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Northwest Territories Supported Living Review

Final Report

Examen de l'aide à la vie autonome aux Territoires du Nord-Ouest

Rapport définitif

Le présent document contient la traduction française du sommaire.

SEPTEMBRE | SEPTEMBER 2022

Government of
Northwest Territories
Government des
Territoires du Nord-Ouest

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Kīspin ki nitawihtīn ē nīhīyawihk ōma ācimōwin, tipwāsinān.
Cree

Tłı̨chǫ yatı k'ę̀è. Dı wegodı newǫ dè, gots'o gonede.
Tłı̨chǫ

ʔerıhtł'ís Dëne Sųłıné yatı t'a huts'elkër xa beyáyatı theɔ ą ɔat'e, nuwe ts'ën yółtı.
Chipewyan

Edı gondı dehgáh got'ı̨e zhatıé k'ǫ́é edatł'éh enahddhę nıde naxets'é edahłí.
South Slavey

K'áhshó got'ı̨ne xədə k'é hederı ɔedı̨htl'é yerınıwę nídé dúle.
North Slavey

Jii gwandak izhii ginjìk vat'atr'ijąhch'uu zhit yinohthan jì', diits'àt ginohkhìi.
Gwich'in

Uvanittuaq ilitchurisukupku Inuvialuktun, ququaqluta.
Inuvialuktun

ᑕᒃᑯᐊ ᑎᑎᖅᑲᐃᑦ ᐱᓕᒍᐃᖏᑦ ᐃᓄᒃᑎᑐᓕᖅᑭᓗᒃ, ᐅᐸᑦᑎᓐᓄᓕᑦ ᐅᖅᑲᓪᓚᕆᓂᖅᑕᑎᑦ.
Inuktitut

Hapkua titiqqat pijumagupkit Inuinnaqtun, uvaptinnut hivajarlutit.
Inuinnaqtun

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Acronyms

ADL	Activities of Daily Living
CARF	Commission on Accreditation of Rehabilitation Facilities
CCAP	Continuing Care Assessment and Placement
DHSS	Department of Health and Social Services
GNWT	Government of Northwest Territories
HRHSSA	Hay River Health and Social Service Authorities
HSSA	Health and Social Service Authority
IADL	Instrumental Activities of Daily Living
NTHSSA	Northwest Territories Health and Social Service Authority
NWT	Northwest Territories
SL	Supported Living
TAC	Territorial Admissions Committee
TCSA	Tłı̨chǫ Community Services Agency
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities

Sigles et abréviations

AIVQ	Activités instrumentales de la vie quotidienne
ASCT	Agence de services communautaires tłı̨chǫ
ASSSSHR	Administration des services de santé et des services sociaux de Hay River
ASTNO	Administration des services de santé et des services sociaux des Territoires du Nord-Ouest
AVA	Aide à la vie autonome
AVQ	Activités de la vie quotidienne
CARF	*Commission on Accreditation of Rehabilitation Facilities*
CCAP	Évaluation et placement des services de soins continus
CNUDPH	Convention des Nations unies relative aux droits des personnes handicapées
CTA	Comité territorial d'admission
GTNO	Gouvernement des Territoires du Nord-Ouest
MSSS	Ministère de la Santé et des Services sociaux
TNO	Territoires du Nord-Ouest

Executive Summary

Introduction

Background

In 2020/21, the Government of the Northwest Territories (GNWT) Department of Health and Social Services (DHSS) committed to conducting a territorial review of Supported Living (SL) services for persons with disabilities. This commitment is in response to previous stakeholder engagement and data analysis through the *Disability Program Review and Renewal Project* (2017), and the *NWT Disability Strategic Framework: 2017-2027*, which revealed inadequate access to equitable and supportive housing for persons with disabilities in the NWT. Through this review, the GNWT aimed to develop a renewed person- and family-centred model for SL services. The new model aligns with the goal of providing community-based, culturally safe, and individualized supports; and will enable participation, community-based living and inclusion, and advance accessibility and equity.

Supported Living

Supported living services provide support to people with disabilities to live as independently as possible in their own homes or in accommodations managed by a SL service provider. Service users may require only a few hours of support per week or may require full-time 24-hour support. SL programs typically provide support with Activities of Daily Living (ADLs) (i.e., bathing, dressing, eating, etc.); and Instrumental Activities of Daily Living (IADLs) (i.e., meal preparation, home maintenance, banking, recreation etc.).

Through this review, an exploration of adopting an updated SL definition in the NWT was conducted to expand from a 24-hour congregate living based care definition to a definition that takes into consideration the need for a continuum of supports that will facilitate inclusion, participation, and community living.

Purpose of the Review

The principal goals of this review were to determine and analyze the SL programs and services currently available to NWT residents; to conduct public and stakeholder engagement to identify strengths and gaps in current service delivery; to report on key barriers and challenges to accessing SL services; to conduct a jurisdictional scan of best practices and SL models, and to develop a renewed person and family-centred, culturally safe, and inclusive model for delivering SL services in the NWT.

Overview of Primary Objectives of the Review:

1. Analyze existing SL programs and services for persons with disabilities
2. Conduct public and stakeholder engagement
3. Analyze the demand for SL services

4. Conduct a jurisdictional scan to gain information about SL services in other parts of Canada and the world
5. Develop an updated definition of Supported Living in the NWT
6. Develop a renewed SL service model for persons with disabilities in the NWT who require support with daily living
7. Develop recommendations to improve SL service delivery in the NWT

Scope of Review

In-Scope

This review included all SL services currently provided and contracted in the NWT, and those delivered through the NTHSSA Adult Out-of-Territory Supportive Living Services Program. The target population for this review was adult residents of the NWT with a disability who require supports to live independently.

The review examined SL program administration, service partnerships and dependencies between government-operated, government-funded, and contracted programs and services. SL services that were examined included in-territory and out-of-territory support for ADLs and IADLs, caregiver support, social inclusion, respite care, housing support and services, supervision, service management services, and related intake, admissions, and eligibility criteria and processes.

Out-of-Scope

This review did not serve as a quality assurance mechanism for in-territory or out-of-territory support services. Additionally, this review did not include facility-based treatment care, transitional care, or temporary care. This review did not include services specifically for children or adolescents, home care, or long-term care for seniors or Elders.

Review Approach and Methodology

The methodology of the review included the following activities:

- **Review Planning Phase** - Involved a review of relevant documents (Appendix A), initial stakeholder mapping, preliminary interviews, and the development of an engagement plan and a Review plan.

- **Data Collection** - Service provider contracts were reviewed and data on SL service users was gathered.

- **Stakeholder Engagement** - Engagement activities included stakeholder interviews, a public survey, SL site visits (in-territory and out-of-territory), public engagements sessions throughout the NWT and virtually, and a priority sorting workshop with the NWT Supported Living Review Steering Committee and Advisory Group, as well as senior leadership.

- **Jurisdictional Scan** -Both broad and focused jurisdictional scans were conducted on national and international jurisdictions.

- **Preliminary Findings Analysis and Reporting** – Preliminary results were presented to the NWT Supported Living Review Steering Committee and Advisory Group, and the Indigenous Advisory Body for validation.

- **Renewed Model and Recommendations Development** – A flexible costing tool was developed, a renewed model was developed and then refined through facilitated engagement with the NWT Steering Committee and Advisory Group, and recommendations for improved SL service delivery were determined.

Overview of Findings

Key findings about current SL services and emerging gaps from this review are summarized below:

Key Findings about Existing Supported Living Services

- At the time of data collection, there were 182 NWT SL service users, with the majority of service users accessing out-of-territory SL services (124), and 58 accessing SL services in-territory. This is due to reported limited capacity of in-territory SL services.
- Within the NWT, there are SL services accessible to all NWT residents in four communities (Yellowknife, Inuvik, Katl'odeeche First Nation, and Hay River) with 32 service users in Yellowknife (55%), 13 in Inuvik (22%), 10 in Hay River (17%) and 3 in Katl'odeeche First Nation (5%).
- If the needs of service users cannot be met within the NWT, service users can access the NTHSSA Adult Out-of-Territory Supportive Living Services Program, which holds contracts with ten service providers in British Columbia, Alberta, and Saskatchewan. Of the 124 service users receiving SL services out-of-territory, 81 service users reside in Alberta (65%), 42 in British Columbia (34%), and one in Saskatchewan (1%).
- The SL settings utilized by service users include:

  In-territory

  - Designated SL settings: 53%
  - Service Provider-Managed Homes: 16%
  - Service User's Own Home/Family Home: 31%

  Out-of-Territory

  - Designated SL settings: 4%
  - Service Provider-Managed Homes: 60%
  - Alternate Family Homes: 36%
- Public engagement revealed that most SL service users and potential SL service users want to receive services in their own home.

- From 2016-17 to 2021-22 the total number of NWT SL service users (in-territory and out-of-territory) has increased from 164 to 182, with the majority of the increase in out-of-territory SL services. This equates to an average increase of 2.2% per year.
- The total annual cost of services is approximately $38 million per year, with in-territory expenditures totalling roughly $8 million, and out-of-territory costs approximately $30 million. In-territory costs have remained relatively stable over the past five years (fluctuating from $7.9 - $8.4 million), whereas the cost for out-of-territory services has increased from approximately $19 million to almost $30 million over the same five-year period.
- Characteristics and demographics of people receiving SL services from October 2021 to January 2022 are:
    - Most service users (86%) have more than one impairment.
    - Almost all in-territory SL service users (97%) have a cognitive impairment, while all out-of-territory service users have a cognitive impairment.
    - More out-of-territory service users have behavioural issues (94%) than in-territory service users (24%).
    - The most frequently reported diagnosis categories for SL service users are listed below, noting that service users often have more than one diagnosis:
        - Mental health 38%
        - FASD 22%
        - Developmental 17%
        - Addictions 5%
        - Autism 3%
        - Musculoskeletal 3%
        - Acquired brain injury 3%
    - 86% of SL service users are Indigenous (First Nation, Métis or Inuit), with 89% of out-of-territory SL service users being Indigenous, and 81% of in-territory service users being Indigenous).

Gaps in Current Supported Living System

- There is confusion among the public and stakeholder groups regarding who is eligible for SL services as well as how other disability supports fit with the SL services.
- There is no clear process to access SL services and there is no common assessment tool to determine eligibility and service needs.
- There are inconsistencies in policies and processes of SL services providers, which leads to inequity for service users.
- Case management is not consistently available for all SL service users.
- Case manager job descriptions vary between regions and there are no case management guidelines and standards.
- There is a mix of mechanisms in place for SL service oversight, no common database to facilitate collecting and reporting of SL service data, and there are no specific NWT SL standards that are audited and enforced.

- There are limited in-territory SL options in community settings, including use of Alternate Family Home settings.
- There is a lack of capacity with in-territory SL services to support the number of service users.
- There is a lack of in-territory capacity for SL users with complex and aggressive behaviours.
- There is a lack of flexible service options in-territory which may result in SL service users being overserved in DSL settings.

Recommendations

The following 33 recommendations will address the gaps in the current SL system, some of which are integrated into a new SL model that is person and family centred, culturally safe and equitable for all adults with disabilities in the NWT. The recommendations are presented in the following categories:

- Scope of Services
- Projected Resource Requirements
- Standards and Oversight
- Access and Equity
- SL Workforce Development
- Client Focussed Services
- Interdepartmental Collaboration

Scope of Services

1. *Adopt the following updated definition of supported living to guide SL services in the NWT that reflects eligibility for individuals with all types of disabilities and that provides a variety of flexible services:*

   Supported living provides a continuum of supports based on individual need to adults with disability, who require long term support to live independently. Supported living services can be provided in an individual's own home or in an accommodation-based supported living setting.*

   The scope of supported living services includes the provision of support with activities of daily living (i.e., bathing, dressing, eating, etc.) and/or instrumental activities of daily living (i.e., meal preparation, maintaining a home, banking, recreation, etc.), as well as supporting the full inclusion and participation of the individual in their community and respite services for caregivers.

   **Adults are defined as age of majority in the NWT, which is 19 years of age or older.*

2. *Clearly define SL service scope to better serve the full range of needs for persons with disabilities of all age groups who require SL services.*

3. *Adopt the proposed new person and family-centred, culturally safe, and inclusive model for delivering Supported Living services in the NWT.*

Projected Resource Requirements

4. *Adequately resource the HSSAs to provide SL assessment, service planning, case management and service user monitoring.*

5. *Expand in-territory SL services to include more communities and more service options so that more persons with disabilities can receive SL services within the NWT.*

6. *Do not plan to expand or build new designated SL settings in the NWT and consider phasing out designated SL settings once significant additional accessible housing options and SL service capacity has been developed within the territory, and as existing infrastructure ages.*

7. *Develop enhanced behaviour supports in-territory to support service users with high risk, complex and aggressive behaviours.*

8. *Increase caregiver supports including expansion of respite services to communities outside of Yellowknife, and overnight respite options.*

9. *Establish a process and resources to plan for the phased repatriation of out-of-territory SL service users, based on their desire to return to the NWT and the ability of in-territory SL services to meet service users' needs.*

Standards and Oversight

10. *Establish a mechanism and resources to support collaboration across and within the HSSAs to develop common policies, processes, and tools for administering in-territory and out-of-territory SL services.*

11. *Develop a standardized approach for SL room and board fees for NWT SL service users.*

12. *Explore an income testing model for SL room and board fees.*

13. *Develop stand-alone NWT Supported Living Standards and implement a regular auditing process to monitor adherence to the Standards.*

14. *Develop a SL performance monitoring framework including indicators for service user satisfaction and data reporting requirements for monitoring SL program outcomes, efficiency, and effectiveness.*

15. *Implement a central database that supports administration of SL services and reporting to meet DHSS performance monitoring and program standards requirements.*

16. *Ensure consistent accountability and oversight for SL Service delivery across all HSSAs.*

Access and Equity

17. *Establish and implement a unified application form and assessment tool which evaluates applicants' strengths, resources, supports and service needs.*

18. *Develop territorial policies and guidelines to guide the delivery of assessment, service planning, case management and service user monitoring.*

19. *When out-of-territory SL services are needed, ensure access is available to persons with all types of disabilities.*

20. *Ensure that all future admissions to designated SL settings require the level of support and services provided by the settings.*

21. *Develop policies for family/community reunification visits to ensure equity of access for SL service users living outside of their home community.*

22. *Develop and implement ongoing communication for the public about SL services and how to access services.*

SL Workforce Development

23. *Establish a training program for SL support staff through an education body such as Aurora College.*

24. *Establish a standardized on-boarding for all SL support staff in the NWT, with additional on-going professional development to ensure skills are up to date and best practices are being shared.*

Client Focused Services

25. *Ensure all SL service providers have a flexible staffing ratio model to ensure that service users receive the appropriate amount of support.*

26. *Ensure that all service users have options to participate in activities that relate to their culture, and that these are integrated into support plans.*

27. *Ensure that SL service providers, including contracted service providers, complete the GNWT cultural awareness training as part of their mandatory staff training.*

28. *Increase awareness on the process to address SL service user complaints and concerns, through the HSSAs and the Office of the Ombud.*

Interdepartmental Collaboration

29. *Work with the Department of Education, Culture and Employment to explore opportunities to enable out-of-territory SL service users to access income assistance.*

30. *Collaborate with other GNWT Departments to determine the best approach to achieving integration of services for NWT residents with disabilities.*

31. *Work with other GNWT Departments to create an integrated transitional support service for NWT youth transitioning to adulthood who require SL services.*

32. *Work with Housing NWT to determine where there is need for accessible housing options in communities to enable persons with disabilities to remain living in their community.*

33. *Work with the Department of Education, Culture and Employment to review options to strengthen vocational supports available and accessible by in-territory SL service users, including availability in communities outside of Yellowknife and Hay River.*

Sommaire

Introduction

Contexte

En 2020-2021, le ministère de la Santé et des Services sociaux (MSSS) du gouvernement des Territoires du Nord-Ouest (GTNO) s'est engagé à mener un examen territorial des services d'aide à la vie autonome (AVA) pour les personnes handicapées. Cet engagement découle de précédents échanges avec les intervenants et de l'analyse des données recueillies dans le cadre du *Projet d'examen et de renouvellement des programmes pour personnes handicapées* (2017) et du *Cadre stratégique des TNO sur les personnes handicapées de 2017 à 2027.* Ces données ont mis en évidence un accès inadéquat à des logements équitables et supervisés pour les personnes handicapées aux TNO. Cet examen a permis au GTNO d'élaborer un nouveau modèle, axé sur la personne et la famille, pour les services d'AVA. Le nouveau modèle vise à fournir des soutiens communautaires, respectueux de la culture et personnalisés; il favorisera la participation, la vie en communauté et l'inclusion des personnes handicapées, ainsi que la qualité des services et l'équité.

Aide à la vie autonome

Les services d'aide à la vie autonome permettent aux personnes handicapées de vivre de manière aussi indépendante que possible chez eux ou dans des logements gérés par un fournisseur de services d'AVA. Les utilisateurs de services peuvent n'avoir besoin que de quelques heures de soutien par semaine ou d'une aide à temps plein en tout temps. Les programmes d'AVA offrent généralement un soutien pour les activités de la vie quotidienne (AVQ), (p. ex. se laver, s'habiller, manger, etc.) et les activités instrumentales de la vie quotidienne (AIVQ) (p. ex. la cuisine, le ménage, les opérations bancaires, les loisirs, etc.).

Cet examen a permis de réfléchir à l'adoption d'une définition actualisée de l'AVA aux TNO afin de passer d'une définition reposant sur des soins dispensés 24 heures sur 24 en milieu collectif à une définition qui prend en compte un ensemble de mesures de soutien qui faciliteront l'inclusion, la participation et la vie en communauté des personnes handicapées.

Objectif de l'examen

Les principaux objectifs de cet examen étaient de déterminer et d'analyser les programmes et services d'AVA actuellement offerts aux Ténois; d'organiser des échanges avec le public et les intervenants afin de cerner les forces et les lacunes de la fourniture actuelle de services; de recenser les principaux défis à l'accès aux services d'AVA; d'effectuer une analyse des pratiques exemplaires et des modèles d'AVA dans d'autres provinces et territoires; et d'élaborer un nouveau modèle de fourniture de services d'AVA aux TNO, modèle axé sur la personne et la famille, respectueux de la culture et inclusif.

Aperçu des principaux objectifs de l'examen :

8. Analyser les programmes et services d'AVA actuellement offerts aux personnes handicapées
9. Organiser des échanges avec le public et les intervenants
10. Analyser la demande en matière de services d'AVA
11. Effectuer un examen des autres provinces, territoires et pays pour obtenir des renseignements sur les services d'AVA dans d'autres régions du Canada et du monde
12. Proposer une définition améliorée de l'aide à la vie autonome aux TNO
13. Élaborer un nouveau modèle de services d'AVA pour les personnes handicapées des TNO qui ont besoin d'aide au quotidien
14. Formuler des recommandations pour améliorer la fourniture de services d'AVA aux TNO

Portée de l'examen

Éléments inclus dans l'examen

Cet examen portait sur tous les services d'AVA actuellement offerts et sous-traités aux TNO, ainsi que sur ceux offerts dans le cadre du programme de services d'aide à la vie autonome adressés aux adultes à l'extérieur du territoire de l'ASTNO. La population cible de cet examen était les résidents adultes des TNO qui vivent avec une incapacité et ont besoin de soutien pour vivre de façon autonome.

Cet examen a permis d'étudier la gestion du programme d'AVA, les partenariats de services et les liens entre les programmes et services gérés et financés par le gouvernement et ceux sous-traités. Les services d'AVA examinés comprenaient : l'aide à l'intérieur et à l'extérieur du territoire pour les AVQ et les AIVQ, le soutien aux aidants, l'inclusion sociale, les soins de relève, les services d'aide au logement, le contrôle et la gestion des services, les critères et processus d'admission connexes.

Éléments exclus de l'examen

Cet examen ne servait pas à vérifier la qualité des services d'AVA offerts à l'intérieur ou à l'extérieur du territoire. Par ailleurs, cette analyse ne portait pas sur les soins en établissement, les soins de transition ou les soins temporaires. Elle a fait abstraction des services adressés spécifiquement aux enfants ou aux adolescents, des soins à domicile et des soins de longue durée pour les personnes âgées.

Approche et méthodologie de l'examen

La méthodologie de l'examen comprenait les activités suivantes :

- **Phase de planification de l'examen** – qui consistait à examiner des documents pertinents (annexe A), dresser une première liste des intervenants, mener des entretiens préliminaires et élaborer un plan de consultation ainsi qu'un plan d'examen.
- **Collecte de données** – les contrats des fournisseurs de services ont été examinés et des données sur les utilisateurs de services d'AVA ont été recueillies.

- **Mobilisation des intervenants** – qui comprenait des entretiens avec les intervenants, un sondage public, des visites de sites d'AVA (à l'intérieur et à l'extérieur du territoire), des séries d'échanges virtuels et en personne avec le public sur l'ensemble des TNO, et un atelier de sélection des priorités avec les hauts dirigeants, le comité directeur et le groupe consultatif sur l'examen de l'aide à la vie autonome aux TNO.

- **Analyses des autres provinces, territoires et pays** – des analyses larges et précises ont été menées auprès des autres provinces, territoires et pays.

- **Analyse et présentation des résultats préliminaires** – les résultats préliminaires ont été présentés au comité directeur et au groupe consultatif sur l'examen de l'aide à la vie autonome aux TNO, ainsi qu'au comité consultatif autochtone pour validation.

- **Élaboration d'un nouveau modèle et formulation de recommandations** – un outil souple de calcul des coûts a été mis au point, un nouveau modèle a été élaboré puis affiné grâce à des échanges avec le comité directeur et le groupe consultatif des TNO, et des recommandations visant à améliorer la fourniture des services d'AVA ont été formulées.

Aperçu des résultats

Les principales conclusions de cet examen sur les services actuels d'AVA et les lacunes constatées sont résumées ci-dessous :

Principales conclusions sur les services actuels d'AVA

- Au moment de la collecte des données, les TNO comptaient 182 utilisateurs de services d'AVA, la majorité d'entre eux ayant accès à ces services à l'extérieur du territoire (124), pour 58 utilisateurs à l'intérieur du territoire. Cet écart s'explique par la capacité limitée des services d'AVA du territoire.
- Aux TNO, les services d'AVA sont disponibles pour tous les Ténois dans quatre collectivités (Yellowknife, Inuvik, Première Nation Katl'odeeche et Hay River) avec 32 utilisateurs de services à Yellowknife (55 %), 13 à Inuvik (22 %), 10 à Hay River (17 %) et 3 dans la réserve de la Première Nation Katl'odeeche (5 %).
- Si les besoins des utilisateurs de services ne peuvent être satisfaits aux TNO, ils peuvent avoir accès au programme de services d'aide à la vie autonome adressés aux adultes à l'extérieur du territoire de l'ASTNO, qui a des contrats avec dix fournisseurs de services en Colombie-Britannique, en Alberta et en Saskatchewan. Sur les 124 utilisateurs de services d'AVA à l'extérieur du territoire, 81 résident en Alberta (65 %), 42 en Colombie-Britannique (34 %) et un seul en Saskatchewan (1 %).
- Les utilisateurs de services d'AVA vivent dans les logements suivants :
    À l'intérieur du territoire
    - Logements réservés aux services d'AVA : 53 %
    - Logements gérés par des fournisseurs de services : 16 %

- Domicile de l'utilisateur du service ou logement familial : 31 %

À l'extérieur du territoire

- Logements réservés aux services d'AVA : 4 %
- Logements gérés par des fournisseurs de services : 60 %
- Logements familiaux de substitution : 36 %

- Les échanges avec le public ont révélé que la plupart des utilisateurs de services d'AVA et les utilisateurs potentiels souhaitent recevoir ces services à domicile.
- De 2016-2017 à 2021-2022, le nombre total d'utilisateurs de services d'AVA aux TNO (à l'intérieur et à l'extérieur du territoire) est passé de 164 à 182, la majeure partie de cette augmentation étant attribuable aux services d'AVA à l'extérieur du territoire. Ces chiffres correspondent à une augmentation moyenne de 2,2 % par année.
- Le coût annuel total des services avoisine les 38 millions de dollars par année, les dépenses dans le territoire se chiffrant à près de 8 millions de dollars et les coûts hors du territoire à environ 30 millions de dollars. Le coût des services à l'intérieur du territoire est resté relativement stable au cours des cinq dernières années (oscillant entre 7,9 et 8,4 millions de dollars), alors qu'à l'extérieur du territoire, il est passé d'environ 19 millions de dollars à près de 30 millions de dollars au cours de la même période.
- Pour la période d'octobre 2021 à janvier 2022, les caractéristiques et les données démographiques des utilisateurs de services d'AVA sont les suivantes :
    - La plupart des utilisateurs de services d'AVA (86 %) vivent avec plusieurs incapacités.
    - La quasi-totalité des utilisateurs de services à l'intérieur du territoire (97 %) présente des troubles cognitifs, tandis que tous les utilisateurs de services à l'extérieur du territoire souffrent de troubles cognitifs.
    - Les utilisateurs de services d'AVA à l'extérieur du territoire sont plus nombreux à avoir des troubles du comportement (94 %) que les utilisateurs de services à l'intérieur du territoire (24 %).
    - Les catégories de diagnostic les plus fréquemment signalées chez les utilisateurs de services d'AVA sont énumérées ci-dessous, sachant que ceux-ci reçoivent souvent plus d'un diagnostic :
        - Santé mentale 38 %
        - Ensemble des troubles causés par l'alcoolisation fœtale 22 %
        - Trouble du développement 17 %
        - Dépendances 5 %
        - Autisme 3 %
        - Trouble musculosquelettique 3 %
        - Lésion cérébrale acquise 3 %
    - Parmi les utilisateurs de services d'AVA, 86 % sont autochtones (Premières Nations, Métis ou Inuits), et 89 % d'entre eux vivent à l'extérieur du territoire tandis que 81 % vivent à l'intérieur du territoire.

Lacunes du système actuel d'aide à la vie autonome

- Le grand public et les groupes d'intervenants ne savent pas très bien qui peut recevoir des services d'AVA et comment les autres mesures de soutien aux personnes handicapées s'intègrent aux services d'AVA.
- Aucun processus clair n'existe pour accéder aux services d'AVA de même qu'aucun outil d'évaluation commun ne permet de déterminer les critères d'admissibilité et les besoins en services des utilisateurs.
- Les politiques et les processus des fournisseurs de services d'AVA présentent des incohérences, ce qui entraîne des inégalités pour les utilisateurs de services.
- La gestion de cas n'est pas toujours disponible pour tous les utilisateurs de services d'AVA.
- Les descriptions de poste des gestionnaires de cas varient d'une région à l'autre et il n'existe ni lignes directrices ni normes en matière de gestion de cas.
- Les mécanismes de contrôle des services d'AVA sont variés. Aucune base de données commune ne facilite la collecte et la communication des données sur les services d'AVA et il n'existe aucune norme spécifique sur l'AVA aux TNO qui soit vérifiée et appliquée.
- Il existe un nombre limité de services d'AVA à l'intérieur du territoire dans les milieux communautaires, y compris le recours aux foyers familiaux de substitution.
- Les services d'AVA à l'intérieur du territoire manquent de moyens pour répondre aux besoins des utilisateurs.
- À l'intérieur du territoire, les services d'AVA ne disposent pas de moyens suffisants pour les utilisateurs de service présentant des comportements complexes et violents.
- Les options de services flexibles font défaut sur le territoire, ce qui signifie que les utilisateurs de services pourraient disposer de trop de logements réservés aux services d'AVA.

Recommandations

Les 33 recommandations suivantes visent à combler les lacunes du système actuel d'AVA, dont certaines sont intégrées à un nouveau modèle d'AVA axé sur la personne et la famille, respectueux de la culture et équitable pour tous les adultes handicapés des TNO. Les recommandations sont présentées dans les catégories suivantes :

- Portée des services
- Besoins en ressources prévus
- Normes et contrôle
- Accès et équité
- Développement de la main-d'œuvre de l'AVA
- Centre de service à la clientèle
- Collaboration interministérielle

Portée des services

34. *Adopter la définition actualisée du concept d'aide à la vie autonome suivante pour guider les services d'aide à la vie autonome aux TNO, qui reflète l'admissibilité des personnes vivant avec différents types d'incapacités et offre une variété de services flexibles :*

> *L'aide à la vie autonome offre un ensemble de soutiens adaptés aux besoins individuels des adultes* handicapés qui ont besoin d'une aide à long terme pour vivre de manière autonome. Les services d'aide à la vie autonome peuvent être fournis au domicile de la personne handicapée ou dans un établissement d'aide à la vie autonome.*
>
> *La portée des services d'aide à la vie autonome comprend la fourniture d'une aide pour les activités de la vie quotidienne (c'est-à-dire se laver, s'habiller, manger, etc.) et les activités instrumentales de la vie quotidienne (c'est-à-dire la cuisine, le ménage, les opérations bancaires, les loisirs, etc.), ainsi que le soutien à la pleine inclusion et implication de la personne handicapée dans sa communauté et les services de relève pour les aidants.*
>
> **Aux TNO, les individus ayant la majorité (19 ans ou plus) sont considérés comme adultes.*

35. *Définir clairement la portée des services d'AVA afin de mieux répondre à l'ensemble des besoins des personnes handicapées de tous les groupes d'âge.*

36. *Adopter le nouveau modèle proposé, axé sur la personne et la famille, respectueux de la culture et inclusif, pour la fourniture de services d'aide à la vie autonome aux TNO.*

Besoins en ressources prévus

37. *Fournir des ressources adéquates aux administrations des services de santé et des services sociaux pour assurer l'évaluation des services d'AVA, leur planification, la gestion des cas et le suivi des utilisateurs de services.*

38. *Élargir les services d'AVA à l'intérieur du territoire pour inclure plus de communautés et plus d'options de services afin que davantage de personnes handicapées puissent recevoir des services d'AVA sur le territoire.*

39. *Ne pas prévoir l'expansion ou la construction de nouveaux logements réservés aux services d'AVA aux TNO et envisager l'élimination progressive de ces logements une fois qu'un nombre important d'options de logement accessibles et de capacités de services d'AVA supplémentaires auront été développées dans le territoire, et à mesure que l'infrastructure existante vieillit.*

40. *Élaborer des mesures de soutien améliorées en matière de comportement à l'intérieur du territoire afin de soutenir les utilisateurs de services présentant des comportements dangereux, complexes et violents.*

41. *Accroître le soutien aux aidants naturels, notamment en étendant les services de relève aux collectivités situées à l'extérieur de Yellowknife et en offrant des options de relève de nuit.*

42. *Établir un processus et des ressources pour planifier le retour progressif des utilisateurs de services d'AVA à l'extérieur du territoire, en fonction de leur désir de rentrer aux TNO et de la capacité des services d'AVA du territoire à répondre à leurs besoins.*

Normes et contrôle

43. *Mettre en place un mécanisme et des ressources pour soutenir la collaboration entre les administrations des services de santé et des services sociaux et au sein de celles-ci afin de développer des politiques, des méthodes et des outils communs pour l'administration des services d'AVA à l'intérieur et à l'extérieur du territoire.*

44. *Élaborer une approche uniforme pour les frais de chambre et de pension des utilisateurs de services d'AVA des TNO.*

45. *Explorer un modèle d'examen de revenus pour les frais de chambre et de pension d'AVA.*

46. *Élaborer des normes uniques pour l'aide à la vie autonome aux TNO et instaurer un processus de vérification régulière pour contrôler le respect de ces normes.*

47. *Développer un cadre de mesure du rendement des services d'AVA, y compris des indicateurs de satisfaction des utilisateurs des services et des exigences en matière de transmission de données pour le suivi des résultats, de la qualité et de l'efficacité des programmes d'AVA.*

48. *Créer une base de données centrale pour soutenir l'administration des services d'AVA et la production de rapports afin de répondre aux exigences du MSSS en matière de contrôle du rendement et de normes de programme.*

49. *Garantir une transparence et une supervision cohérentes de la fourniture des services d'AVA dans toutes les administrations des services de santé et des services sociaux.*

Accès et équité

50. *Concevoir et utiliser un formulaire de demande unique et un outil d'évaluation permettant de connaître les qualités, les ressources, les mesures de soutien et les besoins des demandeurs.*

51. *Élaborer des politiques et des lignes directrices territoriales pour guider l'évaluation des services, leur planification, la gestion des cas et le suivi des utilisateurs de services.*

52. *Garantir l'accès aux services d'AVA aux personnes souffrant de tous types d'incapacités lorsque ceux-ci sont requis à l'extérieur du territoire.*

53. *Veiller à ce que toutes les futures admissions dans les logements réservés aux services d'aide à la vie autonome répondent au niveau de soutien et de services fournis par ces établissements.*

54. *Élaborer des politiques pour les visites de réunification familiale ou communautaire afin de garantir un accès équitable aux utilisateurs de services d'AVA vivant hors de leur communauté d'origine.*

55. *Développer et organiser une communication permanente avec le public sur les services d'AVA et les moyens d'y accéder.*

Développement de la main-d'œuvre de l'AVA

56. *Créer un programme de formation pour le personnel de soutien des services d'AVA par le biais d'un organisme de formation comme le Collège Aurora.*

57. *Établir un processus d'intégration normalisé pour tout le personnel de soutien des services d'AVA aux TNO, avec un perfectionnement professionnel continu supplémentaire pour s'assurer que les compétences sont à jour et que les pratiques exemplaires sont partagées.*

Centre de service à la clientèle

58. *Veiller à ce que tous les fournisseurs de services d'AVA possèdent un modèle flexible de ratio du personnel afin de s'assurer que les utilisateurs de services reçoivent la quantité appropriée de soutien.*

59. *Veiller à ce que tous les utilisateurs de services aient la possibilité de participer à des activités liées à leur culture, et que celles-ci soient intégrées dans les plans d'aide.*

60. *Veiller à ce que les fournisseurs de services d'AVA, y compris les fournisseurs de services sous contrat, suivent la formation de sensibilisation culturelle du GTNO dans le cadre de la formation obligatoire de leur personnel.*

61. *Renforcer la sensibilisation au processus de traitement des plaintes et des préoccupations des utilisateurs de services d'AVA, par le biais des administrations des services de santé et des services sociaux et du Bureau du protecteur du citoyen.*

Collaboration interministérielle

62. *Collaborer avec le ministère de l'Éducation, de la Culture et de la Formation pour explorer les options permettant aux utilisateurs de services d'AVA à l'extérieur du territoire d'accéder à l'aide au revenu.*

63. *Collaborer avec d'autres ministères du GTNO afin de déterminer la meilleure approche pour intégrer les services destinés aux résidents handicapés des TNO.*

64. *Travailler avec d'autres ministères du GTNO pour créer un service intégré de soutien transitoire pour les jeunes des TNO qui entrent dans l'âge adulte et ont besoin de services d'AVA.*

65. *Travailler avec Habitation TNO pour déterminer les besoins en matière de logements accessibles dans les collectivités afin de permettre aux personnes handicapées de continuer à vivre dans leur collectivité.*

66. *Collaborer avec le ministère de l'Éducation, de la Culture et de la Formation pour examiner les moyens de renforcer les soutiens professionnels disponibles et accessibles aux utilisateurs des services d'AVA à l'intérieur du territoire, y compris la disponibilité de ces services dans les collectivités à l'extérieur de Yellowknife et de Hay River.*

Introduction

1.0 - Introduction

In 2020/21, the Government of the Northwest Territories (GNWT) Department of Health and Social Services (DHSS) committed to conducting a territorial review of Supported Living (SL) services for persons with disabilities. This commitment was made in the *GNWT Disability Action Plan 2017/18 – 2021-22* and is in response to stakeholder engagement and data analysis through the *Disability Program Review and Renewal Project* (2017), which revealed inadequate access to equitable and supportive housing for persons with disabilities in the NWT. Through this review of SL services, the GNWT aims to develop a renewed person- and family-centred model for SL services. The new model will align with the goal of providing community-based, culturally safe, and personalized supports; and will enable participation, community-based living and inclusion, and advance accessibility and equity as committed to in the *NWT Disability Strategic Framework: 2017-2027*.

Logical Outcomes was engaged to conduct review activities during the 2021/22 fiscal year, which included:

- An assessment of the current state of NWT SL services
- Engagement with stakeholders, including the public, Health and Social Services system stakeholders, service providers and service users
- A jurisdictional scan to explore SL service provision in other parts of Canada and select countries
- Preliminary analysis of findings and identifying gaps in services
- The development of recommendations and a new proposed NWT Supported Living Model

This report presents the findings and analysis of the review activities, and the resulting recommendations and proposed new service model.

1.1 Background

1.1.1 Terminology

Disability & Related Terms

In 2017, the GNWT adopted the most widely accepted definition of disability in the *NWT Disability Strategic Framework: 2017-2027*[1] , as provided by the World Health Organization (WHO):

> *"**Disability** is an umbrella term for impairments, activity limitations and participation restrictions, referring to the negative aspects of the interaction between an individual (with a health condition) and the individual's contextual factors (environmental and personal factors)"* (WHO, 2011).

- **Impairment:** A problem in body function or structure such as a significant deviation or loss
- **Activity Limitations:** Difficulties an individual may have in executing activities

[1] NWT Disability Framework (https://www.hss.gov.nt.ca/sites/hss/files/resources/equity-accessibility-inclusion-participation-nwt-disability-framework.pdf)

- **Participation Restrictions:** Problems an individual may experience in involvement in life situations

The *International Classification of Functioning, Disability and Health* (ICF) (WHO, 2001) provides the global conceptual framework that positions disability as a dynamic interaction between health conditions and contextual factors, both personal and environmental; promoted as a 'bio-psycho-social model as a workable compromise between the medical and social model' and is viewed as universal because it covers all human functioning and treats disability as a continuum rather than categorising people with disabilities as a separate group.

The *United Nations Convention on the Rights of Persons with Disabilities* (CRPD, 2006) provides further detail to this definition by adopting a social model of disability and defines persons with disabilities as including:

> *"Those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others".*

In keeping with the WHO, ICF and the CRPD, the GNWT also recognizes that disability is an evolving and complex concept that results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others.

Supported Living

Supported Living (SL) services provide support to people with disabilities to live as independently as possible in their own homes or in accommodations managed by a SL service provider. The GNWT currently uses the following description to define SL services:

> ***"Supported Living** provides 24-hour support and supervision for people who have a physical and/or mental health challenge but do not need nursing care. Supported Living provides services in a home-like setting while helping people with disabilities maintain as much independence as possible."*[2]

Service users may require only a few hours of support per week or may require full-time 24-hour support. SL programs typically provide support with Activities of Daily Living (ADLs) (i.e., bathing, dressing, eating, etc.) and Instrumental Activities of Daily Living (IADLs) (i.e., meal preparation, home maintenance, banking, recreation etc.).

Through this review, the NWT has an interest in exploring the potential of adopting an updated SL definition in the NWT, a definition that takes into consideration the need for a continuum of supports that will facilitate inclusion, participation, and community living.

[2] GNWT DHSS website, available at: https://www.hss.gov.nt.ca/en/services/continuing-care-services/supported-living

1.1.2 NWT Context

Geographical Context

The NWT is a geographically large, sparsely populated territory in northern Canada, encompassing approximately 1.2 million km^2, and is home to approximately 45,000 people. The population is distributed among 33 communities ranging in size from fewer than 100 people to more than 20,000 in the capital city of Yellowknife. In addition to Yellowknife, there are five other large population centers: Inuvik and Hay River (~3,500 each), Fort Simpson (~1,200), Fort Smith (~2,700), and Behchokǫ̀ (~2,000). The remaining communities have populations of fewer than 1,000 people. NWT communities are spread across vast distances, and many communities are relatively isolated and can only be reached by winter road access or air travel. Geographical isolation and expensive travel create challenges for the delivery of SL services and other health and social services.

Cultural Context

There are many cultures within the NWT that contribute to its rich diversity. Approximately half the population of the NWT is Indigenous. The NWT is home to three distinct Indigenous groups: Dene, Inuvialuit, and Métis, and the NWT recognizes nine official Indigenous languages as well as English and French. The multiple Indigenous groups in the NWT bring a rich and diverse cultural context to community life and service delivery in the territory.

Indigenous Governments

Seven Regional Indigenous Governments have been established in the NWT to date, and represent multiple communities: the Akaitcho Territory Government, the Dehcho First Nations, the Gwich'in Tribal Council, the Inuvialuit Regional Corporation, the Northwest Territory Métis Nation, the Sahtu Secretariat Incorporated, and the Tłı̨cho Government. In addition, three community based Indigenous Governments represent exclusive negotiations undertaken by individual communities that seek governing powers that are unique to the interests of their membership: the Kátł'odeeche First Nation; the Salt River First Nation; and the Acho Dene Koe First Nation and Fort Liard Métis Local #67.

NWT Health and Social Services System Context

The NWT Health and Social Services system is provided through a partnership between the Department of Health and Social Services and the NWT Health and Social Services Authorities:

Department of Health and Social Services

The Government of the Northwest Territories (GNWT) Department of Health and Social Services (DHSS) is mandated to provide a broad range of health and social programs and services; and to support the Minister of Health and Social Services in carrying out this mandate by:

- Setting the strategic direction for the system
- Developing legislation, regulations, policy, and standards
- Establishing approved programs and services
- Establishing and monitoring of system budgets and expenditures
- Evaluating, monitoring, and reporting on system outcomes and accountabilities

Health and Social Services Authorities

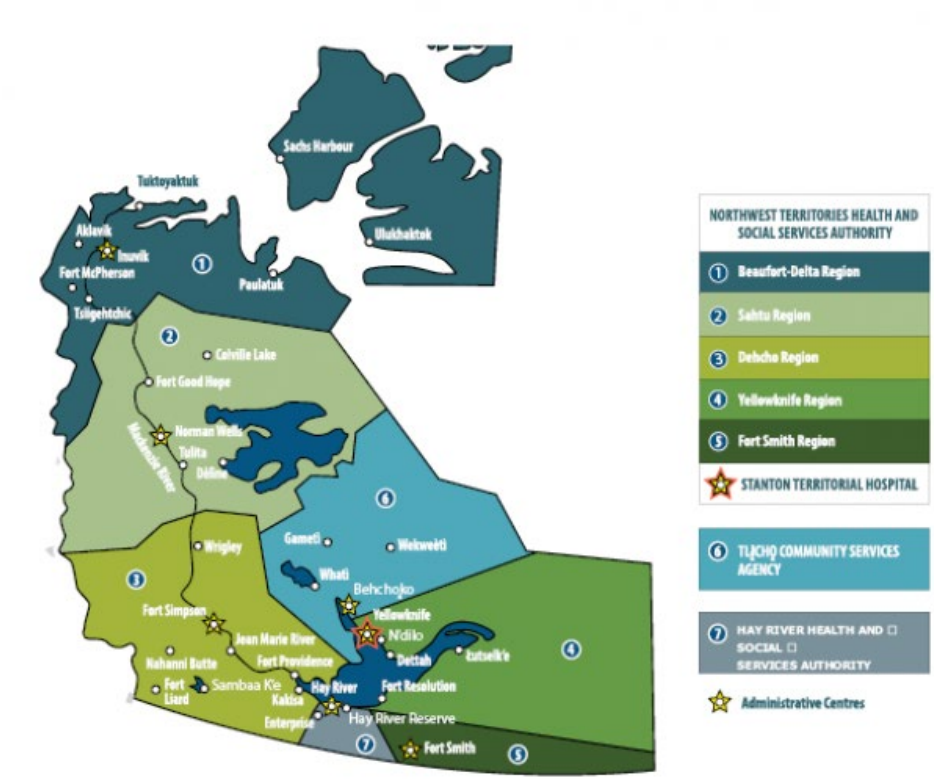
The Health and Social Services Authorities (HSSAs) are responsible for the delivery of health and social services and are funded by the Government of the Northwest Territories through the DHSS. There are currently three HSSAs in the NWT:

1. Northwest Territories Health and Social Services Authority (NTHSSA)
    - Beaufort-Delta Region
    - Sahtu Region
    - Dehcho Region
    - Yellowknife Region
    - Fort Smith Region
    - Stanton Territorial Hospital
2. Hay River Health and Social Services Authority (HRHSSA)
3. Tłı̨chǫ Community Services Agency (TCSA)

The three HSSAs have a mandate to:

- Deliver health services, social services, and health and wellness promotional activities within the NWT
- Manage, control, and operate each health and social services for which they are responsible
- Manage the financial, human, and other resources necessary to perform these duties

Figure 1: *Map of NWT Regions and Communities*



1.1.3 Overview of NWT Supported Living Services

Supported Living Services

NWT Supported Living services are administered under the larger NWT Continuing Care Services program. Continuing Care comprises a continuum of support that includes Home and Community Care (HCC), Supported Living (SL), and Long-Term Care (LTC). All Continuing Care services in the NWT are intended to maintain or improve the physical, social, and psychological health of individuals who are not able to fully care for themselves.

