transition of residents to new services, and on closure of the facility. It is now time to take the next step and begin the transition planning of the residents of VVC. Authorize the Community Services Unit at VVC and the VVC staff to begin person-centred planning.

3.2 Follow the Comprehensive Personal Planning & Support Policy of Community Living Service Delivery

CLSD has an already established policy and process for planning for the transition of any person that the ministry supports.[8] The process is comprehensive in its design and facilitates transitions that are individualized to each person's needs, allows for flexibility and creativity in identification of supports, and enables planning to be conducted in a thorough and thoughtful way.

[8] See appendix 4 for the 15 Policy Statements of the Comprehensive Personal Planning and Support Policy of CLSD and Appendix 5 for Appendix C of the policy, which provides the "Planning Protocol for Moving to a Different Home".

Important considerations already made within the existing policy and processes are to:

- Include the Individual, their family, and their support networks in planning.
- Engage current care staff at VVC in the ongoing transition planning.
- Ensure advocates are available throughout the process.
- Allow individuals choice for the location of their new homes.
- Evaluate the availability of supports in the community.
- Engage community-based supports in a planned manner suitable for each transition.
- Consider the Quality of Life outcomes for each person.

There is no need to recreate an already existing process.

3.3 Adhere to the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD)

Canada has ratified the UN CRPD[9] and it is important to meet the standards set within the convention during the transition.

The general principles include:

- Respect for dignity and autonomy, choices, and independence of persons.
- Non-discrimination.
- Full and effective participation and inclusion in society.
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity.
- Equality of opportunity.
- Accessibility.
- Equality between men and women.

Article 19 of the convention – Living independently and being included in the community – States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by

[9] The United Nations Convention on the Rights of Persons with Disabilities can be found at: http://www.un.org/disabilities/default.asp?id=150

persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

> a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;
>
> b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
>
> c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

By adhering to the principles as outlined above the Government of Saskatchewan will be actualizing Canadian commitments to the UN Convention throughout the planning process, but more importantly will be supporting the human rights of the residents of VVC.

3.4 Develop individualized person-centred plans

In following recommendations 3.1, 3.2 and 3.3, the natural outcome would be the development of 197 individualized person-centred plans for the residents of VVC. By planning this way first the necessary supports can be identified and then put in place around the person. In doing this, planning is able to maximize the personalization of service delivery for each individual and ensure that they are considered as a whole person rather than solely on support needs.

Develop plans on an individualized basis by the means of identifying the specific resource needs of the person first before considering the residential structure required. No overarching plan should be developed to direct people to resources. Instead, plan for the provision of supports, services, and resources for the people first. Do not plan for a building or a resource to ‘place’ people in.

If the development of buildings or facilities were approached first, and planning for the individuals second then it becomes increasingly difficult to accurately support individual needs. The new development would risk

becoming about creating a space for a specific profile, and then fitting someone to that spot. Do not place the importance of systems or economic efficiencies over the importance of people.

3.5 Ensure transition planning is undertaken in the day to day activities of VVC

The transition of residents to new resources should be a primary consideration within the ongoing operational planning of VVC. Focus on identifying and supporting activities that promote independence, life skills development, and self-advocacy. Having these skills will be critical to successful community living for the residents.

VVC Staff and management have transitioned residents to community in the past and have experience with individual transition planning; however, they have never transitioned a facility to closure or undertaken a task of this magnitude. It is imperative that the goal of closure is a consideration throughout all of the day to day activities of VVC in order to best support the residents.

3.6 Allow for flexibility in planning processes, recognizing the unique circumstance of the residents of VVC

The situation of the residents of VVC is not typical and should be accommodated appropriately. Existing processes have the ability to transition residents from VVC to the community, but there may be situations where policies and processes may need to be particularly flexible to accommodate the unique needs of the residents transitioning out of VVC.

RECOMMENDATION # 4: EXPAND THE RANGE OF RESIDENTIAL SERVICES AND FUNDING OPTIONS AVAILABLE CREATING INNOVATION IN SERVICE DELIVERY FOR PEOPLE WITH INTELLECTUAL DISABILITIES

4.1 Look to the existing continuum of service delivery when identifying potential housing options

There is a vast amount of knowledge and resources within the existing service delivery system. Look for opportunities within that system to support the residents of VVC.

The following represents the models of housing currently available in the community:

- Independent living – Individuals live independently in community and receive no formalized support from CLSD. Supports may be accessed through other programs.
- Supported Independent Living Programs (SILP) – Provide adults living in their own homes with limited support and supervision that they may require to live as independently as is possible.
    - Supported independent living Program – 10 to 12 hours of support per week.
    - Enhanced Supported Independent Living Program – as much as 20 hours of support per week.
- Group Living homes – individuals who share a group living home are responsible for paying their basic shelter costs. CLSD provides funds for the support staff that may be required.
    - Roommates living together share supports.
    - Typically not a 24 hour support model.
- Approved Private Service homes (APSH) – are license private homes that provide a family atmosphere for people with intellectual and/or physical disabilities.
    - They provide informal support through the home operator.
    - Typically there is limited access to additional support staff.
- Group homes – licensed homes which are staffed to provide personal care, supervision, and support to usually three to six individuals with intellectual disabilities.
    - They are typically located in residential neighbourhoods across SK.
    - Purpose built homes based on pre-existing criteria.
    - Consider renovating existing homes to meet the needs of VVC Residents.

4.2 Expand current range of funding options

Typically CLSD only funds not-for-profit community-based organizations for the provision of supports for the individuals it supports. However, there are many different ways that services can be delivered, including through the for-profit sector, direct funding models to families and individuals, or in partnership with different service providers such as health regions. By exploring additional funding options there is an opportunity to look for new and creative solutions to housing and service delivery.

4.3 Develop a strategy to implement Self-Directed Funding (SDF)

Self-directed funding options are proven to work for individuals across a diverse range of needs and are particularly successful in supporting individuals with complex support needs. Many of the individuals at VVC may require supports that are not able to be provided in typical fashions through current funding models. Self-directed funding is able to provide a great deal of personalization of supports in ways that other modes are not able to produce.