NWT SL services provides support and supervision for people who have a physical, cognitive, and/or mental health challenge but do not need nursing care. SL provides services in a home-like setting while helping people with disabilities maintain as much independence as possible. SL programming aims to ensure services are comprehensive, culturally safe, accessible, effective, and equitable and responsive to the unique health and social services needs of NWT residents. As mandated by the *NWT Continuing Care Standards (2015)*[3], SL services in the NWT include the following essential service elements:

- Assessment
- Service management
- Support for ADLs and IADLs
- Respite care
- Preventive health services
- Medication supervision and/or administration
- Informal caregiver support
- Social and recreation services
- Access to medical-surgical supplies and equipment loan

Additional services may also be provided depending on the living setting and resources available. These may include accommodation, meals, dietary services (including therapeutic and/or special diets), mental wellness, assistance with employment and volunteer endeavours, and laundry/linen services.

Within the *NWT Continuing Care Standards* there is a tool that assists in sorting the care/ support needs of an individual, known as the *NWT Continuing Care Levels of Service*. This tool is used for a variety of reasons, including assisting with the determination of what continuing care service would best meet the individuals' needs and eligibility into various services.

[3] NWT Continuing Care Standards (2015)https://www.hss.gov.nt.ca/professionals/sites/professionals/files/resources/continuing-care-standards.pdf

SL Service Delivery Structure

The three HSSAs are responsible for the administration and delivery of SL services. In some cases, the HSSAs engage other organizations to provide SL services (SL service providers). An overview of the responsibilities of the various organizations involved in SL services are shown in Figure 2.

Figure 2: *NWT Health and Social Services Context*

Currently Available Supported Living Service Locations and Settings

In-Territory Supported Living Services

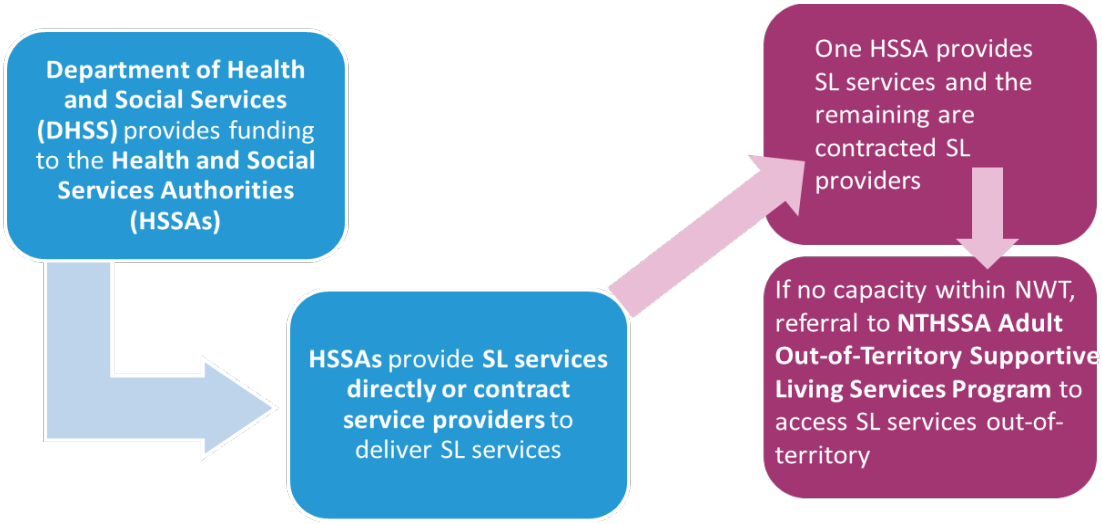
SL services are currently available in Yellowknife, Hay River, Kátł'odeeche First Nation and Inuvik. Services are delivered through a mix of service contracts with non-profit organizations, for-profit organizations and an Indigenous government, and direct service provision by the HSSAs. SL settings are varied and include service users receiving SL services in their own homes; service users living in market-rental houses or apartments managed by the service provider; and service users living in designated accommodations specifically designed for SL that are owned or rented by the service provider or GNWT.

Out-of-Territory Supported Living Services (Southern Specialized Placement Resources)

Although there are several SL service providers and SL settings in the NWT, their limited capacity to meet complex needs and the limited capacity of in-territory SL providers results in many individuals accessing SL services out-of-territory. Access to out-of-territory SL services occurs through the NTHSSA Adult Out-of-Territory Supportive Living Services Program. The NTHSSA Adult Out-of-Territory Supportive Living Services Program holds SL service contracts with several organizations in Alberta, British Columbia and Saskatchewan, and NWT residents may access SL services out-of-territory when no appropriate option is available in-territory.

A summary overview of the SL service delivery structure is shown in Figure 3.

Figure 3: *NWT SL Service Delivery Structure*



1.2 Purpose & Scope of Review

1.2.1 Purpose

The principal goals of this review are to determine and analyze the SL programs and services currently available to NWT residents; to conduct public and stakeholder engagement to identify strengths and gaps in current service delivery; to report on key barriers and challenges with current SL services; to conduct a jurisdictional scan of best practices and SL models, and to develop a renewed person and family-centred, culturally safe, and inclusive model for delivering SL services in the NWT.

Primary Objectives of the Review

1. **Analyze existing SL programs and services for persons with disabilities**
    - Identify the current state of SL services for persons with disabilities from the NWT
    - Conduct a focused assessment on existing SL options and related services currently in place for persons with disabilities from the NWT
    - Identify services accessed through the NTHSSA Adult Out-of-Territory Supportive Living Services Program
    - Analyze existing processes, tools, and practices to assess supported living needs
    - Provide a financial overview of the current program

2. **Conduct public and stakeholder engagement**
    - Include representation from all regions and select communities in the NWT
    - Engage with service users, families, caregivers, and Indigenous Governments

3. **Analyze the demand for SL services**
    - Determine the support needs of adults with disabilities in the NWT
    - Identify services currently in place to serve those needs
    - Identify strengths and gaps in SL service
    - Identify the projected need for SL services

4. **Conduct a jurisdictional scan to gain information about SL services in other parts of Canada and the world**
    - Review SL models, standards and practices in provincial and territorial jurisdictions that are delivered and/or funded by the government
    - Examine partnership arrangements for service delivery including funding models.
    - Conduct research on best practice approaches, trends, and innovative solutions for supporting individuals within SL programs in Canada and other countries with contexts similar to the NWT
    - Explore various funding models, such as individualized and alternative funding models
    - Consider and explore how care is coordinated during the critical transition points of youth to adulthood, and as support needs change over time

5. **Develop an updated definition of Supported Living in the NWT**
    - Consider the need for a continuum of supports that will facilitate inclusion, participation, and community living
    - Include the scope of core SL services in the NWT

6. **Develop a renewed SL service model for persons with disabilities in the NWT who require support with daily living**
    - Recommend a person- and family-centred SL model that is culturally safe and reflects the values of the NWT Health and Social Services system
    - Ensure the new model incorporates the provision of personalized, flexible supports, promotes community-based living and inclusion, enables participation and advances accessibility and equity
    - Identify a costing model to support the renewed SL model

7. **Develop recommendations to improve SL service delivery in the NWT**
    - Recommendations for adopting a coordinated approach to assessing potential for service user repatriation and initiating repatriation planning
    - Recommendations relating to human resource needs, development, training, and education to support the implementation of the recommended SL model
    - Recommendations on determining eligibility and intake process to the SL program including eligibility criteria
    - Recommendations for improving transitional care along the continuum of services for critical transition points from youth to adulthood

- Recommendations for an integrated, coordinated approach to service management for adults with complex supported living support needs
- Recommendations to support persons with disabilities who are experiencing chronic or acute mental health conditions and/or problematic substance use and supporting access to meet their needs
- Recommendations for assessment and decision support tools, staffing standards, training, oversight, and supervision model for supported living staff in various settings
- Recommendations for gathering service user feedback and satisfaction with SL services

1.2.2 Scope of the Review

In-Scope

This review included in its scope all currently provided and contracted SL services in the NWT and through the NTHSSA Adult Out-of-Territory Supportive Living Services Program. The target population for this review was adult residents of the NWT with a disability who require supports to live independently. The review included exploration into how care is coordinated during the critical transition points of youth to adulthood.

The review examined SL program administration and service partnerships and dependencies between government-operated, government-funded, and contracted programs and services. Services examined include support for ADLs and IADLs, caregiver support, social inclusion, respite care, housing support and services in-territory and out-of-territory, supervision, service management services, and intake, admissions, and eligibility criteria and processes.

Out-of-Scope

This review did not serve as a quality assurance mechanism for out-of-territory support. Additionally, this review did not include facility-based treatment care, transitional care, or temporary care. This review did not include services specifically for children or adolescents, or long-term care for seniors or Elders.

1.3 Approach & Methodology

1.3.1 Approach

This Review was guided by values and principles from:

1. **The United Nations Convention of the Rights of Persons with Disabilities (CRPD):** The NWT is guided by the United Nations Convention of the Rights of Persons with Disabilities (CRPD) which is intended to *promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect*

for their inherent dignity.[4] This convention defines disability and sets out general principles and obligations. The principles include:

- Respect for inherent dignity, individual autonomy including the freedom to make one's own 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 of genders
- Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities[5]

2. **The United Nations Declaration of the Rights of Indigenous Persons (UNDRIP):**
The United Nations Declaration of the Rights of Indigenous Persons, ratified by Canada, outlines the rights through 46 articles that recognize the need to respect and promote the inherent rights of Indigenous persons, in particular their rights to lands, territories, and resources. It recognizes the rights of Indigenous people to determine and develop priorities and strategies and be directly involved in planning for their health and well-being. Although several articles in the declaration are applicable to this assignment, Article 24 is particularly relevant:

   - Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals, and minerals. Indigenous individuals also have the right to access, without any discrimination, all social and health services.
   - Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.[6]

3. **The Truth and Reconciliation Commission of Canada (TRC): Calls to Action:**
Through the implementation of the Calls to Action, the Government of Canada has recognized "that the current state of Indigenous health is a direct result of the shameful historical legacy of colonialist policies and interventions against the well-being of Indigenous peoples and communities, including Indian residential schools, the Sixties Scoop, and other harmful practices. The intergenerational impacts of Indian residential schools are well documented in international and national evidence cited in Government of Canada publications and specifically recognized in partnership agreements with Indigenous governments and representatives".[7]

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[4] United Nations Convention on the Rights of Persons with Disabilities, p.4
[5] IBID, p.5
[6] United Nations Declaration of the Rights of Indigenous Peoples (2006) p.18
[7] https://www.rcaanc-cirnac.gc.ca/eng/1524499024614/1557512659251 downloaded March 28, 2021

4. Ethical Guidelines and Evaluation Standards

This Review was conducted in accordance with Canadian Evaluation Society (CES) evaluation standards[8] and the CES Ethical Guidelines for Evaluation. The approach is also consistent with the principles outlined in the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans[9], including respect for human dignity, free and informed consent, vulnerable persons, privacy and confidentiality, and justice and inclusiveness—and recognizing the potential for harm and maximizing benefits for all who are involved. It complied with the NWT *Access to Information and Protection of Privacy Act*.

1.3.2 Methodology

NWT Supported Living Review Steering Committee & Advisory Group

Two oversight and advisory bodies were established to ensure accountability and guidance from a diverse group of key stakeholders at critical points during the review. The *Steering Committee* was comprised of government senior leadership and representatives from non-profit organizations in the disability sector, while the *Advisory Group* consisted of persons with disabilities, and family members and caregivers of persons with disabilities with lived experience with disability and/or SL services.

Methodology Development

Two main activities guided the development of the review methodology by Logical Outcomes from May–August 2021: a preliminary document review (see Appendix A) and initial consultation with key stakeholders. Interviews were conducted with a sample of 22 stakeholders from various sectors of government, NGOs, SL service providers and family members of SL service users to inform the review methodology and the engagement plan, including fulsome stakeholder mapping. The Steering Committee provided further input and feedback into the methodology and engagement plan prior to plan finalization and initiation of engagement activities.

The 22 key stakeholders interviewed to inform the development of the review methodology were:

- 5 GNWT executive leadership representatives
- 5 DHSS representatives
- 2 NTHSSA representatives
- 1 HRHSSA representative
- 1 NGO representative
- 2 other GNWT disability-related and Supported program representatives
- 3 NWT SL service provider representatives
- 3 family members of SL service users

[8] Yarbrough, Donald B., Lyn M. Shulha, Rodney K. Hopson and Flora A. caruthers (2012) The Program Evaluation Standards A Guide for Evaluation and Evaluation Users (Third Edition) Sage Publishing

[9] Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, 1998 (with 2000, 2002 updates)" from http://www.pre.ethics.gc.ca/english/policystatement/policystatement.cfm

Review Methodology & Timeline

The NWT Supported Living Review methodology consisted of the following elements:

Review Planning Phase

May – August 2021

- NWT Supported Living Review Steering Committee engaged
- NWT Supported Living Review Advisory Group established
- ***Methodology Development:***
    - Preliminary document review (see Appendix A)
    - Initial stakeholder interviews (22 interviews)
    - Stakeholder mapping
    - Engagement plan development
    - Draft Review Plan development
    - Feedback from Steering Committee
    - Final Review Plan methodology finalized and approved

Data Collection

September 2021 – January 2022

- ***Service Contract Review:*** Detailed review of current service contracts with all current in-territory and out-of-territory SL service providers
- ***Data Pull:*** Current state information from NWT supported living service providers collected

Public and Stakeholder Engagement

August 2021 – February 2022

- Public Survey
- Broad Stakeholder Interviews
- Supported Living Setting Site Visits: In-territory and out-of-territory
- Public Engagement Sessions (in-person across the NWT and virtual options)
- Priority Sorting Workshop with stakeholder groups (Steering Committee and Advisory Group) and senior leadership

Jurisdictional Scan

September 2021 – February 2022

- ***Broad Jurisdictional Scan:*** Broad scan of several SL models and practices from a variety of national and international jurisdictions
- ***Focused Jurisdictional Scan:*** Detailed description of SL models from 6 jurisdictions with elements of particular interest to the review

Preliminary Findings Analysis and Reporting
February – March 2022

- Presentation of preliminary findings and analysis to stakeholder groups: Steering Committee, Advisory Group, and Indigenous Advisory Board.
- Facilitated a priority sort session on the elements of a renewed SL model with Steering Committee and Advisory Group.

Renewed Model and Recommendations Development
February – June 2022

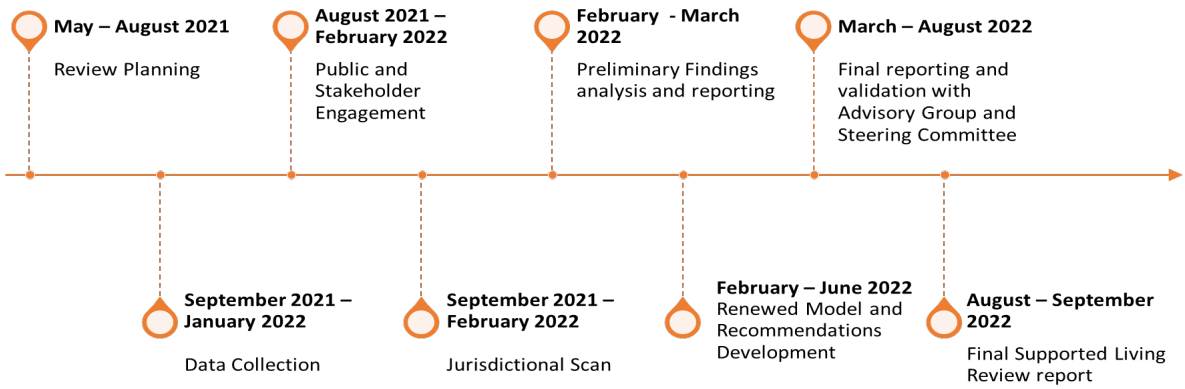
- Development of a flexible costing tool
- Development of draft renewed model
- Development of recommendations

Final Reporting
March – August 2022

- Draft final report preparation
- Final Stakeholder Engagement: Verification and feedback from key stakeholders (Steering Committee and Advisory Group) on recommendations and renewed model
- NWT Supported Living Review report finalization

A visual of the NWT Supported Living Review methodology and timeline is presented below in Figure 4:

Figure 4: *NWT Supported Living Review methodology and timeline*



Current State of Supported Living Services for NWT Residents

2.0 - Current State of SL Services for NWT Residents

This section provides an overview of the current state of SL services for NWT adults with disabilities as of January 2022. This information was gathered from data reported by SL service providers, reviewing NWT SL contracts and contribution agreements, verifying information with SL service providers when necessary, and interviews with all in-territory service providers and five out-of-territory service providers.

2.1 Overview of NWT SL Services Administration

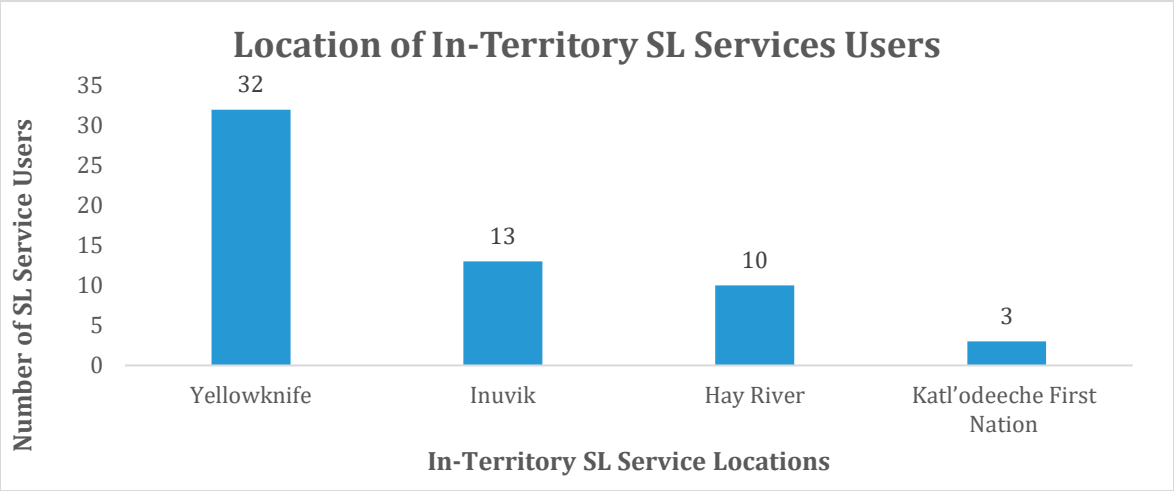
The DHSS provides funding to the HSSAs for the provision of SL services for NWT resident adults with disabilities. The HSSAs provide SL services directly, or contract service providers to deliver SL services. Currently there is one HSSA-operated SL facility, the Hay River Supported Living Campus; the remaining SL services are provided under contracts and contribution agreements between the HSSAs and service providers. If there is no capacity within the NWT to meet the needs of a service user, the service user is referred to a SL program outside the NWT through the NTHSSA Adult Out-of-Territory Supportive Living Services Program.

As of January 2022, there were 182 service users receiving SL services, with 32% (58 service users) receiving services in-territory and 68% (124 service users) receiving services out-of-territory.

2.1.1 In-Territory Supported Living Services

Within the NWT, there are SL services accessible to all NWT residents in four communities (Yellowknife, Inuvik, Katl'odeeche First Nation, and Hay River). Currently, there are thirty-two service users in Yellowknife (55%), thirteen in Inuvik (22%), ten in Hay River (17%) and three in Katl'odeeche First Nation (5%). The location of the in-territory SL service users is outlined in Figure 5.

***Figure 5**: Location of In-Territory SL Service Users*



The services in Yellowknife, Inuvik and Katl'odeeche First Nation are delivered by four different contracted SL service providers: Salvation Army - Mental Health and Support Services (Yellowknife), Inclusion NWT (Yellowknife), Parkland CLASS (Inuvik), and Katl'odeeche First Nation. These service providers are overseen by three separate branches of the Northwest Territories Health and Social Services Authority (NTHSSA): Territorial Operations, Beaufort Delta Region, and Dehcho Region. The HSSA-operated SL facility, the Hay River Supported Living Campus, is operated by the Hay River Health and Social Services Authority (HRHSSA).

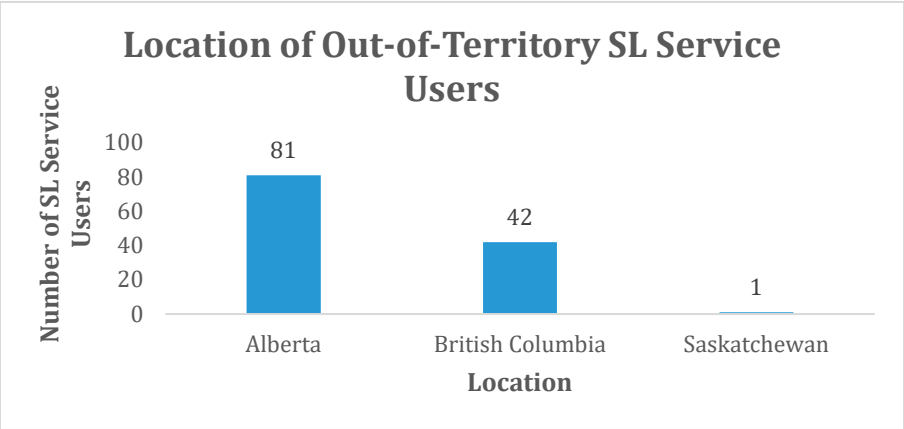
It should be noted that if an individual requires SL services and resides outside these four communities, the individual must relocate to receive services within the NWT. There are minimal supports in other NWT communities to support adults with disabilities and minimal respite options throughout the NWT to support family/caregivers who support adults with disabilities.

In-territory SL service users accessing housing through their SL program must contribute to the cost of room and board. This amount varies depending on the service provider from $850-1343 per month. Most service users cover this cost with Income Assistance funds they receive through the Department of Education, Culture and Employment's Income Assistance Program.

2.1.2 Out-of-Territory Supported Living Services

The NTHSSA Adult Out-of-Territory Supportive Living Services Program holds contracts with ten service providers in British Columbia, Alberta, and Saskatchewan to deliver SL services to any adults with disabilities from the NWT if their needs cannot be met in-territory. Of the 124 service users receiving SL services out-of-territory as of January 2022, 81 service users reside in Alberta (65%), 42 in British Columbia (34%), and one in Saskatchewan (1%). The current service providers are: PLEA Community Services (FolkStone), Independent Counselling Enterprises Inc. (ICE), EXCEL Society, Independent Advocacy, Edmonton Integrated Services, Catholic Social Services, Salvation Army - Edmonton, Parkland CLASS – Red Deer, I Have a Chance Support Services, and Ranch Ehrlo Society. The location of the out-of-territory SL service users is outlined in Figure 6.

Figure 6: *Location of Out-of-Territory SL Service Users*



As SL service users out-of-territory do not reside within the NWT, they are not eligible to receive funding under the Department of Education, Culture and Employment's Income Assistance Program. As a result, out-of-territory SL service users are not required to contribute to the cost of room and board.

2.1.3 Summary of NWT Supported Living Services

Additional details on the service providers' location, number of service users and financial arrangements with the HSSAs are listed below in Table 1.

Table 1: *Overview of SL Providers*
Source: Statistics collected from service providers as of January 2022

Service Provider	Location	# Of Service Users	Financial Arrangement with HSSAs
In-Territory (58 total Service Users)			
Salvation Army – Mental Health and Support Services: Group Supported Living program, and Independent Living Services program	Yellowknife, NWT	**18 total:** **5** in *Group SL program;* and **13** in *Independent Living Services program.*	One-year contribution agreement with NTHSSA – Territorial Operations; on-going
Inclusion NWT: Supported Living program, and Supported Independent Living program		**14 total:** **9** in *Supported Living program*; and **5** in *Supported Independent Living program*	Five-year contract through NTHSSA – Territorial Operations
Parkland CLASS: Charlotte Vehus and Billy Moore group homes	Inuvik, NWT	13	Five-year contract through NTHSSA – Beaufort-Delta
Hay River SL Campus	Hay River, NWT	10	GNWT-operated service provider
Katl'odeeche First Nation: Judith Fabian group home	Katl'odeeche First Nation, NWT	3	One-year contribution agreement with NTHSSA – Dehcho; on-going
Out of Territory (124 total Service Users)			
PLEA Community Services: FolkStone	Abbotsford, BC	42	Contract through NTHSSA – Territorial Operations (Adult Out-of-Territory Supportive Living Services Program.) The contracts are all five-year contracts except for the ones with an asterisk (*) which are on a one-year contract interval.
Independent Counselling Enterprises Inc. (ICE)	Edmonton, AB	25	
EXCEL Society		23	
Independent Advocacy		7	
Edmonton Integrated Services*		3	
Catholic Social Services*		3	
Salvation Army – Edmonton*		1	

Parkland CLASS – Red Deer	Red Deer, AB	12	
I Have a Chance Support Services*	Stoney Plain, AB	7	
Ranch Ehrlo Society	Regina, SK	1	

2.2 Administrative Structure of Supported Living

Although SL services are classified as a GNWT Continuing Care program, SL services are not consistently administered under the direction of Continuing Care managers within the HSSAs. In the HRHSSA and TCSA, SL services are administered under Continuing Care management. Within the NTHSSA, SL services are administered under two program areas (Continuing Care and Mental Health and Community Wellness). However, only one territorial director in the NTHSSA is responsible for SL programs (Mental Health and Community Wellness). In summary:

- In the NTHSSA:
  - Beaufort-Delta Region, and Dehcho Region, have SL services administered under the Continuing Care program; and
  - Yellowknife Region does not have SL services administered by the region but by NTHSSA – Territorial Operations, under Mental Health and Community Wellness.
- The NTHSSA Adult Out-of-Territory Supportive Living Services program, is administered by NTHSSA – Territorial Operations, under Mental Health and Community Wellness.

Due to the disparate administration of SL services within the territory, there is no central resource or mechanism to support the standardization of SL policies, processes, data collection and tools across the three HSSAs. As a result, each region has various policies and service provider expectations.

2.3 Current Supported Living Programs and Service Model

2.3.1 Accommodation Settings and Supported Living Services

SL service providers offer various living settings to meet varying levels of support needs. In this report, the types of SL settings are categorized into the following four definitions:

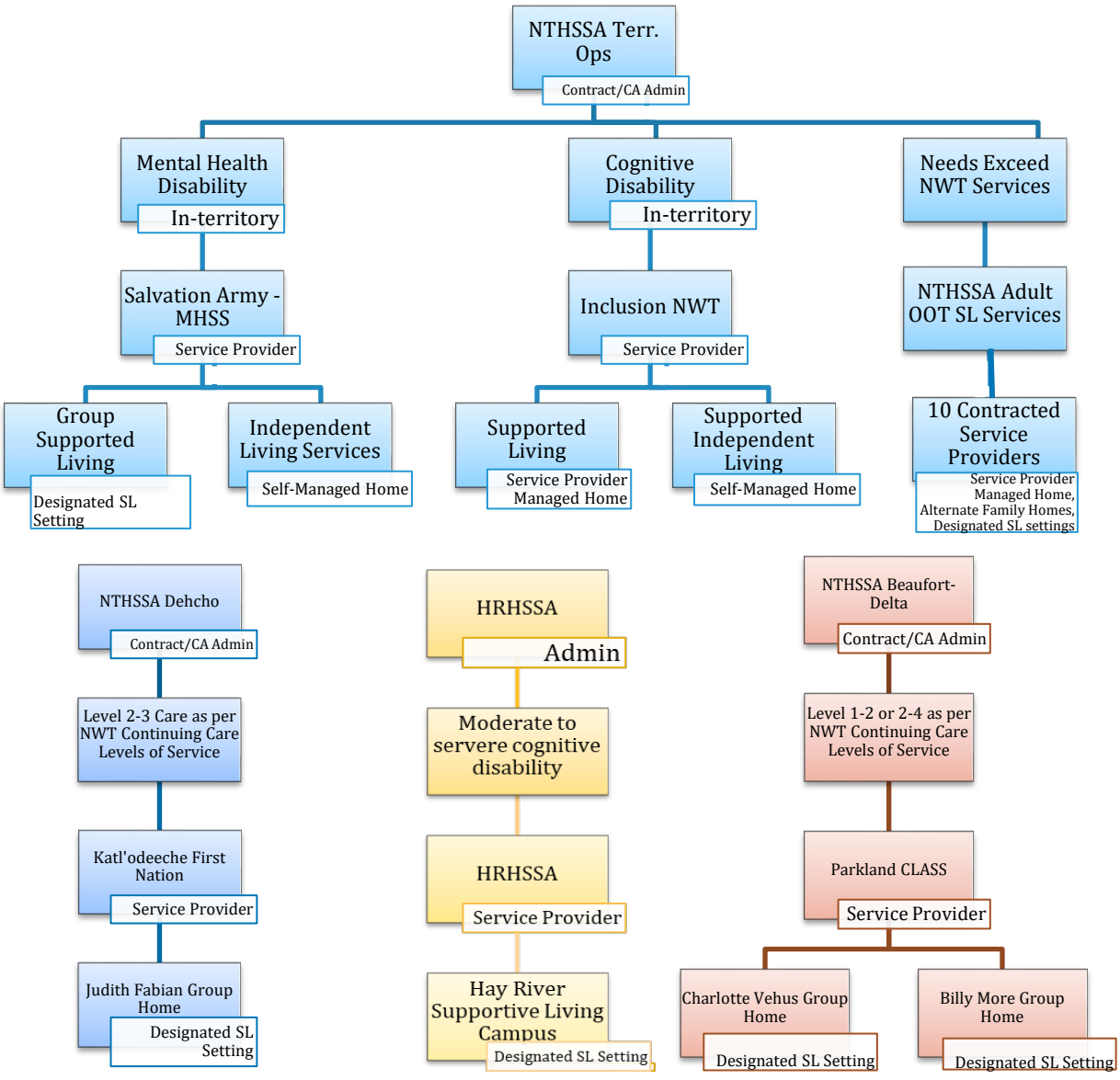
1. **Designated Supported Living Settings -** A type of infrastructure built specifically for the purpose of providing housing and support to multiple persons with disabilities. This type of setting is managed by the service provider and includes private bedrooms and shared living spaces with 24/7 on-site support.
2. **Service Provider Managed Home -** An apartment or house managed (owned or rented) by the service provider that provides support services to one or more service users.
3. **Service User's Own Home -** A house or apartment owned or rented by a service user or their family.
4. **Alternate Family Home (Host Family) -** A living setting where the service user lives in a home with an alternative family to their own. The family is contracted and paid by a service provider to provide supports and a family-like environment to the service user.

Most SL service providers offer a variety of SL service models. In this report, the models of SL services are categorized into the following two definitions:

- **<u>Continuous Supports</u> –** Supports are continuously provided 24 hours/day, seven days/week to the service user.
- **<u>Flexible Supports</u> -** Supports are provided to the service user in a flexible arrangement based on service user need.

To summarize, the current NWT Supported Living Model is depicted below in Figure 7.

Figure 7: *Visual Representation of NWT SL Services*



2.3.3 In-Territory Supported Living Program

This section provides an overview of the in-territory SL service providers, including their setting types, eligibility and exclusion criteria, and oversight and monitoring. All SL service providers require service users to be adult NWT residents.

Salvation Army – Mental Health Support Services (Yellowknife, NT)

The Salvation Army provides two SL program streams for adults requiring supported living services due to a mental health condition:

- **Settings:**
  - ***Group Supported Living*** - Designated SL setting (owned by the Salvation Army) with eight rooms, shared living space and 24/7 supervision and support (i.e., continuous supports)
  - ***Independent Living Services*** – Community-based program where service users live in their own homes. Service users receive up to three hours/week of scheduled daytime support and have access to 24-hour on call staff support as needed (i.e., flexible supports)
- **Eligibility Criteria:** Severe and persistent mental health condition
  - NWT Continuing Care Levels of Services are not used for determining eligibility.
- **Exclusion Criteria:** Service user history of violence/aggression
- **Room and Board Rate** (Group Supported Living program only): $1343 per month ($1000 for room + $343 for food).
- **Oversight & Monitoring:** Contracted service provider with monitoring and oversight for financials and adherence to NWT Continuing Care standards through reporting to NTHSSA – Territorial Operations.
- **Accreditation:** The Salvation Army undergoes an accreditation process every three years with its parent organization.

Inclusion NWT (Yellowknife, NT)

Inclusion NWT provides two SL program streams for adults with cognitive disabilities:

- **Settings:**
  - ***Supported Living*** – Shared apartment settings (rented throughout Yellowknife) with 24/7 supervision and support (i.e., continuous supports)
  - ***Supported Independent Living*** – Community-based program where service users live in their own homes. Service users receive daytime Supported Independent Living services based on service user need and have access to 24-hour on call staff support as needed (i.e., flexible supports)
- **Eligibility Criteria:** Cognitive disability
  - NWT Continuing Care Levels of Services are not used for determining eligibility.
- **Exclusion Criteria:** Complex behaviours, drug and alcohol addictions, criminal history
- **Room and Board Rate** (Supported Living program only): $875-1196 per month
- **Oversight & Monitoring:** Contracted service provider with monitoring and oversight for financials and adherence to NWT Continuing Care standards through reporting to the NTHSSA – Territorial Operations.
- **Accreditation:** Inclusion NWT is currently not accredited.

Parkland CLASS – Charlotte Vehus & Billy Moore Homes (Inuvik, NT)

Parkland CLASS provides designated supported living settings in Inuvik:

- **Settings:**
  - ***Charlotte Vehus Group Home*** – Eight-room designated SL setting (GNWT owned) with shared living spaces and 24/7 support and supervision and nursing oversight (continuous supports)
  - ***Billy Moore Group Home*** **-** Five-bedroom designated SL setting (GNWT rented) with shared living spaces and 24/7 support and supervision (continuous supports)
- **Eligibility Criteria:**
  - ***Charlotte Vehus Group Home*** - Adults who require NWT Continuing Care Levels of Service Level 2-4 care with nursing supports based on medical diagnosis, current assessment, and any other supporting documentation
  - ***Billy Moore Group Home*** **-** Adults who require NWT Continuing Care Levels of Service Level 1- 2 care based on medical diagnosis, current assessment, and any other supporting documentation
- **Exclusion Criteria:** Does not demonstrate significant risk for harm to self or others, does not require ongoing complex medical or complex nursing care.
- **Room and Board Rate**: $850 per month
- **Oversight and Monitoring:** Contracted service provider with monitoring and oversight for financials and adherence to NWT Continuing Care standards through reporting to the NTHSSA – Beaufort-Delta Region. Monitored annually by their parent organization Parkland CLASS.
- **Accreditation:** Parkland CLASS Billy Moore and Charlotte Vehus group homes are accredited through the Beaufort Delta Region - Inuvik Regional Hospital accreditation process through Accreditation Canada.

Hay River Supported Living Campus (Hay River, NT)

Designated supported living setting for adults with moderate to severe cognitive disability.

- **Setting:** Three 4-bedroom designated SL setting (GNWT owned) with shared living spaces and 24/7 supervision and support (continuous supports)
- **Eligibility Criteria:**
  - Adults with moderate to severe acquired brain injury, intellectual or developmental disability as defined by the Territorial Admissions Committee for long term care.
  - Current psychological or psychiatric assessment
    - NWT Continuing Care Levels of Services are not used for determining eligibility.
- **Exclusion Criteria:**
  - High risk aggressive behaviour
  - Acute addiction
  - Acute psychiatric diagnosis
  - Medical interventions that are beyond the scope of available support
- **Room and Board Rate:** $1094 per month ($844 for rent + $250 for food)
- **Oversight & Monitoring:** Hay River SL Campus is operated and monitored by the HRHSSA for financials and adherence to NWT Continuing Care standards.
- **Accreditation -** Hay River SL Campus is accredited through Accreditation Canada.

Judith Fabian Home (Katl'odeeche First Nation, NT)

Designated supported living setting for adults with a cognitive or physical disability who require Level 2-3 care (as per the NWT Continuing Care Levels of Services).

- **Setting:** A five-bedroom designated SL setting (Katl'odeeche First Nation owned) with shared living spaces and 24/7 support and supervision (continuous supports)
- **Eligibility Criteria:** Adults with cognitive or physical disability who require support and supervision with ADLS and IADLS and NWT Continuing Care Levels of Service Level 2-3 care.
- **Room and Board Rate:** Information not provided.
- **Exclusion Criteria:**
    - Alcohol or other addictions
    - People experiencing homelessness
    - High medical needs
- **Oversight and Monitoring:** Contracted service provider with monitoring and oversight for financials and adherence to NWT Continuing Care standards through reporting to the NTHSSA – Dehcho Region.
- **Accreditation –** Not accredited

2.3.4 Out-of-Territory Supported Living Programs

The NTHSSA Adult Out-of-Territory Supportive Living Services Program provides SL services (both continuous supports and flexible supports) out-of-territory when services cannot be accessed in-territory or when the service user's needs are beyond the scope of service available in-territory.

NTHSSA Adult Out-of-Territory Supportive Living Services Program

Eligibility Criteria

Eligibility into the NTHSSA Adult Out-Of-Territory Supportive Living Services Program requires the following:

- Resident of the NWT with a valid NWT health care card;
- Persons over the age of 19;
- Service users who meet **one or more** of the following:
    - Have been diagnosed by a health practitioner with a developmental and/or cognitive delay, or presents with severe emotional and/or behavioural challenges
    - Have been diagnosed with a severe and persistent mental health diagnosis
    - Have been diagnosed with a co-occurring mental health and addiction disorder

Additional considerations include:

- Assessments and referrals have been completed which recommend residential treatment;
- There is supporting evidence that these needs cannot be met within the NWT;
- The service user must be considered stable and accepting treatment as prescribed by their health practitioner; and
- If applicable, the applicant must be deemed *Not Criminally Responsible* under the authority of the NWT Department of Justice – NWT Criminal Code Review Board.

Exclusion Criteria

- Service users who are acutely unwell or in an active psychiatric episode at the time of referral
- A diagnosis of addiction not co-occurring with a mental health diagnosis
- Adults who are eligible for admission through the Territorial Admissions Committee (TAC) and meet the criteria for Long Term Care (LTC) placement
- Special considerations:
    - Health and Social Services care providers have an obligation to disclose any history of criminal charges that they are aware of to ensure appropriate placement arrangements can be made. Service users with a history of or outstanding criminal charges must be considered on a case-by-case basis
    - Service users who have reached the age of 18 with documented evidence that they would benefit from an adult residential placement (not through Child and Family Services).

Program Descriptions

Below is a brief description of the ten out-of-territory service providers currently under contract to provide support to NWT service users:

- **Catholic Social Services (Edmonton, Alberta):** SL programs for adults with developmental, cognitive, physical and/or medical disabilities and/or complex behaviours. Settings include service provider-managed homes, alternate family homes and supported independent living.
- **Edmonton Integrated Services (Edmonton, Alberta):** SL programs for adults with developmental and/or cognitive disabilities. Settings include service provider-managed homes, alternate family homes, and supported independent living.
- **EXCEL Society (Edmonton, Alberta):** SL programs for adults with developmental, cognitive, physical, and mental health disabilities, that may have complex behaviours and needs, and a history of addictions. Settings include 24/7 hour staffed service provider-managed homes and supported roommate outreach placements, where supports can be provided to an individual residing alone or in shared living settings.
- **I Have a Chance Support Services - IHAC (Stony Plain and Edmonton, Alberta)**: SL programs for adults with developmental, cognitive, mental health, and/or physical disabilities, with complex needs and challenging behaviors. Settings include semi-independent living service provider-managed homes, and an accredited complex needs home to support those experiencing significant behavioural challenges that require intensive structured programming.
- **Independent Advocacy (Edmonton, Alberta):** SL programs for adults and seniors with developmental and mental health disabilities. Programs provide specialized support to service users with dual-diagnosis and complex needs and behaviours. Settings include 24-hour support homes and outreach whereby the service user lives independently in the community.
- **Independent Counselling Service Inc. – ICE (Edmonton, Alberta):** SL programs for adults with developmental, cognitive, physical, and mental health diagnoses, and complex needs. The placement settings include service provider-managed homes, and alternate family homes.

- **Parkland CLASS (Red Deer, Alberta):** SL programs for adults and children with developmental disabilities. Settings include agency operated community homes with two or three individuals sharing a home and supported independent living.
- **PLEA Community Services: FolkStone (Vancouver, British Columbia)**: SL programs for high risk and high need service users and their families, who have complex and challenging behaviours, including adults with developmental, cognitive physical, and mental health disabilities. Settings include staff supported family home environments.
- **Ranch Ehrlo Society (Regina, Saskatchewan)**: SL programs for children, adolescents and adults with cognitive disabilities who require long term support. Programs include Supportive Living Program of group homes and a Supportive Independent Living program.
- **Salvation Army (Edmonton, Alberta)**: SL programs for adults with multiple barriers who experience difficulty living on their own in the community. The supportive residence program is shared living space with private rooms with access to various support services.

Oversight and Monitoring

Contracted out-of-territory service providers are monitored through reporting to the NTHSSA, through their own respective provincial legislation and standards, and various accreditation professional bodies such as the Commission on Accreditation of Rehabilitation Facilities (CARF), Canadian Accreditation Council (CAC) and Alberta Council of Disability Services (ACDS).

2.3.5 Complaints Process

The NWT does not have legislation overseeing the provision of SL services. Complaints related to SL services are addressed according to policies and procedures of the SL service provider and the NWT HSSAs.

Complaints not resolved through the service provider and the HSSAs can be brought to the NWT Office of the Ombud. The Office of the Ombud investigates and attempts to resolve unfairness in territorial government administration and services. After the *NWT Ombud Act* was passed in 2018, the Office was established in late 2019 to address complaints and concerns related to territorial government programs and services, such as SL services.

Although the Office of the Ombud does not have jurisdiction over complaints regarding private service providers, the Ombud can investigate GNWT administrative issues such as contract management and oversight, and/or the actions of the private service provider that may relate to the complaint. The Office of the Ombud is a free service accessible to all NWT residents, including those NWT residents accessing SL services out-of-territory through the NTHSSA Adult Out-of-Territory Supportive Living Services Program.

2.4 Current Pathway to Accessing Supported Living Services

The pathway to accessing NWT SL programs under the current model is outlined below. This includes the referral process, the application form and/or assessment tools used, and the determination of admission into the program for each service provider

Salvation Army Mental Health Support Services

- **Referrals:** Accessed through NTHSSA – Territorial Operations Adult Services workers (ASWs)
- **Application Form:** NTHSSA Adult Assessment application form
- **Assessment Tool:** No formal assessment tool
- **Admission Process:** Informal meeting between the service provider, an NTHSSA – Territorial Operations ASW and an NTHSSA Community Mental Health nurse

Inclusion NWT

- **Referrals**: Accessed through NTHSSA – Territorial Operations ASWs and/or service provider
- **Application Form:** NTHSSA Adult Assessment application form
- **Assessment Tool:** No formal assessment tool
- **Admission Process:** Informal meeting between the service provider and the NTHSSA – Territorial Operations, Territorial Manager Supportive Living

Parkland CLASS – Billy Moor and Charlotte Vehus Homes

- **Referrals:** Accessed through NTHSSA Beaufort-Delta, Manager of Continuing Care
- **Application Form: NTHSSA -** Beaufort-Delta Application for Service: Adult Group Homes form
- **Assessment Tool:** Continuing Care Assessment Package[10] (CCAP)
- **Admission Process:** Informal meeting between the service provider, the NTHSSA Beaufort-Delta, Manager of Continuing Care, and an NTHSSA Beaufort-Delta, Medical Social worker

Hay River Supported Living Campus

- **Referrals**: Accessed on the HSS website and accepted by Territorial Admissions Committee[11]
- **Application Form:** TAC application form
- **Assessment Tool:** CCAP
- **Admission Process:** Formal process through the TAC

Katl'odeeche First Nation – Judith Fabian Home

- **Referrals**: Through the Katl'odeeche First Nation - Judith Fabian home program coordinator
- **Application Form:** Katl'odeeche First Nation - Judith Fabian application form
- **Assessment Tool:** CCAP
- **Admission Process:** Consists of an informal meeting between Katl'odeeche First Nation - Judith Fabian home program coordinator and the NTHSSA – Dehcho Manager, Continuing Care

[10] The Continuing Care Assessment Package (CCAP) is a service user needs assessment tool that informs the development of a placement plan for the service user across the continuum of care – including Home Care, SL and LTC.