Self-directed funding options could provide the stability of supports required by the residents of VVC. Self-directed funding can be managed in many different ways including:

- Microboards
- Broker supplied services
- Individual/family managed contracts
- Circles of support

4.4 Provide new and existing agencies with the needed resources to support VVC residents

When existing agencies are utilized to provide support for individuals with intellectual disabilities then they may need additional supports to do so successfully. As new agencies are formed resources will be required to provide them with the knowledge necessary to provide the supports required.

- Ensure resources are in place for agencies to provide the necessary supports.
- Transitional staff supports and knowledge must be available within the new home.
- Training and skills development is required.

4.5 Develop a response that is appropriate to support an aging population

Across the province there is a group of aging clients at CLSD and living at VVC that typical service delivery systems are challenged in their ability to support. A cross government/ministry response is required to ensure that all citizens, regardless of ability are able to access age related services.

The specific health service requirements of the aging population of people with intellectual disabilities needs to be explored further, however particular attention needs to be given to the geriatric and age related needs of the residents leaving VVC.

4.6 Explore new models of housing that fill gaps in the existing continuum of housing

Given the current need to provide housing for the residents of VVC there is an opportunity to expand the continuum of housing that CLSD offers. Authentic independence and real choice is dependent on having a diverse group of options to choose from. As more housing is developed in different ways there will be more options to choose from.

Some of those options might include, but are not limited to**:**

- Roommate supported living – individuals receive limited in home supports, and roommates are contracted to provide a specific support mechanism for reduced rents. Roommates move in to the individual's home.
- 24/7 Supported Independent Living – individuals live independently with 24 hour per day in home supports.
- Key Ring Supports – as many as 10 individuals live in proximity to each other, and have a shared resource person or persons supporting them.
- 24/7 supported group living homes – individuals live with peers and friends in their own home, and have 24 hour a day supports in the home.
- Therapeutic APSH - Provide needed supports and resources for individuals with complex medical and behavioural support requirements in the Approved Private Service Home.
- Home Sharing – close relationships are fostered into the creation of home sharing arrangements and are less about placement into a licensed home and are more about living with family or friends.

- Clustered Housing – develop homes in close proximity throughout condominium developments or neighbourhoods where individuals live independently and share resources.
- Unit Housing – people live in suites with an individual bedroom, bathroom and small living area with a common living and kitchen area in the centre. In this model, people with high and complex needs may share accommodation with people needing lower levels of support, or people without disability.
- Unit Housing with Hub – a number of units on one site surrounding a central hub that includes an office, sleepover and communal living and kitchen facilities.
- Care Related Support Homes – residential housing for individuals requiring close proximity to ancillary services. The current Long-term care system in SK does not have the capacity to appropriately support many individuals transitioning out of VVC. A specialized approach is required to successfully support the residents of VVC. Provide a homecare model of support where the support goes to the individual in their home.
- Technologically supported homes - In the era of technology and telecommunications it is easier to support someone remotely; 5 or 6 people live in close proximity linked by electronic means to a single support worker who is on call overnight.

There are a number of different options that would be appropriate for the residents of VVC, and as the person-centred planning begins, the nuances of those options will become more apparent.

RECOMMENDATION # 5: ENSURE THERE IS CONTINUITY OF SERVICES FOR VVC RESIDENTS

The residents of VVC and their families have been assured that there will be continuity of service during the closure. As the closure approaches it is important to ensure that the level of care the residents receive is not diminished, and that they continue to receive the best support possible.

5.1 Minimize the internal moves of residents prior to transitioning out of VVC

Moves within VVC generally go well, however there is still disruption and turmoil that follows any transition. It is important to reduce the disruption caused by internal moves leading up to the resident's move to community-based services. This will maintain the resiliency and wellbeing of the residents of VVC for the transition to community.

Homes at VVC should not be closed – causing the relocation of residents – only because the population within them declines. Economically this may appear to be a prudent way to gain operational efficiencies throughout the closure; however, homes should remain open and operating with fewer people living in them, in order to reduce the personal impact on the residents.

Moves should only be explored when it is for the purposes of health and safety.

5.2 Manage the operations of VVC as they become less cost effective

As the population of residents at VVC declines, the operations at the centre will become less cost effective. The cost per resident will increase and the cost to provide services will grow. While there is a reasonable requirement to be efficient and responsible with public funds, in order to maintain services, supports, and to provide a smooth transition inefficiencies will necessarily arise.

5.3 Expect for resources to be duplicated through the transition period

For residents that require a slow transition to community there will be a need to have the resident funded in VVC as well as for parallel and similar services to be funded in the community. For example, some residents may have two homes during the transition – one staffed home in the community and their current staffed home at VVC. Duplication of services of this nature can be expected as a requirement to support residents through the transition.

5.4 Plan for appropriate service changes with minimal impact on the residents

As the population of VVC declines the way that services are delivered at the centre may need to change. All changes in service delivery and the operations at VVC should be managed in a planned and intentional way that has the least impact on the residents.

5.5 Transition individuals to community-based supports prior to moving out of VVC

Prior to transition it will be important to separate the lives of the residents of VVC (their services and supports) from the activities and administration of VVC.

Currently centre staff provides the following supports and services to the residents of VVC:

- Day programs and activities.
- Ancillary services.
- Income and personal finances.
- Housing.
- Social networks.
- Programs that may be relevant to the individuals.

Ensure that the residents of VVC have access to income support programs and other MSS benefit programs such as the Saskatchewan Assured Income for Disabilities (SAID). As well, it will be important to ensure that trustee relationships are established to monitor personal finances prior to transition from VVC.

RECOMMENDATION # 6: FACILITATE THE CONTINUATION AND DEVELOPMENT OF NATURAL RELATIONSHIPS

Throughout planning the importance of relationships has become increasingly evident. The residents of VVC have relationships that have formed throughout their lives at VVC; and the ongoing support of those relationships will be critical to the wellbeing of the residents.

6.1 Provide ongoing opportunities for the residents of VVC to maintain relationships with peers

Many of the residents of VVC have lived with their peers for many years and, in some instances, all of their lives. Residents may choose to live with friends, or not; throughout planning it is important to ensure that there are opportunities for those choices to be honoured and realized. The maintenance of those relationships will be critical to the emotional wellbeing of the residents as they move to new community homes.

6.2 Provide opportunities for the residents of VVC to maintain relationships with staff that they are close with; in some cases staff are considered extended family by the resident and their family

It is recognized that many staff know the residents more intimately than family members do. In the situations where the residents do not have family, for some VVC residents the staff members fulfill that family role. Some staff members have VVC residents to their homes for holidays and celebrations, and involve them in their day to day lives.