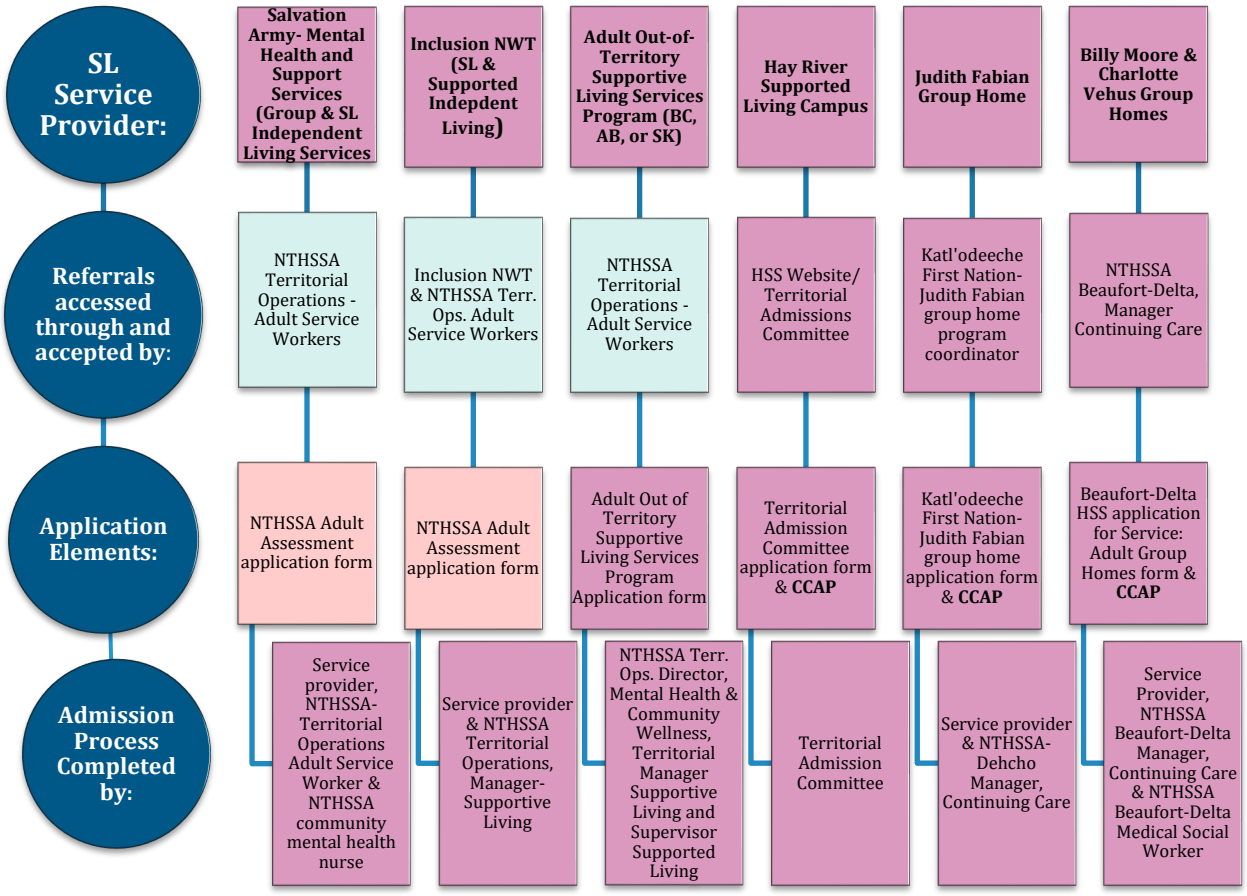
[11] Territorial Admissions Committee is a GWNT committee that reviews service user applications for NWT LTC facilities and for one NWT SL provider, the Hay River Supported Living Campus. It provides a unified process for admission that ensures fair and equal access for service users.

NTHSSA Adult Out-of-Territory Supportive Living Services Program

- **Referrals**: Accessed through and accepted by NTHSSA – Territorial Operations.
- **Application Form:** Adult Out of Territory Supportive Living Services Program Application form
- **Assessment Tool:** No formal assessment tool
- **Admission Process:** Informal meeting between the NTHSSA Territorial Operations Director, Mental Health and Community Wellness, the Territorial Manager Supportive Living, and the Supervisor Supportive Living

The current pathway to accessing SL services in the NWT is illustrated in Figure 8.

Figure 8: *Current Path to SL Service in the NWT*



2.5 Additional Support Services

In addition to the services provided by SL service providers such as support with ADL and IADLs; communication, social, cognitive and life skills; behavioural and emotional management; day programming and community activity participation; and accessing therapeutic services, this section

will discuss the additional support services of cultural activities, vocational support and transitional services used by SL service users.

2.5.1 Cultural Activities

All SL service providers offer or support service user community participation in a variety of cultural activities including access to cultural food, connections to persons within their culture, role models or Elders, and access to cultural activities such as on-the-land activities (i.e., fishing and camping), Indigenous wellness camp, drumming, tea with Elders, crafts, soap stone carving, traditional games, smudging, throat singing, dancing and musical activities. Most current SL service users are accessing cultural activities within their SL programs. It was reported that 71% of service users in-territory and 97% of service users out-of-territory are accessing cultural activities.

2.5.2 Vocational Support

SL service users are supported in the pursuit of vocational activities (i.e., employment and volunteer activities). The engagement of SL service users in vocational activities in-territory is 33% compared to 3% in out-territory service users, with an additional 1% of out-of-territory service users currently seeking employment.

2.5.3 Transitional Services

Within the NWT, there is no integrated transitional support service that encompasses all the supports and services that a person with a disability may require when transitioning from youth to adulthood. Currently individuals access supports separately through various GNWT departments and programs, including the Health and Social Services system, the Department of Education, Community and Culture, and supports provided through non-government organizations.

2.6 Adult Respite Services

Respite services provide planned relief to caregivers who are supporting a person with a disability in their own living setting (i.e., are not in an accommodation-based SL program). Respite aims to decrease caregiver burnout and stress, which supports caregivers in giving the best support to the individual with disability. Respite services can be provided during the day or provide relief on a long-term basis (overnight up to several weeks or months). Respite services can be arranged on a regular schedule (weekly, monthly), or can occur on an occasional, as-needed basis (i.e., to provide support and supervision while regular caregivers are on holiday). Two SL service providers in-territory offer respite services to caregivers of adults with disabilities, with respite services being administered separately from SL services.

2.6.1 Overnight/Long Term Respite

Hay River Supported Living Campus

Currently, the Hay River Supported Living Campus is the only SL provider in the territory with the capacity to provide adult overnight/long term respite stays. The campus has one bedroom

specifically designated for respite stays. Respite users may travel from anywhere in the territory; however, families/caregivers are responsible for the costs of travel. Application for overnight/long term respite is made directly to the Hay River Supported Living Campus.

Parkland CLASS

Parkland CLASS (Billy Moore and Charlotte Vehus homes in Inuvik) have the potential to provide respite stays when there are one or more vacancies in their settings. However, both homes are currently at capacity and have been so for the past five years. When capacity exists for respite stays, the program is accessible to all NWT residents with demonstrated need, and application for this service can be made to the Manager, Continuing Care, NTHSSA – Beaufort Delta Region.

2.6.2 Day Respite for Adults

Inclusion NWT

Inclusion NWT offers respite services to families of adults (and children) with disabilities in or outside of individuals' own homes during the day. The program is accessible to residents of Yellowknife. The service provider has an estimated capacity of supporting 30-45 families per year. Based on the assessed needs, families are offered a range of respite service hours between 39-130 hours every three months. In 2021/22, the program provided respite services to ten families of adults with disabilities, with an average of 21 hours per family per month. As of March 31, 2022, there are 9 families of children with disabilities on the waitlist to access this service, and no families of adults with disabilities on the waitlist.

Home and Community Care

Home and Community Care services provide day respite services to caregivers of adults with disabilities in the NWT based on assessed need and determined by the capacity of the Home and Community Care team in each community.

2.6.3 Paid Family/Community Caregiver Pilot Project

In 2020, the GNWT initiated the Paid Family/Community Caregiver Pilot Project to support seniors as well as persons with disabilities with chronic, ongoing support needs to remain in their homes for as long as possible. Pilot participants select a caregiver of their choice, who is then hired through a local community-based organization to provide up to 4 hours of paid caregiving per week. Caregivers are not meant to replace homecare or long-term care and provide support in the following areas: cleaning or laundry, meal preparation, hauling wood or snow removal, shopping, and running errands. The pilot project is currently being trialed in select communities, including: Behchokǫ̀, Dettah, N'Dilo, Yellowknife, Hay River, and Tuktoyaktuk. In 2021-22 the Paid Family/Community Caregiver program supported 5 of adults with disabilities, 33 Elders and 42 home care clients (which may include persons with disabilities).

2.6.4 TCSA Medical Social Worker Program

The TCSA Medical Social Worker Program run by the TCSA supports adults with disabilities residing in the Tłı̨chǫ region to live at home or with a caregiver of their choice. The program offers monthly funding of up to $1700 to the caregiver for the provision of supports to enable an individual with a disability to live in their home or in the home of the caregiver. This program does

not provide accommodations but rather compensation to the caregivers for providing the supports needed. The caregiver can also use the fund to arrange respite services as needed.

The access point to the program is through the TCSA Medical Social Worker (MSW). Originally, this program was overseen by the Continuing Care Program, but was later transferred under the responsibility of the Medical Social Worker.

The MSW conducts a home study, gathers criminal background checks on the caregivers, and follows up with the service users and caregivers to ensure that their needs are met, and any concerns are addressed. Currently there are 6 service users accessing with no waitlist but anecdotally there are reports of interest from the community for additional service users to access this program.

2.7 Supported Living Case Management

Case management involves assessing, planning, implementing, coordinating, and monitoring a SL service user's support plan based on their needs. Case management in SL involves supporting individuals to access SL services, coordinating service needs for the service user, working with the SL service provider to ensure the provision of SL services, and maintaining contact with the SL service user on an on-going basis.

Contracts between the NTHSSA Adult Out-Of-Territory Supportive Living Services Program and the out-of-territory SL service providers stipulate that it is the GNWT's responsibility to designate an NWT-based case manager to all service users. The NTHSSA Territorial Operations – Supportive Living program also aims to designate a case manager to all in-territory SL service users as well, but this responsibility is not currently outlined in the contracts and contribution agreements with SL Service providers. The HSSAs do not have policies or procedures to guide how this should be achieved.

The assignment of a case manager to the SL service user is determined based on the home HSSA/Region of the service user and/or if a particular case manager assisted with the service user's SL application and placement.

2.7.1 Supported Living Case Management Structure by HSSA and Region

An overview of the case management structure to support SL service users under the three HSSAs in the NWT is as follows:

NTHSSA

- Case management support for SL service users from the regions of the NTHSSA is provided by Case Manager, Adult Services Workers (ASW)s
- As of January 2022, there are currently four NTHSSA ASW positions located in the territory as follows:
  - Two in Yellowknife Region
  - One in the Beaufort-Delta Region

    - One in the Sahtu Region (vacant)
- The ASWs report to the NTHSSA Territorial Operations, Supervisor – Supportive Living
- No guidelines or minimum contact standards for ASW case management services exist
- Determination of case management approach and frequency is at the discretion of the ASW, based on the needs of the SL service user

Tłı̨chǫ Community Services Agency

- Case management support is provided to all SL service users from Tłı̨chǫ communities by the Medical Social Worker who reports to the Manager, Manager Mental Health, and Wellness within the TCSA

Hay River Health and Social Services Authority

- Case management support for out-of-territory SL service users from the HRHSSA region is provided by the Coordinator Foster Care, Adult Services and Adoption, HRHSSA
- Case management support for service users at the Hay River SL Campus is provided by the Supported Living Services Supervisor and the Resident Care Coordinator, who report to the Manager, Continuing Care – HRHSSA

2.7.2 Case Management Assignment

Data from service providers and HSSA SL managers indicates that all out-of-territory service users have a designated case manager, and despite the case management structure outlined above, only 69% of in-territory service users have a designated case manager. It should be noted that the NTHSSA reports that over the last year, work has been underway to assign a designated case manager to all in-territory SL service users.

In addition to the formal designated case manager roles from the three HSSAs listed above, SL service providers reported that in-territory SL service users are receiving informal case management support from other sources, including NGO social workers, public or private guardians, and family and friends.

2.7.3 Additional Case Management

In 2015 the GNWT piloted an Integrated Case Management (ICM) program in Yellowknife, N'dilo and Dettah with the aim to create, foster and deliver a coordinated, collaborative, multi-departmental and client-centered approach that removes system barriers and service gaps for individuals with complex needs, including high risk clients with mental health and addiction needs. The ICM pilot program revealed numerous policy level barriers exist for clients with complex needs that require coordination across departments, and dedicated case management support. A 2020 social return on investment evaluation demonstrated that for every dollar the GNWT invested in

the program, it resulted in at least $4.50 CAD of value[12]. The ICM program continues to provide Yellowknife, N'dilo and Dettah adult residents with support.

2.8 Staff to Service User Ratios

SL programs provide support and supervision to SL service users with varied staff to service user ratios and varied capacity to support the range of service user needs. SL service providers report that in-territory staff ratios are primarily based on the program model, whereas out-of-territory program staff to service user ratios are based on SL service user needs. Staff to service user ratios range from 1:2 to 1:5 in-territory and from 1:1 to 7:2 in out-of-territory. Details on service provider staff to service user ratios are listed in Table 2 and Table 3.

Table 2: *In-Territory Staff to Service User Ratios*

Service Provider/ Program	Staff to Service user Ratio
Salvation Army – Mental Health Support Services: Group SL program	1:3 during the day with 1:6 at night.
Inclusion NWT – SL Program	1:2, some 1:1
Parkland CLASS – Charlotte Vehus	1:2
Parkland CLASS – Billy Moore	1:5
Hay River SL Campus	1:4
Judith Fabian Group Home	1:3

Table 3: *Out-of-Territory Staff to Service User Ratios*

Service Provider/ Program	Staff to Service user Ratio
Catholic Social Services	Varies from 1:1 to less if appropriate for service user
Edmonton Integrated Services	Varies from 1:1 to less if appropriate for service user
EXCEL Society	Varies from 1:2 to 2:1
I Have a Chance Support Services	Varies from 1:4 to 2:1
Independent Advocacy	(Not supplied)
Independent Counselling Service Inc (ICE)	Varies from 1:3 to 1:1
Parkland CLASS (Red Deer)	Varies from 1:6 to 1:1
PLEA Community Services - FolkStone	Varies from 7:2 to 1:2
Ranch Ehrlo Society	Varies from 1:1 to less if appropriate for service user
Salvation Army (Edmonton)	Varies from 1:1 to less if appropriate for service user

2.9 Staff Positions and Training

The required education (if applicable) and staff training of in- and out-of-territory SL service provider staff positions are listed below in Table 4 and Table 5.

[12] https://www.ntassembly.ca/sites/assembly/files/td_139-192.pdf

***Table 4**: In-Territory SL Staff Positions and Training*

Source: Service providers and review of service provider contracts and contribution agreements.

Setting	Support Staff Positions and Required Education *(if applicable/available)*	Staff Training
Salvation Army Mental Health Support Services	**Supervisor** **Primary Support Caseworker** **Case workers -** post-secondary certificate **Support workers**	Non-Violent crisis intervention, ASIST (or similar suicide intervention training), First Aid/CPR and Mental Health First Aid. **Cultural Competency training:** Staff encouraged to complete GNWT Cultural awareness training.
Inclusion NWT	**Coordinators** **Team/ Home Leaders** **Support Workers**	Suicide intervention, medication updates and Non-Violent crisis intervention. **Cultural Competency training:** On the job informal training.
Parkland CLASS - Billy Moore and Charlotte Vehus group homes	**Program Manager –** LPN or RN **Supervisor** **Residential Aides** **RN*** **LPN*** **Homemaker*** **Specialized Staff:** **Behavioural Specialist–** Undergraduate degree. Conducts functional and risk assessments for service users, develops and monitors service user support plans. Based in Alberta but visits NWT to support staff at Billy Moore and Charlotte Vehus group homes. ****= Only at Charlotte Vehus group home**	Pro-Act. Abuse Protocol, Indigenous Awareness, Diversity, Medication Administration, Suicide intervention & Self Harm **Cultural Competency training:** Staff must complete cultural competency course annually.
Hay River SL Campus	**Personal Outcomes Support Workers** **Resident Care Aides** **SLS Supervisor -** Undergraduate degree in health social sciences **Resident Care Coordinator -** LPN (also supports Hay River LTC) **RN Educator/ Mentor -** RN (also supports Hay River LTC and home care staff)	Standard First Aid/CPR, Non-Violent Crisis Intervention, Mental Health First Aide, Supportive Pathways, Positive Behaviour Supports **Cultural Competency training:** Staff must complete GNWT Cultural awareness training.
Judith Fabian Group Home	**Program Coordinator** **Senior Activity Aide** **Activity Aide**	First Aid, CPR and Non-Violent Crisis Intervention. **Cultural Competency training:** No formal training.

Table 5: *Sample of Out-of-Territory SL Staff Positions and Training*

Note: The information in Table 5 provides detailed information on five out-of-territory SL service providers (i.e. a sample of the full ten service providers rather than all in its entirety).

Setting	Staff Positions and Required Education *(If applicable/available)*	Staff Training
EXCEL Society	**Residential Coordinator & Service Coordinator** **Community Support Worker** **Support Home Operator** – aka Host Family **Employment Specialist** – Supports service users in pursuit of employment	Non-Violent Crisis Intervention, First Aid and CPR, Abuse Prevention Training, Medication Administration; Responding to Behaviours of Concern, Positive Behavioural Supports, ASSIST Suicide Prevention training, Picture Exchange Communication System (PECS) Training, Lifts and Transfers **Cultural Competency training:** Staff receive training from GNWT.
I Have a Chance Support Services	**Client Care Manager** **Community Support Workers** **IHAC Provisional Psychologist** - On site or accessible in community **Registered Psychiatric Nurse** **Consulting Psychiatrist –** At one setting	Mental Health First Aid, Suicide intervention, MANDT (Non-crisis intervention), medication administration, Trauma informed care, Inuit and Aboriginal Cultural Awareness Training, Food Safety, First Aid & CPR **Cultural Competency training:** Staff to complete an Inuit training course, and staff work with a Cree Elder to provide spiritual ceremonies to service users.
Independent Counselling Service Inc	**Client Behavioural Services Consultant** **Community Team Coordinator** **Employee Client Assistance Team (ECAT)** **Residential Support Staff**	Pre-employment training, Proactive Behaviour Intervention and Harm Reduction, Medication Administration, Abuse Prevention, and Protection of Persons in Care, Cultural Sensitivity, policy review, health and safety, recording and documentation, food safety, risk management, Applied Suicide Intervention Skills Training (ASIST), Crisis Prevention Intervention Training (CPI), and Mental Health First Aid. **Cultural Competency training:** Staff on-boarding requires an Indigenous educational module.
Parkland CLASS - Red Deer	**Program Coordinators** **Behaviour Supports Coordinator** **Residential Supervisors** **Residential Aides** **Proprietors** **Behavioural Specialist**	First Aid-CPR, Suicide Prevention, Abuse Recognition and Reporting, Quality Improvement and Outcomes Training, Professional Assault Crisis Training, Medications Administration, Aboriginal Awareness, FASD, Positive Behavioural Supports, Sensory Integration, Visual Strategies, Autism training, Meaningful supports, and an 18-month program in 'Foundations' (skill development in the disability services field), Pro-ACT training, Advanced Specialized Foster Care Training, Diversity training, Food Safety training, Meaningful Supports **Cultural Competency training:** None.

PLEA Community Services - FolkStone	**Residential Services Coordinators -** Education in nursing, social science, and social services from master's degrees to diplomas **Cultural Awareness Coordinator** - Responsible for ensuring the entire PLEA team is well versed in NWT culture **Adult Support Workers** - Trained as LPNs, psychosocial rehabilitation workers or healthcare workers **Family Caregivers** – aka Host Family **U-Learn Instructors -** Teaching certificate or education students from teacher education program with completed practicums	Evidence-based best practices on communication, conflict management, de-escalation, resilience, trauma, suicide awareness, mental illness, additions, FASD, self-care and stress management, and annual training on medication assistance (Remedy's Rx) **Cultural Competency training:** Staff must complete GNWT Cultural awareness training, and informal teachings from Elders at staff meetings, established an Aboriginal, Inuit and Métis (AIM) Committee of staff with Aboriginal roots who created an agency wide module 'Indigenous Culture Matters; and staff are encouraged to receive cultural specific training such as the Kathi Camilleri's experimental workshop "Building Bridges through Understanding the Village".

2.10 Utilization Rates

2.10.1 In-Territory Supported Living Utilization Rates

Two of the five SL service providers note that the capacity of their programs to support a certain number of SL service users is flexible, meaning the estimated maximum number of clients they can serve can be adjusted depending on the needs of the SL service users.

To outline the utilization rates for this report, the following two definitions are used:

1. **Maximum Potential Capacity** – The maximum number of SL service users the program estimates it can support based on moderate to low support needs of the SL service users.
2. **Current Actual Capacity –** The adjusted number of service users the program can support based on the needs of the current SL service users and the available resources to support additional SL service users.

As of January 2022, in-territory SL services were at 82% utilization rate for maximum potential capacity, and 86% utilization rate for current actual capacity. For example, both the Salvation Army - Mental Health and Support Services and Inclusion NWT report a maximum potential capacity of 23 and 19 service users, respectively. However, their current actual capacities are 18 service users for both service providers.

Reduced current actual capacities occur when programs are supporting SL service users with higher-than-anticipated service needs, requiring more intensive staffing, and thereby reducing the programs' overall service user capacities. Vacancies can also occur if difficulties arise in appropriately matching new service users with existing occupants in shared apartment settings. Details are provided in Table 6

Table 6: *In-Territory SL Provider Capacity and Waitlists*

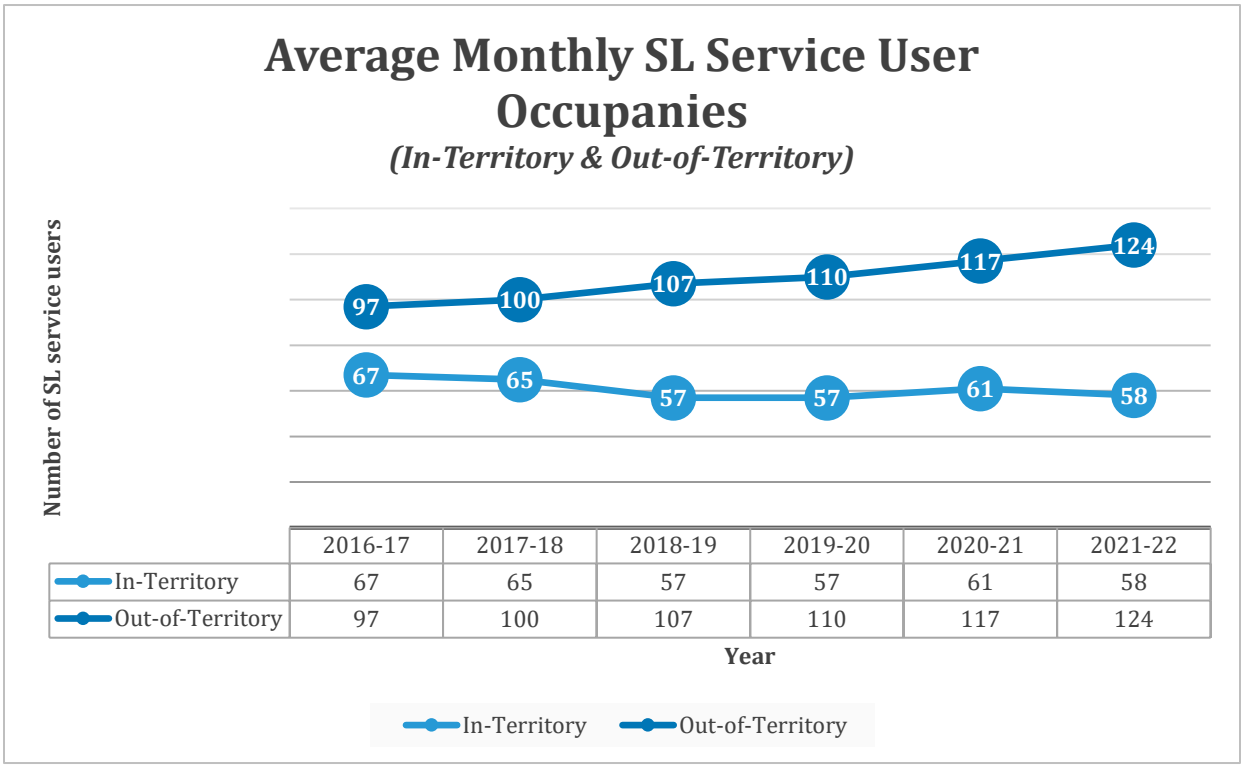
NWT SL Placement	Number of Service users	Maximum Potential Capacity	% Potential Capacity	Current Actual Capacity	% Actual Capacity	Waitlist
Salvation Army – Group Supported Living	5	8	63%	5	100%	0
Salvation Army – Independent Living Services	13	15	87%	15	87%	0
Inclusion NWT – Supported Living	9	11	82%	10	90%	3
Inclusion NWT – Supported Independent Living	5	8	63%	8	63%	0
Parkland CLASS - Charlotte Vehus	8	8	100%	8	100%	0
Parkland CLASS - Billy Moore	5	5	100%	5	100%	0
Hay River SL Campus	10	11	90%	11	90%	0
Judith Fabian Group Home	3	5	60%	5	60%	0
Total	**58**	**68**		**65**		**3**

Average monthly occupancies for the in-territory SL programs have decreased from 67 service users in 2016-17 to 58 service users in 2021-22, with an average annual rate of decrease of 2.6%. Details are outlined in the following section and figure.

2.10.2 Out-of-Territory Supported Living Utilization Rates

When there is no capacity with the in-territory SL services to support an individual requiring SL services, and/or their needs exceed the what the in-territory SL services can offer, they can access immediate support through an out-of-territory placement. There is no maximum number of Adult Out-of-Territory Supportive Living Services placements, and the program does not have a waitlist. As a result of operating at high actual capacity in-territory and a mismatching of SL service user needs with service provider eligibility, the number of out-of-territory SL service users has been steadily increasing over the past several years. From 2016-17 to 2021-22 the number of service users in Adult Out-of-Territory Supportive Living Services Program has increased from an average monthly occupancy of 97 service users to 124 service users, with an average rate of increase in service users of 4.8% per year. Details are outlined in Figure 8.

Figure 8: *Average Monthly SL Service User Occupancies*



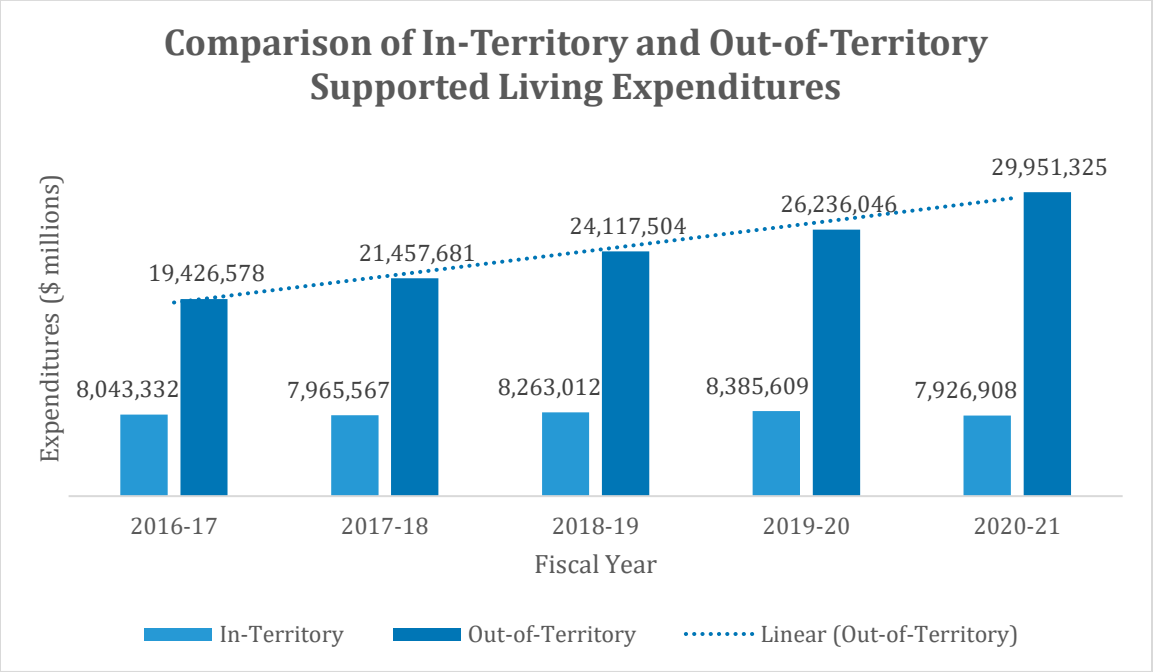
2.11 Costs of Supported Living Services

2.11.1 Overall Supported Living Costs

The total costs of NWT SL services are approximately $38 million per year, with in-territory expenditures totalling roughly $8 million, and out-of-territory costs approximately $30 million. As there are a greater number of out-of-territory SL service users and they frequently have higher service needs compared to in-territory service users, this is somewhat to be expected. However, in-territory costs have remained relatively stable over the past five years (fluctuating from $7.9 - $8.4 million), whereas the cost for out-of-territory services has increased from approximately $19 million to almost $30 million over the same five-year period.

The cost of services for in-territory and out-of-territory from 2016 to 2021 is shown in Figure 9.

Figure 9: Comparison of In-Territory and Out-of-Territory SL Expenditures
Source: GNWT Finance Department



2.11.2 In-Territory Supported Living Program Cost

The total amount the HSSA receive to cover the expenditures of the SL settings in-territory is outlined in Table 7.

Table 7: *In-Territory Supported Living Expenditures*

Service Provider	2016/17	2017/18	2018/19	2019/20	2020/21
Billy Moore	778,188	793,188	785,090	914,044	815,676
Charlotte Vehus	1,542,331	1,585,562	1,445,794	1,419,887	1,225,800
Hay River Campus	2,802,946	2,956,515	2,964,769	3,013,570	2,817,324
Inclusion NWT*	1,879,490	1,507,493	1,946,108	1,916,108	1,946,108
Judith Fabian	290,377	372,977	371,251	372,000	372,000
Salvation Army*	750,000	750,000	750,000	750,000	750,000
TOTAL	**8,043,332**	**7,965,567**	**8,263,012**	**8,385,609**	**7,926,908**

Source: Service Agreements and HSSA Finance

*Inclusion NTW and Salvation Army - Mental Health and Support Services note this amount does not cover the full costs of SL services and must be augmented by other funding sources, as indicated in their budget submissions.

2.11.3 Out-of-Territory Supported Living Program Cost

The total amount the DHSS provides to the NTHSSA to cover the expenditures of the out-of-territory SL settings through the NTHSSA Adult Out-of-Territory Supportive Living Services Program is outlined in Table 8.

Table 8: *Out-of-Territory SL Costs Expenditures*

Service Provider	2016/17	2017/18	2018/19	2019/20	2020/21
NTHSSA Adult Out-of-Territory Supportive Living Services Program	19,426,578	21,457,681	24,117,504	26,236,046	29,951,325

Source: Service Agreements; HSSA Finance

2.11.4 Average Supported Living Costs

The average cost of SL services per SL service user varied between the in-territory and out-of–territory programs. The average in-territory cost for 2020/21 was $136,671 per SL service user while the average out-of-territory cost was $241,543 per SL service user. Comparison between the various SL providers is challenging as the SL providers offer a range of services dependent on the needs of the SL service user.

The higher levels of support often needed by out-of-territory SL service users is likely a large driver in the increased expenditures of the out-of-territory SL program. Approximately 25% of current out-of-territory SL service users require levels of support that are exceeding $300,000 per service user/year due to the complexity of their needs. Between 2016-17 to 2020-21, the number of SL service users in out-territory SL program who require supports costing greater than $300,000 per year has increased by an average of six SL service users each year.

Service needs of SL service users vary widely, and as such the cost to provide services to SL service users varies widely. However, it was noted overall that programs providing SL services to SL service users living in their own homes are less costly on average than programs providing accommodations and continuous SL services. For example, the Hay River Supported Living Campus offers accommodations to all of the service users with an average cost of $281,732 per SL service user annually compared to Salvation Army – Mental Health Support Services and Inclusion NWT who provide two streams of SL programming (i.e., accommodations with SL services, and SL services that are provided in the service users' own home) with costs of $41,667 and $139,008 per year per service user, respectively.

2.11.5 Additional Out-of-Territory Supportive Living Costs

The NTHSSA Adult Out-of-Territory Supportive Living Services Program annual budget includes funding for costs beyond the contracts with the SL service providers. This supports SL service users who are out-of-territory with funds towards an annual community or family visit, monthly allowance, case management visit, and medical expenses/assessments beyond what is covered by the Northwest Territories Health Care Insurance, or any other agency or plan. These supports include:

- **Community or Family Reunification Visit** - A fund of up to $2000 per SL service user annually for family/community reunification visits. With this funding, SL service users can either return to their home community or have family visit them in their out-of-territory location. Family reunification aims to promote service user connection with their family, home community and culture.

- **Monthly Allowance** - A monthly allowance of $300 per SL service use for miscellaneous personal expenses (i.e., personal care, entertainment, clothing). This allowance is provided to all OOT SL servicer users as they may not have an income and are not eligible for NWT Income Assistance when they reside out-of-territory.

- **Case Management Visit** - HSSA staff and case managers travel to see SL service users in the out-of-territory SL settings each year (public health restrictions permitting). Case management visits support oversight and relationship-building with the service users' NWT case manager.

- **Medical Expenses and/or Assessments** - Costs of SL service users in SL out-of-territory programs that are not covered by the Northwest Territories Health Care Insurance, or any other agency or plan are covered by the NTHSSA Adult Out-of-Territory Supportive Living Services Program.

It should be noted that funding for a yearly community or family trip is not available for in-territory SL service users who have relocated to one of the four NWT communities currently offering SL services.

2.12 Characteristics and Demographics of Supported Living Services Users

This section provides an overview of the SL service user characteristics and demographics including age, impairments, guardianship status and Indigenous status.

2.12.1 Impairments

Examining impairment (rather than diagnosis) provides a closer understanding of what functional needs a SL user requires support for in a SL setting. Impairments experienced by SL service users, both in-territory and out-of-territory, were gathered from service providers using the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0), which is a 36-item measure that assesses disability in adults aged 18 years and older. The function categories are:

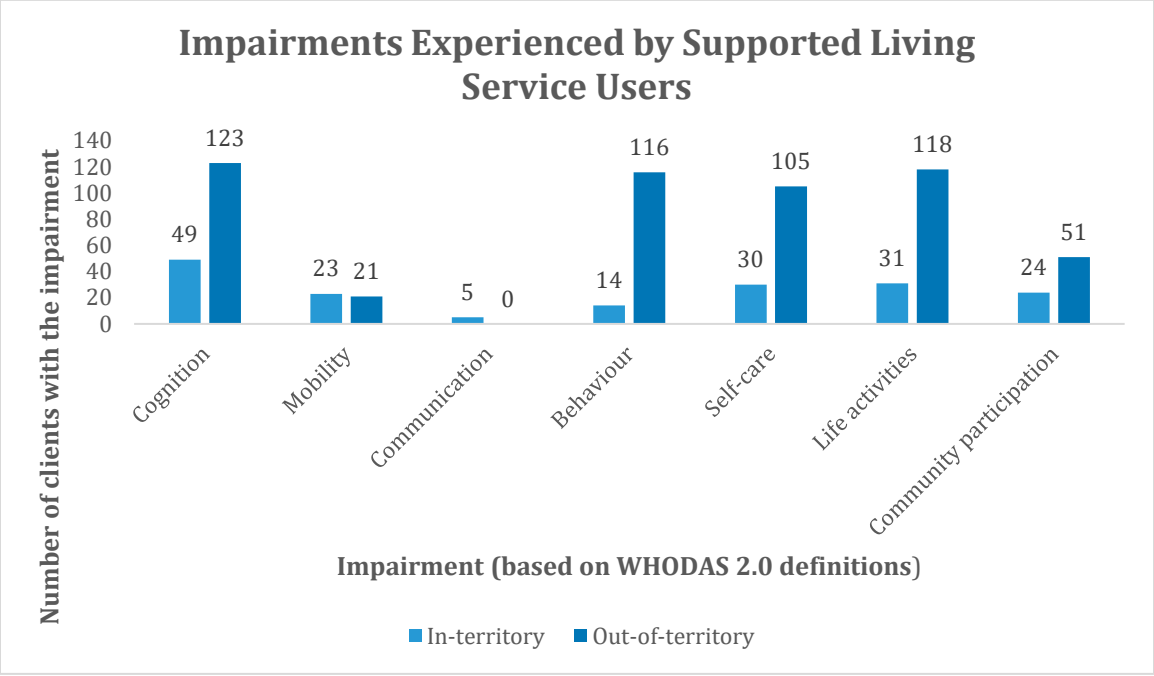
- **Cognition:** Understanding/ communicating
- **Mobility:** Moving/getting around
- **Self-Care:** Hygiene, dressing, eating, staying alone
- **Getting Along**: Interacting with others
- **Life Activities:** Domestic responsibilities, leisure, work, school
- **Participation:** Joining in community activities, participating in society

Service providers were asked to select all impairments that applied to each SL service user. A significant number of SL service users (86%) have more than one impairment, which varies from 60% of in-territory SL service users to 98% of out-of-territory SL service users.

Almost all in-territory SL service users (97%) have a cognitive disability, while all out-of-territory service users have a cognitive disability. More out-of-territory service users have behavioural issues (94%) than in-territory service users (24%). Based on communication with service providers, this is expected because the in-territory settings are less likely to have the capacity to support service users with behavioural issues. This is in alignment with the exclusion criteria of most in-territory service providers, which limits admission of service users with high risk, complex and aggressive behaviors, as noted previously in Section 2.3.2.

It was noted that there are no service users out-of-territory with a physical impairment only (i.e., without a cognitive or mental impairment as well); this is consistent with the eligibility requirement to have a cognitive or mental health impairment to be referred to the out-of-territory program. It was also noted there is only a very small number of SL service users with a physical impairment only receiving SL services in-territory (two service users, or 3%). Only two of the five service providers in-territory (i.e., Parkland CLASS and Katl'odeeche First Nation) allow for service users to enter the program with a physical impairment only. Service user impairments are displayed in Figure 10.

***Figure 10**: Impairments Experienced by SL Service Users*
Source: Statistics collected from service providers, October 2021–January 2022, N=182.



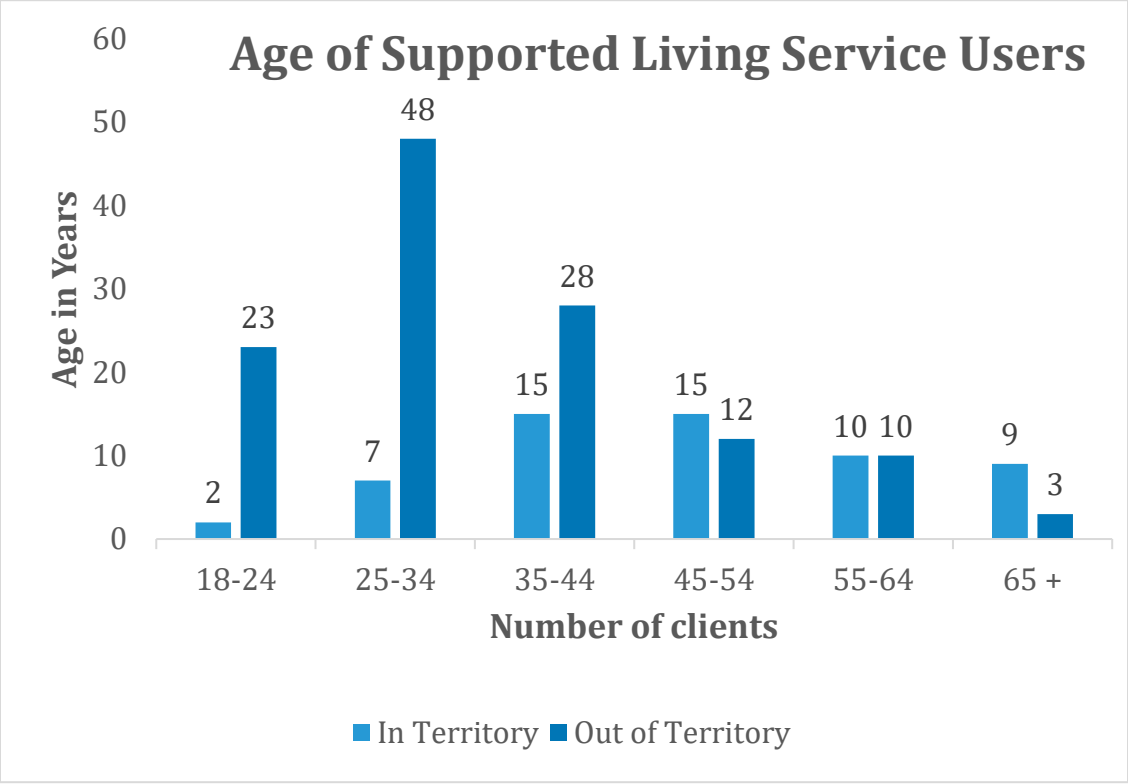
From data gathered from SL service providers from October 2021- January 2022, the most common types of disability for SL service users (in-territory and out-of-territory combined) are listed below, noting that SL service users often have more than one type of disability:

- Mental Health 38%
- FASD 22%
- Developmental 17%
- Addictions 5%
- Autism 3%
- Musculoskeletal 3%
- Acquired Brain Injury 3%

2.12.2 Age

The age range of NWT SL service users vary from 18 to 81 years old. The majority of SL service users in-territory and out-of-territory are between ages 25 and 44 (54%). Based on the data provided by SL service providers, on average, SL service users in out-of-territory placements are generally younger (average age of 32 years) than SL service users of in-territory settings (average age of 46 years). Age ranges of SL service users as of January 2022 is displayed in Figure 11.

Figure 11: *Age of SL Service Users*
Source: Statistics collected from service providers, October 2021–January 2022, N=182



2.12.3 Guardianship Status

The *NWT Guardianship and Trusteeship Act* (*GTA*) provides for the court appointment of a guardian and/or trustee to make decisions on behalf of an adult, 18 years of age or older, who is incapable of independently managing his or her affairs. Guardianship orders cover non-financial decisions (i.e., personal care and/or health care) whereas Trusteeship orders cover areas related to financial or estate decisions. The *GTA* is designed to allow people to live as independently as possible by restricting guardianship or trusteeship decisions to only those areas in which the person is unable to make their own decisions. The Court reviews each Guardianship and/or Trusteeship application and appoints the proposed guardian or trustee with the appropriate powers. Both guardians and trustees can be either public (i.e., the NWT Public Guardian or NWT Trustee) or private (i.e., a family or friend).

Many in-territory and out-of-territory SL service users are under a guardianship order. The notable differences between in-territory and out-of-territory SL service users are that a higher percentage of out-of-territory SL service users have a guardianship order (56% compared to 43%), a greater percentage of those SL service users with guardianship status in out-of-territory have a guardianship order under the NWT Public Guardian (73% as compared to 40%), and a smaller percentage of those SL service users in out-of-territory are under private guardianship (27% compared to 60%). Guardianship status of SL service users is depicted in Figure 12 and Figure 13.

Figure 12: *Guardianship Status of SL Service Users (In-Territory and Out-of-Territory)*
Source: Statistics collected from service providers, October 2021–January 2022, N=182

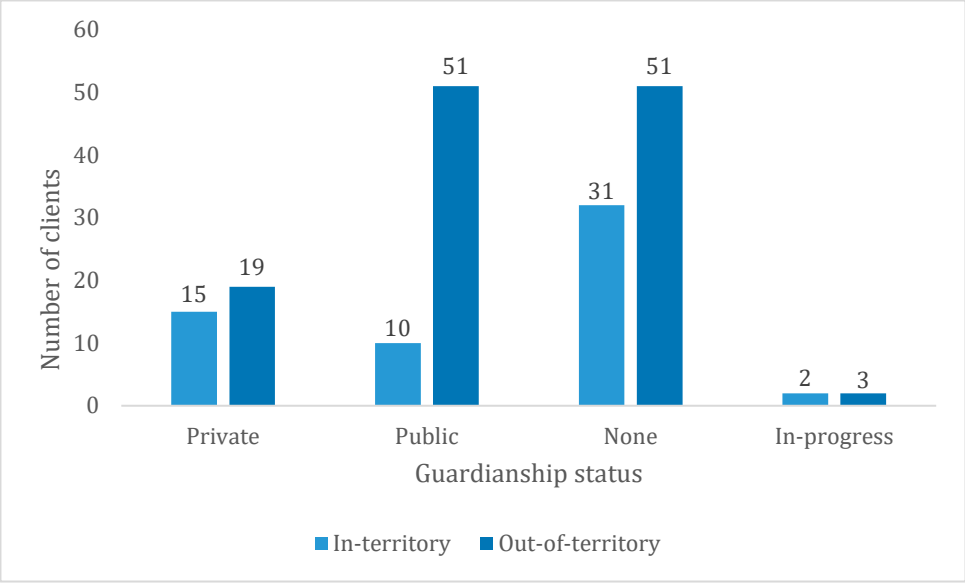
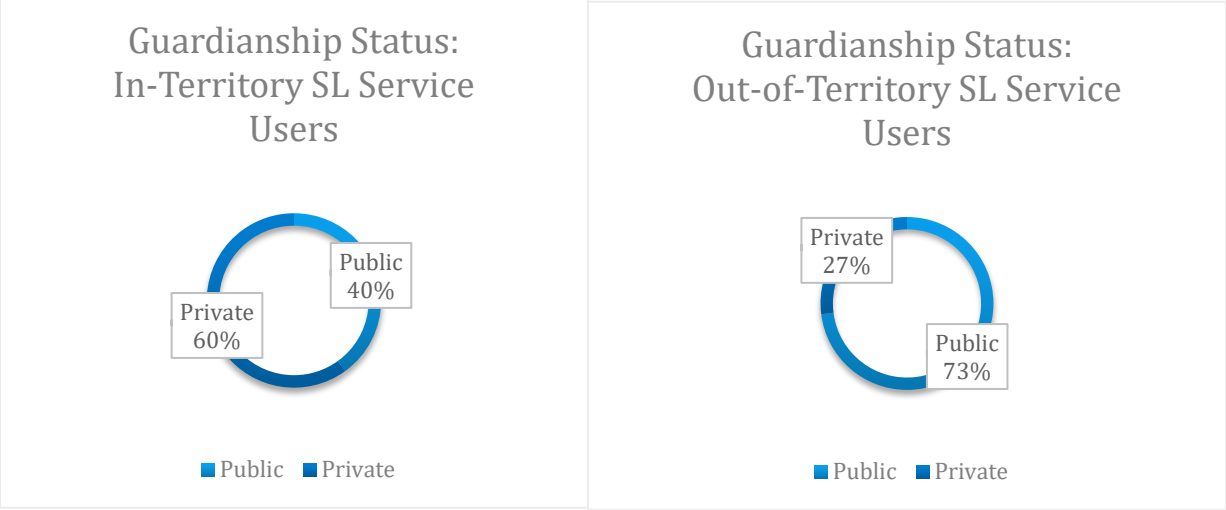


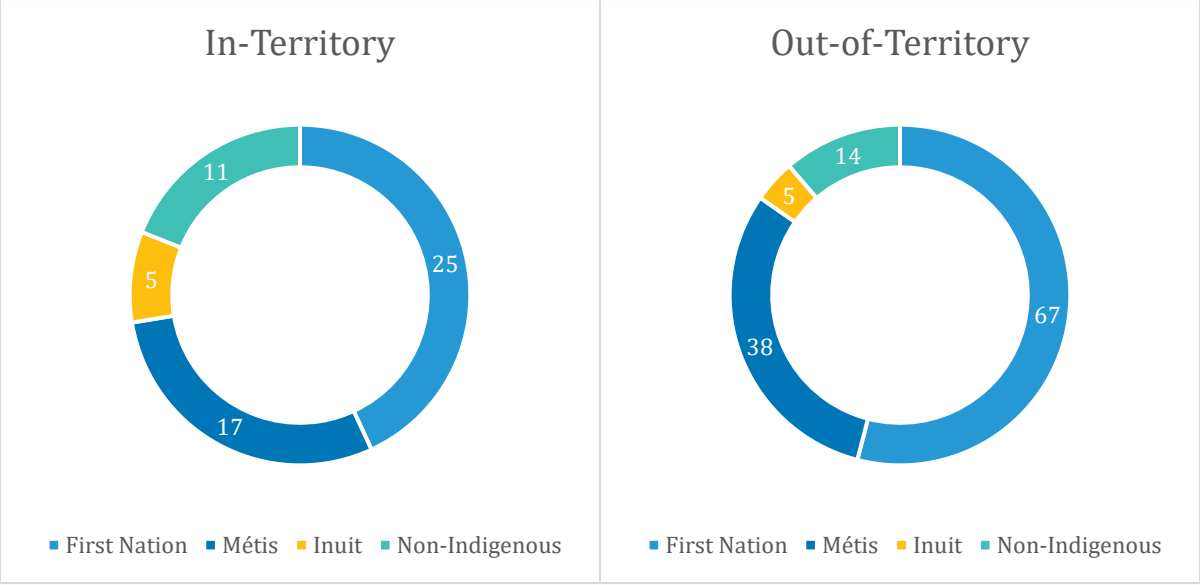
Figure 13: *Breakdown of Type of Guardianship Status of SL Service Users (In-Territory and Out-of-Territory)*
Source: Statistics collected from service providers, October 2021–January 2022, N=95



2.12.4 Indigenous Status

Currently, 86% of SL service users are Indigenous (First Nation, Métis or Inuit), where 89% of out-of-territory SL service users are Indigenous, and 81% of in-territory service users are Indigenous. Indigenous status of SL service users is shown in Figure 14.

Figure 14: *Indigenous Status of SL Service Users*
Source: Statistics collected from service providers October 2021–January 2022, N=182



What We Heard

Public & Stakeholder Engagement

3.0 – What We Heard

Significant public and stakeholder engagement was undertaken throughout the review to ensure that a broad spectrum of perspectives and experiences were gathered to determine the strengths, weaknesses, and gaps in the current SL services, and identify opportunities for improvement and recommendations for a new SL model in the NWT. Engagement activities included an online public survey, stakeholder interviews, visits to SL sites both in-territory and out-of-territory, public engagement sessions in every region of the NWT, and a facilitated workshop with key stakeholders to determine the priorities for a renewed SL model. In this section, the term "family/caregivers" refers to family members and caregivers of persons with disabilities.

3.1 Public Survey Results

An online survey using the platform Survey Monkey sought feedback during the fall of 2021 from the public, specifically persons with disabilities and family/caregivers. The survey was first shared with a target group of NWT stakeholders interfacing with persons with disabilities (using a stakeholder list established during the review planning phase). This was followed by a public launch on the GNWT Public Engagement website, and public advertisement from October 25, 2021, to November 17, 2021, to further amplify the response rate. The survey was promoted through additional stakeholder distribution, radio and newspapers advertisements across the NWT, social media advertisements on Facebook, Public Service announcement, and letters to MLAs. Government Service Officers across the NWT provided further promotion and support in assisting residents with online platform and/or paper copies of the survey.

The survey targeted persons with disabilities and family/caregivers in or from the NWT receiving or requiring supported living services. The aim of the survey was to determine the support needs of survey respondents, the types of support currently available, the satisfaction levels with current supports, and the perceived strengths and weaknesses of current supports (a complete list of survey question can be found in Appendix B). A more detailed summary of survey results can be found in Appendix C.

3.1.1 Respondent Characteristics

There were 144 respondents to the survey, with breakdown of respondent type as follows:

- 10 persons with disabilities currently accessing SL services
- 28 family/caregivers of persons with disabilities currently accessing SL services
- 28 persons with disabilities not currently accessing SL services
- 78 family/caregivers of persons with disabilities not currently accessing SL services

Health Condition/Diagnosis Contributing to Disability

Survey respondents reported that multiple types of health conditions and diagnoses contribute to their disability or the disability of their family member/ person they are providing caregiving support. The five most frequently reported categories reported were[13]:

1. Mental health condition 38%
2. Developmental disability 22%
3. Addictions 19%
4. Autism 19%
5. FASD 18%

Other less frequently reported categories (less than 15% response rate) were cardiovascular, autoimmune, hearing, endocrine, musculoskeletal, and chronic pain conditions.

3.1.2 Respondent Support Needs

Activity Areas Requiring Support

Survey respondents currently receiving and those who identified as not receiving SL services reported requiring support with broad areas of activities. The five most frequently reported types of activities requiring support were[14]:

1. Hobbies/work/school activities 53%
2. Cognition/Comprehension 50%
3. Self-care 49%
4. Communication 41%
5. Mobility/getting around 40%

Other less frequently reported areas requiring support (less than 40%) included interacting with others (29%), hearing (16%), and seeing (7%).

Specific Activities Requiring Support

Survey respondents currently receiving and not receiving SL services had similar support needs in terms of specific activities. The six most common activities requiring support and their response rates are outlined in Table 8.

[13] The total adds up to greater than 100%, as individuals may have more than one contributing factor to their disability

[14] The total adds up to greater than 100%, as individuals may have more than one activity area requiring support

Table 9: *Specific Activities Requiring Support*

Activity	Persons with Disabilities Currently Receiving SL	Persons with Disabilities not Currently Receiving SL
Managing Money	85%	57%
Housework	77%	62%
Preparing Meals	73%	53%
Social/Recreational Activities	73%	59%
Shopping	58%	42%
Taking Medication	58%	33%

Other less frequently reported activities requiring support included using the telephone, eating, bathing, getting dressed, mobility/getting around, toileting, obtaining equipment, accessing meaningful employment, accessing affordable housing, staying safe in the community, managing a daily schedule, and attending and understanding health care appointments.

Unmet Support Needs

Survey respondents with disabilities, and family/caregivers both receiving and not receiving SL services reported unmet support needs with the four following activities:[15]

1. Managing money
2. Housework
3. Bathing
4. Social and recreational activities

3.1.3 Current Supports – Persons Not Currently Receiving SL Services

Non-Supported Living Service Provision

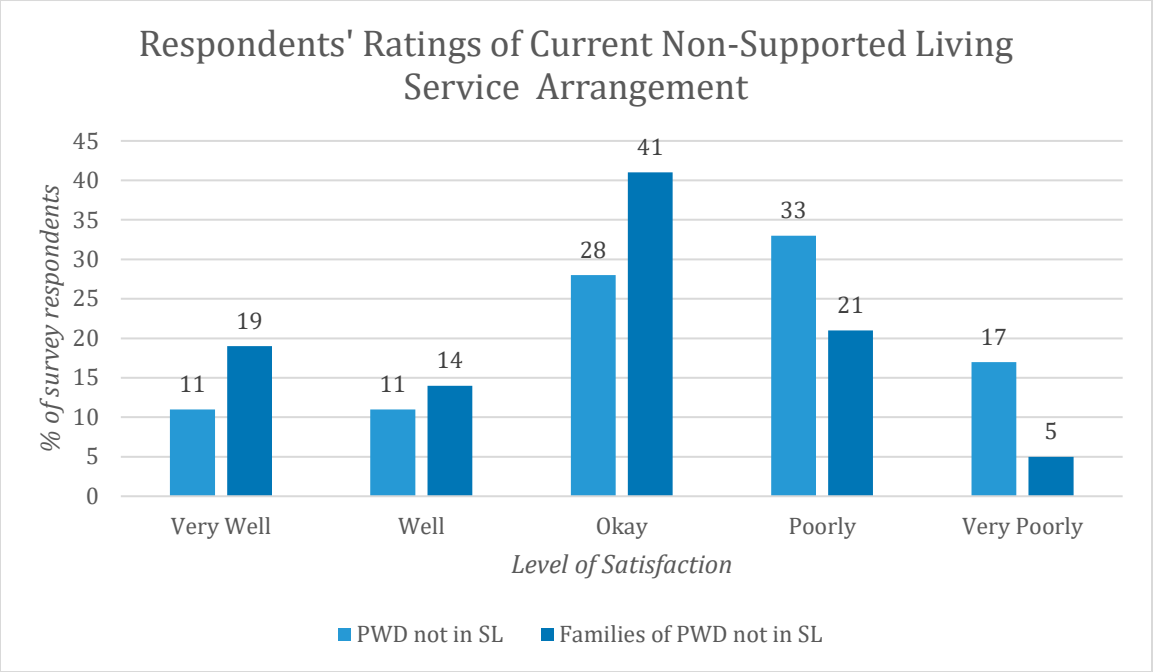
The majority (61%) of respondents not currently receiving SL services (and family/caregivers) reported that service needs are currently being met by parents. Other types of people meeting the service needs of persons with disabilities not currently receiving SL services are siblings (26%), other relatives (22%), friends and neighbours (13%), and other types of people/organizations (local community living organization, foster parents, homecare, spouse, community support workers, Adult Service Workers, and housecleaning services).

Satisfaction with Current Non-Supported Living Service Provision

Survey respondents not currently receiving formal SL services were asked to describe how their current service provision arrangement is working out. The results indicate that 50% of persons with disabilities and 26% of families/caregivers reported that their current arrangement is working out "Poorly" or "Very Poorly". The results are depicted in Figure 15 below:

[15] Activities listed had greater than a 10% response discrepancy between requiring and receiving support

Figure 15: *Respondent's Ratings of Current Non-SL Service Arrangements*



Family/caregivers of people with disabilities not receiving SL services reported several challenges regarding their current arrangement. Comments described two main themes: caregiver stress and burnout, and the limited SL options available in the NWT. Some examples are provided below:

Caregiver Stress and Burnout

- Exhausted, fatigued or burning out
- Stressful, time consuming, challenging
- Unable to meet the needs of other family members due to caregiving
- Supporting their loved one becoming more difficult over time as caregivers are aging
- Need more support in the home

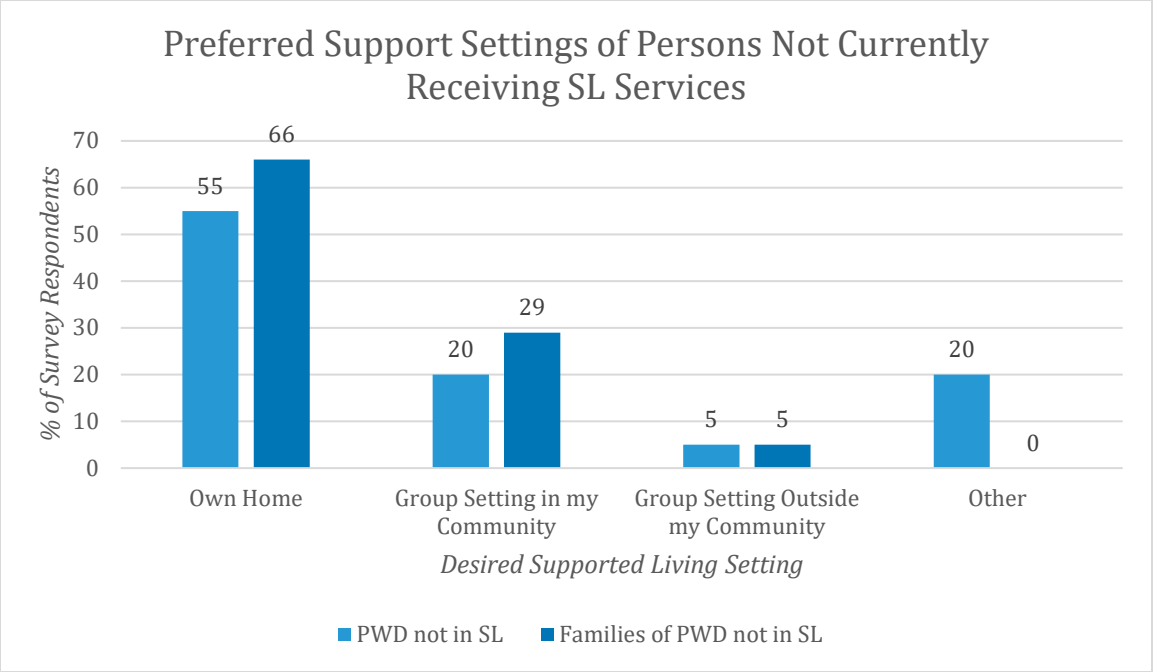
Limited SL Options in the NWT

- Difficult removing the individual from home community
- Limited support in (home community) for an individual with higher support needs
- Services providers not in their community often enough
- Need to send (our loved one) out of territory if not living at home with us
- No respite

Preferred Support Setting of Persons Not Receiving Supported Living Services

Survey respondents not currently receiving SL services (and family/caregivers) were asked to indicate their preferred location for receiving support services. The majority of respondents reported that they would prefer to receive supports in their/their loved one's own home (55% and 67% respectively for persons with disabilities and family members/caregivers). The results are depicted in Figure 16 below.

Figure 16: *Preferred Support Settings*



3.1.4 Current Supports – Persons Currently Receiving SL Services

Satisfaction with Current Supported Living Services

Survey respondents with disabilities currently receiving SL services reported being pleased with their current SL services: 100% reported that they were "Very Satisfied" or "Satisfied" (60% and 40% respectively). Family/caregivers currently receiving SL reported a mix of satisfaction responses with their loved ones' current SL services: while 78% reported being "Very Satisfied" or "Satisfied" (45% and 33% respectively), 22% reported being "Dissatisfied" or "Very Dissatisfied" (11% response rate for each).

Reported Strengths of Current Supported Living Services

Survey respondents currently receiving SL services (and family/ caregivers) generally liked the people/staff providing the service (77%), and the help that is provided (65%). A further 27% reported that they liked that their loved one can live with friends within the SL setting. Only 4% of respondents liked "Nothing" about the SL services currently being provided. Other reported strengths of current SL services were good availability of staff, good communication with families, provision of a team approach and integrative services, and the independence that SL services provide outside the family.

Areas for Improvement in Current Supported Living Services

Areas for improvement highlighted by survey respondents with disabilities currently receiving SL services and family members/caregivers of persons with disabilities currently receiving SL were: "Would like to receive all the services that are required" (48%), "Would like to live in their own

community" (26%), "Would like to live with family" (17%), and "Would like SL caregivers to be friendlier" (9%).

Two respondents commented on the lack of continuity of care in service provider staff and the challenges this poses:

> *"Switching staff often makes it difficult for the person with the disability to develop a trusting relationship. The staff could develop a better understanding of the person and therefore provide appropriate supports"*

and,

> *"Constant change of caregivers leads to lack of communication with family, consistency in caregiving and increased anxiety for both parents and users of services."*

3.2 Stakeholder Interview

From August 2021 to February 2022, interviews were conducted with a broad variety of stakeholder groups to further explore the support needs of adults with disabilities in the NWT, the strengths and weaknesses of current SL service delivery, and stakeholder thoughts, values and preferences for an improved model of service delivery. Multiple interview guides were developed to best suit the target audience with additional questions asked of SL service providers (both in the NWT and out-of-territory) to learn more about the current state of existing SL services. Interview guides can be found in Appendix D.

In total, 133 interviews were conducted, and 8 SL site visits were completed:

Interviews with the following stakeholders:

- 8 DHSS staff
- 15 Health Authorities staff
- 6 Other GNWT staff
- 14 non-governmental organizations
- 5 Indigenous Governments and community governments
- 17 supported living service provider staff
- 12 persons with disabilities currently receiving SL services in the NWT
- 31 persons with disabilities from the NWT, currently receiving SL services out of territory
- 12 persons with disabilities in the NWT not currently receiving SL services
- 6 family members of persons with disabilities needing SL services
- 7 family members of persons with disabilities currently receiving SL services

Supported Living Site Visits: Despite COVID-19 travel and visiting guidelines shifting several times over the course of the review, the consultant interviewer had the opportunity visit eight SL sites (in the NWT and out of territory). Service providers and persons with disabilities receiving SL services were interviewed during the site visits. Supported Living sites visited during the review were:

- PLEA Community Services - Abbotsford, British Columbia
- Parkland Community Living and Supports Society (CLASS) - Red Deer, Alberta
- I Have a Chance - Stoney Plain, Alberta
- Independent Counselling (ICE) - Edmonton, Alberta
- Excel Society- Edmonton, Alberta
- Billy Moore Home - Inuvik, NWT
- Charlotte Vehus Home - Inuvik, NWT
- Inclusion NWT - Yellowknife, NWT

3.2.1 Summary of Key Finding from Stakeholder Interviews

Strengths of Current NWT Supported Living Services

Quality of Services Received

Of the persons with disabilities currently receiving SL services, family/caregivers generally discussed being pleased with the SL services being provided. They reported being happy with living arrangements, appreciating having choice in their day-to-day lives, and being satisfied with the help and support they are receiving. However, interviewees receiving SL services in southern Canada under a court-ordered placement reported being less happy with SL services during interviews.

Availability of Urgent Placements

Persons with disabilities who urgently require SL services have little to no wait time for service. However, they likely need to leave the territory to receive support.

Weaknesses and Gaps in Current NWT Supported Living System

System Resource Issues

Need For more Affordable and Accessible Housing

Interviewees from the HSSAs and NGOs spoke of the general lack of housing and need for more affordable and accessible housing in the NWT. This would allow more persons with disabilities who require supported living to receive it in their own home rather than have to relocate to a regional center where SL services with accommodation are available.

Lack of Coordination, Oversight & Communication

No Coordinated NWT Supported Living or Disability Program

GNWT staff noted that there is no single NWT SL program or office that encompasses all available services and settings, making coordination and oversight challenging. A related topic was the lack

of a coordinated disability program, which results in a lack of coordination of services between different GNWT departments for persons with disabilities.

Need for Better Oversight, Reporting and Accountability

GNWT and HSSA interviewees both discussed the need for better reporting, accountability, guidelines, oversight and updated standards.

Need for Better Communication

NGO service provider representatives spoke of the need for better and more frequent communication between NGOs and health system SL staff.

Awareness & Access Issues

Lack of Awareness about Supported Living Services

Supported living services were sometimes poorly understood by stakeholders outside the HSS system, or those with direct experience with SL. Interviewees reported difficulty finding online information about NWT SL services.

Difficult Access to SL Services

Accessing SL services (and finding information on accessing services) was described by health system staff, NGO staff, and family members of persons with disabilities as being confusing and difficult. Staff noted that one application form used is long and complicated. Interviewees noted that there was no central contact person, number or office for information on SL.

Service Availability Issues

Over-Reliance on Out-of-Territory Placements/Not Enough SL Placements in the NWT

Interview participants from nearly all stakeholder groups expressed that there are not enough SL settings and placements in the NWT, and as a result too many individuals are receiving placements in southern Canada to meet their support needs. If persons with disabilities do not want to leave the territory to access SL services, there is a possibility of long wait times depending on the person's needs.

Need for SL Services in more NWT Communities

Interviewees from the GNWT and the HSSAs noted that there is a complete lack of SL services outside the three NWT areas of Yellowknife, Inuvik and Hay River/Kátł'odeeche First Nation, and the need for SL services in additional communities to provide services as close to home as possible.

Need for more Case Management/Adult Service Workers

GNWT, HSSA and NGO staff spoke about the need for Adult Service Workers to provide more on-going case management to persons with disabilities, and the need for ASWs availability in all communities.

Need for more In-Home Support

Interview participants from the GNWT, NGOs, family members, and persons with disabilities not currently receiving SL spoke of the need for in-home SL services in the NWT. Currently, any additional support needs provided to persons with disabilities living with family or other

caregivers is being provided by Home Care. Interviewees expressed that more in-home support services would decrease caregiver stress, burnout and exhaustion, and enable persons with disabilities to remain in their current home situation longer.

Need for More Respite Care

Interview participants from the GNWT, family members, and persons with disabilities not currently receiving SL spoke of the need for more respite services as an adjunct or formal element of SL services. For persons with disabilities who are currently having their support needs met by family or other caregivers (i.e., not receiving SL), many interviewees expressed that expanded respite services would decrease caregiver stress, burnout and exhaustion, and enable persons with disabilities to remain in their current home situation longer.

Supported Living Staffing Issues

Need for Greater SL Staff Consistency & Less Staff Turnover

Family members of persons currently receiving SL services spoke of a need for greater consistency in staff and less staff turnover.

Need for Staff Training and Development

The need for training and development for SL staff was reported by GNWT and HSSA interviewees.

Need for Competitive Pay for SL Staff

HSSA interviewees spoke of the need for SL staff to receive competitive remuneration for their work.

Preferred Elements in an Improved NWT Supported Living Model

Guiding Principles & Values

Aligned Commitments

GNWT staff spoke of the need for an improved model of SL services to be guided by the principles in the *UN Declaration on the Rights of Persons with Disabilities,* the *Truth and Reconciliation Commission,* and the principles of cultural safety, integrated approach, self-determination, dignity, fostering independence, individualized and family-based care.

Keeping People in the NWT

Interviewees across all stakeholder groups expressed the need and desire to keep more people who require SL services in the NWT and as close to home as possible.

Choice, Flexibility and Responsiveness

GNWT and NGO interviewees noted the need for a renewed model to be flexible and responsive to a range of needs which may change over time, where persons with disabilities have choice in their living arrangements.

Home-Like Settings

Service provider interviewees spoke about the importance of non-clinical home-like environments for SL settings.

Eligibility, Access & Intake

Eligibility Based on Need

Interviewees from the GNWT reported that eligibility for SL services should be based on level of impairment and need for support, not diagnosis.

Single Point of Entry

Health system staff and families of persons with disabilities all reported that a single, coordinated point of entry for SL services would be an important element of an improved SL model.

Standardized Assessment

Updated and standardized assessment forms were discussed and requested by SL Providers

Individualized Assessments & Support Plans

The need for all service providers to perform assessments and develop individualized support plans was reported to be a preferred element of a new SL model.

Supported Living System Features

Partnerships in Service Delivery

GNWT staff and NGO representatives reported that partnerships with NGOs and other community services for SL service delivery and SL programming should be maintained and expanded (vs. moving to a solely government-delivered service).

Transition Services for Teens/Adolescents with Disabilities

NGO interviewees suggested a transition service for teens with disabilities to ensure awareness of available SL services.

Case Management

Strengthened and appropriate amounts (based on the service users' needs) of case management for people accessing SL services was highlighted by GNWT and HSSA staff, families, and caregivers as being an important component of improved SL services.

Adequate Staffing

SL service providers in the NWT reported that they would like to see improved staff to client ratios and more staff in general.

New Methods of Service Delivery

Paid Family Caregivers

The concept of paid family caregivers was suggested by GNWT staff to enable some persons with disabilities to remain in their current home environments for a longer period of time.

In-Home Support for Persons with Disabilities Living with Family Caregivers

One suggested new service method was a regular amount of in-home support for persons with disabilities living in the family home or with family caregivers and coaching for parents to learn how to teach independence. This would enable persons to remain in their family homes for longer.

More Respite Services

More respite services as being an integral element in a new model of SL was strongly recommended by many interview stakeholder groups as a family-centred and cost-effective way to keep people with disabilities in their homes and home communities longer.

Elements of Supported Living Programs

Mental Health, Counselling and Addictions Services

GNWT staff and NGO representatives stated they would like to see mental health and addictions services linked and available to service users of SL. Families/ caregivers of persons with disabilities who are supporting the person with disability to live at home, noted that mental health supports for caregivers is pivotal for caregiver longevity. Persons with disabilities receiving SL services also reported that counselling and mental health supports would be an important element of an improved SL model.

Education and Employment for Persons with Disabilities

Some interviewees from the GNWT stated that supported education and/or employment for persons with disabilities be a standard element of SL programs where appropriate.

Repatriation

Many groups of interviewees spoke of the need for repatriating persons with disabilities back to the NWT who are currently receiving SL services out-of-territory, including many persons with disabilities receiving services out-of-territory. While out of territory placements can be arranged quickly, they require that a person uproots themselves, leaving family and friends behind. Interviews with clients in out-of-territory placements indicate that in some instances moving from a home community is beneficial, usually when the family or community environment is not healthy for the particular individual. Approximately half of the persons with disabilities interviewed in out-of-territory SL settings said they would like to return to the NWT. The remainder indicated they want to stay in their out-of-territory setting because "*my family is too unhealthy*", and/or " *my community is too unhealthy*", *"my new community is larger with more things to do",* or they have settled into their situation and do not want the disruption of a move.

3.3 Public Engagement Sessions

A total of 33 people participated in 11 public engagement sessions held in every region of the NWT between November 29 and December 14, 2021, using a mix of in-person and virtual formats. Sessions were advertised and promoted via the GNWT website, radio ads, Facebook, and targeted email blasts to stakeholders. The locations, dates and formats of the sessions are listed below:

1. Inuvik November 29, 2021
2. Norman Wells November 30, 2021
3. Behchokǫ̀ December 2, 2021
4. Yellowknife December 3, 2021 (afternoon)
5. Yellowknife December 3, 2021 (evening)
6. Fort Smith December 6, 2021
7. Hay River December 7, 2021
8. Fort Simpson December 8, 2021
9. Virtual December 9, 2021
10. Virtual December 13, 2021
11. Virtual December 14, 2021

3.3.1 Summary of Public Engagement Session Feedback

Guiding Principles, Values & Preferences

- People want to stay in own communities
- People should be supported to remain in their own homes
- A range of choice/options should be available (not just group homes)
- New model should be person-centred
- People with disabilities should be involved in the development of a new SL model
- Community members and community leaders should be involved in the development of a new SL model

Territorial System-Wide Issues

- Territory-wide lack of housing is an issue, particularly accessible and affordable housing
- Extended health benefits should be needs-based not diagnosis-based
- Adequate resources/funding should be provided to contract agencies
- The need for improved accessible transit was noted; suggestion of subsidized taxi vouchers to increase community participation was made
- Confusion over how to connect and integrate disability supports offered by the GNWT including Supported Living
- Lack of public understanding around how to access SL services, and lack of knowledge and integration within GNWT staff/programs as to how to guide the public in accessing SL services. In many cases it requires the service user to go through many doors to find the right one

Awareness of Supported Living

- Confusion around what is Supported Living
- Confusion and questions around what services are available and how to access SL

Supported Living System Issues

- A system-wide SL database is required
- There is a need for standardized policies in NWT SL settings
- Recommendation for a system navigator or more case managers
- More oversight is required

Service Elements, Methods & Models

- A full range of services based on need should be offered
- Flexibility and a range of service models should be available
- A paid family caregiver model should be considered
- It was suggested that SL be provided to persons with disabilities still living in their parents' or family home as needed
- Mixed units of persons with and without disabilities should be explored
- A shared homes model can provide structure, friendship, and community participation
- Host family placements should be explored
- There is a need for more respite
- Mental health and substance abuse issues should be covered under the SL program
- Vocational support/employment support program should be included in SL programming
- Transitional support from adolescence to adulthood should be provided
- An expanded day centre in Yellowknife for persons with (cognitive) disabilities was suggested
- A coaching program for parents to teach independence was suggested
- Peer support for persons with disabilities and for family/ caregivers of persons with disabilities
- Programs/activities to integrate SL service users in the community is important
- A SL program for persons with physical disabilities (without cognitive disability) is required, with living settings separate from settings for persons with cognitive disabilities

Staffing Issues

- Some SL staff in-territory need more training, however although it is important that staff are well-trained requiring a specific diploma or certification can be a barrier to hiring staff
- Consistency/continuity of care in SL staff is important

General Comments & Observations

- Many people with physical disabilities are currently having their support needs met by home care, not SL, and some people with disabilities with complex medical conditions are having their needs met through high care level settings such as long-term care facilities and extended health units.
- For people with complex needs, the choice is to stay home with little support or move south

- There is a need for more capacity in the NWT and in communities to support people to stay in-territory
- Some individuals may be over-serviced (not a good fit/match for their setting)
- Two SL settings in the NWT have regular nursing staff

3.4 Key Stakeholder Priority Sorting Session

On February 3, 2022, a facilitated session with 17 key stakeholder participants from HSS, the Steering Committee and the Advisory Group was conducted to determine the most important priorities for a renewed NWT Supported Living Model. The format below was followed during the session:

- Overview of Preliminary Findings of the Review
- Breakout Groups: Rapid Sort
- Breakout Groups: Forced Sort
- Discussion

Further details on the Priority Sort Session results can be found in Appendix E.

The priority sort session indicated the following are the most important elements of a Supported Living system:

1. Ensure the new model is a non-medical model
2. Supported living services are provided in persons' own homes
3. More supported living placements are available in the NWT
4. Full range of disabilities are served
5. Services are matched to service users' needs
6. Case management services are provided
7. Supported living services are available in smaller communities
8. Specific standards for supported living are developed and enforced

Other elements also deemed more important were communication about supported living services, development of a common assessment tool, and linkages between supported living and youth services. However, the group noted that the NWT SL system needs to be more fully developed before many of the other elements can be implemented.

Jurisdictional Scan

4.0 Jurisdictional Scan

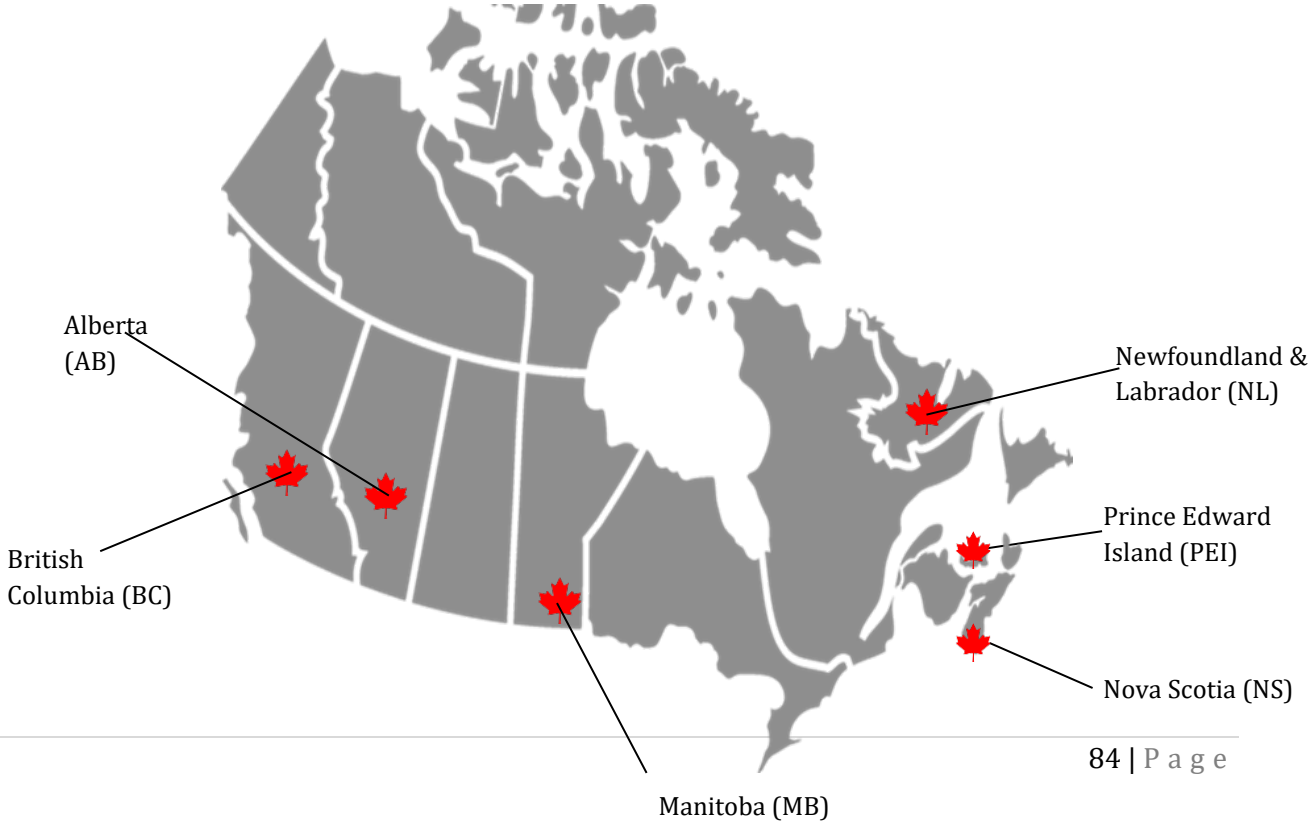
As outlined in Section 1, the methodology of the NWT Supported Living Review included a jurisdictional scan of other Canadian and international jurisdictions. This was to determine leading practices in SL service delivery in regions most relevant to the NWT, to help guide the development of a new SL model. A brief review of the supported living policies and models available for people with disabilities in the Canadian jurisdictions of Alberta, British Columbia, Manitoba, New Brunswick, Newfoundland, Nova Scotia, Nunavut, Ontario, Prince Edward Island, Saskatchewan, and the Yukon was completed. Additionally, the following international jurisdictions were reviewed with the same focus: Australia, Denmark, Finland, New Zealand and the United Kingdom.

Following this brief review, six Canadian jurisdictions and one international jurisdiction were selected based on similarity to the NWT context and on available information to be reviewed in further detail, focusing specifically on general program information, eligibility criteria, service model and delivery settings, funding model, transitional programs, and any other relevant elements. The in-depth review of the seven jurisdictions can be found in Appendix F. Subsequently, the following section is a summary of the most relevant components and highlights from the selected jurisdictions.

4.1 Canadian Jurisdictions

Six Canadian jurisdictions, as depicted in Figure 17 were selected for in-depth review due to their contextual relevance the NWT, their exceptional disability and SL programming, transition services, their geographic location, rurality and size, as well as any commitments to Indigenous populations.

***Figure 17**: Map of Selected Canadian Jurisdictions*



4.1.1 Similarities across Provinces

Upon completing the in-depth review of six provinces, certain overlapping themes emerged as best practices and of interest to an improved SL model in the NWT. These key elements are shown in the following categorized figures. Figure 18 depicts some general aspects of an SL/disability program model, while Figure 19 shows the type of service model and support planning the province uses. Figure 20 depicts more specific elements of Support Living service settings and access. Finally, Figure 21 is a representation of the responsible/answerable government branch for SL services.

Figure 18: *Chart of general overlapping elements across Canada*

	AB	BC	MB	NL	NS	PEI
Different programs designed for specific type of disability	☑	☑	☑	☑		
Financial Assessment	☑	☑	☑	☑	☑	☑
Specific peds-adult Transitional Programs	☑	☑	☑		☑[16]	☑[17]
Single department responsible for disability services					☑	☑
Official adopted definition of disability and/or SL	☑	☑	☑		☑	☑
Case Managers[18]	☑	☑	☑	☑	☑	☑
Standards/Legislation	☑	☑	☑	☑	☑	☑

Figure 19: *Chart of Service Models adopted by each province*

Model	AB	BC	MB	NL	NS	PEI
Person Centered	☑	☑	☑			
Person/Client Directed					☑	☑
Client Focused				☑		

[16] Not necessarily disability specific
[17] Not a specific transition program but under the responsibility of AccessAbility Supports Coordinators
[18] May have different names depending on the province but generally hold the same responsibilities and services

Figure 20: *Chart of SL specific elements across Canada*

	AB	BC	MB	NL	NS	PEI
Shared/Family Homes and/or Supportive Roommate Models		☑		☑	☑	
Self-Managed Homes/Independent Living option	☑	☑	☑	☑	☑	☑
Service Provider Managed Homes	☑	☑	☑		☑	☑
Cluster Living Option		☑		☑	☑	
Respite Programming	☑	☑	☑	☑	☑	☑
Single/Central point of entry for service			☑		☑	☑
Co-payments required for service access	☑	☑		☑		☑

Figure 21: *Government Department answerable for SL Services*

	AB	BC	MB	NL	NS	PEI
Department of Community and Social Services	☑					
Ministry of Social Development and Poverty Reduction		☑				
Department of Families			☑			
Department of Health and Community Services				☑		
Department of Community Services					☑	
Department of Social Development and Housing						☑

4.1.2 Unique Elements from Specific Provinces

Although there were many areas of overlap between the six selected Canadian jurisdictions, three provinces emerged as being leaders in disability and/or supported living services. Unique aspects in programming for disability services as a whole, or specific services such as supported living, respite, etc. were noted in Manitoba, Nova Scotia, and Prince Edward Island.

Manitoba

The province of Manitoba has committed to serving residents with disabilities in an equitable and inclusive manner. This commitment led to the formation of the program known as Community Living disABILITY Services (CLDS), which supports adults with intellectual disabilities to live full and satisfying lives in the community of their choice. They offer a variety of programs based on the assessed level of support each service user requires, the community they live in, and their personal goals.

Standardized Assessment Tool

Manitoba is the only jurisdiction in Canada to utilize the **Supports Intensity Scale**, a standardized assessment tool used by CLDS to identify the support needs for individuals receiving services in Manitoba. The SIS is a valid and reliable assessment tool developed over a five-year period by a team from the American Association on Intellectual and Developmental Disabilities (AAIDD), specifically designed to measure the type of support, frequency of support, and the intensity of support an individual needs to fully participate in personal and community life. It was created for person-centred planning, standardized for individuals with intellectual and developmental disabilities, and has been successfully implemented in jurisdictions across North America. More information on the Supports Intensity Scale can be found at https://www.aaidd.org/sis

The SIS measures support needs in the areas of home living, community living, lifelong learning, employment, health and safety, and social activities usually for individuals aged 16-72. The tool also assesses how an individual protects and advocates for themselves and what (if any) extra support might be needed to manage exceptional medical and/or behavioural needs. The SIS can be used in conjunction with other assessment tools if necessary or as a standalone tool. The assessment process is done through an assessment form and a guided interview with the individual and those who know them best. The data is collected and entered and transformed into scale scores. Using the SIS scale scores, the assessed individual is assigned a Level of Support Need from 1 to 7 (1 being the lowest level of need and 7 being the highest). The Level of Support Need is a significant contributing factor in determining the allocation of monthly funding an individual will receive. The results of the SIS and Support Budgets are 100% shared with the individual and their chosen support team, and they are encouraged to become involved in the support plan and care. CLDS states that:

> *"Supports Budgets create a truly Person-Centred process by assuming that people with Intellectual Disabilities can and should take an active role in every part of service planning"*

Nova Scotia

Nova Scotia has a variety of comprehensive supportive living options for people with disabilities that emphasize, among many things, independence and self-reliance, community involvement and skill development. These supports are offered through an overarching program known as the Disability Supports Program.

Disability Supports Program

Operated by the Department of Community Services, the Disability Supports Program (DSP) oversees a wide variety of policy and programs designed to support individuals with intellectual or physical disability and/or long-term mental illness. It is an integrated umbrella-type program that houses all the Disability Support Services available to residents, including supportive living services, all of which encourage personal choice and service-user involvement. Having all available supports to people with disability under the purview of one government department not only facilitates access to services for people with disabilities and their families, but the coordinated approach has been proven to offer more effective programming. As all supports are only available through DSP, the single-entry point nature of the program and application process is widely supported by referring family/friends, health and/or education professionals, and the disability workers in Nova Scotia. This is of great interest to the Northwest Territories.

One of the DSP Supported Living Program's goals is delaying the need for, or assisting in the prevention of, admission to a staffed residential support home. This is of particular interest to the NWT as the current model often results in individuals entering congregate living designated supported living settings when they do not require that level of support (over-served), or service users are referred out of their home community and the NWT to access the supports they need. This goal encourages the explorations of other community-based options that could be better suited to an individual and their unique needs and goals no matter the level of support they require.

Prince Edward Island

Much like Nova Scotia, Prince Edward Island has recently reviewed the types of disability supports and methods in which supports are accessible to residents in need. In 2018, this review created a change in programing resulting in the AccessAbility Services Program.

AccessAbility Services

The Prince Edward Island Department of Social Development and Housing operates the AccessAbility Supports (AAS) Program which offers a plethora of support plans for Islanders deemed to be in need and/or in vulnerable positions; this includes but extends beyond people with disabilities (i.e., low-income, homeless, fleeing domestic violence, etc.). Similar to the DSP in Nova Scotia, all the available supports for people with disabilities are housed in AAS (including supported living, respite, income assistance, etc.) which helps with service-user accessibility, intake, and support access, as well as service-provider management/governmental legislation. The program encourages accountability and structure and streamlines access to services with the assignment of a Supports Coordinator when an individual is accepted into the program.

The eligibility criteria requires that individuals apply for the AAS program before the age of 65, however, they will then be able to access AAS services for the remainder of their lifetime instead of

having to transition fully to senior-specific services. This element is unique to PEI and helps distinguish the lines and responsibilities of services designed for seniors, home care, long-term care, and people with disabilities. It also assists by possibly eliminating the need for another transitional period after the initial pediatric to adult services transition.