It is important to explore opportunities for relationships with VVC staff to continue and to be enhanced. These relationships, outside of the typical care giver/care recipient connection, epitomize inclusion and should be fostered. Relationships can be maintained informally through social activities or can be formalized by involving staff in the ongoing supports and resources that are developed.

6.3 Ensure VVC staff is able to participate in the resident's transition to their new homes

Additional resources will be required to allow VVC staff to support residents as they move to new homes and to support new staff during transitional periods, while maintaining the ongoing operations at VVC.

VVC staff will be critical to providing consistent and knowledgeable support to the VVC residents throughout the transition. VVC Staff have a long history of providing the residents with required supports and will be essential to transferring that knowledge to community. As residents move, and as new supports are

introduced, ensuring that there is continuity of care that includes the VVC staff and support is important to individual wellbeing and success.

6.4 Leverage existing relationships to expand social networks and develop broader natural support networks around individuals

By the provision of social supports and intentional engagement during the transition process, it will be possible to expand the social networks of VVC residents. In the community natural support networks are critical in providing many of the supports that are offered through supports available at VVC. Natural supports that would typically be created by living in community-based settings may not exist for the VVC residents. Establishing these supports is necessary for success in community.

6.5 Recognize the natural limitations to relationships

There are various models of care which by their nature may inadvertently decrease an individual's ability to perform basic daily living activities and that may inhibit choice and decision making. This is seen frequently when people are hired to care for others within institutional settings. Staff working in these models may not always recognize that their environment might perpetuate this.

Many people have opinions about the supports required by the residents of VVC. Advocates, staff, and community stakeholders may have different views about the best models of housing and support provision than the residents and their families. However, regardless of the best intentions or professional advice of these people, it is important to maintain the right to choose for the residents of VVC.

The residents of VVC have similar needs to the approximately 4100 other people with intellectual disabilities supported across the province by CLSD. Research confirms the ability of individuals who leave institutions to thrive in the community, and there are many examples of past VVC residents who are doing just that, despite best intention and professional opinion. Prioritize the needs and choices of the resident and his/her family throughout the transition process over and above the opinions of others.

RECOMMENDATION # 7: ENSURE VVC RESIDENTS CONTINUE TO HAVE ACCESS TO ANCILLARY SERVICES

Commitments have been made to ensure that all of the residents of VVC continue to receive the same level of services as what they are receiving at VVC, or better when possible.

Individuals, families, advocates, VVC staff, and service providers in the community all recognize that there are difficulties to accessing ancillary services in the community that are typically offered in-house at VVC.[10]

There are two ways that can be utilized and combined to ensure that these services will continue to be provided:

1. By accessing typical service delivery systems.
2. By developing supplemental systems to deliver services.

While the provision of supports through typical service delivery systems is best practice it is broadly recognized that those systems may not necessarily have the knowledge or capacity at this time to appropriately support many of the individuals transitioning out of VVC. This is particularly relevant in the City of Moose Jaw where there will be a larger influx of VVC residents to the typical services there. The residents of VVC are frequent users of many services, and many of the community systems have indicated that they would not be able to appropriately meet their ongoing needs at this time.

7.1 Develop and establish ancillary supports in community prior to moving residents from VVC, or in parallel with transitions, to ensure that services are not diminished during transition

Ensure continuity of care and meet the obligations to the residents of VVC that access to ancillary supports will be consistent with what is currently being delivered. When developing new resources, services should be planned in advance of the move. When accessing existing community supports, relationships and connections should be established and formalized prior to the move.

This should minimize the likelihood of gaps in service delivery occurring.

[10] On site at VVC there are : List the in house ancillary services

7.2 Develop new relationships with the healthcare community including access to family physicians and community-based supports

Expand the existing outreach capabilities of CLSD to develop capacity within typical service delivery systems and provide knowledge translation about supporting citizens with intellectual disabilities.

Access to typical community-based supports is the best practice in service delivery for people with intellectual disabilities. However, typically at VVC the residents have accessed these services in-house at the Centre and not had to draw greatly upon community-based resources. Typical systems have not had to develop knowledge or capacity to support the unique needs of these residents in the past.

The best way to grow the capacity of the typical service delivery systems, and to instill knowledge with the service providers, is to develop relationships that foster growth and understanding about supporting individuals with intellectual disabilities. Outreach can provide ongoing knowledge, support and engagement with typical service systems strengthening the systems for all individuals with intellectual disabilities in Saskatchewan.

7.3 Create a community-based ancillary service response in Moose Jaw dedicated to providing ongoing clinical and professional services for the residents of VVC and all CLSD clients in the Moose Jaw region

Given the identified capacity and constraints of typical service systems, it is necessary to provide supports that are supplemental to them in order to meet the commitments made to residents of VVC and their family for the continuation of services.

To develop a community-based ancillary services response, the following will be necessary to ensure that ongoing needs can be met:

- Provide the physical structure necessary for the ongoing delivery of ancillary supports in the community of Moose Jaw. A physical space will be required to administer required supports and for the direct provision of services.
- Retain the expertise of VVC staff in the provision of ancillary services in the community. The knowledge exists within VVC, and an opportunity is available to continue to provide exemplary access to ancillary supports through that knowledge.

- Follow an outreach model of care that sees ancillary services delivered to individuals in their home, similar to a homecare approach.

Moose Jaw is notably the best location for a concentration of these supports because of the number of residents that have identified the city as their preferred future home, and also because of the concentration of knowledge and experience that can be found in the existing VVC staff. Moose Jaw will experience an influx in the population of individuals with intellectual disabilities that will require the greatest level of supplemental supports of any of the communities affected by the closure.

7.4 Increase capacity to provide ongoing clinical and professional services for the residents of VVC and to all CLSD clients across the province

Not all residents of VVC are choosing to remain in the Moose Jaw area after they transition. However, the same commitments to equal or better support were made to all VVC residents regardless of their location of choice. It is important to ensure that there is reasonable access to needed ancillary supports.

To establish a suitable provincial response that will support the residents of VVC the following will be necessary:

- Provide the necessary infrastructure for the ongoing provision of ancillary supports across the province. Supplement the services of the existing system through dedicated service delivery.
- Utilize the expertise of VVC staff and community staff in the provision of ancillary services in the community. VVC staff can train and mentor community staff in the provision of ancillary supports.
- Follow an outreach model of care that sees ancillary supports delivered to individuals in their home, similar to a home care approach.

With VVC residents moving to new homes across the province there is an opportunity to strengthen the access of all CLSD clients to ancillary supports. In many communities there are existing struggles to access basic ancillary supports, regardless of level of ability. By providing supplemental support systems the needs of some of our most vulnerable citizens will be met and pressure will be alleviated from other service delivery sectors until capacity can grow.

7.5 Engage with typical ancillary service systems to ensure that they have the capacity to support individuals with intellectual disabilities

Individuals living in Saskatchewan who happen to have intellectual disabilities are citizens and should have full citizenship rights to equal access to typical service delivery systems. However, until such a time as those systems are able to appropriately meet their needs it is important to ensure that they are still receiving required services. In the meantime, expand the capacity of the typical ancillary services to support individuals with intellectual disabilities through knowledge transfer, training, and support.

It is not reasonable to expect that these service delivery systems will immediately have the knowledge and capacity to support these citizens. What can be reasonably expected is if systems are provided with knowledge, experience, and time the capacity to support people with disabilities will be developed.

There is an opportunity with the transition to develop capacity in a thoughtful and coordinated manner.

7.6 Ensure appropriate transportation options are available

Transportation is available to residents at VVC as a part of the operations at the centre. Public transportation is provided by municipal governments and in some cases by private agencies. Establishing partnerships for the provision of transportation will provide a means for ensuring that there is transportation provided through typical service providers. The commitment was made to retain or improve the services available, and thus, transportation needs to be available.

7.7 Recognize limitations to accessing ancillary services

Saskatchewan is a large province with many diverse places to live. As individuals choose where they live, there will be trade-offs to be made. Some people choose to live in rural communities because it suits them as individuals, but that choice is at the expense of access to urban amenities. Some people choose to live in urban centres, but may give-up a rural lifestyle.

Given the diverse geography of our province, providing immediate access to ancillary supports regardless of location is not a reasonable expectation. Not having access to a particular support should not be a barrier to transition; however attention on how services will be accessed is a necessary consideration during planning.

RECOMMENDATION # 8: EXPAND AND ENHANCE CRISIS PREVENTION AND SUPPORT SERVICE CAPACITY

One of government's key responsibilities is to protect the provinces most vulnerable persons by providing a safety net for those individuals who at times are not supported effectively. Historically, VVC has operated as that safety net and the staff has had a role in the ongoing provision of those services. The families of the residents of VVC continue to expect that a safety net system be in place in the event that a transition does not work.

The expansion and enhancement of the current Crisis Prevention and Support Service program and network is required to ensure the existence and ongoing maintenance of an effective safety net for both the residents transitioning from VVC and those individuals currently living within the community. Leverage the experience and knowledge of the VVC staff for crisis prevention and support.

8.1 Expand crisis response services and the capacity to respond

In the absence of a planned and coordinated crisis response service with capacity to meet demands on services, individuals with intellectual disabilities can end up in dangerous and inappropriate locations including mental health and criminal justice facilities. As well, in the absence of crisis supports individuals end up accessing services that cost substantially more than a dedicated crisis program would cost.

The existing crisis response system currently encounters bottlenecks that limit the capacity to respond to crisis needs. Expanding the existing system will ensure ongoing safety net access for residents of VVC, and strengthen the provincial service system.

There number of crisis residential spaces needs to be increased to enable it to meet the potential future needs of the VVC residents. Crisis response should be readily available 24 hours per day. It is necessary to expand the number of places with a zero-rejection policy to a level where there will always be access to those spaces without bottlenecks or response delays.

Crisis spaces should have the mandate to return individuals to their home once the crisis has passed.

In addition, to address the bottlenecks in the system that occasionally occur because an appropriate resource is not available or is under development, an appropriate short to medium term response is required. A strong safety net requires not only crisis prevention and support services, but also intermediate housing options.

8.2 Expand the ability of crisis prevention and support services to provide training and education

Prevention is considered the best practice for addressing crisis, and education and training are the best way to prevent the development of crisis. More resources dedicated to providing necessary training and education will reduce the impact of crisis on resources, but more importantly will provide a preventative approach to crisis and support the residents of VVC better.

8.3 Expand the outreach capabilities of crisis prevention and support services to provide crisis response in-home first

Movement to crisis housing should be a last resort. Crisis response provided in the individual's home is the best practice. When an individual is released from their home the costs for crisis support increase dramatically compared to a proactive approach in the home. If an individual is in crisis, being in unfamiliar places can escalate the crisis and when appropriate, maintaining the home is a component of providing stability and minimizing crisis. Crisis response in home also provides opportunity to provide training and knowledge for agencies and to further support recommendation 8.2.

8.4 Ensure access to required specialists

Individuals who are experiencing a crisis situation often require skilled and specialized supports to assist them through the crisis. A team of the necessary skilled professionals should be accessible before a crisis and in the event of crisis to the Crisis Prevention and Support team to assist in addressing crisis. This team can be made available to the residents of VVC through different models, either through the development of an ancillary services team, the existing Multi-Disciplinary Outreach team, or both.

8.5 Create formal transitional supports with a mandate to support individuals for up to 18 months

Intermediate housing is required to address the issue of "bottlenecks." The current CBO service delivery system requires time to respond to requests for new services. In the situation where a space currently is available it may take as little time as a month to two months to prepare for accepting the individual. In situations where no space is currently available it may take well over a year to a year and a half to create a new space. Transitional housing is set up with the notion that the person will be there a short period of time. This resource prevents the "bottleneck" in the crisis residential space, which is an extremely high cost space, from occurring.

RECOMMENDATION #9: EXPAND RESPITE SERVICES

Respite is recognized as best practice for supporting individuals. The ability for some residents to secure a "vacation" away from their home community is beneficial for the individual and for her/his care givers. Respite is also a key device to prevent and avoid crisis.

Over the past few years the use of planned respite has become more common in CLSD funded agencies. When supporting individuals who present complex needs and behavioural challenges, community agencies utilize planned respite time to provide staff training, repair and maintain the house, and prepare the agency for the individual to come home.

Specialized Programs of CLSD receives numerous requests each year for support in the form of respite for the individual, or for the residential service provider. Respite for the individual is usually related to an increase in support needs. For many individuals who experience complex challenges, a change or break from an environment is required to mitigate the impacts of their challenges.