4.2 Summary

The in-depth jurisdictional scan found in Appendix F uncovered a great deal of information on how other provinces manage and provide SL services to people with disabilities, particularly regarding eligibility criteria, assessments, and funding/service models. This knowledge helped guide the formation of recommendations to implement new elements to the SL model in the NWT and address the current identified gaps. Of most importance to the scope and purposes of the NWT Supported Living Review are the following elements:

- **Variety of ways for the service-user to choose to manage their SL Services**
    - This includes self-managed services (service-user takes responsibility of their care), family managed services (family and/or friends support network help take responsibility for service user care), or agency managed care (a government contracted community-based agency or health authority takes responsibility for the SL services of the individual).
    - Whichever route the service user chooses, services should offer the individual control, choice, and independence in their life and how their care is managed.
    - *Found in:* Alberta, Manitoba, and Newfoundland & Labrador.
- **Providing several supported living setting options**
    - Includes options such as independent living/own home, shared/family homes, cluster apartment living, market-value rentals with supports, congregate settings, live-in support, etc.
    - Having a variety of different options with different levels of support helps meet the needs of service-users and supports them staying in the community of their choice.
    - *Found in:* Alberta, British Columbia, Manitoba, Newfoundland & Labrador, Nova Scotia, and Prince Edward Island.
- **Single department responsible for all disability related support services**
    - Integrated multidisciplinary services under the guidance/management of a single department creates more coordinated service delivery and less confusion.
    - Helps with accessibility to resources, information, and acquisition of services.
    - *Found in:* Nova Scotia and Prince Edward Island.
- **Employing disability-specific case workers/managers/coordinators**
    - Although each province has a different name for these employees, they generally all hold the same responsibilities.
    - Help navigate disability services, complete assessments and identify services for which the individual is eligible, streamline the intake process, provide ongoing support to participants and their families throughout their lifetime.
    - *Found in:* Alberta, British Columbia, Manitoba, Newfoundland & Labrador, Nova Scotia, and Prince Edward Island.

- **Government Supported Transition Programs**
    - Transitional programs designed to aid youth/young adults transitioning from pediatric to adult services and/or adults transitioning from adult to senior care services. These transitional periods tend to be uncoordinated, stressful, and confusing. As a result, transition programs supported and/or guided by government bodies have become more common.
    - Help mitigate the stress associate with aging out of one category of service and offer stability to people with disabilities in managing their care (includes building relationships with caseworkers).
    - *Found in:* Alberta, British Columbia, Manitoba, Nova Scotia (not disability specific), and Prince Edward Island (indirectly-see Appendix F).

5.0 Analysis, Conclusions & Recommendations

Section 5.0 Analysis, Conclusions & Recommendations

Information collected from the current state of SL services in the NWT, public engagement activities, and the jurisdictional scan was aggregated and analyzed. Several common themes emerged from the analysis relating to gaps, strengths, and opportunities for SL service improvement. Gaps, strengths, and opportunities for improvement were noted in the areas of the definition SL in the NWT, program administration, monitoring and oversight, access to services and information, staffing and human resources, in-territory SL options, and SL program elements. Forecasting was conducted to inform future need for SL services in the NWT, and a proposed new model for NWT SL services was created.

5.1 Definition of Supported Living

Through stakeholder interviews and public engagement sessions, confusion was reported around what supported living entails and who is eligible for services (i.e., what types of disabilities qualify to receive SL services and how this is determined). In addition, confusion was reported over how disability is defined for SL programs, and the scope of services included in SL. The differing eligibility criteria for each SL service provider adds to this confusion. Stakeholders clearly stated that SL services should be available to adults with all types of disabilities, that a continuum of service options should be available, and that services should focus on non-medical services. The jurisdictional scan revealed substantial variation in the definition of supported living, however most jurisdictions offer a range of SL services that are non-medical in nature and are delivered in various settings to meet the unique needs of adults with disabilities.

The current HSS definition of SL is:

> *"Supported Living provides 24-hour support and supervision for people who have a physical and/or mental health challenge but do not need nursing care. Supported Living provides services in a home-like setting while helping people with disabilities maintain as much independence as possible."*

The current SL definition states:

- That SL services are for people with a '*physical and/or mental health challenge',* thereby excluding other persons with disabilities including those with other cognitive disabilities beyond mental health. This is incongruent with the current state of SL services, as the majority of current SL service users have cognitive disabilities.
- That service users *'do not need nursing care',* however:
    - The current state revealed that two of the five in-territory SL service providers have an LPN and/or RN on staff to support SL service users daily; and
    - SL service users may need health care services that might be provided through collaboration between outsourced staff and SL supports staff, as applicable.

- '*Supported Living provides 24-hour support*' which implies that all SL service users receive 24-hour support rather than the amount of service based on the service user's specific need.
- '*Supported Living provides services in a home-like setting'*, which does not clearly convey that SL services may or may not include accommodations in addition to SL support services.

Conclusion: *The current SL services definition is ambiguous and does not clearly capture the intended population, services that are included and not included, and that the amount of services should be based on the individual's need.*

Recommendation: *Adopt the following updated definition of supported living to guide the SL services in the NWT that reflects eligibility for individuals with all types of disabilities and that provides a variety of flexible services:*

> *Supported living provides a continuum of supports based on individual need to adults* with disability, who require long term support to live independently. Supported living services can be provided in an individual's own home or in an accommodation-based supported living setting.*
>
> *The scope of supported living services includes the provision of support with activities of daily living (i.e., bathing, dressing, eating, etc.) and/or instrumental activities of daily living (i.e., meal preparation, maintaining a home, banking, recreation, etc.), as well as supporting the full inclusion and participation of the individual in their community and respite services for caregivers.*
>
> **Adults are defined as age of majority in the NWT, which is 19 years of age or older.*

5.2 Supported Living Services Administration, Monitoring, and Oversight

5.2.1 Supported Living Services Administration

Under the current system, SL services are administered by the HSSAs. There are currently no resources or mechanisms to facilitate HSSAs to work collaboratively to ensure that common policies, processes, and tools are in place to support the administration of SL services, or to coordinate and maximize the use of existing resources to meet SL service user needs. In addition, within one HSSA (i.e., the NTHSSA) there are different program streams (Continuing Care, and Mental Health and Community Wellness) and regions that oversee the delivery of SL services, and there is no common reporting point or communication mechanism in place to support the standardization or SL policies, processes and tools within the NTHSSA. As a result, there is variation in what is expected of SL service providers in each region, the financial instruments used to engage SL service providers, and how in-territory and out-of-territory services and resources are administered. This results in inequities for SL service users, including the room and board rate paid by service users, and the services they are able eligible to receive. Interviews with stakeholders revealed that it is challenging to oversee SL programs not under their portfolio, and therefore it is

difficult to collectively track data (i.e., referrals, waitlists, client demographics, client movement, etc.) and to collaborate on strengths and weaknesses of SL services. Collaboration across the three HSSAs would improve administration and increase standardization of SL service provider expectations and equity of SL service provision.

Conclusion: *There are disparities and inequities in the delivery of SL services between HSSAs/regions and between in-territory and out-of-territory programs.*

Recommendation: *Establish a mechanism and resources to support collaboration across and within the HSSAs to develop common policies, processes, and tools for administering in-territory and out-of-territory SL services.*

5.2.2 Oversight and Monitoring

Analysis of the current state of SL services in the NWT revealed that while NWT SL Standards do exist, they are integrated within the NWT Continuing Care Standards and are not used to guide SL service delivery by all SL service providers. Additionally, there is limited data collection, monitoring, and oversight of SL service providers to ensure SL service providers adhere to the Standards. The current state further revealed that there are no dedicated DHSS core funded positions to ensure that SL Standards are updated or to conduct audits of SL service providers. Interviews with stakeholders revealed that SL Standards are more applicable to SL service providers providing accommodation-based SL settings and less relevant to service providers delivering SL services to people in their own homes.

Public complaints and concerns related to SL services are managed according to policies and procedures of the SL service provider and the NWT HSSAs. If a complaint is not resolved through the service provider and the HSSAs, complaints may be brought to the NWT Office of the Ombud, an independent body launched in 2019 dedicated to investigating and attempting to resolve unfairness in territorial government administration and services. Stakeholders voiced the importance of having a mechanism such as the Office of the Ombud to support SL service user concerns, but most stakeholders were unaware of the existence of the office.

Conclusions:
Oversight for SL services is inconsistent and sometimes insufficient.

There is a lack of awareness of the complaints process, including the role of the Office of the Ombud.

Recommendations:
Develop stand-alone NWT Supported Living Standards and implement a regular auditing process to monitor adherence to the Standards.

Increase awareness on the process to address SL service user complaints and concerns, through the HSSAs and the Office of the Ombud.

5.2.3 Supported Living Service Data

Documentation by SL Service providers is paper-based and there are currently no data reporting requirements to guide the collection of data from SL service providers. Additionally, there is no territorial database to collect data to track SL demand and usage in the NWT, and no mechanism of collecting service user satisfaction with SL services. Central databases are commonly used by other jurisdictions to enable collection and track demand and usage of SL services, assist in the coordination of services, track referrals, intake, assessment, assign case managers, organize re-assessments dates, and the types of SL services utilized. In some jurisdictions, these databases are also used by other disability support programs and services.

During the SL Review, considerable time was invested in working with the HSSAs and SL service providers to gather data to support the understanding of the current state of SL services. In the absence of a central database, monitoring of service user demographics, utilization trends, and planning for future demand is complex and challenging. A central database would facilitate planning of effective resource use to achieve intended outcomes for SL service users.

Conclusion: *Data collection and reporting processes are not developed, and there is no central database for the HSSAs to effectively monitor SL services or report data to inform decision-making for the DHSS.*

Recommendations:

Develop a SL performance monitoring framework including indicators for service user satisfaction and data reporting requirements for monitoring SL program outcomes, efficiency, and effectiveness.

Implement a central database that supports administration of SL services and reporting to meet DHSS performance monitoring and program standards requirements.

5.2.4 Room and Board Fees and Support Living User Income

Room and Board Fees

Analysis of current state established that in-territory SL service users are required to pay room and board fees when accommodations are provided by the SL service provider. There is no NWT legislation that sets room and board fees for SL services, and there is no standardized rate or formula set by the HSS system; as a result, room and board fees are set by SL service providers and vary from one SL service provider to another. Many in-territory SL service users receive funding from the Department of Education, Culture and Employment's Income Assistance Program to pay their room and board fees. Out-of-territory SL service users are not charged room and board fees, and SL service and accommodation costs are fully funded by the NTHSSA. Lack of a standardized approach results in an inequity for SL service users who receive similar accommodation-based SL services.

The jurisdictional scan demonstrated that most other jurisdictions in Canada require co-payments for SL services in varying amounts based on an assessment of the person's income, which determines the person's income and ability to co-pay. However, persons receiving income support are generally exempt from income testing, as it is pre-established that an individual's income must be low to be eligible for income assistance support.

Persons not receiving income assistance elsewhere in Canada are usually required to declare their annual income, most often verified through income tax submissions. Income is generally defined as Line 260 of the T1 General Form. The NWT is currently not performing any type of income assessment for SL applicants or service users, and it is possible that SL service users exist (both in-territory and out-of-territory) with a greater ability to contribute to their SL service costs than is currently required.

Conclusion: *There is variation in the room and board fees charged to SL service users for accommodation-based SL settings, resulting in inequity between service users; existing fee rates do not consider the SL service user's ability to pay,*

Recommendations:
Develop a standardized approach for SL room and board fees for NWT SL service users.

Explore an income testing model for SL room and board fees.

Supported Living User Income

SL service users who access the NTHSSA Adult Out of Territory Supportive Living Services Program and who receive SL services from a contracted provider in another jurisdiction remain NWT residents and receive NWT healthcare coverage during their SL out-of-territory placement. During stakeholder interviews, a policy barrier related to SL service user income was identified, whereby out-of-territory SL service users are currently ineligible to receive funding under the NWT's Income Assistance Program because they do not reside within the NWT. As a result, out-of-territory SL service users may not have a source of income, as many have significant disabilities presenting barriers to securing and maintaining paid work. As a result, the NTHSSA Adult Out of Territory Supportive Living Services Program provides a $300/month living stipend to each out-of-territory SL service user without a source of income. While intended to ensure out-of-territory SL service users have some funds to purchase personal care supplies and clothing, the HSS system is using funding outside the scope of its mandate to deliver core HSS services to NWT residents.

Conclusion: *SL service users who access SL services out-of-territory are not eligible for income support under the current legislation, which creates inequities between in-territory and out-of-territory service users.*

Recommendation: *Work with the Department of Education, Culture and Employment to explore opportunities to enable out-of-territory SL service users to access income assistance.*

5.2.5 Disability Supports Program

Public engagement revealed that services and supports for persons with disabilities in the NWT are fragmented and disconnected. Beyond SL services, persons with disabilities may require or access income assistance, housing supports, guardianship, respite, medical equipment and supplies, accessibility equipment, employment support, home care services, housing modifications and others. Public engagement participants with lived experience (i.e., persons with disabilities, family members, caregivers of persons with disabilities) expressed confusion and frustration about the

lack of coordination between various services for persons with disability and how to access the many services and programs.

The jurisdictional scan demonstrated that some other jurisdictions in Canada have a disability program which includes SL services. There are a variety of approaches to how jurisdictions achieve this, including separate government departments operating under an integrated governance structure or in some cases, a single government department with responsibility for social programs which coordinates services for all persons with disabilities. For example, the Disability Support Program in Nova Scotia is a multidisciplinary program operated by the Department of Community Services and acts as the point of entry for a multitude of programs designed to support people with a variety of disabilities. Similarly, the Prince Edward Island Department of Social Development and Housing operates the AccessAbility Supports Program, which offers support plans for Prince Edward Island residents deemed to be in need and/or in vulnerable positions. These services range from income assistance, educational support, rehabilitation services, respite, supported living options, etc.

The GNWT has been piloting an integrated approach to service delivery to reduce barriers for clients who access services across multiple social programs department, including Housing NWT and the Departments of HSS, Justice, and Education, Culture, and Employment. This pilot has revealed numerous policy level barriers for clients with complex needs, as it requires coordination across departments, and dedicated case management support.

Conclusion: *The GNWT lacks a coordinated approach to providing social programs for NWT residents with disabilities, including SL services.*

Recommendation: *Collaborate with other GNWT Departments to determine the best approach to achieving integration of services for NWT residents with disabilities.*

5.2.6 Transitional Services

In addition to the lack of an overarching disability support program in the NWT, there is a lack of an integrated transitional service to support youth with disabilities in their transition to adulthood. Support services for youth and adults with disabilities are housed in various GWNT Departments providing formal and informal supports during the transition period from youth to adulthood, however there is no integrated or standardized approach. Through public engagement, stakeholders voiced the need for a transitional support program from youth to adulthood as this time can be stressful, uncoordinated, and confusing. The jurisdictional scan uncovered that most jurisdictions have a transitional services program within a disability support program supporting service users transitioning from youth to adult and from adult to senior, including transitioning into supported living programs.

Conclusion: *The GNWT lacks an integrated and coordinated approach to providing transitional supports to youth with disabilities transitioning into adulthood.*

Recommendation: *Work with other GNWT Departments to create an integrated transitional support service for NWT youth transitioning to adulthood who require SL services.*

5.3 Access to Supported Living Services and Information

5.3.1 Public Awareness about Supported Living Services

Interviews with stakeholders and public engagement sessions noted that there is a lack of understanding as to what SL services are available and to how to access SL services. Public stakeholders repeatedly indicated that they were unaware of how SL services are structured in the NWT, how to access services, how to access information about SL, and whom to reach out to for answers.

Conclusion: *There is minimal public communication across the HSSAs and regions on Supported Living services, the types of services offered, or how to access services.*

Recommendation: *Develop and implement ongoing communication for the public about SL services and how to access services.*

5.3.2 Supported Living Service Delivery Cycle

Analysis of the jurisdictional scan revealed that current Canadian leading practice for an SL service delivery cycle involves the following key steps led by a single overarching central SL program:

1. ***Referral to the SL Program***
2. ***Determination of Eligibility***
3. ***Assessment***
    - Intake and assessment to identify the service needs and strengths of the individual
4. ***Service Planning***
    - Development of an individual service plan and goal setting with the service user
    - Identification of the service provider(s) to support the service plan
5. ***Case Management and Monitoring***
    - Service plan and goals are monitored re-assessed and adjusted accordingly on a regular and ongoing basis
    - Case management links the service user to other required services as needed

Referral, Eligibility, and Intake

Access to NWT SL services is currently available through five different entry points for the various in-territory and out-of-territory SL settings, with five separate application forms currently in use. Similarly, applications are reviewed, and eligibility determined by six different groups or committees, depending on the setting. The groups or committees are composed of various combinations of contracted service providers and HSS and HSSAs staff, with only one established as a formal committee. Stakeholder feedback indicated that this creates confusion for potential service users and adds to the challenges of communication between SL programs, oversight, and monitoring. The jurisdictional scan demonstrated that Canadian leading practice is to manage applications and intake for publicly funded SL services with a single, streamlined entry point. The current NWT SL entry points, associated application forms, and intake groups for NWT SL settings are summarized in *Table 10 – Current NWT Entry Points, Application Forms and Intake Groups for NWT SL Settings* below.

Table 10: *Current NWT Entry Points, Application Forms and Intake Groups for NWT SL Settings*

Setting/Program	Entry Point	Application Form	Intake Committee/Group
Salvation Army Mental Health supported living programs	NTHSSA Adult Services Workers	*NTHSSA Adult Assessment Application Form*	• Service provider • NTHSSA Adult Services Worker • NTHSSA Community Mental Health nurse
NTHSSA Adult Out of Territory Supportive Living Services Program		*Adult Out-of-Territory Supportive Living Services Program Application Form*	• NTHSSA Territorial Operations, Director Mental Health and Community Wellness • NTHSSA Territorial Operations, Manager Supportive Living • NTHSSA Territorial Operations, Supervisor Supportive Living
Inclusion NWT supported living programs	NTHSSA Adult Services Workers and/or Inclusion NWT	*NTHSSA Adult Assessment Application Form*	• Service provider • NTHSSA Territorial Operations, Manager Supportive Living
Hay River Supported Living Campus	Territorial Admissions Committee	*TAC Long-Term Care/SL Application Form*	• Territorial Admissions Committee (DHSS and HSSA representatives)
Judith Fabian Group Home	K'atl'odeeche First Nation – Judith Fabian Group Home Program Coordinator	*K'atl'odeeche First Nation – Judith Fabian Group Home Application*	• Katl'odeeche First Nation – Judith Fabian Group Home Program Coordinator and NTHSSA – Dehcho, Manager Continuing Care
- Charlotte Vehus Home - Billy Moore Homes	NTHSSA – Beaufort-Delta, Manager Continuing Care	*Beaufort-Delta HSS Application for Service: Adult Group Homes Form*	• Service provider • NTHSSA Beaufort-Delta, Manager Continuing Care • NTHSSA Beaufort-Delta, Medical Social Worker

Assessment and Service Planning

There is no common assessment tool or process to determine the service needs of SL service users. Three of the five in-territory SL service providers use the Continuing Care Assessment Package (CCAP) as part of their assessment process, whereas the remaining two in-territory SL service providers and the out-of-territory SL service program do not. SL service providers who use the CCAP noted that the CCAP is lengthy, is not a validated evidence-based assessment tool, and is not the most appropriate tool to assess SL needs. This assertion has previously been reported in the NWT Home and Community Care Review (2019)[19].

The assessment process described above is not clearly linked to a service planning process, a variety of tools and currently is not consistently led by the HSSAs. It is equally unclear what positions in the HSSAs are responsible for assessment and service planning.

[19] https://www.ntassembly.ca/sites/assembly/files/td_150-192.pdf

Case Management and Monitoring

Through interviews with stakeholders and data collection from current state, it was identified that case management support is available to assist all applicants with the application process to SL services, and the intake and assessment for the NTHSSA Adult Out-of-Territory Supportive Living Services Program. Once an individual is receiving SL services, there is a process to assign a case manager to the SL service user for on-going support. Currently, all out-of-territory service users have a designated case manager, however only 69% of in-territory service users have a designated case manager. It should be noted that the NTHSSA reports that over the last year, work has been underway to assign a designated case manager to all in-territory SL service users.

Across the three HSSAs, various roles and job titles provide case management support for SL service users. Case manager positions do not exist in all regions, and most case manager positions exist primarily in Mental Health/ Community Wellness programs. Position titles for case managers across the HSSAs are:

- Coordinator Foster Care, Adult Services and Adoption in the HRHSSA (1 position)
- Medical Social Worker in the TCSA (1 position)
- Case Manager, Adult Services Workers in the NTHSSA – Territorial Operations (4 positions)

These case management positions have varied job descriptions and are not solely dedicated to case management of SL service users. They also provide support to adults with disabilities not in SL, adults experiencing homelessness, and adults accessing indigent benefits to access a variety of programs and benefits. It appears that there is no dedicated workforce to support all SL service users through the full cycle of service (i.e., intake, determining eligibility, assessment, service planning, service initiation, and monitoring service user needs). In addition, there are no policies or guidelines to direct case managers in their role (i.e., minimal contact and reporting guidelines). While SL is a Continuing Care program, only two Continuing Care Managers provide oversight to SL services (NTHSSA – Dehcho Region and NTHSSA – Beaufort Delta Region). The remaining oversight to SL services is provided through NTHSSA – Territorial Operations, Mental Health and Community Wellness, and within he TCSA is under the Medical Social Worker and in HRHSSA is under Adult Services and Adoption. The involvement in various program areas in the oversight and delivery of SL services increases the potential for fragmented and uncoordinated SL service delivery and oversight.

Case management was noted by stakeholders as a key pillar in ensuring that SL service users receive appropriate support, and is a key support to family/caregivers supporting a person with disability. Family members and caregivers reported that they are primarily focused on providing supports, making it difficult to advocate and explore possible support options.

Conclusions:

The HSSAs do not have a clear entry point/pathway for SL services, and use a variety of tools and processes to make decisions regarding eligibility for SL services. These activities are not clearly linked to service planning and case management activities.

Oversight of SL service contracts and delivery of case management are offered in different program areas which has the potential to lead to confusion for the public and other service providers, and to create fragmented and inconsistent services for SL service users.

There is a lack of consistent SL services case management workforce that can support SL users through the full cycle of service (intake, assessment, service planning, service initiation, monitoring needs).

Recommendations:
Establish and implement a unified application form and assessment tool which evaluates applicants' strengths, resources, supports and service needs.

Ensure consistent accountability and oversight for SL Service delivery across all HSSAs.

Adequately resource the HSSAs to provide assessment, service planning, case management and service user monitoring.

Develop territorial policies and guidelines to direct the delivery of assessment, service planning, case management and service user monitoring.

5.4 Staffing and Human Resources

5.4.1 Staffing Ratios

Staffing ratios of the various SL service providers serving residents from the NWT vary widely depending on the service provider and SL setting. The NTHSSA Adult Out-of-Territory Supportive Living program matches staffing ratios to service users' needs. Certain in-territory SL service providers (Inclusion NWT and Salvation Army) also have a flexible model in which staffing ratios fluctuate according to the needs of the SL service users, although absolute staff numbers remain fixed. This can result in a reduced number of eligible SL places within those settings (in the event of intake of service user(s) with greater needs, requiring greater than anticipated staff time). The other in-territory SL service providers (the Parkland CLASS homes, Hay River Supported Living Campus and Judith Fabian home) have fixed staffing ratios – the number of staff remain constant regardless of the service users' needs. The current state analysis showed that the fixed staffing ratio model has resulted in some service users being overserved, for example, individuals receiving 24/7 support or having access to nursing care who do not require such a high level of service.

Conclusion: *The approach to assigning staff to SL service users in NWT SL programs is inconsistent.*

Recommendation: *Ensure all SL service providers have a flexible staffing ratio model to ensure that service users receive the appropriate amount of support.*

5.4.2 Staff Recruitment and Retention

Service providers and participants at public meetings conveyed challenges with continuity of care due to difficulties in retaining SL staff, and the negative impacts that high rates of staff turnover have on the SL service user. It was noted that this limits the ability to both provide and expand SL services.

From the public survey, two respondents commented on the impacts of high staff turnover in SL services:

> "*Switching staff often makes it difficult for the person with the disability to develop a trusting relationship. The staff could develop a better understanding of the person and therefore provide appropriate supports"*

and,

> *"Constant change of caregivers leads to lack of communication with family, consistency in caregiving and increased anxiety for both parents and users of services."*

All SL service providers commented on the need to be able to pay competitive wages to attract and retain qualified staff, as they feel this is the primary reason staff leave. Although the Hay River Supported Living Campus pays GNWT-level wages, management reports persistent challenges in recruiting qualified staff. It was reported that recruiting qualified staff is challenging because compensation does not balance the high cost of living in the NWT, and even when qualified staff with appropriate education or training are hired, SL service providers reported a trend of skilled employees often moving onto other jobs.

SL service providers noted that one challenge in recruiting qualified staff is the lack of education programs within the NWT to prepare workers to work in SL settings. Although Aurora College provides a certificate program for personal support workers, that program is medically oriented and not specific to supporting the needs of a younger adult population with a range of disabilities, who may require behavioral and mental health supports.

Conclusions: *All SL service providers report difficulties with recruiting and retaining a skilled workforce in SL settings.*

Recommendations:

Establish a training program for SL support staff through an education body such as Aurora College.

Establish a standardized on-boarding training for all SL support staff in the NWT, with additional on-going professional development to ensure skills are up to date and best practices are being shared.

5.5 Supported Living Settings and Service Needs

5.5.1 Need for more In-Territory Supported Living Services

There are limited options of SL in-territory with all programs either fully utilized or having limited capacity to support additional service users. Currently there are SL options in four communities within the NWT (Yellowknife, Inuvik, Katl'odeeche First Nation, and Hay River), and service users

from outside those communities must move to these locations to receive services within the NWT. Data from the examination of the current state of SL in the NWT demonstrates steadily increasing rates of service users accessing SL services out-of-territory, while interviews and public meetings note that people want more SL services within the NWT, and more options to receive SL services in (or as close as possible to) their home community.

5.5.2 Designated Supported Living Settings

Currently, 53% of in-territory SL service users (31/58) live in designated SL settings (infrastructure leased or owned by the HSS system built specifically for the purpose of providing housing and support to multiple persons with disabilities and with continuous 24/7 support). These settings are the Charlotte Vehus Home in Inuvik, the Billy Moore Home in Inuvik, Salvation Army's Group SL Program in Yellowknife, the Hay River Supported Living Campus in Hay River and the Judith Fabian Home on K'atl'odeeche First Nation.

There are currently five NWT SL service users (4%) living in designated SL settings out-of-territory through the SL service provider, *I Have a Chance* in Alberta. This SL service provider has the capacity to provide intensive supports for SL service users with complex behavioural needs.

The jurisdictional scan revealed a national movement away from the use of designated SL settings, with a trend towards providing supported living services in market-type houses and apartments. This trend reflects a desire of persons with disabilities to live in housing options in non-segregated settings, which enables inclusion and full community participation. Designated SL settings are also limited to a rigid staffing ratio model to ensure 24/7 services are available, which can lead to inefficiencies in service provision and the potential for individuals being over-served, for example, if a service user lives in a designated SL setting but does not require 24/7 support. Some jurisdictions, such as Nova Scotia, are in the process of phasing out designated SL settings. Existing service users are supported to continue living in remaining designated SL settings if they wish to do so, but no new service users are admitted into designated SL settings.

Given the high proportion of in-territory service users currently living in designated SL settings, it would likely be challenging and impractical to phase out designated SL settings in the NWT in the immediate future. Significant capacity-building of alternate accessible housing options would be required, so that SL services could be offered in market-type housing without increasing out-of-territory SL usage.

5.5.3 Service Provider-Managed Homes

Currently 16% of in-territory SL service users (9/58) live in service provider-managed homes (houses or apartments rented or owned by the service provider). Inclusion NWT's SL Program in Yellowknife is the only service provider in the territory offering SL in service provider-managed homes. Service provider-managed homes usually offer a shared living arrangement with one or two other service users. Most out-of-territory SL users (60%) live in shared living service provider-managed homes, with either continuous 24/7 supports or day supports based on the needs of the SL service user. This model is widely used in other jurisdictions, as it provides inclusive community living for SL service users who require housing, with flexible options for support determined by

service user need (from a few hours a week to 24/7 continuous support). The NWT does not currently regulate SL living settings for safety or state of repair.

5.5.4 Self Managed Homes with Flexible Supports

The remaining 31% of in-territory SL service users (18/58) live in their own homes (apartment or home owned or rented by the service user or their family) and receive a flexible amount of day support based on their needs. Flexible supports are currently only available in Yellowknife and are provided by Inclusion NWT's Supported Independent Living Program and Salvation Army's Independent Living Services Program.

According to feedback from the public survey and public engagement sessions, many persons with disabilities and their families and caregivers are keen to stay in their own homes for as long as possible and receive SL services in their current home setting. There was a lack of awareness that flexible supports for people living with caregivers is an existing SL service currently available in Yellowknife (although the programs providing this type of support are currently at their maximum actual capacity).

This service delivery model is also popular in other jurisdictions in Canada, as it enables service users to remain in their own homes and communities with their existing supports for as long as possible. This type of service is cost effective, as service amounts are tailored to the needs of service users, and the provision of housing is not required. It also supports the inclusion of persons with disabilities in the community.

5.5.5 Alternate/Host Family Supported Living

The remaining 36% of out-of-territory SL service users (45/124) live with an alternate or host family (in Alberta or BC). In this type of SL setting, a SL service provider contracts families (who can be individuals, couples, or families with children) in the community to provide accommodations and support to an SL service user in their home. Families are carefully screened prior to selection and provide the SL service user with inclusive family and community activities and experiences.

Although not currently available within the NWT, the jurisdictional scan revealed this model to be prevalent elsewhere in Canada. An Alternate/Host Family stream of SL services in the NWT could have the potential to greatly expand SL services into small communities, particularly in cases where youth with disabilities living successfully with foster families are transitioning into adulthood, and both the family and the individual wish to continue the living arrangement.

5.5.6 Services for Persons with Complex Behaviours

Although nearly all in-territory SL service providers support people with cognitive disabilities, all in-territory SL service providers have exclusion criteria to limit the admission of applicants with high risk, complex and aggressive behaviors. As a result, SL service users with complex behavioural needs are currently ineligible for SL services in-territory. Out-of-territory service providers fill this gap by providing support options to service users with complex and challenging behaviours.

5.5.7 Supported Living Services for Persons with a Physical Disability Only

There are currently very few supported living services available to individuals with a physical disability only (i.e., without a concurrent cognitive disability) in the NWT. Currently, only two in-territory service providers provide SL to people with only physical disabilities (i.e., Judith Fabian Home on K'atl'odeeche First Nation and the Parkland CLASS homes in Inuvik). There are currently two individuals with only a physical disability receiving SL under any NWT SL program. Furthermore, persons with a physical disability only are not eligible for the NTHSSA Adult Out-of-Territory Supportive Living Services program, regardless of how intensive their needs are.

Stakeholder engagement revealed that many individuals with SL service needs due to physical disability are currently supported through other continuing care services (home care or long-term care) regardless of their age. In many small communities, there are no SL services, so personal support and home support may be provided through Home Care. Non-elderly individuals with physical disabilities may be admitted to LTC if they require high levels of ADL supports throughout the day and/or have nursing care needs and require monitoring of a health condition.

The jurisdictional scan revealed that it is not standard Canadian best practice to support persons with intensive physical support needs in settings designed for the elderly population and those with dementia, but instead to integrate the necessary support services into the community to meet service users' needs in fully accessible housing. However, stakeholders identified that accessible housing for persons with disabilities is challenging to find or does not exist in the NWT, creating barriers for persons with physical disabilities to remain living in their community.

5.5.8 Additional Support Services

Home Care

The Home and Community Care Review (2019) identified that many Home Care clients with chronic continuous health conditions have functional and cognitive disabilities that require support to remain living in their communities. Further to this, the Disability Review and Renewal Project reported that the growth in the number of older adults in the NWT is expected to be the largest driver of increasing disability rates in the NWT. Analysis of Home Care data revealed that there are currently 551 home care clients in the NWT with a "chronic continuous condition, a chronic mental health condition, or a disability".

Stakeholder engagement indicates that Home Care services are likely filling some of the gaps in services for persons with disabilities. It is unknown whether this population's support needs are adequately being met under existing Home Care services, or whether Home Care is adequately resourced to support this population. It is also unknown whether this population's needs would be more appropriately served with additional SL services (examining the use and capacity of Home Care to meet the needs of persons with disabilities was out of scope of the current review).

Paid Family/Community Caregiver Pilot Project

The Paid Family/Community Caregiver Pilot Project, offered since 2020, has demonstrated some success in providing a small amount of supplementary support services (up to 4 hours per week) to

seniors and persons with disabilities in pilot communities (Behchokǫ̀, Dettah, N'Dilo, Yellowknife, Hay River, and Tuktoyaktuk). Additionally, the TCSA has a self-managed caregiver program, in which funding is provided to persons with disabilities and/or their caregiver of choice to facilitate the provision of caregiving. Public engagement with families of persons with disabilities revealed that many families want to continue caring for their loved one at home, however, they are struggling to do so with the lack of current SL services available in-service users' homes.

Conclusions:

There are inadequate in-territory SL services to meet the needs of all persons with disabilities who require SL services.

The majority of current in-territory SL services are accommodation-based (designated SL settings or service provider-managed homes).

Designated SL settings can overserve some individuals due to the required staffing level to operate the setting safely, and it is not clear if all current SL service users require this intensity of service.

Developing new designated SL settings would not align with Canadian leading supported living practice.

Models of providing accommodation-based services showing promise in meeting the needs of adults with disabilities from the NWT are SL Service provider–managed homes and Alternate/Host Family.

Other Continuing Care program areas such as Home Care and Long-Term Care are supporting the unmet service needs of adults with disabilities in the NWT.

Growth in out-of-territory supported living services is being driven by lack of SL service options and service capacity for persons with complex behavioural needs.

Recommendations:

Expand in-territory SL services to include more communities and more service options so that more persons with disabilities can receive services SL services within the NWT.

When out-of-territory SL services are needed, ensure access is available to persons with all types of disabilities.

Ensure that all future admissions to designated SL settings require the level of support and services provided by the settings.

Work with Housing NWT to determine where there is need for accessible housing options in communities to enable persons with disabilities to remain living in their community.

Do not plan to expand or build new designated SL settings in the NWT and consider phasing out designated SL settings once significant additional accessible housing options and SL service capacity has been developed within the territory, and as existing infrastructure ages.

Develop enhanced behaviour supports in-territory by building capacity in the NWT to support service users with high risk, complex and aggressive behaviours.

Clearly define SL service scope to better serve the full range of needs for persons with disabilities of all age groups who require SL services.

5.6 Supported Living Program Elements and Associated Supports

In addition to providing supports for activities of daily living, instrumental activities of daily living and community inclusion, additional elements were identified during the review process as being important elements of SL programs or important associated supports.

5.6.1 Vocational Support

Vocational supports provide SL service users with assistance in pursuing and maintaining meaningful, productive paid or volunteer employment. The rate of in-territory SL service users receiving vocational support is 33% compared to 3% in out-territory service users, with an additional 1% of out-of-territory service users currently seeking employment.

Vocational support services are currently offered in Yellowknife by Inclusion NWT and in Hay River by the Hay River Committee for Persons with Disabilities, with funding support from other GNWT departments and agencies. Family members and caregivers of persons with disabilities participating in public engagement reported that progressive vocational support is an important associated support element, but that existing resources do not always meet the needs of persons with disabilities. Currently the Department of Education, Culture and Employment (ECE) provides labour market programs and services for individuals, employers, organizations, and communities, including persons with disabilities.

Conclusion: *Vocational support is an important associated support element that is under utilized by SL service users and existing resources do not always meet the needs of persons with disabilities.*

Recommendation: *Work with the Department of ECE to review options to strengthen vocational supports available and accessible by in-territory SL service users, including availability in communities outside of Yellowknife and Hay River.*

5.6.2 Cultural Services

Currently, 86% of all NWT SL service users are Indigenous (First Nation, Métis, or Inuit), with minimal differences between in-territory and out-of-territory service users (89% of out-of-territory service users are Indigenous, compared to 81% of in-territory service users). As the majority of SL service users are Indigenous, inclusion of appropriate Indigenous cultural activities is an important

aspect of SL services. It was reported by service providers that 71% of service SL users in-territory and 97% of out-of-territory service users are accessing cultural activities. In terms of staff training in cultural awareness, there is not a standard approach between SL service providers in-territory and out-of-territory.

Conclusions: *The majority of SL service users are Indigenous both in-territory and out-of-territory, and the majority of SL Service users are accessing cultural activities.*

Recommendations:
Ensure that all service users have options to participate in activities that relate to their culture, and that these are integrated into support plans.

Ensure that SL service providers, including contracted service providers, complete the GNWT cultural awareness training as part of their on-boarding mandatory staff training.

5.6.3 Respite Services

The majority (61%) of respondents from the public survey not currently receiving SL services reported that their support needs are currently being met by parents. Many public engagement participants (including public meeting attendees, persons with disabilities and family members/caregivers interviewed, and public survey respondents) reported that for persons with disabilities currently living with parents or caregivers, the preferred support setting is to remain in their home. However, they raised the following concerns regarding the caregiving role:

- Stressful, time consuming, challenging
- Unable to meet the needs of other family members due to caregiving
- Exhausted, fatigued or burning out
- Need more support in the home
- Supporting their loved one becoming more difficult over time as caregivers are aging

A frequent suggestion emerging from public engagement to enable individuals to stay in their home settings longer was to make more respite options available to family members and caregivers, with the goal of decreasing caregiver stress and burnout. Most jurisdictions include respite services within their SL programming.

There are currently limited respite options available to families and caregivers in the NWT. A day respite option is available for adults with disabilities is offered in Yellowknife by Inclusion NWT. Overnight respite for families requiring respite care for multiple days or weeks currently requires the service user to leave their own home to receive services, which are available in Hay River (at the Hay River Supported Living Campus, which maintains a room specifically for this purpose). The Parkland CLASS homes in Inuvik (Billy Moore Home and Charlotte Vehus Home) also offer overnight respite when there are SL vacancies in those settings; however there have been no vacancies at either setting in the past five years. Additionally, some caregivers in small communities are receiving respite services through Home Care, however the user rates of this service are unknown.

Conclusion: *In order to support persons with disabilities to live at home with their caregiver, additional supports to caregivers such as respite services can lessen caregiver burnout. Currently, there is limited access to respite services for caregivers of adults with disabilities with the NWT.*

Recommendation: *Increase caregiver supports including expansion of respite services to communities outside of Yellowknife, and overnight respite options.*

5.6.4 Family/Community Reunification Visits

The NTHSSA Adult Out-of-Territory Supportive Living Services Program covers the costs for out-of-territory SL service users to make one visit to their home community in the NWT once a year, or for a family member to visit the service user out-of-territory. This element of the program promotes service user connection with their family, home community and culture. It was discovered during the examination of the current state of SL services that this service is not funded for in-territory SL service users accessing SL services outside their home community. This creates an inequity between in-territory and out-of-territory SL service users.

Conclusion: *The out-of-territory SL program funds an annual family/community reunification visit, whereas the in-territory SL program does not, creating an inequity between programs.*

Recommendation: *Develop policies for family/community reunification visits to ensure equity of access for SL service users living outside of their home community.*

5.7 Forecasting of Future Supported Living Services Need

5.7.1 Forecasting of Future Service Users

From 2016-17 to 2021-22 the total number of NWT service users receiving SL (in-territory and out-of-territory) has increased from 164 to 182. This represents a total of 18 new service users over the past five years, or an increase of approximately 11% in that time period. This equates to an average increase of 2.2% per year.

Using this rate of change, the following ***Table 11:*** *SL Service User Projections 2022-27* outlines the projections estimate the total number of service users for the next five years:

Table 11: SL Service User Projections 2022-27

Year	SL Service User Projection (2.2% increase per year)
2022-23	186
2023-24	190
2024-25	194
2025-26	198
2026-27	202

It should be noted that several factors may further increase the projection of future SL service users, including:

- The possibility that Home Care clients currently receiving on-going home care services for their disability and/or chronic condition that may require or be more appropriately supported by SL services (there are currently 153 home care clients under the age of 65 with a chronic continuous condition, a chronic mental health condition, or a disability in the NWT, whose needs might be better supported by SL services).
- The capacity of aging family caregivers to support persons with disabilities to remain in their home, which was a concern brought forward through the public survey and public engagement sessions.
- The inclusion of persons with disabilities who are not currently accessing or eligible for SL services but would benefit from SL services.

Note: Beyond qualitative reports through stakeholder engagement, there is no data on the number of adults with disabilities who are currently supported by family caregivers that potentially require SL services.

5.7.2 Forecasting Future SL Services Costing

A flexible costing tool was developed by Crowe Mackay LLP Accounting Services through the Department's contract with Logical Outcomes to assist in projecting costs of the renewed SL model. The costing tool allows for adjustments in varied projections of service users in each region, number of SL service users that may be repatriated back to the NWT, accommodation expenses, and staffing expenses between GNWT employees and non-government organizations.

As there are many recommendations in this report that impact on the overall delivery of SL services, including the new model of service, costing will need to be considered as work progresses to implement SL service elements.

5.7.3 Repatriation

Public engagement and stakeholder interviews established a general value of wanting to provide SL services to people in-territory, and a desire to repatriate people who are currently receiving SL services out-of-territory. However, interviews with service users currently accessing SL services outside the NWT revealed that while many people do want to return to the NWT, while many others do not.

Approximately half of out-of-territory service users interviewed stated they would like to return to the NWT, while the remainder would prefer to stay in their out-of-territory setting. Reasons for wishing to remain in an out-of-territory SL setting included that their family is too unhealthy, their community is too unhealthy, the new community is larger with more things to do, or they have settled into their situation and do not want the disruption of a move.

Significant in-territory SL capacity development is required prior to repatriating out-of-territory service users. Current in-territory SL settings are either at or near full capacity, and current actual vacancies exist only in designated SL settings. Almost all out-of-territory service users (96%) are currently living in integrated community settings (regular house or apartment settings) with the remaining 4% in designated supported living settings, and it is unknown if those who have

expressed a desire to return to the NWT would still wish to do so if the only option was to move into a designated SL setting (which are prevalent in the NWT).

Recommendation: *Establish a process and to plan for the phased repatriation of out-of-territory SL service users, based on their desire to return to the NWT and the ability of in-territory SL services to meet service users' needs.*

5.7.4 Priority Elements for a Future Supported Living Model

Priority elements for a future SL were identified through the priority sort session involving both persons with lived experience from the Advisory Group, and health system senior leadership from the Steering Committee. The results from the session indicate that the following elements are most important in creating a new model for SL service delivery in the NWT:

- Ensure the new model is a non-medical model
- Provide supported living services in people's own homes
- Develop more supported living placements in the NWT
- Serve the full range of disabilities
- Services are matched to service users' needs
- Provide case management services
- Develop supported living services in smaller communities
- Develop specific standards for supported living and enforce the standards

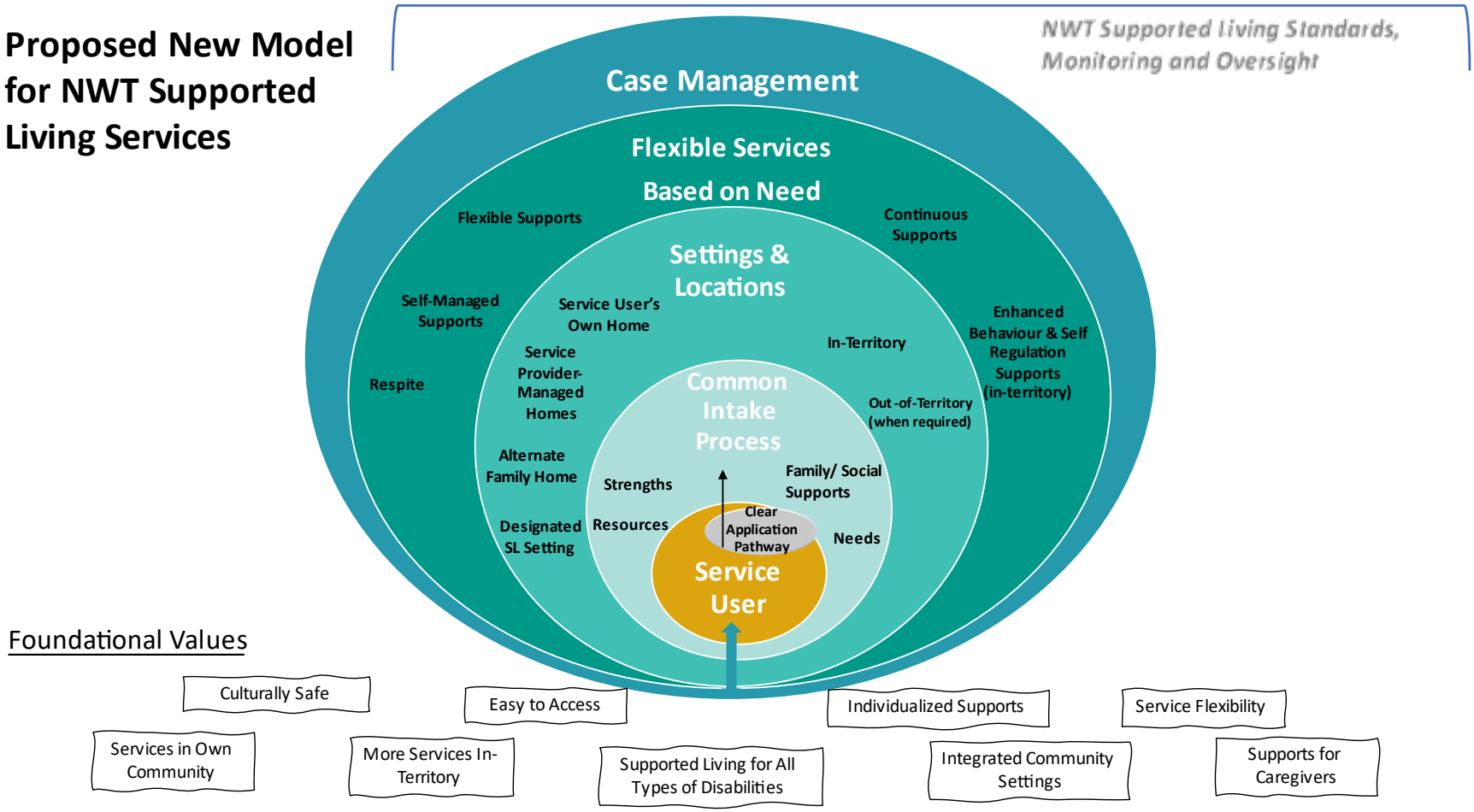
Other elements, such as communication of services, development of a common assessment tool, and linkages between youth services and Supported Living, were also considered to be important elements by priority sort session participants.