Many individuals currently residing at VVC will require ongoing respite supports in order to ensure a successful community placement.

9.1 Develop formal respite services for the individuals transitioning out of VVC

Proactive respite has been demonstrated as being best practice and is important in preventing crisis. Care providers can use the respite time to re-charge and take a break away from stressful situations. Respite and ability to respond on an as needed basis helps to maintain placements. The longer a placement is maintained the more stable the individual's life becomes. With stability comes growth opportunity for the individual.

Options for formal respite are required. Optimally, maintaining the individual in their own environment which they know well and are comfortable may be the best option. Respite supports that can be placed "in-home" work well for many individuals.

Alternatively, the option to provide respite away from home is also required in many circumstances. The opportunity to provide a holiday away from home can also be effective in supporting individuals. The break also allows the individual and the household a breather and a chance for the staff to engage in training opportunities.

9.2 Provide training opportunities for staff and agencies during respite

Training as part of respite is extremely important. The objective is to teach the service provider new ways or reinforce current practices in supporting the individual. The ultimate goal is to provide the right skills so that they can reduce the need for respite and that support becomes an internal response.

9.3 Provide opportunities for family, former VVC staff, and advocates to be involved in respite

The staff of VVC has a significant amount of knowledge and experience in supporting individuals who present unique challenges. Utilizing previous relationships can also be useful in providing respite. Familiarity with another individual can create a sense of safety and trust for the individual receiving the supports. Positive relationships are extremely important in any type of support that is provided to individuals who have an intellectual disability.

9.4 Expand and enhance 'vacation' style respite programming

Individuals who present challenges are often not accepted or welcomed by the generic recreation or camp systems. The operation of Camps Thunderbird and Buffalo provides skilled intervention in the context of a camping experience. The expanded capacity of these resources will be necessary to continue to provide high quality respite services.

RECOMMENDATION # 10: ENSURE EACH RESIDENT HAS ACCESS TO INDIVIDUALIZED ACTIVITIES OF CHOICE

Residents of VVC currently experience a range of daily activities; both within the VVC and in the community. Attention needs to be given to ensuring all residents experience meaningful activities that support and promote a quality of life. Individuals will require intentional engagement to ensure they do not spend their days in isolation in the community.

10.1 Ensure that the residents of VVC have access to meaningful activities

Many residents enjoy a retirement lifestyle, some residents have vocational programs, and some residents are active in many ways at VVC. It is important to provide a continuation of the opportunity for the lifestyle of the residents following transition. Ensure that individuals have opportunity to continue their vocational and daytime activities of choice.

As the residents leave VVC there will also be opportunities to expand programming in ways that VVC has been unable to provide. Look for opportunities to develop new activities based on the planning for the residents as they move to their new communities.

10.2 Develop community-based programs for employment, recreation, leisure, and therapeutic activities

Person-centred planning can identify innovative and new opportunities for day programming for the residents of VVC based on their personal preferences.

Current centre-based day programs available in the Moose Jaw community may not have the capacity to support the number of residents who choose to stay in Moose Jaw. Dedicate resources toward establishing a leading community-based program of activities that will capitalize on natural supports and acceptance found in the community of Moose Jaw, rather than investing in the development of capital resources. Look to established programs to provide daytime, recreational and leisure activities, and support the creation of person-centred community-based programs.

For residents with vocational programs, look for opportunities for community-based vocations that will support inclusion and community involvement through employment and work programs.

10.3 Create opportunities for residents to continue to participate in activities that they currently enjoy

Develop similar programs available in VVC with community agencies, such as the choir and other social groups. This will maintain the level of support VVC residents receive, maintain a continuity of service, and provide an opportunity to enrich the community-based services experience.

RECOMMENDATION # 11: ENSURE FUNDING IS AVAILABLE TO SUPPORT INDIVIDUALS THROUGH TRANSITION

Flexible funding and support options will be required to support the residents through transition. Identify what resources will be available, how they can be accessed, and what they can be used for.

Transitional funding will be required to support the transitional needs of the residents of VVC. Unexpected expenses and support needs may be experienced by all parties to support the residents through transition. It is important to provide the funding and resources early in the process, to ensure success later.

11.1 Ensure flexible funding is available to maintain continuity of services while providing for a successful transition

Parallel funding needs may develop during the transition period.

For example:

- As homes are reduced in size, they may become less economically efficient to operate; therefore, resources should be made available to minimize internal moves.
- As person-centred planning proceeds, individualized activities and programming will be required, and this may have implications on resources.

VVC is a large facility, and given the direction of the recommendations put forward, will run more inefficiently as the population declines. This can be minimized, however, it is important to acknowledge that in order to best serve and maintain continuity of service for the last residents to leave VVC it will operate inefficiently.

11.2 Ensure adequate and accessible transportation is available

Access to transportation is necessary to support community inclusion. In many smaller communities there is little or no infrastructure to provide transportation services for individuals with intellectual disabilities.

Typically, CLSD does not fund transportation. However, at VVC there is access to transportation. As part of the continuity of services, access to transportation should be maintained in community placements.

RECOMMENDATION # 12: DEVELOP AN ACTION PLAN TO IMPLEMENT THESE RECOMMENDATIONS

An action plan for the transition will be required to support the residents of VVC to have successful transitions.

12.1 Maintain the Transition Steering Committee as the governance committee that oversees the transition

The TSC should continue as the committee that governs the transition and oversees the closure of VVC and the transition of the residents to their new services to support transparency and accountability.

12.2 Create an action plan for the work required to transition the residents out of VVC

An action plan should be developed in consultation with the partners to the TSC and the residents of VVC. The action plan should include the set of critical activities required for the transition, and the timelines required to complete the closure within the allotted time. The action plan should address:

- Development of new government and non-government community resources
- Person-centred planning and transition of residents to new homes
- Staged downsizing of the centre
- A human resource strategy
- A communication strategy

The action plan should identify who would be on the implementation team, and should clearly articulate the roles of the different stakeholder groups. The team should include:

- The Ministry of Social Services.
    - Community Living Service Delivery management and staff.
    - VVC management and staff.
- The VVC Family Group.
- The Saskatchewan Association for Community Living.
- Self-Advocates from VVC.