5.8 Proposed New Model for NWT Supported Living Services

From synthesis of the analysis of the current state of SL services; input from public engagement (public survey, stakeholder interviews, and public meetings); information from the jurisdictional scan; and feedback from meetings with the NWT Supported Living Steering Committee and Advisory Groups (including the priority sort session), a proposed new model for NWT Supported Living Services was developed (*Figure 22 – Proposed New Model for NWT Supported Living Services*). A summary and description of the elements in the new proposed model is presented below.

Recommendation: *Adopt the proposed new person and family-centred, culturally safe, and inclusive model for delivering Supported Living services in the NWT.*

Figure 22: *Proposed New Model for NWT Supported Living Services*



5.8.1 Foundational Values

Drawing from feedback received during public engagement and the Priority Sort session, nine foundational values were identified to form the base of the new NWT SL model. In no particular order, it was determined that the new SL model should:

- Be easy to access
- Provide flexible services
- Provide individualized supports
- Be culturally safe
- Provide services in service users' own communities
- Provide more services in-territory
- Provide support for persons with all types of disabilities
- Have SL settings integrated into the community
- Provide more supports for caregivers

5.8.2 Service User and a Clear Application Pathway

In the proposed new model, the service user is placed at the centre of the model, with a clear, uncomplicated pathway to accessing SL services. Access under the new model is proposed through a single, standardized application form, widely available both online and in paper format in common government and health and social services locations. The application form could be completed by a variety of sources (including independently by the applicant and/or their family). Applicants could receive support with the application process by regional HSSA Supported Living staff if needed. The HSSA Supported Living staff could further assist in educating the proposed service user and family and/or caregivers on the SL services available.

5.8.3 Common Intake Process

The first circle around the service user indicates that all applications for SL will be received through a common intake process and assessed for strengths and service needs. An inventory of the applicant's current social/family supports and resources will also be explored. SL staff within the HSSAs will use the common assessment tool to determine eligibility for SL services and service needs. This will ensure that all applicants' service needs are equitably assessed and will facilitate matching appropriate SL services to individual service users. Consideration will be given to utilize previous recent assessments where possible to lessen the burden and barriers of repeat assessments on the service user. In addition, the data from the common assessment form and tools will be compiled in a unified tacking database to oversee the SL delivery, including the demand and utilization of SL services, to inform matching available SL services to users and for future planning.

5.8.4 Supported Living Settings and Locations

The second circle around the service user describes the possible supported living settings and locations proposed under the new model. These are:

- **Service User's Own Home –** The service user lives in a house or apartment owned or rented by the service user or their family.
- **Service Provider-Managed Homes -** An apartment or house owned or rented by a SL service provider. Service users usually share the setting with 1-2 other service users.
- **Alternate Family Home -** Families, couples, or individuals living in the community are contracted by a service provider after careful screening, to provide a family living environment to the service user.
- **Designated Supported Living Settings -** A type of infrastructure built specifically for the purpose of providing housing and support to multiple persons with disabilities. This type of setting includes private bedrooms and shared living spaces with on-site 24/7 support.

These settings can be accessed two locations:

- **In-territory;** and
- **Out-of-territory** – *When needs of the person cannot be met in-territory, they will continue to have access to the NTHSSA's Adult Out-of-Territory Supportive Living Services program*.

5.8.5 Flexible Services Based on Need

The third circle outlines the various types of SL services that can be provided to a service user and their family/caregivers, based on their individual needs. The proposed new model has a range of flexible supports and will enable service users to move across the continuum of service options depending on changing needs. These services are:

- **Flexible Supports -** A flexible range of SL supports based on service user needs and not involving overnight support. This can be provided to a service user living in their own home (with or without family/caregivers), or in a service provider-managed home.
- **Continuous Supports -** 24/7 SL support including overnight support, provided by a service provider in a service user's own home, a service provider-managed home or a designated SL setting.
- **Self-Managed Supports –** A program under which funding is provided to a service user to fund caregiving and supports.
- **Enhanced In-Territory Behaviour Supports –** Enhanced in-territory SL services to support service users with higher risk, complex and aggressive behaviours, including (but not limited to) enhanced staff training in behaviour and self regulation techniques, and service user access to behavioural support specialists.
- **Respite –** A service to provide planned relief for caregivers supporting a person with a disability living in their home.
    - ***Day Respite*** - May occur on a regular or as-needed basis, in a service user's home or in community settings, and may occur on weekdays, evenings or weekends.
    - ***Overnight Respite*** – Is provided overnight for up to several weeks. Overnight respite services can be requested on an occasional basis and are usually provided in a designated SL setting. Options to provide overnight respite in service users' own homes will be explored.

5.8.6 Case Management

The largest circle represents wraparound case management care for the service user and their family. Case management support will be provided by HSS to all SL service users throughout the full cycle of supported living services (application, intake, assessment, service planning, and ongoing reassessments and monitoring of service needs). This wraparound case management will assist service users with system navigation and provide advocacy and support in accessing additional disability supports as needed. This case management service will be in addition to any service provider case management, which will provide a safety mechanism to for the service user to share freely any concerns related to their service provider. Having a designated, reliable, and constant key contact for the service user and their family and caregivers is a critical element in the new proposed SL model.

5.8.7 NWT Supported Living Standards, Monitoring, and Oversight

The final component of the model overarching all service components are new NWT Supported Living Standards, monitoring, and oversight. Standards specific to SL will be developed and monitored on a regular basis to ensure high quality, safe, and equitable service for all service users.

Appendices

Appendix A: Reviewed Documents

- Government of Northwest Territories Equity, Accessibility, Inclusion and Participation NWT Disability Strategic Framework: 2017 – 2027
- Government of Northwest Territories Disability Matters. A companion to the NWT Disability Strategic Framework: 2017–2027
- Government of Northwest Territories GNWT Programs and Services for Persons with Disabilities Inventory, 2nd Edition (June 2020)
- Government of Northwest Territories Continuing Care Facilities Legislation for the Northwest Territories Discussion Paper (March 2019)
- Government of Northwest Territories Disability Action Plan 2018/19–2021/22
- Government of Northwest Territories NWT Disability Program Review and Renewal Project Public Engagement Questionnaire
- Northwest Territories Health and Social Services Northwest Territories Continuing Care Standards (February 2015)
- Northwest Territories Health and Social Services NWT Caregivers Guide (March 2015)
- Northwest Territories Health and Social Services Continuing Care Assessment and Placement
- NWT Disabilities Council NWT Disability Services Project 2015 Final Report
- Truth and Reconciliation Commission Mandate
- United Nations Convention of the Rights of Persons with Disabilities (2006)
- United Nations Declaration on the Rights of Indigenous Peoples (2007)

Appendix B: Public Survey Questions

Supported Living Survey

The Government of the Northwest Territories Department of Health and Social Services (DHSS) has engaged LogicalOutcomes to conduct a review of the Supported Living Program. Supported living services provide many services that can include housing, caregiving, social, recreational, educational, employment opportunities and life skills for persons living with challenging disabilities. Your input will help us learn more about the current system and plan for improvements to that system.

No one besides the review team will know what your answers are. It will only be used for this review.

Your participation in this survey is voluntary and you may say no at any time.

By completing this survey and submitting it, you are giving LogicalOutcomes permission to use it in their review of the NWT Supported Living program.

Completed paper copies can be emailed or mailed back to:

Martha McGuire, Lead Contractor, Logical Outcomes
martha@logicaloutcomes.net
1-647-201-9680 | www.logicaloutcomes.net
Logical Outcomes c/o Centre for Social Innovation
720 Bathurst Street, Toronto Canada M5S 2R4

I am a:

☐ Person with disability in Supported Living **(Go to page 2)**

☐ Family or caregiver of a person with disability in Supported Living **(Go to page 5)**

☐ Person with disability not in supported living **(Go to page 8)**

☐ Family or caregiver of a person with disability not in supported living **(Go to page 11)**

Person with a Disability in Supported Living

1. What kind of difficulties do you have with your disability? (Check all that apply):

   ☐ Difficulty with mobility (walking, moving/ getting around, using your arms and legs)
   ☐ Difficulty communicating (talking, expressing)
   ☐ Difficulty hearing
   ☐ Difficulty seeing
   ☐ Difficulty understanding
   ☐ Difficulty getting along (interacting with others)
   ☐ Difficulty with self-care (bathing, dressing, eating, staying alone safely)
   ☐ Difficulty taking part in activities (leisure, hobbies, work, school)
   ☐ Difficulty thinking
   ☐ Other – with space to enter a response

2. Do you have a health condition or a diagnosis that causes your disability? (Check all that apply or skip if none apply):

   ☐ Addictions
   ☐ Autoimmune (e.g. Lupus, Rheumatoid arthritis)
   ☐ Cardiovascular (e.g. Heart, Stroke, Hypertension)
   ☐ Dental
   ☐ Endocrine and metabolic (e.g. Diabetes, thyroid, adrenal)
   ☐ Gastrointestinal (e.g. Ulcers, Celiac, Crohn's)
   ☐ Hearing
   ☐ Mental health
   ☐ Musculoskeletal (e.g. Muscles, joints and bones)
   ☐ Autism Spectrum Disorder
   ☐ Developmental (e.g. Down's, Intellectual disability, Cerebral Palsy)
   ☐ FASD
   ☐ Neurological – Other (e.g. head injury, aneurism)
   ☐ Respiratory (e.g. Asthma, Cystic fibrosis)
   ☐ Visual
   ☐ Other – with space to enter a response
   ☐ None

1. What types of help do you need?
   ☐ Preparing meals
   ☐ Managing money
   ☐ Shopping
   ☐ Performing housework
   ☐ Using the telephone
   ☐ Eating
   ☐ Bathing
   ☐ Getting dressed
   ☐ Walking or getting around

- ☐ Toileting
- ☐ Medication
- ☐ Social and recreation activities
- ☐ Equipment
- ☐ Other – with space to enter a response

2. What types of supports are you currently getting?
   - ☐ Preparing meals
   - ☐ Managing money
   - ☐ Shopping
   - ☐ Performing housework
   - ☐ Using the telephone
   - ☐ Eating
   - ☐ Bathing
   - ☐ Getting dressed
   - ☐ Walking or getting around
   - ☐ Toileting
   - ☐ Medication
   - ☐ Social and recreation activities
   - ☐ Equipment
   - ☐ Other – with space to enter a response

3. How satisfied are you with the Supported living Services you receive?
   - ☐ Very satisfied 
   - ☐ Satisfied 
   - ☐ Neither satisfied nor unsatisfied 
   - ☐ Unsatisfied 
   - ☐ Very unsatisfied 

   Why?

4. What do you like best about the service? (check all that apply)
   - ☐ The people who provide the service
   - ☐ Living with my friends
   - ☐ The help I get
   - ☐ Other – please say

5. What would like to see changed? (check all that apply)
   - ☐ To be able to live in my community
   - ☐ To be able to live with my family
   - ☐ For people to be nicer to me

- ☐ For me to get all of the services I need
- ☐ Other – please say

6. Any other comments?

Family or caregiver of a person with disability in Supported Living

1. What kind of difficulties does the person with the disability have? (Check all that apply):

   - ☐ Difficulty with mobility (walking, moving/ getting around, using your arms and legs)
   - ☐ Difficulty communicating (talking, expressing)
   - ☐ Difficulty hearing
   - ☐ Difficulty seeing
   - ☐ Difficulty understanding
   - ☐ Difficulty getting along (interacting with others)
   - ☐ Difficulty with self-care (bathing, dressing, eating, staying alone safely)
   - ☐ Difficulty taking part in activities (leisure, hobbies, work, school)
   - ☐ Difficulty thinking
   - ☐ Other – with space to enter a response

2. Does the person with the disability have a health condition or a diagnosis that causes their disability? (Check all that apply or skip if none apply):

   - ☐ Addictions
   - ☐ Autoimmune (e.g. Lupus, Rheumatoid arthritis)
   - ☐ Cardiovascular (e.g. Heart, Stroke, Hypertension)
   - ☐ Dental
   - ☐ Endocrine and metabolic (e.g. Diabetes, thyroid, adrenal)
   - ☐ Gastrointestinal (e.g. Ulcers, Celiac, Crohn's)
   - ☐ Hearing
   - ☐ Mental health
   - ☐ Musculoskeletal (e.g. Muscles, joints and bones)
   - ☐ Autism Spectrum Disorder
   - ☐ Developmental (e.g. Down's, Intellectual disability, Cerebral Palsy)
   - ☐ FASD
   - ☐ Neurological – Other (e.g. head injury, aneurism)
   - ☐ Respiratory (e.g. Asthma, Cystic fibrosis)
   - ☐ Visual
   - ☐ Other – with space to enter a response
   - ☐ Neurological – Other
   - ☐ Respiratory (i.e. Asthma, Cystic fibrosis)
   - ☐ Visual
   - ☐ Other – with space to enter a response
   - ☐ None

7. What types of help do they need?
   - ☐ Preparing meals
   - ☐ Managing money
   - ☐ Shopping
   - ☐ Performing housework
   - ☐ Using the telephone
   - ☐ Eating
   - ☐ Bathing
   - ☐ Getting dressed
   - ☐ Walking or getting around
   - ☐ Toileting
   - ☐ Medication
   - ☐ Social and recreation activities
   - ☐ Equipment
   - ☐ Other – Please say

8. What types of supports are they currently getting?
   - ☐ Preparing meals
   - ☐ Managing money
   - ☐ Shopping
   - ☐ Performing housework
   - ☐ Using the telephone
   - ☐ Eating
   - ☐ Bathing
   - ☐ Getting dressed
   - ☐ Walking or getting around
   - ☐ Toileting
   - ☐ Medication
   - ☐ Social and recreation activities
   - ☐ Equipment
   - ☐ Other – Please say

9. How satisfied are you with the Supported living Services they receive?
   - ☐ Very satisfied 
   - ☐ Satisfied 
   - ☐ Neither satisfied nor unsatisfied 
   - ☐ Unsatisfied 
   - ☐ Very unsatisfied 

   Why?

10. What do you like best about the services they get? (check all that apply)
    - ☐ The people who provide the service
    - ☐ Being able to live with friends
    - ☐ The help that is provided
    - ☐ Other – please say

11. What would like to see changed? (check all that apply)
    - ☐ To be able to live in their own community
    - ☐ To be able to live with their own family
    - ☐ For the caregivers to be friendlier
    - ☐ For them to get all of the services they need
    - ☐ Other – please say

12. Any other comments?

Person with disability not in supported living

1. What kind of difficulties do you have with your disability? (Check all that apply):

    - ☐ Difficulty with mobility (walking, moving/ getting around, using your arms and legs)
    - ☐ Difficulty communicating (talking, expressing)
    - ☐ Difficulty hearing
    - ☐ Difficulty seeing
    - ☐ Difficulty understanding
    - ☐ Difficulty getting along (interacting with others)
    - ☐ Difficulty with self-care (bathing, dressing, eating, staying alone safely)
    - ☐ Difficulty taking part in activities (leisure, hobbies, work, school)
    - ☐ Difficulty thinking
    - ☐ Other – with space to enter a response

2. Do you have a health condition or a diagnosis that causes your disability? (Check all that apply or skip if none apply):

    - ☐ Addictions
    - ☐ Autoimmune (e.g. Lupus, Rheumatoid arthritis)
    - ☐ Cardiovascular (e.g. Heart, Stroke, Hypertension)
    - ☐ Dental
    - ☐ Endocrine and metabolic (e.g. Diabetes, thyroid, adrenal)
    - ☐ Gastrointestinal (e.g. Ulcers, Celiac, Crohn's)
    - ☐ Hearing
    - ☐ Mental health
    - ☐ Musculoskeletal (e.g. Muscles, joints and bones)
    - ☐ Autism Spectrum Disorder
    - ☐ Developmental (e.g. Down's, Intellectual disability, Cerebral Palsy)
    - ☐ FASD

- ☐ Neurological – Other (e.g. head injury, aneurism)
- ☐ Respiratory (e.g. Asthma, Cystic fibrosis)
- ☐ Visual
- ☐ Other – with space to enter a response
- ☐ None

13. What types of help do you need?
    - ☐ Preparing meals
    - ☐ Managing money
    - ☐ Shopping
    - ☐ Performing housework
    - ☐ Using the telephone
    - ☐ Eating
    - ☐ Bathing
    - ☐ Getting dressed
    - ☐ Walking or getting around
    - ☐ Toileting
    - ☐ Medication
    - ☐ Social and recreation activities
    - ☐ Equipment
    - ☐ Other – with space to enter a response

14. What types of supports are you currently getting?
    - ☐ Preparing meals
    - ☐ Managing money
    - ☐ Shopping
    - ☐ Performing housework
    - ☐ Using the telephone
    - ☐ Eating
    - ☐ Bathing
    - ☐ Getting dressed
    - ☐ Walking or getting around
    - ☐ Toileting
    - ☐ Medication
    - ☐ Social and recreation activities
    - ☐ Equipment
    - ☐ Other – with space to enter a response
    - ☐

15. Who provides those services to you?
    - ☐ Mother or father
    - ☐ Brother or sister
    - ☐ Other relatives
    - ☐ Friends and neighbours
    - ☐ Other – please say

16. How well is that working out?

- ☐ Very well 
- ☐ Well 
- ☐ Okay 
- ☐ Poorly 
- ☐ Very poorly 

Why?

17. How would you like to receive services? (check all that apply)
    - ☐ In my own home
    - ☐ In a group setting in my own community
    - ☐ In a group setting outside of my own community
    - ☐ Other – please say

18. Any other comments?

Family or caregiver of a person with disability not in supported living

1. What kind of difficulties does the person with the disability have? (Check all that apply):

    - ☐ Difficulty with mobility (walking, moving/ getting around, using your arms and legs)
    - ☐ Difficulty communicating (talking, expressing)
    - ☐ Difficulty hearing
    - ☐ Difficulty seeing
    - ☐ Difficulty understanding
    - ☐ Difficulty getting along (interacting with others)
    - ☐ Difficulty with self-care (bathing, dressing, eating, staying alone safely)
    - ☐ Difficulty taking part in activities (leisure, hobbies, work, school)
    - ☐ Difficulty thinking
    - ☐ Other – with space to enter a response

2. Does the person with the disability have a health condition or a diagnosis that causes their disability? (Check all that apply or skip if none apply):

    - ☐ Addictions
    - ☐ Autoimmune (e.g. Lupus, Rheumatoid arthritis)
    - ☐ Cardiovascular (e.g. Heart, Stroke, Hypertension)

- ☐ Dental
- ☐ Endocrine and metabolic (e.g. Diabetes, thyroid, adrenal)
- ☐ Gastrointestinal (e.g. Ulcers, Celiac, Crohn's)
- ☐ Hearing
- ☐ Mental health
- ☐ Musculoskeletal (e.g. Muscles, joints and bones)
- ☐ Autism Spectrum Disorder
- ☐ Developmental (e.g. Down's, Intellectual disability, Cerebral Palsy)
- ☐ FASD
- ☐ Neurological – Other (e.g. head injury, aneurism)
- ☐ Respiratory (e.g. Asthma, Cystic fibrosis)
- ☐ Visual
- ☐ Other – with space to enter a response
- ☐ Neurological – Other
- ☐ Respiratory (i.e. Asthma, Cystic fibrosis)
- ☐ Visual
- ☐ Other – with space to enter a response
- ☐ None

19. What types of help do they need?
    - ☐ Preparing meals
    - ☐ Managing money
    - ☐ Shopping
    - ☐ Performing housework
    - ☐ Using the telephone
    - ☐ Eating
    - ☐ Bathing
    - ☐ Getting dressed
    - ☐ Walking or getting around
    - ☐ Toileting
    - ☐ Medication
    - ☐ Social and recreation activities
    - ☐ Equipment
    - ☐ Other – Please say

20. What types of supports are they currently getting?
    - ☐ Preparing meals
    - ☐ Managing money
    - ☐ Shopping
    - ☐ Performing housework
    - ☐ Using the telephone
    - ☐ Eating
    - ☐ Bathing
    - ☐ Getting dressed

- ☐ Walking or getting around
- ☐ Toileting
- ☐ Medication
- ☐ Social and recreation activities
- ☐ Equipment
- ☐ Other – Please say
- ☐

21. Who provides those services to them?
    - ☐ Mother or father
    - ☐ Brother or sister
    - ☐ Other relatives
    - ☐ Friends and neighbours
    - ☐ Other – please say

22. How well is that working out?
    - ☐ Very well 
    - ☐ Well 
    - ☐ Okay 
    - ☐ Poorly 
    - ☐ Very poorly 

    Why?

23. How would they like to receive services? (check all that apply)
    - ☐ In my own home
    - ☐ In a group setting in my own community
    - ☐ In a group setting outside of my own community
    - ☐ Other – please say

24. Any other comments?

Appendix C: Summary of Public Survey Results

Respondent Characteristics

Health Condition/Diagnosis Contributing to Disability

Survey respondents with disabilities and families/caregivers of persons with disabilities reported that the following categories of health conditions/diagnoses contribute to their disability/the disability of their loved one (results reported for groups both currently receiving and not receiving SL services), as outlined in the table below:

Table 1: Health Conditions/Diagnoses Contributing to Disability

Condition	Percentage of Persons with Disabilities Receiving SL Services (26 respondents)	Percentage of Persons with Disabilities NOT Receiving SL Services (81 respondents)	Aggregated Responses (107 respondents)
Addictions	23%	17%	19%
Autoimmune	15%	11%	12%
Cardiovascular	4%	16%	13%
Dental	0%	6%	5%
Endocrine and metabolic (diabetes, thyroid, adrenal)	0%	14%	10%
Hearing	19%	9%	11%
Mental Health	42%	37%	38%
Musculoskeletal	8%	11%	10%
Autism	12%	21%	19%
Developmental (Down Syndrome, cognitive disability etc…)	38%	17%	22%
FASD	35%	12%	18%
Neurological (i.e., head injury, aneurism etc.…)	8%	9%	8%
Respiratory	4%	1%	2%
Visual	4%	5%	5%
Other	15%	19%	18%

Functional Activity Areas Requiring Support

Survey respondents with disabilities currently receiving SL services and family members/caregivers of persons with disabilities not currently receiving SL services reported experiencing the following functional challenges requiring support, as outlined in the table below:

Table 2: Functional Challenges Requiring Support

Area of Challenge	Percentage of Persons with Disabilities Receiving SL Services (27 respondents)	Percentage of Persons with Disabilities NOT Receiving SL Services (84 respondents)	Aggregate Responses (111 respondents)
Mobility/getting around	41%	39%	40%
Communication	59%	35%	41%
Hearing	22%	14%	16%
Seeing	11%	6%	7%
Comprehension	52%	46%	48%
Interacting with others	33%	27%	29%
Self-care	56%	46%	49%
Occupational activities (hobbies/work/school)	48%	55%	53%
Cognition/thinking	63%	45%	50%

Support Needs

Types of Support Required and Currently Received

Survey respondents with disabilities currently receiving SL services and family members/caregivers of persons with disabilities currently receiving SL services reported requiring and currently receiving support with the following activities, as listed in the table below:

Table 3: Types of Support Required and Currently Received

Activity	Percentage of Persons with Disabilities Receiving SL Services		Percentage of Persons with Disabilities NOT Receiving SL Services	
	Requires Support with this Activity (26 respondents)	Receiving Support with this Activity (25 respondents)	Requires Support with this Activity (79 resp.)	Receiving Support with this Activity (67 resp.)
Preparing meals	73%	76%	53%	51%
Managing money	85%	60%	57%	46%
Shopping	58%	76%	42%	43%
Housework	77%	60%	62%	54%
Using the telephone	31%	32%	15%	21%
Eating	27%	28%	9%	12%
Bathing	46%	36%	27%	22%
Getting dressed	27%	36%	16%	15%
Mobility/getting around	46%	40%	25%	21%
Toileting	27%	28%	13%	15%
Taking medication	58%	56%	33%	37%

Social and recreational activities	73%	68%	59%	34%
Obtaining equipment	19%	16%	18%	18%
Other	15%	24%	16%	36%

Other areas requiring support were listed being as managing anxiety, accessing meaningful employment, reminders, organization, adjusted spaces, accessing affordable housing, scheduling, staying safe in the community, connecting with others, mentoring, managing a daily schedule, requiring a walk-in shower, managing mental health and frustrations, and attending and understanding health care appointments.

Other areas of support currently being received by persons with disabilities who are currently accessing SL services include attending medical appointments, meaningful employment, affordable housing, addiction supports, respite services.

Non-Supported Living Support Provision

For persons with disabilities not currently receiving formal SL services, their support needs are currently being addressed by the following types of people, as listed in the table below:

Table 4: People Meeting the Support Needs of Persons with Disabilities Not Currently Receiving Supported Living Services

Type of People Meeting Support Needs	Percentage (69 respondents)
Parents	61%
Siblings	26%
Other Relatives	22%
Friends and Neighbours	13%
Other	22%

Other types of people/groups meeting the support needs of persons with disabilities not currently receiving formal SL services are: local community living organization, children, foster parents, homecare, spouse, community support workers, Adult Service Workers, and housecleaning services.

Satisfaction & Feedback on Current Supports

Satisfaction with Current Non-SL Support Provision

The table below outlines the responses of survey respondents with disabilities not currently receiving formal SL services and family members/caregivers of persons with disabilities not currently receiving SL services to describe how their current support provision arrangement is working out:

Table 5: Satisfaction with Current Non-Supported Living Support Provision Arrangement

Current Non-SL Support Provision Arrangement is Working Out…	Persons with Disabilities (18 respondents)	Family Members/Caregivers (57 respondents)

Very Well	11%	19%
Well	11%	14%
Okay	28%	41%
Poorly	33%	21%
Very Poorly	17%	5%

People not receiving SL services reported the following comments regarding their current support arrangements:

Caregiver Stress

- "Very stressful/time consuming for parents/caregivers - unable leave town,
- Unable to meet the needs of other family members due to caregiving (2)
- Exhausted at times
- Exhausting
- Caregivers are burning out, can't get extra help
- Caregiver gets fatigued
- No respite
- Burned out – no proper resources and nobody to turn to, can't have a normal life
- Need more support in the home
- It can be very challenging…
- Supports become more difficult as parents become older
- We are getting to the age where the care is wearing us out"

Limited options

- Difficult removing the individual from home community
- Limited support in (home community) for an individual with higher support needs
- Services providers not in our community often enough
- Need to send (our loved one) out of territory if not living at home with us

Preferred Support Settings of Persons Not Receiving SL Services

The table below outlines survey responses from respondents with disabilities not currently receiving formal SL services and family members/caregivers of persons with disabilities not currently receiving SL services to report that their location preference for receiving support services would be:

Table 6: Preferred Support Settings of Persons Not Currently Receiving SL Services

Support Location Preference	Persons with Disabilities (20 respondents)	Family Members/Caregivers (57 respondents)
In Own Home	55%	67%

In a Group Setting in Own Community	20%	28%
In a Group Setting Outside Own Community	5%	5%
Other	20%	

Satisfaction with Current Supported Living Services

Survey respondents with disabilities currently receiving SL services and family members/caregivers of persons with disabilities currently receiving SL reported the following rates of satisfaction with the current SL, as outlined in the table below:

Table 7: Satisfaction with Current Supported Living Services

Level of Satisfaction with Current SL Services	Persons with Disabilities (5 respondents)	Family Members/Caregivers (18 respondents)
Very Satisfied	60%	45%
Satisfied	40%	33%
Neither Satisfied nor Dissatisfied	0%	0%
Dissatisfied	0%	11%
Very dissatisfied	0%	11%

Reported Strengths of Current Supported Living Services

Survey respondents with disabilities currently receiving SL services and family members/caregivers of persons with disabilities currently receiving SL reported what they like about current SL services, as outline in the table below:

Table 8: Reported Strengths of Current Supported Living Services

Reported Strength	Persons with Disabilities (5 respondents)	Family Members/Caregivers (21 respondents)	Aggregated Responses (26 respondents)
The people who provide the service	80%	76%	77%
The help that is provided	60%	67%	65%
I/my loved one can live with friends	0%	33%	27%
Nothing	0%	5%	4%
Other	0%	24%	19%

Other strengths of current SL services were reported as being the availability of staff, good communication provided to families, provision of a team approach, provision of integrative services, provision of respite services, and the independence that the service provides the individual with outside the family.

Areas for Improvement in Current Supported Living Services

Survey respondents with disabilities currently receiving SL services and family members/caregivers of persons with disabilities currently receiving SL reported what they would to see changed about current SL services, as outline in the table below:

Table 9: Reported Areas for Improvement of Current Supported Living Services

Reported Area for Improvement	Persons with Disabilities (3 respondents)	Family Members/Caregivers (20 respondents)	Aggregated Responses (23 respondents)
Would like to live in own community	33%	25%	26%
Would like to live with family	33%	15%	17%
Would like to receive all the services that are required	100%	40%	48%
Would like SL caregivers to be friendlier	0%	10%	9%
Other	0%	40%	35%

Other reported areas for improvement in current SL services include inconsistency in support staff and constant change of caregivers:

"Switching staff often makes it difficult for the person with the disability to develop a trusting relationship. The staff could develop a better understanding of the person and therefore provide appropriate supports."

"Constant change of caregivers leads to lack of communication with family, consistency in care giving and increased anxiety for both parents and user of services."

More education for staff regarding addictions and mental health, job coaches to support employment in the community, better communication between staff and family.

Appendix D: Interview Guides

DHSS, other GNWT, NGO, Executive - Interview Guide

The Government of the Northwest Territories Department of Health and Social Services (DHSS) has engaged LogicalOutcomes to conduct a review of the Supported Living Program. Your input will help us learn more about the current system and plan for improvements to that system.

The information you provide will be kept confidential and only presented in aggregated format. It will only be used for this review.

Your participation in this interview is voluntary and you may withdraw your consent at any time.

Do you consent to this interview and to our using the information you provide in planning this review?

___Yes (proceed with interview)

___No (do not proceed with interview)

Do you consent to this interview being audio recorded?

___Yes (audio record)

___No (do not audio record)

Before we start do you have any questions about this review?

1. Tell me about your position and how your work is related to Supported Living.

2. What is your understanding of what the NWT Supported Living program does? Probe: who do they serve? What services do they provide? How do they provide those services? What are the accommodation arrangements?

3. What are the underlying principles and values that guide the provision of NWT Supported Living services?

4. If a person with disabilities needs assistance with daily living, what programs are available to them? How would they access those programs?

5. Based on your experience, what are the ranges of Supported Living needs of people with disabilities in NWT?

6. What are the gaps in the current program for filling those needs?

7. Are you familiar with any other supported housing programs in other provinces or countries? Please tell me about those. Probe: Who do they serve? How are they funded? What services do they provide? What is the accommodation arrangement? What current program is working well and could be expanded on?

8. If the NWT Supported Living program were working at its best, what would that look like? Probe: who would it serve? What services would it provide? How would it provide those services?

9. What is needed to achieve that?

10. Who do you know who is not receiving SL but needs it or may need it in the future? Please share their name and contact information (with their permission) with us.

Service Provider Interview Guide

The Government of the Northwest Territories Department of Health and Social Services (DHSS) has engaged LogicalOutcomes to conduct a review of the Supported Living Program. Your input will help us learn more about the current system and plan for improvements to that system.

The information you provide will be kept confidential and only presented in aggregated format. It will only be used for this review.

Your participation in this interview is voluntary and you may withdraw your consent at any time.

Do you consent to this interview and to our using the information you provide in planning this review?

___Yes (proceed with interview)

___No (do not proceed with interview)

Do you consent to this interview being audio recorded?

___Yes (audio record)

___No (do not audio record)

Before we start do you have any questions about this review?

Service Provider/ Facility		Location		Type of Facility	
Interviewee Name		Job Title		Date	

Full scope of services directly provided	
Service Delivery Model	
Referral Process	
Eligibility Criteria	
Waitlist ☐ No ☐ Yes	If yes, average waitlist time: ☐ < 30 days ☐ 1-6 mths ☐7-12 mths ☐ > 1 yr

What tools used to assess initial and ongoing SL needs and resource allocation? Probe: name of tool, frequency of application, use)	
What methods are used to track client support plans, incident reports and communications on clients? (Probe: paper, excel, electronic software).	
What processes are in place to ensure quality assurance/ service delivery standards adherence?	
What is the staff to client ratio?	

How are staff supervised? Probe: performance development system	
What are the minimum staff education/ training requirements?	
What level of education/training do most staff have?	
What inter-agency/service partnerships exist? Probe: rehab, day programming, mental health etc.)	
What culturally relevant activities or cultural preservation efforts are offered? (Probe: specific activities and for what culture, if applicable to clients)	
How do clients participate in the day-to-day operations of the facility that align with their abilities? Probe: meal planning, shopping, planning, housekeeping, cleaning etc	
How are policy and procedure manuals made available for clients, families and quality assurance reviews?	
Please describe your approach of case managing the clients (in and out of scope items), role of coordinating integrated service management of the clients, frequency of reviewing clients support plan? Probe: How is the support plan created (i.e. with client, family and staff involved)? How is it communicated to the support	

team? Is it accessible for all team members, client and family/guardians to review?	
What cultural competency training is provided for staff? Probe: mandatory, frequency	
What is your complaint resolution process? Probe: Received from clients Received from family	
How are decisions made regarding the day-to-day care and activities of each client?	
What mechanisms are in place to receive feedback regarding program structure, quality control, suggestions for improvement, performance management?	
How is client satisfaction determined? Probe: method, frequency, use	
If the NWT Supported Living program were working at its best, what would that look like? Probe: who would it serve? What services would it provide? How would it provide those services?	
What is needed to achieve that?	
Is there anything else that you think is important for us to know in conducting this review?	
Who do you know who is not receiving SL but needs it or may need it in the future? Please share their name and contact information (with their permission) with us.	

Persons with Disabilities in the SL System – Interview Guide

The Government of the Northwest Territories Department of Health and Social Services (DHSS) has engaged LogicalOutcomes to conduct a review of the Supported Living Program. Your input will help us learn more about the current system and plan for improvements to that system.

No one besides the review team will know what you say. It will only be used for this review

Your participation in this interview is voluntary and you may say no at any time.

Do you consent to this interview and to our using the information you provide in planning this review?

___Yes (proceed with interview)

___No (do not proceed with interview)

Do you consent to this interview being audio recorded?

___Yes (audio record)

___No (do not audio record)

Before we start do you have any questions about this review?

1. Tell me about your Supported Living set-up. Probe: How long have you been in the program? What services do you receive?

2. What do you like about Supported Living?

3. What do you want to see changed?

4. If you could have things just like you want, what would that look like?

5. Who do you know who is not receiving SL but needs it or may need it in the future? Please share their name and contact information (with their permission) with us.

Families of Persons with Disabilities in the SL System – Interview Guide

The Government of the Northwest Territories Department of Health and Social Services (DHSS) has engaged LogicalOutcomes to conduct a review of the Supported Living Program. Your input will help us learn more about the current system and plan for improvements to that system.

No one besides the review team will know what you say. It will only be used for this review

Your participation in this interview is voluntary and you may say no at any time.

Do you consent to this interview and to our using the information you provide in planning this review?

___Yes (proceed with interview)

___No (do not proceed with interview)

Do you consent to this interview being audio recorded?

___Yes (audio record)

___No (do not audio record)

Before we start do you have any questions about this review?

1. Tell me about your (family member's) Supported Living set-up. Probe: How long have they been in the program? What services do they receive?

2. What do you like about their Supported Living arrangement?

3. What do you want to see changed?

4. If you could have things just like you want for your family member, what would that look like?

5. Who do you know who is not receiving SL but needs it or may need it in the future? Please share their name and contact information (with their permission) with us.

Persons with Disabilities not in the SL System – Interview Guide

The Government of the Northwest Territories Department of Health and Social Services (DHSS) has engaged LogicalOutcomes to conduct a review of the Supported Living Program. Your input will help us learn more about the current system and plan for improvements to that system.

No one besides the review team will know what you say. It will only be used for this review.

Your participation in this interview is voluntary and you may say no at any time.

Do you consent to this interview and to our using the information you provide in planning this review?

___Yes (proceed with interview)

___No (do not proceed with interview)

Do you consent to this interview being audio recorded?

___Yes (audio record)

___No (do not audio record)

Before we start do you have any questions about this review?

1. Tell me why you need Supported Living (now or in the future)?

2. What types of services do you need?

3. Who provides those services to you now?

4. How well is that working? Probe: What do you like about their current situation? What would you like to see changed?

5. What have you done to try to get the services you need?

6. If you could have things just like you want, what would that look like?

7. Who do you know who is not receiving SL but needs it or may need it in the future? Please share their name and contact information (with their permission) with us.

Persons with Disabilities not in the SL System – Interview Guide

The Government of the Northwest Territories Department of Health and Social Services (DHSS) has engaged LogicalOutcomes to conduct a review of the Supported Living Program. Your input will help us learn more about the current system and plan for improvements to that system.

No one besides the review team will know what you say. It will only be used for this review

Your participation in this interview is voluntary and you may say no at any time.

Do you consent to this interview and to our using the information you provide in planning this review?

___Yes (proceed with interview)

___No (do not proceed with interview)

Do you consent to this interview being audio recorded?

___Yes (audio record)

___No (do not audio record)

Before we start do you have any questions about this review?

1. Tell me why you need Supported Living (now or in the future)?

2. What types of services do you need?

3. Who provides those services to you now?

4. How well is that working? Probe: What do you like about your current situation? What would you like to see changed?

5. What have you done to try to get the services you need?

6. If you could have things just like you want, what would that look like?

7. Who do you know who is not receiving SL but needs it or may need it in the future? Please share their name and contact information (with their permission) with us.

Families of Persons with Disabilities not in the SL System – Interview Guide

The Government of the Northwest Territories Department of Health and Social Services (DHSS) has engaged LogicalOutcomes to conduct a review of the Supported Living Program. Your input will help us learn more about the current system and plan for improvements to that system.

No one besides the review team will know what you say. It will only be used for this review.

Your participation in this interview is voluntary and you may say no at any time.

Do you consent to this interview and to our using the information you provide in planning this review?

___Yes (proceed with interview)

___No (do not proceed with interview)

Do you consent to this interview being audio recorded?

___Yes (audio record)

___No (do not audio record)

Before we start do you have any questions about this review?

1. Tell me why your family member needs Supported Living (now or in the future)?

2. What types of services do they need?

3. Who provides those services to them now?

4. How well is that working? Probe: What do you like about their current situation? What would you like to see changed?

5. What have you done to try to get the services they need?

6. If you could have things just like you want, what would that look like?

7. Who do you know who is not receiving SL but needs it or may need it in the future? Please share their name and contact information (with their permission) with us.

Focus Group Guide

Sign in sheet for persons with disabilities:

The Government of the Northwest Territories Department of Health and Social Services (DHSS) has engaged LogicalOutcomes to conduct a review of the Supported Living Program. Your input will help us learn more about the current system and plan for improvements to that system.

No one besides the review team will know what you say. We ask that whatever is said in this room stays in this room. The information you provide will only be used for this review.

Your participation in this focus group is voluntary and you may say no at any time.

By signing below, you are giving us permission to record what you say and use it in our report.

Name	Age	Signature

Persons with Disabilities in SL - Focus Group Guide

Type of Question	Question	Discussion Time
Introductory	Please introduce yourselves. First names are fine. We want everyone to have a chance to speak so we will let everyone speak before people speaking a second time to each question	5 minutes

Exploratory	Why do you need supported living services?	15 minutes
	What services are you receiving?	15 minutes
Probing	What do you like about the services?	15 minutes
	What do you want to see changed?	15 minutes
Wrap-up	Is there anything else you think we should know?	10 minutes

Sign in sheet for care providers:

The Government of the Northwest Territories Department of Health and Social Services (DHSS) has engaged LogicalOutcomes to conduct a review of the Supported Living Program. Your input will help us learn more about the current system and plan for improvements to that system.

No one besides the review team will know what you say. We ask that whatever is said in this room stays in this room. The information you provide will only be used for this review.

Your participation in this focus group is voluntary and you may say no at any time.

By signing below, you are giving us permission to record what you say and use it in our report.

Name	Signature

Type of Question	Question	Discussion Time
Introductory	Please introduce yourselves stating your position in [name of organization]. We want everyone to have a	5 minutes

	chance to speak so we will let everyone speak before people speaking a second time to each question	
Exploratory	What are the underlying principles and values underlying the supported living program?	10 minutes
	What services are provided?	10 minutes
Probing	What are the gaps in the current system?	15 minutes
	If the NWT Supported Living Program were working at its best, what would that look like? Probe: Who would it serve? What services would it provide? How would it provide those service?	25 minutes
Wrap-up	Is there anything else you think we should know?	10 minutes

Public Meeting Facilitation Guide

Introduce yourself and any other officials with you.

Announce: The Government of the Northwest Territories Department of Health and Social Services (DHSS) has engaged LogicalOutcomes to conduct a review of the Supported Living Program. Your input will help us learn more about the current system and plan for improvements to that system. By participating in this meeting you are giving us permission to use what you say in this review of Supported Living.

The questions we are exploring are:

1. What supported living services are provided in your community?

2. What happens when someone needs supported living services in your community, and they cannot get them?

3. What should supported living look like in the NWT?

Depending on the set-up, people can line up at microphones. There should be at least two. The facilitator will switch between microphones. If the microphones are cordless, ask people to raise their hands and they can speak on a first come basis, with people who have not spoken being given the opportunity before people who have spoken.

Ask that they keep their comments to no more than five minutes.

Acknowledge whatever people say or feel, even if there is anger. Thank each person for their input

Announce that the session is being recorded.

Appendix E: Priority Sort Session Methodology and Results

On February 3, 2022, a facilitated session with 17 key stakeholder participants from HSS, the Steering Committee and the Advisory Group was conducted to determine the most important priorities for a renewed NWT Supported Living Model. The format below was followed during the session:

- Overview of Preliminary Findings of the Review
- Breakout Groups: Rapid Sort
- Breakout Groups: Forced Sort
- Discussion

Rapid Sort

Rapid Sort Process

Following a summary of preliminary findings of the review at the time, participants were divided into four breakout groups and presented with 25 potential elements of a renewed SL model:

1. Basic qualification requirements for supported living staff
2. Case management services are provided
3. Clear definition of supported living
4. Clear referral, application and assessment process
5. Communication to professionals regarding supported living services
6. Communication to the public regarding supported living services
7. Consistent and easy to administer service user support planning/reporting tools
8. Cultural training for staff
9. Ensure the new model is a non-medical model
10. Full range of disabilities are served
11. Funding is provided to in-territory contracted services
12. Linkages between youth services and supported living services
13. More supported living placements are available in the NWT
14. Services are matched to service users' needs
15. Single point of access for supported living services
16. Standardized assessment tools
17. Supported living services are available in smaller communities
18. Supported living services are provided in persons' own homes
19. Supported living services are provided to people with disabilities and addictions
20. Supported living services are provided to people with disabilities and behavioural issues
21. Supported living services are provided to people with disabilities and mental illness
22. Supported living services are provided to people with disabilities who are homeless
23. Supported living services legislation

24. Supported living Standards are developed and oversight is provided
25. Training in the NWT for supported living staff

Groups were given a short amount of time and instructed to assign a value between 1 (less important) and 5 (more important) for each element, based on initial impressions. The guiding question was: "*What elements do you think are the **most important to include** in a Supported Living program and in Supported Living Setting?*" Groups were advised to use a democratic process and move quickly. Final value assignment for each element within each breakout group was determined through a vote.

Rapid Sort Results

There were no elements ranked "1 – Least Important" by all groups. Almost all elements were ranked a 4 or a 5. Groups had difficulty moving elements into low priority groups.

Forced Sort

Forced Sort Process

Breakout groups were then instructed to refine their sorting results so that there were no more than 5 elements in each ranking group. Groups were given a longer period of time, and were encouraged to discuss and reach consensus, using concession, if necessary, i.e. "*I can live with it even though I don't like it".* The same guiding question was provided to give direction to the process: "*What elements do you think are the **most important to include** in a Supported Living program and in Supported Living Setting?*"

Forced Sort Results

The priority sort session indicated the following are the most important elements of a Supported Living system:

9. Ensure the new model is a non-medical model
10. Supported living services are provided in persons' own homes
11. More supported living placements are available in the NWT
12. Full range of disabilities are served
13. Services are matched to service users' needs
14. Case management services are provided
15. Supported living services are available in smaller communities
16. Specific standards for supported living are developed and enforced

Other elements also deemed more important were communication about supported living services, development of a common assessment tool, and linkages between supported living and youth services. However, the group noted that the NWT SL system needs to be more fully developed before many of the other elements can be implemented.

Elements of a Supported Living system	Level of importance					Discussion
	1	2	3	4	5	
Ensure it is a non-medical model					✓	One group put it as a *1* because they assumed it would remain a non-medical model. Another group suggested adding: '…that supports medical needs'
Supported Living provided in own homes					✓	This was considered a high priority by all groups. One group noted that the more Supported Living could be provided in people's own home, the less need for to build residences
Supported living placements in NWT					✓	One group put this as a *1* because they felt if Supported Living increased for people with disabilities that it would result in increased Supported Living placement in NWT. Two other groups noted that people with disabilities who are homeless, have mental illness, have addictions, and/or have behaviour issues are all strongly linked and should be combined prior to ranking
Full range of disabilities served					✓	This was also seen as directly related to people with disabilities who are homeless, have mental illness, have addictions, and/or have behaviour issues are all linked and should be combined prior to ranking
Services are matched to client needs					✓	One group indicated that this also covered serving people with the full range of impairments including people with disabilities who are homeless, have mental illness, have addictions, and/or have behaviour issues
Supported living for people with disabilities and addictions				✓		The ranking varied from 3 to 5 depending on whether the group considered these as subset of Supported Living placements in the NWT. Some noted that this speaks to the need for an expanded definition of Supported Living
Supported living for people with disabilities and mental illness				✓		
Supported living for people with disabilities who are homeless				✓		

Elements of a Supported Living system	Level of importance					Discussion
	1	2	3	4	5	
Supported Living for people with disabilities and behavioural issues				✓		
Supported Living Standards with oversight				✓		Some people were aware of Continuing Care Standards, they felt the need for something specific to Supported Living with a strong emphasis on oversight
Case management services				✓		This was generally ranked high because of the challenges with system navigation. Case managers are seen to be responsible for assessment and appropriate placement
Supported Living in smaller communities				✓		
Funding to in-territory contracted services			✓			There was diversity in ranking with two groups placing it at *2*, one group at *4*, and one at *5*. It was seen as part of increasing services in the NWT and repatriation
Standard assessment tools			✓			One group expanded the wording to read 'Standard Service Needs Assessment Tools.' This was generally seen as a lower priority than expanding the system
Clear referral, application, and placement process			✓			Groups placed it at *2*, *3*, and *4*. This was seen as important in the development of the Supported Living system
Single-point access for Supported Living services			✓			The rankings on this varied across the groups from *1* to *5*. Three groups saw it as a higher priority that is important in the development of a Supported Living System. One group suggested 'Every door' is the right door
Cultural training for staff			✓			Rankings spread evenly, with some indicating that cultural training for staff is essential
Consistent easy to administer client progress tools			✓			The rankings ranged from *1* to *4*. This was seen as a detail to be worked out once a system is in place
Basic qualification requirements for Supported Living staff			✓			This was not seen as important by all. Some felt that trained staff would not be as effective as those with lived experience. Others felt that this would be clearer once an expanded system was in place

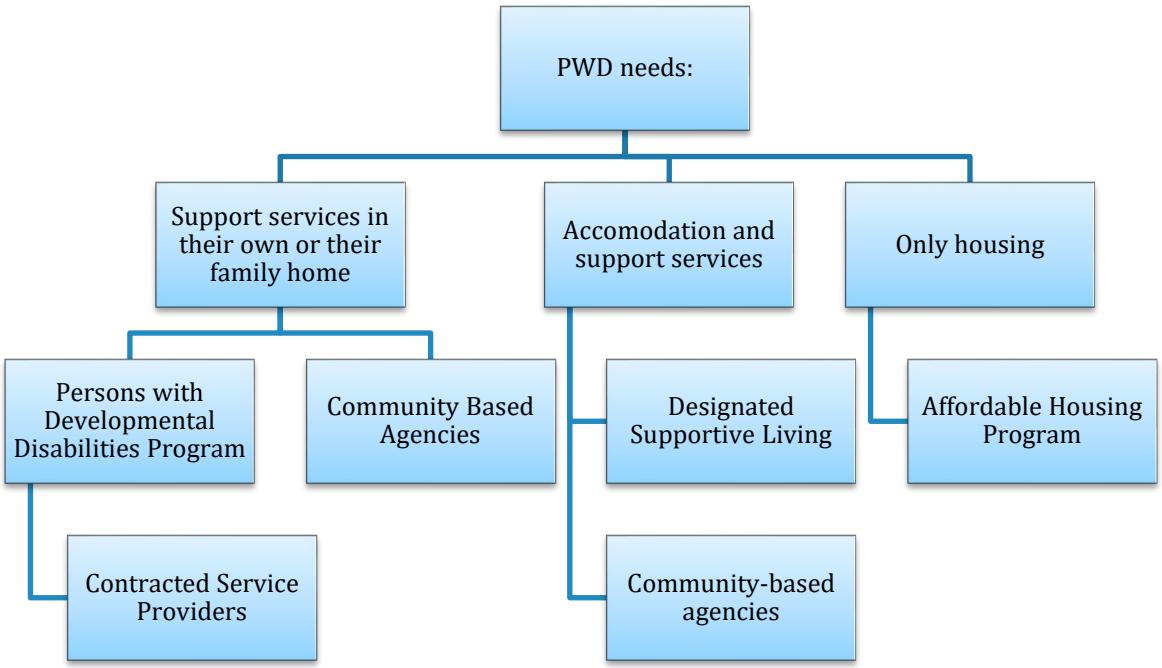
Elements of a Supported Living system	Level of importance					Discussion
	1	2	3	4	5	
Definition of Supported Living			✓			This was added as a high priority by one group
Communication to professionals regarding Supported Living services		✓				It was pointed out that there is no point in communicating anything until such time as a Supported Living system is in place
Communication to the public regarding Supported Living services		✓				
Supported Living services legislation		✓				Two groups had this as a *1* and two groups had it as a *5*. The reasoning for a *5* is the understanding that legislation ensures that a program is solidly in place and cannot be readily removed. The groups that placed it as a *1* said that legislation is not required to make the needed modifications to the Supported Living system and trying to get such legislation would only slow down the process.
Training in NWT for Supported Living staff		✓				Generally seen as less important. One group felt that exploring what is needed to build a qualified workforce based on the model being developed was an important part of developing a system. One group ranked this as a *4* as they felt well-trained staff were needed in order to serve a wider range of disabilities.
Linkages between youth services and Supported Living		✓				Although there was recognition that the transition from youth into adult services was a challenge, it was noted that until the Supported Living system was expanded that challenge could not be resolved

Appendix F: In-depth Jurisdictional Scan

A detailed account of the six Canadian jurisdictions outlined in section 4.0.

Alberta

Varying types of Supported Living services in Alberta are available through the efforts of multiple different provincial government departments and health authorities, alongside many community-based agencies and non-governmental organizations. Supported Living and disability services are quite uncoordinated in Alberta which has resulted in multiple calls from the public to conduct reviews on the current states of service delivery. The following is a brief overview of the supported living programs and services available, although only one is disability specific.



Persons with Developmental Disabilities (PDD)

The Government of Alberta administers the Persons with Developmental Disabilities (PDD) Program to help adults with developmental disabilities live as independently as possible in their chosen community. The PDD Program funds, monitors and evaluates the provision of services for individual Albertans with developmental disabilities; the services of which are intended to supplement the support of family, friends, and community members. Support services are usually divided into four categories: home living supports, employment supports, community access supports, and specialized community supports. PDD Disability Support Caseworkers help the applicant to plan, coordinate and access the services that are best suited to them.

Note: This program provides services within the individual's (or family) home. It does NOT provide housing or other such physical accommodations

Support	Description
Home Living Supports	Supports that help PWD do daily activities such as banking, caring for their home, making meals, laundry, etc. Also includes respite services to give caregivers a break, as well as short-term support or training to help caregivers when things are difficult
Employment Supports	Designed to help PWD learn new skills, find, and keep a paid job
Community Access Supports	Supports that help PWD take part in community activities so they can socialize, learn, develop, relax, and have fun with others
Specialized Community Supports	Specialized supports from experts to help if the individual has additional needs because of mental illness, behavioural issues, addictions, and/or involvement with the law

Eligibility

To be eligible for PDD programming, an applicant must meet the following criteria.

Type	Criteria
General	• Be 16 years of age or older to apply and be 18 years old when PDD services start • Live in Alberta and receive PDD services within the province • Be a Canadian citizen or permanent resident
Disability	• A developmental disability that presents itself before applicant is 18 • Provide documentation of disability by a qualified professional (usually in the form of a psychological assessment report, psycho-educational assessment, or neuropsychological assessment) • IQ of 70 or lower (in certain instances) • Undergo an assessment of ability to engage in ADLs

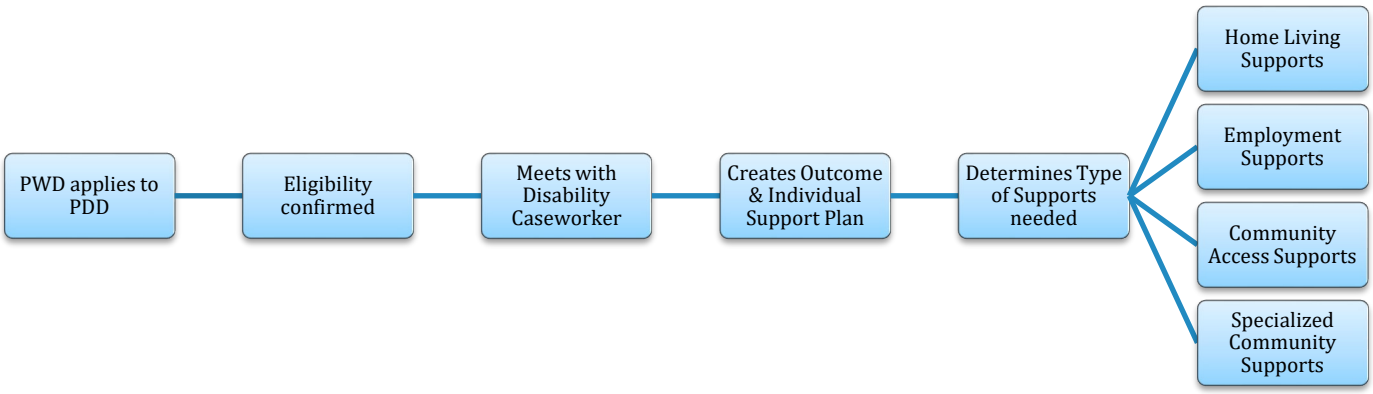
The process of procuring PDD services begins with an individual or their family member/chosen representative complete an application available online or at a local Disability Services office. Along with this application, the individual must also provide documentation proving their age and residency, professional confirmation of disability along with information on the disability, and finally any documentation if they have been or are currently involved in other social programs with as Family Support for Children with Disabilities, Assured Income for the Severely Handicapped, etc.

Service Model

Once an applicant has met the eligibility requirements, they are assigned a Disability Services Caseworker who will then meet with them, their family/guardians, friends, and anyone else they would like on their support team. The caseworker will administer an Adaptive Skills Inventory which evaluates 24 descriptor activities ranging from reading to mobility skills to communication and whether the individual requires any assistance in completing these activities. Once this is complete the team works together to create an Outcome Plan and an Individual Support Plan, as described below:

Plan	Description
Outcome Plan	Created soon after program acceptance, this is the base for more detailed planning and includes the applicants': • Vision for the kind of life they would like to have • The outcomes that will help them achieve that vision over time • The needs and ideas for reaching their visions and outcomes • The services that will help meet needs • Where to find the services in their chosen community
Individual Support Plan	This plan is finalized within three months of when the individual begins receiving services and includes the applicants': • Goals they want to reach within a year • The ways they will reach these goals • Who will provide support to reach their goals • How to know when the goals have been met • What to do if the plan needs to be changed

The Outcome and Individual Support Plans will be reviewed on a regular basis and updated as needed. Once these plans are in place, the caseworker helps determine which of the four categories of support are best suited towards the individual



Accessing Services

The Disability Support Worker will help the individual access the services based off the goals and needs listed in their plan. These supports may come from one of the following service providers:

- Community agencies or individuals specializing in helping people with disabilities
  - Alberta has many community-based and NGO's that offer a variety of general and focused services for people with disabilities
- The Persons with Developmental Disabilities Program

- Other provincial programs such as Alberta Aids to Daily Living (funding for medical equipment and other necessary supplies) or Assured Income for the Severely Handicapped (AISH)
- Community services such as recreation or day programming

Once the type of support the individual needs is established, they have two options to access services through the PDD program:

1. Family Managed Services

Family Managed Services (FMS) allows for individuals (or someone on their behalf) to find, hire and train their own staff who provides all or most of their support services. The individual/person on their behalf is subsequently known as the FMS Administrator and is responsible for creating and updating an Individual Support Plan, adhering to Alberta Employment Standards, and staying in regular contact with the PDD Case worker. Funds from PDD are allocated to the FMS Administrator to pay for supports.

2. Agency Managed Services

If the individual chooses this option, the PDD worker will help them choose an agency to best meet their needs. These agencies are required to work with the individual, PDD staff, legal guardians, and support team to create the Individual and Outcome Support Plans. PDD then pays the agency directly to provide the necessary support services and ongoing case management/support.

Designated Supported Living

Offered by Alberta Health Services (AHS) and legislation managed by Alberta Health (equivalent to the GNWT DHSS) Designated Supported Living (DSL) are settings that provide individuals with a home where they can enjoy privacy and independence with the comfort of knowing there are onsite support staff to help manage health and personal care needs. A Case Manager from AHS will also complete and assessment of applicants through the InterRAI assessment tool, specifically the RAI-HC, which will help determine which DSL setting the individual is best suited for. There are three levels of Designated Supported Living:

DSL 3

Designated Supportive Living 3 (DSL3) provides accommodation in housing complex specifically built for SL, meals, housekeeping, and recreational services. It also provides a higher level of personal care supports compared to other programs such as Adult Day programs, respite, etc. Health Care Aides are onsite 24 hours a day to provide support, personal care, and minor medical assistance (such as medication administering). Depending on the level of need and location/size of the facility, scheduled professional care from nurses, rehabilitation professionals, etc. can be provided as well.

Eligibility

DSL3 is specifically for individuals who:

- Are medically and physically stable

- Living with physical disability, mental health diagnosis, or mild dementia with no known risk of wandering and who are not a risk to self or others
- Can move independently or with the assistance of just one other person
- Could be experiencing increased healthcare needs that cannot be scheduled
- Would be able to use a call system to get help if needed

Funding

Individuals utilizing DSL3 will have to contribute financially to their support services depending on their annual income. This an Alberta Health pre-decided amount that is subsidized partly through Alberta Health Services. Generally, it costs service-users about $1300 for a standard room per month. Individuals are allowed to use their AISH , PDD, or any other government funded income support programs to help pay for DSL.

DSL 4

Like DSL 3, Designated Supportive Living 4 also provides accommodation, meals, housekeeping and recreational services to residents, along with a higher level of personal and health care supports (both scheduled and unscheduled). Health Care Aides are on side 24 hours a day for personal care supports and Licensed Practical Nurses are also on site 24/7 to provide nursing care. If a service-user has complex needs and requires more supports from healthcare professionals such as an RN or rehabilitation therapist, the individual disability Case Manager will help have this arranged.

Eligibility

DSL4 is for individuals who:

- Have more complex medical needs that are predictable and safely managed with onsite profession LPN level nursing care
- May require chronic disease management
- May require assistance with daily activities such as meal preparation and eating, mechanical lift or two person transfers, medication assistance or administration, etc.

Funding

Individuals utilizing DSL4 will have to contribute financially to their support services depending on their annual income. This an Alberta Health pre-decided amount that is subsidized partly through Alberta Health Services. Generally, it costs service-users about $1300 for a standard room per month. Individuals are allowed to use their AISH, PDD, or any other government funded income support programs to help pay for DSL.

DSL 4D

Designated Supportive Living 4D (DSL 4D) offers specialized dementia care for individuals with a high flight risk and will not be further covered in this review.

Affordable Housing Program

The Government of Alberta works with a variety of stakeholders, including municipalities, housing management bodies, non-profit and private organization, to build, operate and manage affordable housing for Albertans with low income or with specifical circumstances. There are three different options to assist with the costs of rent:

- Subsidized housing for families, seniors, and individuals with low income
    - Certain persons with disabilities may fit within this category
- Monthly rent benefits
- Other below-market options by select housing providers
    - Such as mixed income apartments

Eligibility

In order to be eligible for any Affordable Housing Program, applicants must have an income below local income thresholds, as determined by the market for their specific community. Applicants must also be a Canadian citizen or permanent resident and a resident of Alberta. Once deemed eligible, applicants undergo an assessment based on their income, assets, number of dependants, current housing condition and any other special circumstances, and assigned a priority level based on their need.

Funding

There are variety of different ways funds reach eligible individuals for the costs associated with their accommodations, usually based off their annual income and number of dependants. People with Disabilities may use the funding they receive from the Assured Income for the Severely Handicapped program (income support program for PWD in Alberta) in addition to the subsidies (such as Rent Assistance Benefits) provided through the program.

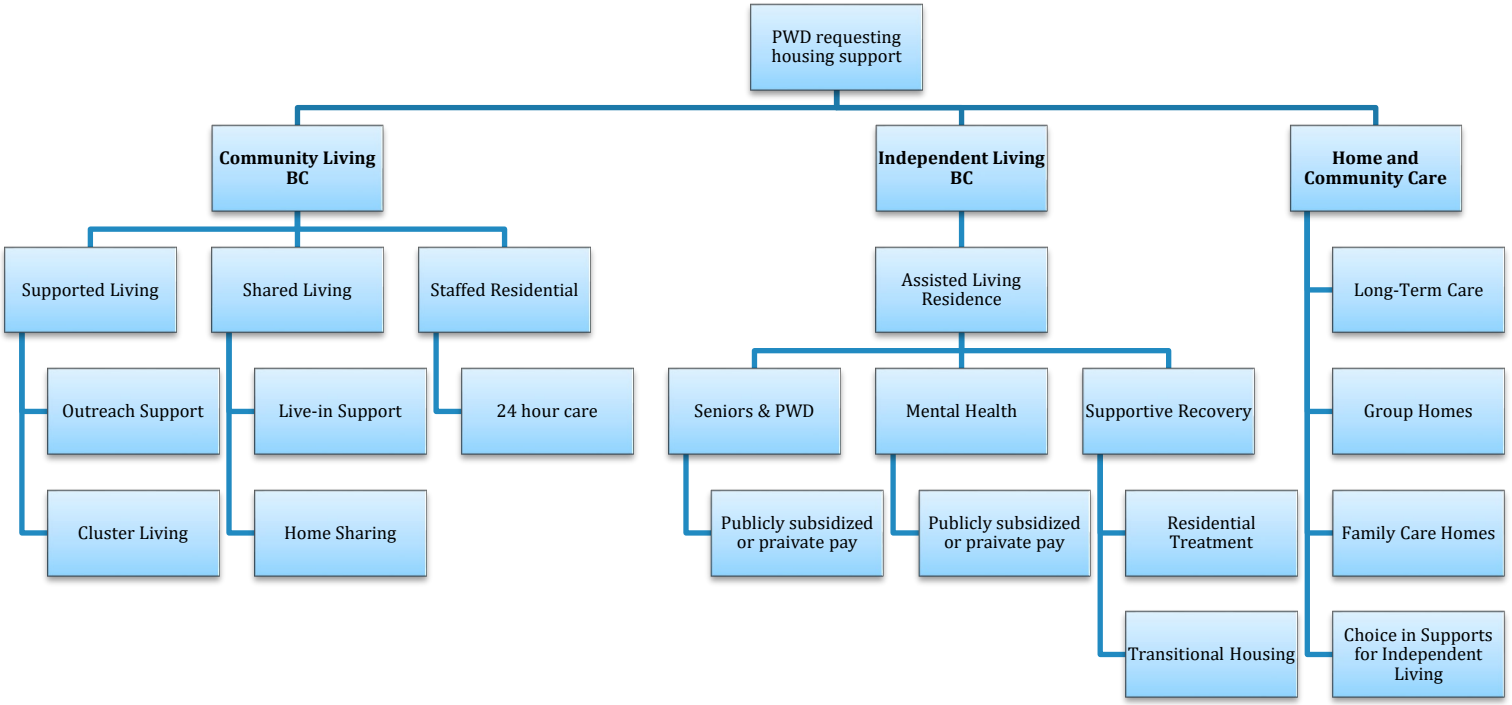
Special Needs Housing

Special Needs Housing options are available for individuals who have unique needs and in certain cases can include support services for residents. The populations this program is designed for are:

- People with developmental disabilities (on a case-by-case basis)
    - The government holds contracts with certain community-based organization and offers limited amounts of funding for providing specialized accommodations
- People with physical disabilities/challenges
    - Accessible housing can be provided if required
- Victims of family violence
- Wards of the provincial government
- The hard-to-house
- Any other group with special housing needs

British Columbia

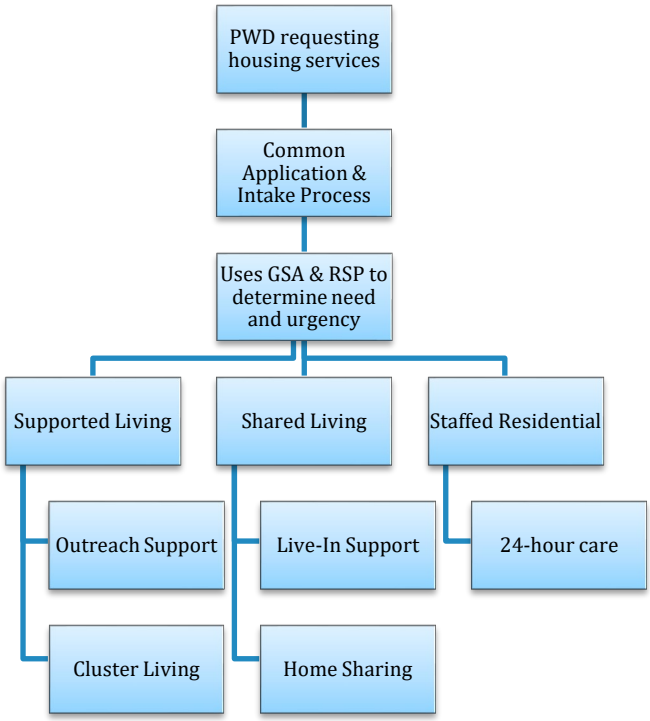
British Columbia offers many types of supported living services for individuals with varying levels and types of disability across the province. Depending on the individual's situation, these supports are available through one of three main programs: Community Living British Columbia (CLBC), Independent Living British Columbia Program (ILBC) or Home and Community Care, the latter two of which are very closely connected. Eligibility for these programs is mainly decided by type of disability. The province of British Columbia is divided into five regional health authorities (RHAs) and each of these authorities play a role in the funding/coordination of services for people with disabilities including assessments and case management. Supported/Assisted Living Policy and Transition Planning services are largely overseen by the Ministry of Social Development and Poverty Reduction.



Community Living British Columbia

Community Living British Columbia, better known as CLBC, is a provincial Crown Corporation that funds supports and services to adults with developmental disabilities, as well as adults with an Autism Spectrum Disorder (ASD) or Fetal Alcohol Spectrum Disorder (FASD) diagnosis (the latter of which are part of a sperate branch of programming known as the Personalized Supports Initiative (PSI). CLBC receives funding from the government to provide services to more than 20,000 individuals and welcomes more than 1,000 new eligible applicants each year. CLBC provides a variety of services including behavioural support, respite for families, mental health support, employment support, residential support, community inclusion support, as well as planning and transition supports. These can either be offered by CLBC or through contracted community

agencies. CLBC recognizes that where an individual lives is an integral part of their life and provides the foundation, they need to learn life skills, feel welcomed, and meet their goals. Therefore, CLBC has many different residential supports options that offer varying levels of support to best suit the individual's goals and needs. Residential Supports are divided into three categories: Supported Living, Shared Living, and Staffed Residential, each of which also offer subcategories of support. A CLBC facilitator will help the applicant decide which option they would thrive best in, and complete a more thorough assessment of their goals, needs, financial eligibility, and what (if any) other CLBC services they are receiving.



GSA: Guide to Support Allocation // RSP: Request for Service Priority Tool (the assessment from CLBC)

Eligibility

To be eligible for CLBC services (including PSI), individuals must meet specific disability requirements. Individuals may apply for services after their 16th birthday but will not begin to receive services until they are 19 years of age or older, the age in which they are deemed to be an adult. A CLBC facilitator completes the application process, directs the individuals to the best suited support services, and provides ongoing case support to the individual and their family.

Disability	**Criteria**
Developmental Disability	An Adult has: • Impaired intellectual functioning (an IQ of 70 or below when tested by a qualifying practitioner; some exceptions apply) • Impaired adaptive functioning (contributing factor in making a diagnosis of Intellectual Disability in accordance with DSM-5) • These impairments must have started and been diagnosed before the age of 18
Personalized Supports Initiative (PSI)	An adult who does not have a developmental disability but has: • Significant limitation in adaptive function AND either: • A diagnosis of Fetal Alcohol Spectrum Disorder (FASD) or • A diagnosis of an Autism Spectrum Disorder (ASD)

Funding

Funding for the three streams of Residential Supports is usually composed of a combination of CLBC funding and individual contribution, the later of which can include the individual's employment income (if any), or government income-assistance programs from the Ministry of Social Development and Poverty Reduction (such as PWD Benefits or Old Age Security and Guaranteed Income Supplement). Typical costs associated with residential supports that service users pay for include rent and basic living costs, while CLBC covers most of the support services within the home environment.

Types of Support

Supported Living

CLBC Supported Living means the individual lives independently in a home that they own, lease/rent, but receive in-house support with activities of daily living. These supports may include things like cooking, budgeting, personal care, recreational activities, and initiative community connections. It is important to note that this option does require a higher level of personal independence from the individual. There are two streams of Supported Living:

Outreach Support

This option involves a support person, either from CLBC or a contracted community agency, visiting the individual's home to provide support with ADLs at set times throughout the week. This can be provided in a on-on-one or in a group environment.

Cluster Living

This option involves a support person(s) providing support to the individual and a group of other CLBC residential support clients who live close to each other, usually in the same building. The support person, again either from CLBC or a contracted community agency, usually lives in close proximity to this group as well.

Shared Living

One of the more common programs, Shared Living is a residential supports option where the CLBC individual shares a home with a contracted person that provides ongoing support, known as the shared living provider. In some instances, this can be a singular person, while in others it may be a couple or family. Although CLBC does directly manage a small number of shared living agreements, this service is usually provided by outside service provider agencies. These agencies must meet CLBC standards and be approved before engaging in service provision. Again, there are two streams of Shared Living:

Live In Support

This option involves the CLBC individual living in their own home (whether it be owned or rented) and the contracted support person (shared living provider) moves in with them to provide support.

Home Sharing

The more common of the two streams, this option involves in the CLBC individual living in the shared living provider's own home. They will have to pay a predetermined amount similar to a rental which is based on the applicants assessed GSA level. Total compensation to the homeowner ranges from $1,716.00 to $5,641.00 and is made up of a combination of CLBC funding and the individual contribution of the individual requiring services.

Staffed Residential

Interchangeably used with the term 'Group Home', the Staffed Residential option involves the individual living in a home within their community with at least one other CLBC client that is staffed 24/7/365 with support workers to assist them throughout both day and night. Staff who work in the home help the residents with activities such as cooking, budgeting, personal care, recreation, community involvement, household talks, etc. Residents will have their own room that they may decorate and do with as they please. Individuals who utilize staffed residential supports tend to have a high amount of support needs with ADLs and IADLs.

Independent Living BC

As part of their Housing with Support Initiative, and in partnership with provincial health authorities, the Canada Mortgage and Housing Corporation, and non-profit and private-market housing providers, BC Housing offers the Independent Living BC Program (ILBC). ILBC is a subsidized, assisted-living program that provides housing with support services to three categories of people: seniors and people with disabilities, mental health, and addictions. It is intended to provide a middle option between home care visits and facility-based care, so individuals can continue to live as independently as possible with the unique supports they need. If an individual qualifies, they can live in their own or shared unit in an Assisted Living Residence. The ILBC provides funding to build and continue to provide a certain amount of financial aid to maintain 119 of these residences across the province. Houses are categorized into one of the five health authorities and then by municipality to help ensure individuals have the opportunity to remain in

their home community, or as close as possible. Admission to these houses is the responsibility of the individual's respective health authority; individuals cannot apply themselves to an assisted living residence. ILBC is very closely linked with Home and Community Care (explored in the next section), especially with the operation of Assisted Living Residences.

Assisted Living Residences

Assisted living residences can range from a unit in a high-rise apartment complex to a private home. Units can vary from one room to private, self-contained apartments. Approved Assisted Living Residences are given designation from the Registrar and must provide elements of the following three categories on a full or part time basis:

Service	Description
Housing Services *Possible accommodation & amenities may include:*	• A self-contained unit • Shared dining room, social areas, resource room, outdoor space or gardens • Parking, wheelchair access, sooter access • Smoking and pet policies • Social and recreational activities
Hospitality Services *All residences provide:*	• Two meals a day (lunch and supper) • Weekly housekeeping • Laundered towels and linens • Access to laundry for personal items • 24-hour emergency response system
Personal Care Services *Each residence offers two or more of the following:*	• Daily help with bathing, dressing, grooming, mobility or eating • Reminders or help with taking medications • Monitoring of food intake and therapeutic diets • Help with paying bills, managing funds and making purchases • Individualized physical, occupational, or psycho-social therapy • A structured, individualized program to improve life skills

Eligibility

To apply to an ILBC Assisted Living Residence, an individual must speak with a health care worker or representative at a provincial health authority who will begin the referral process. They will review the individuals needs, complete an assessment, and place the individual on a waiting list for a unit should they be eligible. The RHA worker will then send the completed assessment and recommendations to ILBC. To be eligible for ILBC services, the applicant must:

- Meet Home & Community Care basic eligibility (Canadian citizen/permanent resident, be 19 years of age or older, have lived in BC for a minimum of 90 days)

- Have a documented health condition (including mental health and/or addiction), disability, long-term need, and/or recent discharge from a hospital or health care facility that affects their ability to function independently
- Need both hospitality services and at least one regulated assisted living/personal care service
- Be able to communicate and be understood by others
- Be able to make decisions on their own behalf, or live with a spouse who can make said decisions on their behalf
- Do not behave in ways that may put the safety and well being of others at risk
- Be at a level of risk in their current home
- Be able to function safely in assisted living (including the ability to take direction in an emergency and ability to use an emergency response system)

Funding

There are two options a service-user can access to fund their Assisted Living Residence:

Publicly Subsidized Assisted Living

The individuals wishing to utilize ILBC are expected to pay 70 percent of their after-tax income (regardless how little or large the amount, or if it's from Income assistance programs), plus a hydro surcharge of up to a maximum of $18 a month. The remaining amount is covered through the partnership with provincial health authorities, the Canada Mortgage and Housing Corporation, and BC Housing. The totality of this contribution includes accommodation from non-profit and private-market housing providers, hospitality services, individualized supports, and personal care services.

Private Pay Assisted Living Services

These residences are available across the province, operated by private organizations and charge market rate for accommodation and services. An individual wishing to opt for the private-pay route is responsible for the acquisition of said service and all necessary payments. There is no circumstance where government and/or health authority funding may be used.

Types of Assisted Living Residences

Seniors & People with Disabilities

As one of the three Assisted Living classes, this is for adults who are receiving assisted living services due primarily to chronic or progressive conditions linked to the aging process or a disability (since birth or acquired). Residences usually have an emphasis on physical and structural accessibility and tend to have more hospitality and personal care services with full time staff.

Mental Health

As one of the three Assisted Living classes, this is for adults receiving assisted living services due primarily to a mental disorder. Residences tend to have more personal care services with part- or full-time staff.

Supportive Recovery (Addictions)

As one of the three Assisted Living classes, this is for adults receiving assisted living services due primarily to substance use. There are two housing options in this class: residential treatment or transitional housing. Neither are designed for life-time care but rather as a bridge to independence.

Home & Community Care

Home and Community Care, a division of the BC Ministry of Health, provides publicly subsidized home and community care services for people who have acute, chronic, palliative, or rehabilitative healthcare needs or disability. The five regional health authorities hold responsibility for most of the funding and service delivery of the assisted living services (including eligibility assessments, case management, ongoing support, etc.) while the Ministry of health manages legislation, which embraces the principles of choice, privacy, independence, individuality, dignity, and respect. Home and Community Care works closely with ILBC to provide the Assisted Living Residences service, along with the following:

Long-Term Care

Long-term care (LTC) services are 24-hour professionally staffed environments that provide supervision and care in a protective and supportive residences to people who have complex care needs. These individuals must have a need greater than would be met in their own home or in an assisted living residence. Some homes have personal support workers, rehabilitation professionals, social workers, and recreational therapists in addition to nursing and medical staff to help support independence. LTC services include:

- Standard accommodation
- Development and maintenance of a care plan
    - Clinical support services that are identified in the care plan
- Ongoing, planned physical, social, and recreational activities
- Meals and meal replacements as per dieticians or physicians
- General hospitality services (laundry, housekeeping, etc.)
- General hygiene supplies and assistance with bathing
- Routine medical supplies and incontinence management
- Basic wheelchairs and maintenance/cleaning of wheelchairs
- Any other specialized services as needed by the client that the Long-Term Care home has been contracted to provide

Eligibility

To be eligible for Long-Term Care Services, the applicant must meet the basic eligibility criteria for Home and Community Care Services in addition to LTC specific criteria, as follows:

Program	Criteria
Home and Community Care Services *(Requirement for all the 11 programs offered)*	• Be a Canadian Citizen (some exceptions may apply) • Be a resident of British Columbia for at least 3 months (some exceptions may apply) • Be 19 years of age or older
Long-Term Care Services	• Have severe behavioural problems on a continuous basis • Are cognitively impaired, ranging from moderate to severe • Are physically dependent, with medical needs that require professional nursing care, and/or a planned program to retain or improve functional ability • Are clinically complex, with multiple disabilities and/or complex medical conditions that require professional nursing care, monitoring and/or specialized skilled care
Long-Term Care *(Many, not all, of these requirements must be met to be accepted into LTC)*	• Have been assessed as having 24-hour professional and/or nursing supervision and care needs that cannot be adequately met in your home or by housing and health services • Are at significant risk by remaining in your current living environment, and the degree of risk is not manageable using available community resources and services • Have an urgent need for long-term care services • Have been investigated and treated for medical causes of disability and dependency that may have been remedial • Have a caregiver living with unacceptable risk to their well-being, have a caregiver who is no longer able to provide care and support, or do not have a caregiver • Have agreed to pay the assessed rate for LTC and charges for any additional optional services, programs, or supplies not included in the benefit

There are many Long-Term Care homes across the province that provide different types of levels of support services to residences, thus an RHA caseworker or other health professional will help guide the applicant to the one best suited for their individual needs. This includes a review of their needs, goals, and finances.

Funding

If an individual is approved for publicly subsidized LTC services, they will pay a monthly rate of up to 80 percent of their after-tax income towards the costs of housing and hospitality services. This will be assessed by an RHA caseworker and there are minimum and maximum amounts an individual is required to pay, especially if a couple in is Long-Term care together. Serious financial hardships will be assessed by RHA caseworkers and may be approved for special circumstances fully paid support and/or temporary reductions. By responsibility of the service user, additional support services and personal amenities can be purchased in LTC facilities at a reduced rate.

Group Homes

Group Home services are unlicensed congregate housing arrangements where people with disability or other unique conditions share personal care resources. These services are designed to maximize independence and to support building responsibility, especially in areas such as household management, vocational pursuits, community involvement and relationships. Group Homes are often operated by non-government organization or non-profit societies and range from stand alone residences to apartment complexes to accommodate four to six residents.

Eligibility

To be eligible for Group Home Services, the applicant must meet the basic eligibility criteria for Home and Community Care Services in addition to Group Home specific criteria, as follows:

Program	Criteria
Home and Community Care Services *(Requirement for all the 11 programs offered)*	• Be a Canadian Citizen (some exceptions may apply) • Be a resident of British Columbia for at least 3 months (some exceptions may apply) • Be 19 years of age or older
Group Homes	• An adult with a disability that could benefit from a group living setting to help support personal and community independence
Group Homes *(Many, not all, of these requirements must be met to be accepted into FCH)*	• Be assessed as requiring group home services • Be appropriately matched with the residence • Be compatible with existing clients • Can make independent decisions, either individually or in cooperation with others • Have agreed to pay the assessed client rate.

Funding

If an individual is receiving group home services, there is no required client rate, but there the home as a whole is responsible for sharing all living costs such as rent, food and utilities. Many individuals use a combination of personal income and government disability assistance income for these expenses.

Family Care Homes

Family Care Homes (FCH) offer services provided in a single-family residence that accommodates individuals with specialized care needs that cannot be optimally met in a long-term care home or are better suited in this type of environment. These homes provide a comfortable home-like atmosphere, balanced meals, laundry/housekeeping services, supervision, and another other assistance with activities of daily living the individual may need. Family Care Homes are unlicensed and can house no more than two clients at any given time.

Eligibility

To be eligible for FCH Services, the applicant must meet the basic eligibility criteria for Home and Community Care Services in addition to Family Care Home specific criteria, as follows:

Program	Criteria
Home and Community Care Services *(Requirement for all the 11 programs offered)*	• Be a Canadian Citizen (some exceptions may apply) • Be a resident of British Columbia for at least 3 months (some exceptions may apply) • Be 19 years of age or older
Family Care Home Services	• Have an immediate need for long-term care services and are unable to find other suitable alternatives • Would benefit from a more home-like environment
Family Care Home Services *(Many, not all, of these requirements must be met to be accepted into FCH)*	• Be assessed as requiring family care home services • Be appropriately matched with the residence • Be compatible with existing clients • Have agreed to pay the assessed client rate.

Funding

If an individual is approved for publicly subsidized family care home services, they will pay a monthly rate of up to 80 percent of their after-tax income towards the costs of housing and hospitality services. This will be assessed by an RHA caseworker and there are minimum and maximum amounts an individual is required to pay. If an individual receives support and/or shelter allowance under the Employment and Assistance Act or the Employment and Assistance for Persons with Disabilities Act, they will pay a fixed monthly rate for family care home services. Serious financial hardships will be assessed by RHA caseworkers and may be approved for special circumstances fully paid support.

Choice in Supports for Independent Living

Choice in Supports for Independent Living (CSIL) is a self-directed option for eligible home support clients that provides funding directly from the respective health authority for the individual to purchase their own home support services. CSIL clients become employers who manage every aspect of procuring, supervising, and paying staff to come into their home and assist with ADLs and iADLs.

Eligibility

To be eligible for CSIL services, the applicant must meet the basic eligibility criteria for Home and Community Care Services in addition to CSIL specific criteria, as follows:

Program	Criteria
Home and Community Care Services *(Requirement for all the 11 programs offered)*	• Be a Canadian Citizen (some exceptions may apply) • Be a resident of British Columbia for at least 3 months (some exceptions may apply) • Be 19 years of age or older
Choice in Supports for Independent Living	• An adult with a physical disability that desires more control and flexibility in managing home support services
Choice in Supports for Independent Living *(Many, not all, of these requirements must be met to be accepted into FCH)*	• Be assessed as requiring home support services as part of their care plan • Be assessed as having high physical care needs, a physical disability but are medically stable • Assessed needs have can be met within CSIL and available resources • Have agreed to pay the assessed client rate • Can safely coordinate and manage CSIL services or have a client support group or a CSIL representative

Funding

The applicants' regional health authority provides the funding for services, as determined, and outlined in an agreement between the health authority and the individual (also known as the CSIL employer). The amount is calculated by multiplying the CSIL hourly rate (which was $33.40 as of April 1st, 2021) by the number of hours of home support service the applicant requires each month. The number of hours required is based on a clinical assessment performed by the health authority.

Services to Adults with Developmental Disabilities

Services to Adults with Developmental Disabilities, or STADD, is a partnership between the following stakeholders:

- Ministry of Children and Family Development (MCFD)
- Ministry of Social Development and Poverty Reduction (SDPR)
- Schools and school districts province wide
- Delegated Aboriginal Agencies (DAAs)
- Community Living BC (CLBC)
- WorkBC Employment Service Centres
- Ministry of Advanced Education, Skills and Training (AEST)
- Health Authorities
- Public Guardian and Trustee
- Various other community organizations

STADD helps young people with developmental disabilities and their families with the transition from pediatric to adult services. A STADD navigator will make individuals and their family aware of supports and programs from the government and community organizations that they may be eligible for, help plan for the future, and provide ongoing adulthood transition support.

Eligibility

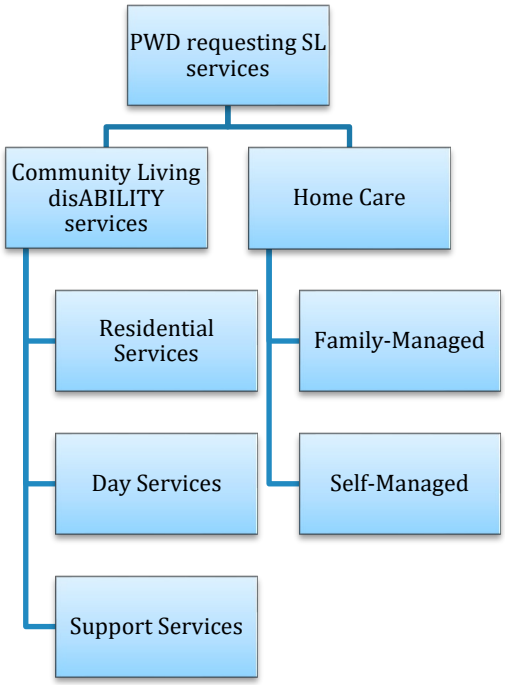
STADD provides services to individuals who have a developmental disability, Autism Spectrum Disorder, or Fetal Alcohol Spectrum Disorder, that are between 16 and 24 years of age, and would like help planning their future and navigating the transition period.

Planning

The STADD navigator will complete an unofficial assessment and review of goals to help them become familiar with the individual and their selected 'team'. This team, in addition to the navigator and the person with a disability, may include family members/guardians, caregivers, teachers, social workers, therapists, counsellors, government support workers, doctors and nurses. By working together, the team will help create a transition and ongoing support plan that will connect the individual to the relevant supports and services that will help them achieve their goals. The plan is divided into three categories: big goals, milestones, and action items.

Manitoba

The Department of Families is the main branch of the Government of Manitoba responsible for services for persons with disabilities. They, along with community-based partner organizations, offer a wide range of support services, including supportive living options, for individuals with a variety of disabilities. There are different streams offering supportive living services an individual may be eligible for depending on their type of disability, level of unmet needs and capabilities, types of supports wanted and needed, and support systems already in place.



Note: *Certain Supported Housing/employment Services may be provided by Regional Health Authorities as part of Community Based Mental Health Services but for the purposes of this SL review are not of interest to the NWT.*

Community Living disABILITY Services

Community Living disABILITY Services (CLDS) supports adults with intellectual disabilities live full and satisfying lives in the community of their choice. They offer a variety of programs based on the level of support everyone may require, the community they live in, and their personal goals.