12.3 Establish regular reporting on the progress of implementation

As the committee guiding the transition there needs to be regular reporting to the TSC about the progress of transition planning and the ongoing transitions of the residents.

RECOMMENDATION # 13: DEVELOP AN EVALUATION FRAMEWORK

Residents and their families, VVC Staff, and advocates have all expressed concern about the long-term wellbeing of the residents of VVC. Research indicates that the outcomes for people following deinstitutionalization are better; however there is little reference to ongoing oversight and monitoring outside of typical case management practices in other instances of institutional closure. There is a desire on the part of all parties to ensure that there is ongoing planned oversight and monitoring in order to meet commitments to quality of life and quality service.

13.1 Establish a mechanism to provide ongoing monitoring of the residents who transition out of VVC

To meet commitments and assurances of continuity of care and exceptional service delivery monitoring of the transitions of the residents of VVC is required. This is of particular importance for residents with complex support needs. Fund the SACL, as the provincial advocacy organization in Saskatchewan, to provide ongoing individual and systemic advocacy for the residents of VVC. CLSD is responsible and to provide ongoing monitoring of the residents following the closure of the centre, and ensuring that its commitment for service delivery are being met.

13.2 Develop an ongoing reporting mechanism to the stakeholders of the transition regarding the outcomes of transitions for the residents

Concern has been raised that, following the transition the supports the residents of VVC access will wane or cease all together. Ongoing reporting protocols about the state of the residents of VVC following transition should be developed in order to retain long-term accountability on the part of government for the outcomes of the transition.

RECOMMENDATION #14: INCREASE PUBLIC AWARENESS REGARDING COMMUNITY INCLUSION

14.1 Support a communications and public education strategy about community inclusion

Many questions have surfaced about the merits of the planned closure for VVC, and the ability of the residents to live in community. As a society that values the rights of individuals regardless of ability and that seeks to be the best place in Canada for people with disabilities there is much work to do to educate the general public on inclusion and community living.

Develop a collaborative strategy to provide public education about inclusion, the benefits of inclusion, and the social and economic benefits of inclusion for the community. Utilize CLSD, the SACL, and other community stakeholders to provide community education. As well, there will be opportunities to work with community-based agencies and stakeholder groups to support education about community inclusion.

By collaborating on a public education campaign the message of community inclusion for people with disabilities will have a broader reach and greater impact.

14.2 Support ongoing engagement with community and stakeholder groups

The three partners meet regularly with stakeholders to provide updates and information regarding the transition. Examples of groups engaged include, but are not limited to:

- Municipal governments.
- Regional Intersectoral Committee.
- Local business associations.
- Local service providers.
- Other community stakeholders who come forward with requests for information.

Ensuring stakeholders are engaged and informed in the transition will enable them to be more responsive to the needs of the residents of VVC.

Conclusion

This report represents our understandings of how best to support the residents of VVC when they transition out of the Centre and into new resources.

The focus of the TSC and in planning still rests with the development of 197 individual transition plans; however, further to individual planning there is an opportunity to strengthen service delivery for the entire 4,100 people that Community Living Service Delivery supports. All of the partners to the transition recognize the need to attend to the many different service needs of the residents.

Additionally to the 197 individual plans, attention should be given to:

- Community living
- Expanding service and funding options
- Ensuring there is continuity of service
- The importance of relationships
- Access to ancillary services
- Crisis prevention and support programming
- Respite services
- Individualized activities
- Transitional funding
- Implementation planning
- Community inclusion

The recommendations provided in this report provide a roadmap for the government setting direction in how best to move forward with transition planning and for attending to the needs of the residents of VVC in a thoughtful and appropriate manner.

Thank you for the opportunity for the TSC and its partners to engage in the consultations for creating the improved services for the residents of VVC. We look forward to the response of government to these recommendations.

1. Welcome and introductions
2. General information and discussion
3. Family discussion about future dreams/wishes/hopes/fears
4. Presentation from VVC Multidisciplinary team:

    - General overview
    - Social participation
        - Friends/relationships
        - Social networks
        - Social activities at VVC
        - Involvement in the community
    - Well-being
        - Positive experiences/successes
        - Safety and security
        - Positive physical being
        - Physical abilities
        - Income and possessions
    - Independence
        - Personal skills/development
        - Self-determination/choices/autonomy

5. Discussion of residential supports required
6. Discussion of day program requirements
7. Opportunity for general discussion/questions/final thoughts
8. Adjournment

Appendix 2: Needs Assessment Meeting Template

Resident's Name: Date of Meeting:

Meeting attendees – roles and relationships:

		Initial Needs Assessment	**Significant Changes (add date new information provided)**
Overview	Introduction	*Provide a generalized overview/comment of the individual (e.g. general well-being, general comments on what the basic day looks like)*	
Social Participation	Interpersonal Relationships	*Friendships/Relationships (e.g. family, friends, staff; they are close to)*	
		Social Networks (e.g. peer group, church groups, sporting teams, who is important and why)	
		Social Activities (e.g. leisure activities at VVC, what is important, what does the person do for fun, what supports are required for social inclusion)	
	Social Inclusion	*Involvement in the community (e.g. where do they go and what do they do; what supports are required; identity other options for inclusion and being part of the community)*	
Well-being	Emotional Well-being	*Positive experiences/Success (e.g. what makes the person happy, how do you know, what successes have been experienced such as coping strategies to self regulate etc.)*	
		Safety and security (e.g. special requirements and considerations; what makes the person feel safe and secure and how do you know)	
	Physical Well-being	*Positive physical being (e.g. what supports the person to be healthy, how do you know they are feeling healthy and strong, how do they tell you when they are not feeling good, etc.) Medical requirements (e.g. important medical issues; complex medical issues; health/nutritional status; medical adaptive devices and requirements such as requires gastric tubes/2 person transfers/incontinence supplies/uses wheelchair or other mobility devices; therapy programs etc. – not for a listing of medications/vital signs)*	
		Physical abilities(e.g. capabilities; what happens if there is too much exertion; ability to self-regulate, including sensory processing; options for physical activity and stamina etc.)	

	Material well-being	*Income and possessions (e.g. what items are of value to the individual and why; what does the person do for income and what are important items they like to purchase)*	
Independence	Personal Development	*Personal skills/adaptive behaviours (e.g. what abilities have been identified and the care plan highlights; what can people do; challenging behaviours including the trigger/interventions; how does the person react to change; identify opportunities for lifelong learning)*	
	Self Determination	*Choices/Decisions/Autonomy/Control (e.g. what are typical decisions/choices does the individual make; how do they let you know what they want; what format for participation – individual attend all meetings in future; non-verbal)*	
Residential Supports	Options for residential requirements based on need	*What type of residential supports are required and why (e.g. awake staff at night, own bedroom, ability to walk freely and safely, mobility accommodations etc.)*	
Day Program Supports	Options for day program based on need	*What type of day program is required and why (e.g. vocational, leisure, recreational oriented, centre or community based, group or individualized, retirement, etc.)*	
Other		*Include any information not previously reported*	

List of Specific Locations – rolled into Regions

Northwest
- North Battleford
- Hafford

Northeast
- Tisdale
- Middle Lake

Southwest
- Gravelbourg
- Swift Current
- Assiniboia
- Kindersley

Southeast
- Melville
- Balcarres

Out of Province
- Port Moody, BC
- Edmonton, Alberta
- Medicine Hat, Alberta

COMPREHENSIVE PERSONAL PLANNING AND SUPPORT POLICY (CPP&SP)

February 4, 2005

POLICY 1: All supports provided shall recognise the participant's rights and reflect ethical practices.

POLICY 2: Service providers shall interact with participants in a supportive and respectful way.

POLICY 3: Participants shall be provided with the support that they need to make decisions.

POLICY 4: Any act or omission that causes a participant to experience physical, emotional, or sexual harm, loss of individual rights, or the misuse of their personal property shall be prohibited.

POLICY 5: Procedures perceived by a participant to be aversive shall not be used with that participant.

POLICY 6: **A person-centred planning process shall be used as a means of supporting the participant in deciding and planning her goals and supports required.**

POLICY 7: The person-centred planning process shall involve the participant and a core group of people who know and care about the participant and are committed to supporting her.

POLICY 8: **The person-centred planning process shall identify the roles and responsibilities of those providing support to the participant in achieving her goals.**

POLICY 9: The person-centred plan shall be documented.

POLICY 10: Comprehensive Behaviour Support shall be used when designing support strategies to affect a participant's challenging behaviour, or dangerous or harmful behaviour.

POLICY 11: Comprehensive Behaviour Support strategies shall be based upon the analysis of objective and thorough assessment information.

POLICY 12: Comprehensive Behaviour Support strategies shall be documented in a *Comprehensive Behaviour Support Plan*.

POLICY 13: The use of medication intended to affect challenging behaviour is a component of, not a substitute for, Comprehensive Behaviour Support and shall be carefully planned and strictly monitored.

POLICY 14: Service providers shall have an established policy for addressing participants' new behaviours that are dangerous or harmful to self, others or animals.

POLICY 15: Dangerous or harmful behaviours that have not occurred before shall be documented.

APPENDIX C

Planning Protocol for Moving to a Different Home

Purpose

The purpose of this protocol is to establish a systematic planning process for all participants moving to a different home. Within the protocol all the activities necessary to support the participant's successful transition to another living arrangement are identified, co-ordinated and implemented. The participant is the central focus of planning and her participation is critical. The processes outlined in this document are based on the principles of Person Centred Planning and supported decision-making. The planning guidelines that follow are designed to facilitate, not hinder the realisation of a meaningful life for the participant.

Overview

The planning protocol establishes standards for effective planning with participants. It outlines the tasks and issues critical to a successful move, provides a protocol for addressing these in a systematic and co-ordinated fashion and identifies roles and responsibilities of the various key players.

Application

The planning process is to be implemented whenever a participant is moving to a different home. The process is initiated whenever there is a request or a need for a new service or change in existing service. The process described below applies to any type of residential move.

It is the responsibility of each core group member involved in planning to be familiar with the protocol outlined in this document and to assume the responsibilities that pertain to him or her.

General Planning Processes

1. Initiation of Planning
2. Initial Meeting
3. Notice of First Planning Meeting
4. Development of a Support Profile
5. Implementation
6. Transition
7. Follow-up

1. Initiation of Planning

Planning is initiated when there is a request or a need for a change in the current home or a request for a different home. The participant, family members, present service providers or Community Services Workers may make a request or identify the need for a change in service. The participant's Community Service Worker will be made aware of the request or need, and is responsible to organise the initial meeting. It is the responsibility of the Community Service Worker to assemble at the initial meeting, those individuals currently involved in providing supports to the participant.

2. Initial Meeting

The group of individuals assembled for the initial meeting is responsible to:

a. Identify an Appropriate Person to Help the Participant Prepare for her First Planning Meeting

Prior to the scheduling the first planning meeting, the identified person will meet with the participant to discuss the planning and to determine the participant's wishes. An appropriate level of support must be provided so that the participant has the opportunity to discuss her wishes and other matters, including:

- The purpose of the first planning meeting and what will take place
- Who the participant wants to include as members of her core group and who will participate in the planning process
- What she would like to have discussed at the first planning meeting
- Where the participant would like the first planning meeting to take place

b. Identify Members of the Core Group

The core group will engage in the planning process and function as a planning team to arrange appropriate supports for the participant. The core group consists of those identified below, unless the participant has objected to their participation:

- The participant
- Family member(s)
- Those requested by the participant
- Community Living Division Community Service Worker
- Those providing program support currently or in the future, where appropriate
- Current primary service providers (as appropriate)
- Future service provider (if known and as appropriate)
- Others with specific expertise as requested by core group members

c. Identify Information Required for the First Planning Meeting

The group will determine relevant information required for planning, and will determine responsibilities and timelines for compilation, collection and distribution of planning information. Those preparing reports and sharing information will ensure that the participant (or her guardian) has agreed to the sharing of each of these reports. If the participant refuses, the reports are not shared.

Relevant information will include:

- A description of the participant's functional abilities, quality-of-life activities, daily routines, current Person-centred Plan and her Comprehensive Behaviour Support Plan, as appropriate
- A report describing family involvement, if the family will not be present at the initial planning meeting

If the participant has a history of challenging behaviours a report will be prepared following the guidelines for Confidential Client Information Reports (CCIR). The CCIR guidelines can be obtained from a Community Living Division Program Development Consultant or VVC Behaviour Therapy Co-ordinator.

d. Identify Key Person

The Key Person is the fixed point of responsibility that oversees the planning process, co-ordinates the efforts of all, and ensures that all actions are carried out as agreed upon by the team. Any member of the core group (see #2b.) can fill the role of the Key Person, and the Key Person may change, when appropriate, throughout the planning process.