Eligibility

To be eligible for CLDS services, an applicant must meet the following criteria:

- Have significantly impaired intellectual functioning with impaired adaptive behaviour, existing prior to the age of 18
- Be 18 years of age or older
- Require assistance to meet your basic needs with regard to personal care or management of property

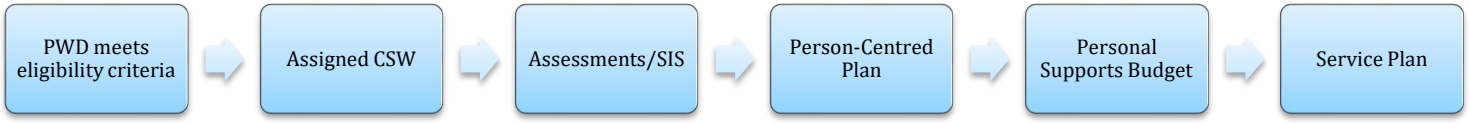
- Be a Canadian citizen or legal entitled to permanently live and work in Canada
- Be a person who normally makes their home in Manitoba or are ordinarily present in the province. (Does not include students or visitors)
- Have an established permanent residence off-reserve in Manitoba prior to referral or request for services, if of registered treaty status in Manitoba

An individual wishing to apply for CLDS services (or a family member, teacher, doctor, agency, etc. with the individual's permission) can do so by contacting one of the many local offices throughout the province. Certain support services offered through CLDS require further eligibility based on the unmet needs and goals of the applicant. This will help determine which services are best suited to the individual.

Model

After an applicant is deemed to have met the basic eligibility criteria above, they will be appointed a Community Service Worker who will complete an assessment on the individual focusing on their functional impairments, needs and personal goals, healthcare professional recommendations (usually a registered psychologist), and what supports have been helpful in the past. Part of this review includes the use of the Supports Intensity Scale, a standardized assessment tool that determines how often eligible participants need support, what type of support is needed and how much support they need in areas of daily life (see later section for more information). Following this assessment process, the Community Service Worker will help the individual and the personal support network of their choice (therapists, family, teachers, friends, etc.) develop a Person-Centred Plan.

This plan is intended to best reflect the applicant; it will explore the elements most important to the applicant, their goals, and what supports are needed to reach said goal(s). Based on this, a level of support is identified, known as their Person Supports Budget, which will help determine the type of services they are eligible for and the amount of funding they will receive. The individual will be assigned a Level of Need ranging rom 1-7 (1 being the lowest level of support needed and 7 being the highest). Once the Person-Centred Plan in in place and the individual receives their Personal Supports Budget, a Service plan is created to identify the support best suited for the individual.



The applicant's Community Service Worker then helps connect them to the services or supported funding by CLDS. These supports are listed below, categorized into 4 main streams:

1) Supports to People Living at Home with Family

Depending on the level and type of needs the service user has, these supports could include:

Respite

If this program is determined to be the best fit for the service-user and family's needs, a respite worker will either come to the home or take the individual out into the community with a focus on helping learn new skills to be more independent, participate in the community, follow a behavioural and/or rehabilitation plan. Respite services are intended for individuals assessed to have Level 1 or 2 needs. There are three options for accessing respite services:

Self-Administered Respite: service user and family hire, train, and pay the respite worker directly

Agency delivered respite: an agency will ire, pay, and manage respite works for the service user and their family

Manitoba Families Direct Service Providers: Direct Service Providers that are employed by the province may provide the service user and their family with respite.

In-Home Services

In home Services provide the service-user and their families with further support for complex needs. These services are only for individuals assess with Level 3-7 support needs.

Supports to families: These supports are intended to help the service user and their families to live well and functionally together. Supports may include person-centred and family focused planning, help with problem solving, before and after school/day service support, activities within the community, training or learning opportunities.

Outreach: Outreach support services are intended to be used during transitional or big change periods in the service users' life such as moving out of a family home, developing skills to live independently and meet personal goals, etc.

2) Day Services

Day Services are support designed to help young adults (minimum age of 21) with employment opportunities, job skill training, and community involvement.

3) Residential Services

CLDS provides support for individuals to live in a home that best meets their needs through the following four programs:

Living at Home with Family

A variety of supports to help family dynamics and find the best ways to support independence

Supported Independent Living

For individuals who live away from family (but may have roommates of their choosing sharing living costs) who need additional support in one of two ways:

Direct support from a Worker: eligible individuals will receive a set amount of support work from a professional per week to help manage household duties, shopping and meal prep, finances, etc.

Rent Top-Up: for CLDS eligible individuals who receive Employment and Income Assistance but will require additional financial support to live independently.

Home Care

This living situation involves the service user sharing a home with an unrelated adult or family care provider that helps supports their needs. The service user can choose to either access a home share model of care privately (meaning their CSW helps find a private family/person to provide the support) or agency managed care (where the agency then assumes all the responsibly of arranging a licensed home and support). It is an expectation that the service user pays a portion of the costs of living associated with the home, whether they use their own income, CLDS funds, or income assistance.

Shift-Staffed Homes

Also known as Group Homes, this option involves service users living in a group setting/house that is staffed 24/7 with support workers. Certain homes offer day programming and/or the opportunity to attend school or work throughout the day (returning to the home at night), while others offer in-home programming only. Both homes require the applicant to demonstrate significant support need.

4) Clinical Services

Offered to help determine program eligibility and help meet the service user's needs as identified in their Person-Centred Plan

Clinical Assessment

Assessments are offered in a variety of specialities including those to determine program eligibility, feeding, independent living assessments, behavioural assessments, and/or OT & PT.

Clinical Therapy

Short-term services are available to CLDS clients, including those utilizing residential services to help support mental health and well-being.

Crisis Intervention

Safety is a top priority for the CLDS program, and as such 24/7 crisis intervention and support is available to ensure the well-being of everyone involved.

Funding

Depending on which CLDS service the induvial is utilizing, a variety of funding models exist. However, where possible CLDS prefers to give funds directly to the service users to help promote independence, and they would then pay their service providers and provide an invoice/receipt back to CLDS. Where this is not possible, CLDS will pay the service provider directly, whether it be a contracted individual or a community-based organization.

The SIS (see later section) will assign a Personal Supports Budget number to the service-user from 1-7 that will also help determine the maximum amount of financial aid they are eligible to receive each month. Respite services usually receive the lowest amount of funds per month, while those accessing residential services, especially higher need options such as Shift-Staffed Homes, receive the highest. It is also important to note that depending on the location of the individual and the community in which they are accessing services, there are different rates (i.e., service users in more northern and/or rural areas receive more funding than those who live in larger centres). This is both due to the increased cost of living in northern/rural areas, and to allow service-users the opportunity to stay in their home community to access the necessary supports.

Transition Services

CLDS offers transition planning services for 'Youth in Care' who are eligible for CLDS in the future to help ease the transition between child and adult care. Transition planning may begin at age 15 and includes the following four steps

Step	Description
Step 1: Assessment	Starts at age 15. Through the case planning and clinical assessment process, the youth's needs are identified
Step 2: Referral	Done around age 15/16 by a Child and Family Services Worker. Ensure that a referral application along with supporting documentation and assessment(s) are submitted to CLDS
Step 3: Planning	Should start prior to age 17. CLDS eligibility will ideally be confirmed and communicated to the referral source. The CFS worker and CLDS CSW work together to develop the transition plan and service plan for CLDS supports.
Step 4: Transition	When the individual turns 18 they will transition into CLDS. The CFS worker and CLDS CSW continue to meet and review the effectiveness of the transition and service plans until the individual has fully transitioned (and comfortably) into CLDS programming

Home Care

The first ever program in Canada, Home Care in Manitoba is a community-based program provided through the Regional Health Authorities (RHAs) and in collaboration with the Department of Health (policy & planning), to eligible Manitobans who require health services or help with daily living activities. Although Home Care offers a range of supports, in the context of Supported Living the most relevant services offered are:

- Personal care (bathing, dressing, toileting)
- Home support (cleaning, laundry, meals)
- Health Care (nursing, therapies)
- In-home relief to caregivers and/or respite care services in alternative settings
- Community housing with supports
- Access to alternate care settings (ex. Personal care homes)

These services may be provided in the individual's home, educational setting on workplace based on the assessed needs. Families or individuals may have the opportunity to manage their own home care services through family-managed or self-managed care options (which is unregulated and allows them to be the responsible employer), or individuals can have their care managed through their respective RHA, more specifically an RHA Case Coordinator. Funds are provided directly to the individual or Family if they choose that option so they can arrange private service. Otherwise, service providers are RHA employees, and the service user does not receive the funding as it stays within the health authority.

Eligibility

To be eligible for the Home Care program, the applicant must be a Manitoba resident and registered with Manitoba Health. They must also demonstrate they require health services or assistance with activities of daily living and that their need is higher than any current of potential community supports they are utilizing. Finally, they must also require service to stay in their home for a long as safely possible.

Assessment

In addition to the basic eligibility criteria above, applicants must partake in an assessment completed by a RHA Case Coordinator, who are healthcare professionals. The case coordinator will meet with the applicant, and if appropriate any other members of their support system (family, friends, professionals, etc.) to discuss care needs and what services will meet said needs. From this assessment, a care plan is established.

Supports Intensity Scale

The Supports Intensity Scale (SIS) is a standardized assessment tool used by CLDS to identify the support needs for individuals receiving services in Manitoba. The SIS is a valid and reliable assessment tool developed over a five-year period by a team from the American Association on Intellectual and Developmental Disabilities (AAIDD), specifically designed to measure the type of support, frequency of support, and the intensive of support an individual needs to fully participate in personal and community life. It has been created for person-centred planning, standardized for individuals with intellectual and developmental disabilities, and his been successfully implemented in jurisdictions across North America. More information on the Supports Intensity Scale can be found at https://www.aaidd.org/sis

The SIS measures support needs in the areas of home living, community living, lifelong learning, employment, health and safety, and social activities usually for individuals aged 16-72. It also assesses how an individual protects and advocates for themselves and what (if any) extra support might be needed to manage exceptional medical and/or behavioural needs. The SIS can be used in conjunction with other assessment tools if necessary or as a standalone tool. The assessment process is done through an assessment form and a guided interview with the individual and those who know them best. This data is collected and entered to transformed into scale scores.

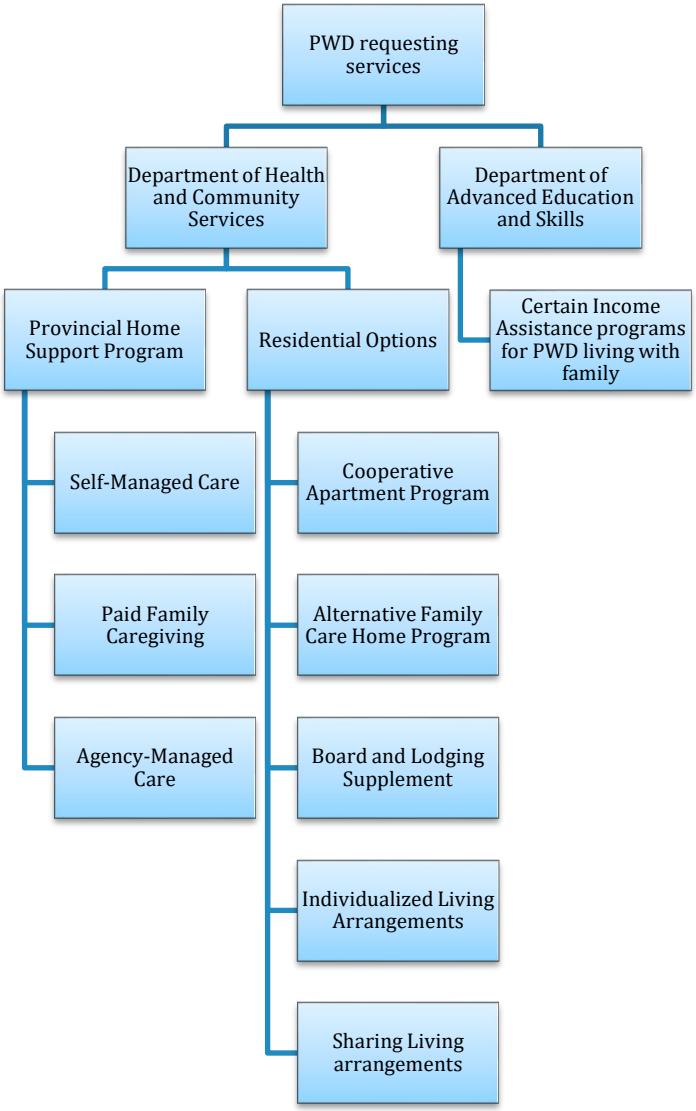
Using the SIS scale scores, the assessed individual is assigned a Level of Support Need from 1 to 7 (1 being the lowest level of need and 7 being the highest). This number is one of the biggest

contributing factors in how CLDS determines the amount of allocated monthly funding an individual is eligible for. The results of the SIS and Support Budgets will be 100% shared with the individual and their chosen support team and encouraged to become involved in their support plan and care. CLDS states that:

> *Supports Budgets create a truly Person-Centred process by assuming that people with Intellectual Disabilities can and should take an active role in every part of service planning*

Newfoundland & Labrador

The Newfoundland and Labrador Department of Health and Community services provides, among others, policy direction, funding, and operation standards to the four Regional Health Authorities (RHAs). In return, these authorities deliver the province-wide programs and services to individuals with disabilities and their families. The majority of supportive living services are funded by the Department of Health and Community Services and delivered either through the Provincial Home Support Program or through the Residential Options program.



Provincial Home Support Program

The Home Support Program (HSP) is intended to help support individuals to live independently in their own home (or that of a relative's) for as long as possible. It is available on a short- or long-term basis and helps to provide (usually) non-professional assistance to help an individual with personal care and homemaking, respite care, and behavioural support. The services provided through the HSP are intended to supplement, and not replace, the support already provided by the individual's family and/or support network. Unless otherwise stated in the individuals Support Plan, services are non-professional in nature and are delivered in one of three ways:

- Self-Managed Care
- Paid Family Caregiving
- Agency-Managed Care

Eligibility

The Provincial Home Support Program is available to residents of Newfoundland and Labrador who have a valid provincial health care card and fall into one or more of the following categories:

- A senior (65 years of age or older)
- An adult with a disability
- A child with a disability
- A person requiring end of life care or short-term support upon discharge from hospital to aid in recovery

The applicant must also display the need for assistance with their activities of daily living (ADLs) that cannot be met on their own or with their current support system. Once they meet the above criteria, a social worker or community health nurse from their respective Regional Health Authority will complete an assessment that considers all areas of their life including personal care, homemaking needs, social and community inclusions, and personal goals, needs, and abilities. Part of this process includes the use of the interRAI assessment tool. Depending on the applicant, this can specifically include RAI-HC or RAI-ID. The social worker or community health nurse will discuss the individuals' needs and goals with them and their family/support members to help determine which support services are best suited.

Service Model

Once the applicant has met the eligibility criteria and undergone assessment by a social worker or community health nurse, a Support Team is established, and an Individualized Support Plan (ISP) is created. Depending on an individuals' needs and goals, members of Support Team may include a combination of a Social Worker, Community Health Nurse, Behavioural Management Specialist, Dietitian, Licensed Practical Nurse, Physician, Physiotherapist, Occupational Therapist, Pharmacist, Home Support Worker, and/or Informal Caregiver(s). Working alongside the individual and their family, the Support Team creates an ISP that is then shared with the Supported Living service provider (see below). A yearly clinical review will be completed to ensure the ISP is still meeting

the individual's needs and goals to maintain overall wellness. Dependent on the level of support needed and individual circumstances, an HSP participant can access the Program one of three ways:

Self-Managed

Should an individual choose the Self-Managed route, they are responsible for choosing and employing their own support service provider; essentially becoming the employer and thus responsible for recruiting, hiring, training, scheduling, supervising, paying, and terminating employees. If the individual is receiving additional funding for these services from the DHCS they must provide receipt of service hours and bookkeeping. In accordance with the Self-Managed Care Provider Handbook published by the DHCS, the Service Providers must also provide regular progress reports to their respective RHA case manager and the Department.

The services provided by Self-Managed Care Providers usually fall within one or more of four categories:

Service	Description
Personal Care	Support with self-care activities and ADLs • *Including eating, bathing, grooming and oral care, dressing, toileting, positioning and transferring, mobility/ambulation*
Homemaking	Support for household activities such as light housekeeping, laundry, vacuuming, and in-home meal preparation • *Can also include feeding support*
Respite Care	Support to provide substitute caregiving services so that primary caregivers can get temporary relief or support • *Including medical appointments or church activities that support their caregiving role*
Behavioural Support	Support for individuals living in the community who may need help due to behavioural concerns. A Behaviour Management Specialist will help implement programs and interventions • *Including support with personal development (such as understanding relationship boundaries), social relationships, social inclusion, emotional well-being, and physical well-being*

Paid Family Caregiving

This option is similar to Self-Managed Care which the exception that you choose a family member for your support provider. An individual's spouse or common-law partners are not eligible.

Agency-Managed Care

If an individual chooses this option, they will receive home support services through an approved community agency. These agencies are approved by the Department and must comply with a set of regulations and standards. They provide Progress Reports on the individuals utilizing HSP to the respective Regional Health Authority. A complete list of approve Home Support Agencies is available on the Department of Health and Community Services' website.

Funding

For all three options of the HSP, it is expected that most costs are paid for by the individual and/or their family. However, there are varying levels of public grants to help subsidize the costs. To be eligible for such a subsidy, the individual must undergo a functional and financial assessment by a staff member from the RHA. In addition, a service user may also utilize their income support from the government as a registered person with a disability to pay for their services.

Residential Options

The Department of Health and Community Services offers five residential options for individuals needing more or different supports than those offered through the Provincial Home Support Program. They are as follows:

Option	Description
Cooperative Apartment Program	This program offers a private residential setting that is operated by an incorporated community board of directors and is staffed by both live-in and relief staff. These residences are usually rented houses and are shared by up to three adults, all of whom have intellectual disabilities. The goal of this program is on skill teaching and supports to emphasize independent living • *A provincial Standards Manual for the Cooperative Apartment Program exists*
Alternative Family Care Home Program	This program offers private homes approved by the Regional Health Authority for up to two unrelated adults with intellectual disabilities in a family atmosphere. These homes provide room and board, supervision, as well as personal and social support. Further supports and services are available as necessary, such as a personal support worker who visits the home daily (if needed). Monitoring of the home and an individual's progress is provided by the RHA assigned social worker. • *A provincial Standards Manual for the Alternative Family Care Home Program exists*
Board and Lodging Supplement	This option provides a funding supplement that is available, based on assessed needs, to adults (18 years of age or over) with psychiatric, physical and/or intellectual disabilities, who reside either with relative or non-relatives. These individuals have been identified as having higher needs thus requiring a higher board and lodging rate than the amount normally allocated. • The basic rate of board and lodging is available through the Department of Human Resources, Labour, and Employment (HRLE) and the supplement is available from the RHAs
Individualized Living Arrangements	If no other option is found to be best suited for an individual with an intellectual disability, an Individualized Living Arrangement is established. They must meet home support criteria but be unable to reside with their natural family. While this program usually supports one client per home, there may be situations approved where the living arrangements are shared by individuals who wish to reside together. • The funding for basic income support is provided by the Department of Human Resources Labor and Employment (HRLE) with additional funding for home support and other related costs provided by the RHAs. Once

	established, the ILAs are managed by the individual, family, or operations committee.
Shared Living Arrangements	In some instances, individuals with disabilities who require a higher level of home and living support may choose to share the cost of a living arrangement and home support staff with other individuals with disabilities. Funding may be provided from several sources such as the Department of Human Resources, Labour, and Employment (HRLE), the Department of Health and Community Services (DHCS), and the Regional Health Authorities (RHA) • As in an individual living arrangement, all benefits of income support including rent, heat, and electricity along with any other benefits available, are obtained from HRLE and supplemented as per policy by RHAs and the Department of Health and Community Services

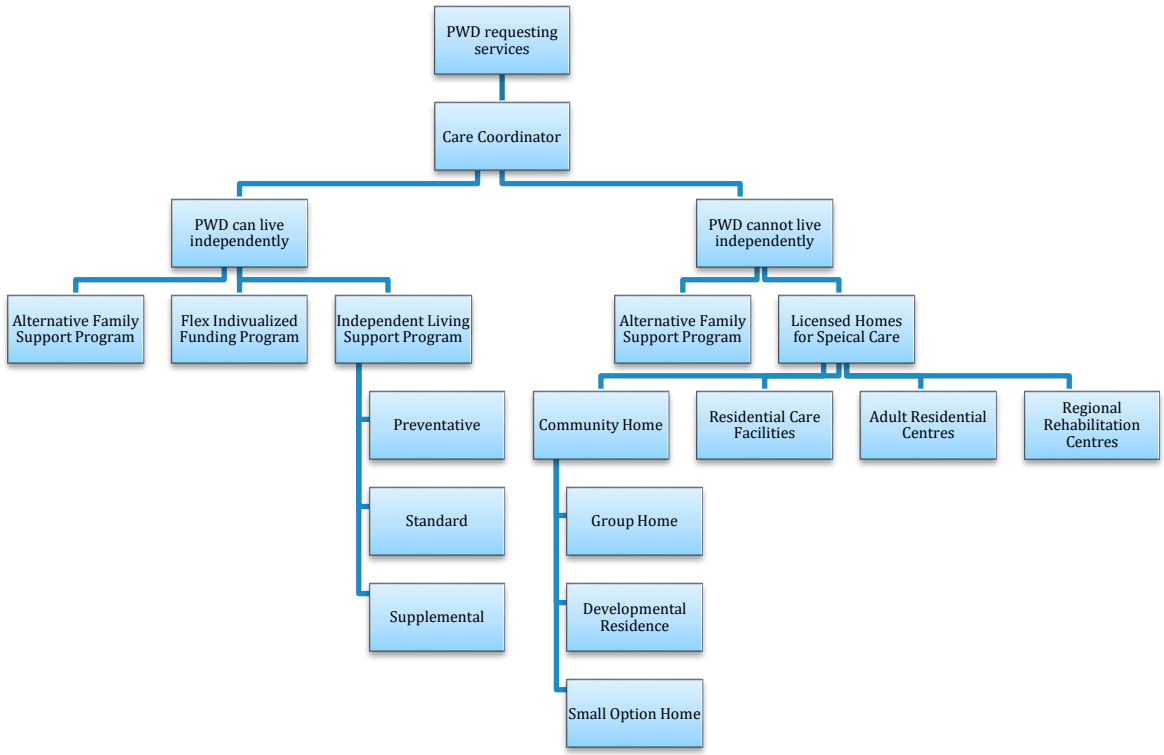
Eligibility & Funding

Eligibility requirements are different for each of the five categories of Residential Options; an individual must contact their RHA to determine the exact criteria and undergo assessment. The amount of funding provided to the service user by the government and RHA is determined based on their assessed income and a combination of other financial aid from other social programs offered by the Government of Newfoundland and Labrador, such as income assistance.

Nova Scotia

The Nova Scotia Department of Community Services (DCS) operates the Disability Support Program (DSP), a wide variety of policy and programs designed to support individuals with intellectual/physical disabilities and/or long-term mental illness. Within this umbrella-type program are two options for individuals wishing to access supported living and varying levels of supportive services they may require.

An individual, or a family member on behalf of an individual, would contact the DSP office and be directed to a DCS staffed Care Coordinator who would help assess and determine the type and level of care the individual would be best suited for. If the individual can live independently, meets the eligibility criteria and (usually) has their own residence, they are directed to a branch of three programs: Flex Individualized Funding Program, Alternative Family Support Program, or the Independent Living Support Program, the later of which is broken down further into three categories based on the number of hours and type of support needed. If the individual cannot live independently, meets eligibility criteria, and requires a residence they are directed to either Alternative Family Support Program or to Licensed Homes for Special Care. These homes in this last program are residential support options divided into five types of homes based on the level of support and need individuals required.



General Disability Support Program Information

As part of Nova Scotia's Department of Community Services, the Disability Support Program is the over arching body of support services for people with disabilities. To be eligible for any of its programs and services, an individual must first complete the DSP intake process and meet eligibility criteria before being assigned a Care Coordinator, undergoing an assessment, and finally accessing services.

Eligibility

To be eligible for any of the DSP programs or services, the following main criteria must be met:

Requirements	Criteria
Disability	Must have a diagnosis that confirms one or more of the following disabilities based on the definitions outlined in the DSP Policy: • Intellectual or Developmental Disability (does not include learning disabilities) • Long Term Mental Illness • Physical Disability ** An individual with an Acquired Brain Injury may also fall within one of these categories and qualify for DSP services depending on their functional assessment **
Age and Residency	• 19 years of age or over (exemptions can be made in certain scenarios) • Lawfully entitled to be in and to remain in Canada • Makes their home in and is a resident of Nova Scotia • Has a valid Nova Scotia health care card
Other	• Provide a physician report – medical assessment • Consent to participation in an assessment for SDP services (includes the collection and sharing of their information for the purpose of determining eligibility • Undergo a functional assessment of their support level requirements • Complete a program application • Undergo a financial assessment

Once an individual meets the DSP requirements and completes the intake process, their assigned Care Coordinator completes an assessment of needs and goals, functional capabilities, health conditions, support networks, financial resources, etc. and are subsequently categorized into one of five different Level of Supports (level 1 being the most independent and level 5 being requiring the most support. This will help determine which DSP services and supports the individual is best suited for. The assessment tool used by the DSP is extensive and was internally developed after consultations and reviews of Best Practice guidelines

Flex Individualized Funding Program

Also known as Flex, the Flex Individualized Funding Program provides people with disabilities who live at home with their families or can live independently, with funding. This funding is used to:

- Purchase supports specific to a participant's disability-related needs and goals
- Promote the participant's independence, self-reliance, and social inclusion
- Offer an alternative to, prevent, or delay a participant's placement in a DSP funded residential support option

This program is intended to supplement the supports that a participant receives from their family/personal support network and through other standard community resources available to residents of Nova Scotia. It is divided into three categories based on how much monthly funding is provided to participants: foundational, intermediate, and enhanced.

Eligibility

In addition to the general DSP eligibility requirements and a completed assessment of functional abilities and financial resources, an individual wishing to access Flex funding must demonstrate that they have sufficient personal support networks. A Care Coordinator will also assess their level of responsibility with managing money, arranging their own supports, and ability to report to DSP. The eligibility and support needs of a Flex funding participant will be reviewed at a minimum of every two years.

Funding

Flex funding is paid directly to eligible participants, or the person acting on their behalf. This money may be used to purchase supports directed related to their needs and goals. The Casework Supervisor can approve a Foundational Allowance and Intermediate Funding up to $2200 per month. Should an individual require future support, a DSP director may approve an Enhanced funding arrangement (subject to the availability of DSP financial resources). Examples of potential supports to purchase are:

- Day activity programming
- Evening and overnight in-house support
- Weekend support
- Personal Support Worker hours (limited per week)
- Community participation
- Skill development

Note: *Flex is not intended to pay for full time 24/7 support services, compensate a participant's primary caregiver, parents, spouse, or children for providing support, nor to prevent, delay, or serve as an alternative to, a participant's placement in a Department of Health and Wellness support options such as Nursing Homes.*

Alternative Family Support Program

The Alternative Family Support (AFS) Program provides an approved, private family home, where support is provided for up to two persons who are not related to the AFS provider. Participants may receive varying levels of support with activities of daily living, and routine home and community

activities. The program expands the range of sustainable options available in the community and allows individual needs to be met in a more flexible and personal manner. The goals of the AFS Program are to:

- Provide a safe and secure place to live in a family-like setting
- Offer an environment that encourages and supports participants' participation in day-to-day activities and decisions
- Assist participants in achieving the highest level of independence possible
- Support and promote community participation
- Offer an alternative to, prevent, or delay a participant's placement in a DSP funded residential support option

DSP contracts approved AFS Providers to provide residential support to people with disabilities. Individuals wishing to offer their home environment for the AFS program have applied, been carefully screened, had a home assessment done, and completed orientation and training modules from DSP. DSP also conducts ongoing monitoring of the AFS Providers and their homes.

Eligibility

In addition to the general DSP eligibility requirements and a completed assessment of functional abilities and financial resources, an individual wishing to participate in the AFS Program must:

- Demonstrate that their assessed support needs can be successfully accommodated in an AFS setting
- Ensure that the appropriate supports identified in the Care Coordinator's assessment are available
- Demonstrate they do not require long term or ongoing night awake support
- Ensure the placement is within approved funding levels of AFS Program resources
- Applicant or the person acting on their behalf agree that the available AFS placement is indeed an appropriate residential program option.

Once an AFS Program participants meets all eligibility criteria and is approved, they are matched by the efforts of a Care Coordinator with a AFS Provider.

Funding

If the AFS Program participant is assessed to be unable to manage their own financials, funding from DSP is paid directly to the approved AFS provider. If the participation can manage their own financials, DSP directs the funding to them, and they assume the responsibility of paying the AFS provider.

Independent Living Support

The primary supported living option in Nova Scotia is known as the Independent Living Support (ILS) Program, a community-based option that assists with the necessary funding to obtain support services from a Service Provider. There are three level of support services offered and the placement of an individual is dependent on their assessed needs and individual circumstances. The goals of the ILS program are to:

- Assist a participant to maximize independence in their instrumental activities of daily living (ADLs), such as:
    - Maintaining a household
    - Laundry
    - Shopping and baking
    - Preparing meals
    - Transportation for community access and involvement
    - Participating in leisure, volunteer, or work activities
- Assist a participation to build and maintain connections and relationships with family, friends and other community members and resources
- Assist a participant with the promotion and maintenance of their health and wellness
- Recognize the potential of a participant and facilitate opportunities for their continuing growth and personal development
- Delay the need for, or assist in the prevention of, admission to a staff residential support option

It is important to note that this program is <u>not</u> to be used as a funding source for 24/7 care.

<u>Eligibility & Assessment</u>

Eligibility for the Independent Living Support is based off an individual's eligibility for the overarching Disability Support Program, in addition to the applicant ability to:

- Be alone at home and in the community for periods of time
- Independently evacuate from their home in the event of an emergency
- Access crises support and/or use an emergency response system
- Manage their medication, and other personal safety risks to themselves, other or their environment, safely and reliable, either independently or with available supports
- Communicate their needs and preferences to others, and participate in decisions about their needs and activities
- Participate in the individual assessment and support planning processes

Once an individual meets the DSP requirements and completes the intake process, their assigned Care Coordinator (or in necessary cases, a Specialist) completes an assessment of needs and goals, functional capabilities, finances, etc. Once assessed, participants are assigned one of three categories- preventative, standard, or supplemental – that determine the amount, type, and level of services they qualify to receive.

<u>Service Providers & Model</u>

Providers

As per the ILS policy, Service Providers are individuals or community organizations that are contracted through the Department of Community Services, Disability Support Program. These individuals and community organizations must meet certain qualifications/eligibility criteria. For ILS Program participants categorized in the Preventative option, contracted individuals are more often used whereas for those categorized in the Standard or Supplemental categories use

contracted community organizations (such as Community Living Nova Scotia) due to the need for more support.

Model

Once an individual has been approved for ILS programming, they can either seek out their own approved DSP Service Provider or their Care Coordinator can help them establish a relationship with one. In collaboration with the participants' Care Coordinator, people of their choosing such as family or friends, and the ILS service provider, a support plan is created and scheduling set. The preference is to provide the ILS funding directly to the participant who then pays their service provider (who must provide DSP with an expense report), but it is possible for DCS to enter into an agreement directly with the service provider on behalf the participant.

Funding

Financial aid is provided to purchase hours of support needed by a participant from an approved ILS Service Provider. Funding for the pre-determined hours of support for an individual comes directly from the Department of Community Services, as seen below.

ILS Program Funding	Maximums
*Total ILS funding may not exceed **$3400** per month per participant*	
ILS Options for Hours of Support	
Preventative A participant who only requires minimal support with instrumental activities of daily living to live on their own.	Up to 12 hours per month and up to 90 additional hours annually.
Standard A participant who requires ongoing skill development and weekly assistance with a variety of instrumental activities of daily living to live independently in their own home.	Up to 90 hours per month, equivalent to up to 21 hours per week.
Supplemental A participant who has ongoing increased support needs and may require more monthly funding than the equivalent of 21 hours of support per week to live independently in their own home due to their need for additional supports described in section 6.1.4 of this policy.	Standard plus an addition 10 hours per week, or the equivalent to $1000 per month in other supports.

Licensed Homes for Special Care

Separate from the Independent Living Support program, the Disability Support Program provides five different levels of residential supportive living options for adults with disabilities. The goal is to create a range of residential programs that can support people at various stages of their development and independence. These homes provide support and supervision in home with three or more beds. The options for placement in any of the Homes for Special Care are limited to the Level of Support the participant requires and the support/programs offered at the residence(s).

Eligibility

Comparable to the ILS program, individuals wishing to access Licensed Homes for Special Care must also meet the DSP criteria. Further eligibility for these homes is determined through an assessment of both financial resources and functional capabilities. The assessments are conducted by a Care Coordinator and if necessary, a Specialist who provides recommendations.

Service Model

Once an individual meets the eligibility criteria, is assessed, and determined to fit within this program, their Care Coordinator helps them, and their families (if applicable) explore which of the Licensed Homes best suits the needs and goals of the individual. The follow table provides a description of each of the homes and the supports/services they offer:

Licensed Homes for Special Care	Description
Small Option Home	Provide support for three to four persons with disabilities in community homes. The residents in these homes are supported by qualified staff through a combination of live-in and shift models
Group Homes / Developmental Residences	Provide a continuum of developmental rehabilitation programs for individuals with disabilities in four-to-twelve-person residential settings. They emphasize the develop of inter-personal community-oriented skills, and ADLs. Group Homes primarily serve younger persons with one of more of the following types of disabilities: intellectual disability, long-term mental illness, or physical disability. Comparatively, Developmental Residences primarily serve younger adults with an intellectual disability or dual diagnosis
Residential Care Facilities	Provide a residential support option to four or more adults with disabilities only require minimal support and supervision with routine personal-care activities, community skills and activities. Individuals are thus provided with limited direct support and must not have any major health or behavioural support needs,
Adult Residential Centres *	Provide long-term structures supports and services to adults with disabilities to enhance the development of their interpersonal, community oriented and ADL skills. Approved support is provided on a 24 hour /7-day a week basis by onsite professional staff
Regional Rehabilitation Centres *	Provide both rehabilitation and developmental programs to adults with disabilities who require an intensive level of support and supervision related to com-plex behavioral challenges and skill development needs. Approved support is provided on a 24 hour /7-day a week basis by on-site professional staff.

** **Note:** Nova Scotia's Disability Action Plan emphasizes the goal of phasing out ARCs and RRCs as supportive living options and instead shifting to more community-based supports. Therefore, as of 2017, the Department of Community Services has terminated all funding to these two options. Current residents are encouraged to seek other options but have the opportunity to stay for the time being. However, no new clients are or will be accepted.*

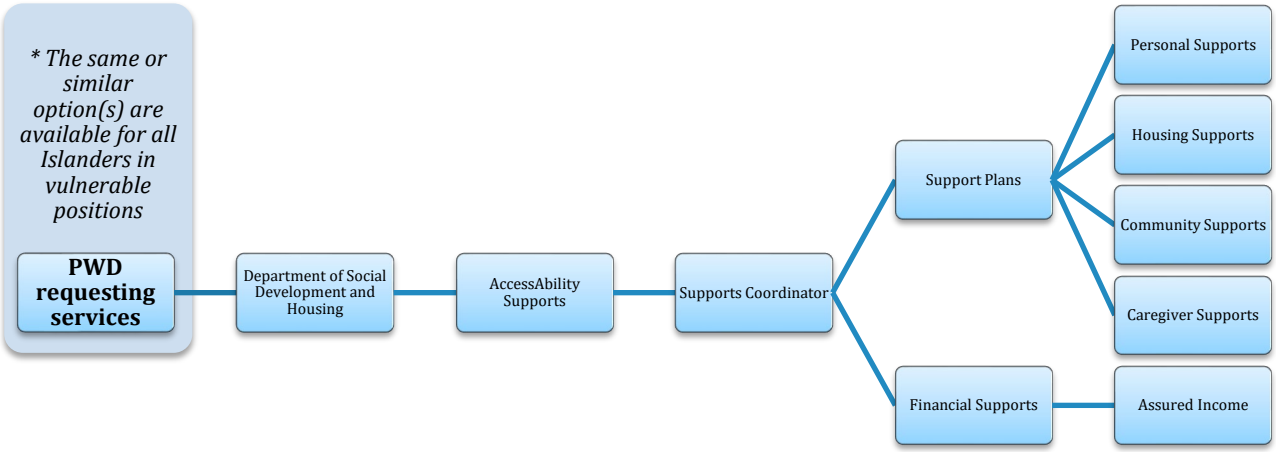
Funding

No specific funding information is available to the public for this program as it often operates through a collaboration of DSP and income support funds.

Prince Edward Island

AccessAbility Supports

The Prince Edward Island (PEI) Department of Social Development and Housing (DSDH) supports residents in need and assists them in becoming more self-reliant. Within this department lies the People with Disabilities division who strives to ensure that Islanders living with disabilities can access the tools and supports necessary to reach their full potential and contribute to society and their communities. Originally known as the Disability Support Program, in 2018 the PEI government expanded its services to offer new and improved supports and is now known as AccessAbility Supports (AAS); the overarching program name that offers a plethora of services. These services are not only offered to people with disabilities, but to all Islanders in what they describe as vulnerable positions (i.e., low-income families, PWD, individuals without a home, etc.).



Eligibility

There are a variety of different eligibility criteria for the AccessAbility Supports Program depending on which category you are applying for (i.e., caregiver support services, family income assistance, etc.). As the majority of AAS services are indeed used by people with disabilities, the following criteria is specifically for these applicants:

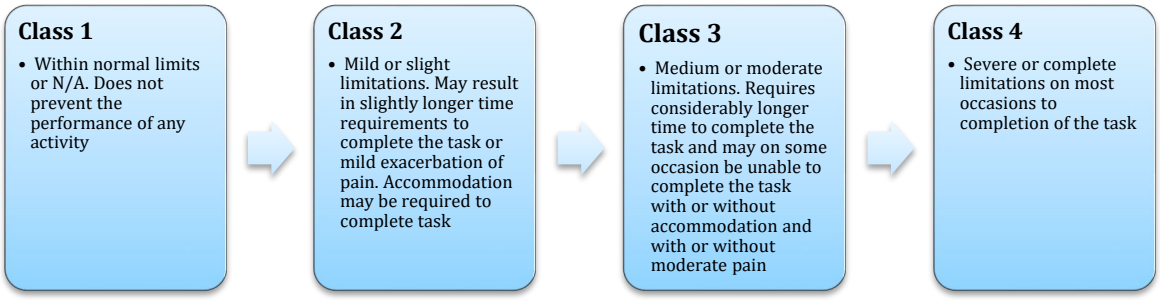
- Applicants must be under the age of 65, a resident of Prince Edward Island with a provincial health number, and have a substantial physical, intellectual, sensory, neurological, or mental impairment diagnosed by a medical practitioner. This disability must be continuous or recurrent, and expected to last for at least one year. The direct and cumulative effects of the impairment on the person's ability to attend to personal care, function in the community, or function in a workplace resulting in a substantial restriction in one or more of these activities of daily living.

The applicant must also participate in an assessment(s) by the program that will confirm the degree of impairment, the level of unmet needs, and required supports. A similar assessment would also occur if an individual did not have a disability but was still accessing the service under AccessAbility Supports. A yearly review is conducted by the individuals assigned case manager, known as a Supports Coordinator.

Note: *If an individual applies and is accepted into the AAS program before the age of 65, they can remain a part of the program for their rest of their lifetime. However, an individual 65 years or older may not apply for the first time or be accepted into the program, no exceptions.*

Service Model

Once an individual meets the eligibility requirements, they will be assigned a Supports Coordinator who will complete an assessment of the level of impairment the individual is experiencing, a clinical and/or health assessment, a support needs assessment, and a financial assessment. The different assessments are amalgamated into one evaluation process that has been developed internally through collaboration with many governmental departments, best practice guidelines, and healthcare workers. The applicant is placed into one of four categories based on the restrictions they face to everyday tasks; restrictions being defined as the limitation(s) to the activities of daily living arising directly or indirectly from the impairment. The categories are as follows:



Once this assessment is completed, a Supports Coordinator will navigate all available AAS services and develop a personalized plan to meet the individuals needs. This plan may include consultation and collaboration with the applicant, healthcare providers (including physicians, occupational and physical therapists, community health nurses, etc.), family members and/or caregivers. Depending on the needs highlighted in this plan, the individual will be eligible for one or more of the five AAS categories of support. Once it has been established which category or categories would best serve the individual's needs, the Supports Coordinator helps implement the necessary funding, resources, personnel, and ongoing support as is needed. The table below provides a brief description of the services offered within each of the five Support Plan Categories, of which some are not directly related to supportive living services.

Type of Support	Description
Personal Supports	*Help with personal daily living assistance such as:* • life skills training and help in areas such as meal preparation, budgeting, grocery shopping, and recreational activities. • funding for technical aids and assistive devices such as a wheelchair • supports that enable an individual to be self-sufficient and live as independently as possible (such as in-home supports or client-hired personal care workers)
Housing Supports	*Help with Independent living and may include assistance such as:* • funding residential supports: supervised housing in a community-based setting that is provided by NGOs that have entered into a contract with the DSDH (these are not operated or staffed by the Department, but the Department creates standards and operational policies) • financial help to support home or vehicle modifications
Community Supports	*Help increase active participation in the community and may include:* • supports and services to promote inclusion in the community, to assist with participation in the community, and to develop personal competence to access community services and supports • employment focused services to assist applicants with disabilities in preparing for, obtaining, and maintaining meaningful employment
Caregiver Supports	*Help family members or caregivers and may include:* • respite for caregivers to allow for breaks to recharge • support to provide supervision for adults who are unable to stay home alone safely so that caregivers can go to work or school
Financial Supports	*Help with basic living expense and may include:* • assistance for basic needs such as food, clothing, shelter, household, and personal supplies through what is known as Assured Income *(see section on funding)*

These AAS services are funded partially through the personal/family funds of the individual and through the Department of Social Development and Housing (see Funding section). The amount of funding an individual is eligible for is determined based on their level of need (11 categories with predetermined monthly maximum payments that range from $400 or $4,000). A more in-depth description of supports and services that can be funded through AAS is available online.

Funding

Funding for AccessAbility Supports is dependent on the service/support the participant is accessing, their support needs, their level of income, and/or if they need Assured Income (AI). For housing supports (residential living or 24/7 in-home support), the usual process is for the DSDH to pay the community NGO (who they have entered into a contract or contribution agreement with) directly for the provision of service for each client utilizing said service. This financial contribution may not cover the entirety of the costs for housing supports, so the service user must either use their own funding through Assured Income or enter into an agreement with the NGO they are receiving services from.

For the other AAS services, partial funding is provided by the DHDS directly to individuals with disabilities to purchase the required supports needed to live as independently as possible. These supports can include daily check-ins and assistance from a personal support worker, community day programming, grocery shopping and meal preparation, etc. The individual is responsible for hiring the person(s) they would like support from and for paying them for said services. Financial Support is also available for individuals using AAS and are living with parents or relatives. This section of financial support is intended to help with shelter costs and/or any additional supports that help the individual live as independently as possible (policy 3.4.4)

Individual Contribution

As mentioned above, it is a possibility that the individual utilizing AAS services will need to contribute financially themselves to receive the necessary supports. The amount is determined through the individual's total income and policies set by the DSDH, and the following equation:

Line236(00) on Tax Forms – Annual Income Threshold = AAS Eligible Annual Household Income

The applicants Annual Income threshold is a DSDH set amount determined based on the size of the household, regardless of if only one of the individuals in the home has a disability. This amount is subtracted from line 236(00) on the applicant's federal tax form to determine the percentage they will have to contribute to AAS supports and the amount of financial assistance they can receive. The less they are over the pre-determined threshold, the less they will have to contribute and vice versa. If the applicant is entirely dependent on AAS Assured Income, they do not have to contribute any funding for their support service(s).

Assured Income

In addition to the Support Plans, AAS offers Assured Income support to eligible Islanders in need (often who have disabilities) with monthly financial supports to use towards securing basic needs. This includes essentials (such as clothing, household supplies, etc.), food allowance, shelter supports, communication supports, special needs, medical supports, transportation, and any other supports that would allow the individual to live as independently as possible (such as the five categories of Support Plans from AAS). The monthly entitlements provided to the individual/family are determined by considering their necessary expenses, amount (if any) of income, family size, and if they have additional any additional challenges/barriers. For a people with disabilities, they may use this funding to secure living accommodations (24/7 support or not), additional living supports (such as personal support works to help with meal prep, bathing, etc.) and any other community or personal supports (as listed by the AAS Support Plan categories).

Transition Services & Programs

While PEI does not have an accountable or monitored pediatric to adult transition program, an individual within the AccessAbility Supports program is assigned a Supports Coordinator who stays with them and offers the same supports and services throughout their lifetime. Although there are issues with staffing, such as recruitment, retention and turnover, an individual is never left without a Supports Coordinator and all these positions are trained to offer the same continuum of supports and services regardless of the client's age. This is in an effort to mitigate the stress associated with aging out of pediatric services, and to offer stability to people with disabilities in managing their care.