At this initial meeting a Key Person is identified to ensure the planning processes identified above are completed following the timelines agreed by the core group. This person is also responsible to co-ordinate the first planning meeting.

3. Notice of First Planning Meeting

The Key Person is responsible to ensure that core group members identified at the initial meeting are informed of; the initiation of planning, the date for the first planning meeting and any responsibilities that have been assigned to them, with the appropriate timelines. At this time, core group members will be requested to identify other people with specific expertise (e.g., psychiatrist, community physician) who should be invited to the first planning meeting.

At the first planning meeting, the Key Person will ensure that the following items are included on the agenda:

- Explanation of the process of comprehensive planning
- Explanation of the role of the Key Person

- Discussion of the principles of effective planning
- Clarification of any information contained in the reports distributed prior to the meeting

4. Development of a Support Profile

The development of a support profile is initiated at the first planning meeting. Discussion during this meeting and all subsequent meetings will be conducted in a manner that centres on the participant and is respectful of her wishes and dignity. The objective of planning is to determine the participant's vision of a meaningful life, program support requirements and appropriate financial arrangements. The following items provide a useful guideline for identifying and co-ordinating supports necessary to ensure the participant's successful transition to her new home setting.

a. Participant's Vision of a Meaningful Life

One of the first steps in planning is determining what the participant sees as a meaningful life (e.g., where or with whom the participant wants to live, how she would like to spend her leisure time and how she might wish to be involved in community life).

If the participant is unable to talk about her vision, the members of the planning team who know the participant well may assist in identifying the kinds of people, experiences, and activities to which the participant reacts positively or negatively. This process may help to create a picture of the opportunities that would contribute to a satisfying lifestyle for the participant. A strategy needs to be established that provides the participant with opportunities to engage in a broad range of life experiences. Her reactions to such experiences may be helpful in the modification of plans in the future.

b. Program Supports

Program supports that enable the participant to live a meaningful lifestyle are identified. Such program supports may include:

- Providing an appropriate living arrangement that accommodates a participant's level of independence, required supports, preference for roommates, need for respite, etc.
- Determining what the participant's typical day might look like
- Making community connections and maintaining ongoing personal relationships
- Identifying what medical supports are required (including the administration of medications, specialised procedures and follow-up)
- Providing specialised equipment
- Accessing required behavioural supports
- Accessing required mental health supports
- Providing other opportunities required to assist the participant in realising her vision

c. Financial Arrangements

Financial arrangements are identified, including any new funding sources required:

- INAC (Indian and Northern Affairs Canada)
- OAS (Old Age Security)
- SAP (Saskatchewan Assistance Plan)
- EI (Employment Insurance)
- EAPD (Employment Assistance for Persons with Disabilities)
- GIS (Guaranteed Income Supplement)
- Worker's Compensation
- Canada Pension Plan
- Self
- Trusteeship

Financial arrangements are identified for associated costs:

- Transportation
- Special needs
- Transition

5. Implementation

Upon consideration of the participant's vision of a meaningful life and supports required, a decision will be made regarding:

- Whether the existing resource can be modified to meet the participant's needs and preferences
- Whether applications will be made to existing community services which meet the participant's needs and reflect her preferences (these are to be specified with options if any)
- Whether a new resource needs to be developed to meet the participant's needs and preferences (the person responsible for exploring the development of such resources will be identified at the planning meeting)

If a move is required the Key Person will identify actions, assign tasks and ensure that those tasks are carried out. The required actions include:

- Establishing liaison with the Community Service Worker in the district where applications are being made or where resource development is being explored
- Completing and submitting application forms along with necessary supplementary reports and information
- Presenting application information an agency Admission Committee meeting by appropriate core group members

- Updating the planning team on the status of applications/resource development
- Determining medical supports and resources required to meet needs, including consent for medical procedures
- Informing or updating the PDC who may become involved
- Determining behavioural supports:
- Strategies to be implemented prior to move, with responsibility assigned.
- Assessment of the need for the development of a comprehensive behavioural support plan
- Initial follow-up by current program support person or immediate transfer to another community resource person.

Throughout the planning process, the Key Person is responsible for ensuring that the participant's vision for a meaningful life is being fulfilled.

6. Transition

When the participant moves to an existing resource or a new resource the core group will identify the transition process that would best meet the needs of the participant. The core group will also identify who is responsible for carrying out each of the various tasks. The following issues will be addressed:

- Whether visits to her current home by people supporting the participant in her new home are necessary, and who is responsible for co-ordinating the visits
- What support the current service provider may provide after the participant moves to her new home and how this will happen
- What the process will be to provide necessary information about the participant and her required supports to the new service provider
- What the process will be to help the participant become familiar with her new home
- How the participant will be prepared for leaving her current home (including when and who is responsible for the details of the arrangements)
- What special equipment is required
- What medications are required
- How clothing and personal items are arranged for both during visits and the eventual move
- What behavioural supports are required, including:
- Strategies to be implemented prior to move, with responsibility assigned
- Assessment of the need for the development of a comprehensive behavioural support plan
- Initial follow-up by current program support person or immediate transfer to another community resource person
- Referral for PDC services, if not already in place, and if deemed to be required.

7. Follow-up

Once the participant has moved to her new home a Person-centred Planning meeting will be convened within 6 weeks. The Person-centred Plan will reflect the participant's needs and desires in her new environment. The Key Person co-ordinates this meeting. The core group members will change once a move has occurred.

The core group will consist of those identified below, unless the participant has objected to their involvement:

- Participant
- Family member(s)
- Those requested by the participant
- Key Person
- Community Living Division Community Service Worker
- Program support person
- Primary service provider
- Others with specific expertise as requested by core group members

The role of Key Person is transferred at the first Person-centred Planning meeting in her home. The new Key Person is identified by the participant and her core group and becomes the fixed point of responsibility for future planning and co-ordination of supports.

Transfer arrangements include:

- Forwarding to the Community Living Division Community Service Worker the participant's Community Living Division file containing current chronological recordings, program information, correspondence, medical information, assessments, social history, Person-centred Plans, applications, etc.
- Transfer of program support