



Review of Residential Supports – Final Report

NL Departments of Health and Community Services & Children, Seniors and Social Development

January 2023

“I am concerned for my safety and afraid of my neighbours. I am surrounded by people who use drugs and do illegal things. I wish I was able to find an apartment to rent that I felt safe in. I wish there were safer rental options that I could afford. When you're in my position you have no choice. You have to take what you get.”

- 25 year old male from Gander, receiving Board and Lodging (Non-Relative) supports

“He advised that staff would leave, sometimes staff he had known and been connected to, and they would leave without even saying goodbye.”

- Child in care, age 14 (as reported to social worker) in Level 4 placement

“I would have family-like settings created, with well paid staff, so that in a couple of years I can move out of my aging parents' home”

- 21 year old male, St. John's, receiving Board and Lodging (Relative) supports

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Executive Summary

Executive Summary

Background & context for this review

- Housing is a basic human right and requirement for good health. According to the United Nations' *Universal Declaration Of Human Rights*, the right to housing is protected under international law. Canada has endorsed such rights, guaranteeing "an adequate standard of living... including adequate food, clothing and housing."¹
- Most provinces also have endorsed this concept. While there are various housing strategies that are intended to provide Canadians to enjoy a safe and stable physical living environment, in which one has his or her needs met, is enabled to be as independent as possible, and participate meaningfully in the community, many Canadians remain challenged to live well in the place they call home.
- Many individuals – namely children, youth and adults with significant physical, intellectual and developmental disabilities, chronic and persistent mental illness or addictions – require supports of varying types and intensity in the place they live.
- For individuals with these needs, provincial governments typically provide a range of residential services and supports, which allow them to live more stable, productive and healthy lives, although there is variation in the types of residential services and housing supports that are offered by each province.
- Like many other jurisdictions, Canada has a bleak history of mass institutionalization of people with significant disabilities and mental illness. Records dating back to the 1800s indicate that many were housed in overcrowded conditions, without adequate care, education or community contact. Some experienced abuse.
- Most provinces have moved away from this institutional model to other types of community-based living arrangements where inclusion and independence are enabled. These provinces have taken bold strides along their journey of change, while others are beginning their journey to modernization.
- Many jurisdictions now face the challenge that community-based residential supports, services and social housing programs have not kept pace with client needs and complexities. Many issues such as

¹ Source: [National Housing Strategy Act](#), SC 2019, c. 29, s. 313

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What are residential supports and services?

Residential supports are a cornerstone of health and social programs in most Canadian provinces.

Residential support includes a broad array of services and supports including:

- Financial benefits
- Community access support hours
- Around the clock supervision
- Other forms of care depending on the individual's level of need

Services can be provided in an individual's home, family member's home, an apartment with support staff that may in or out, in a group or other supportive housing arrangement.

Executive Summary (cont'd)

Background & context for this review (cont'd)

those described in the box to the right, are believed to be present in NL as well.

- Provinces are seeking new ways to continuing supporting people in the community, and have tried a range of innovative models of support. Some of these models may be of interest to NL's residential support community.
- However, adoption of any models of residential services and support issues must be considered in the context of NL's significant demographic, geographic and socio-economic pressures – not the least of which is the economic crisis outlined in Dame Moya Green's *Big Reset* report published in 2021, and seismic changes anticipated by *the NL Health Accord* also released earlier this year.

Project Scope and Approach

- The NL Department of Health and Community Services ("HCS"), in partnership with Department of Children, Seniors and Social Development ("CSSD"), sought to better understand the current landscape of residential supports in the province, assess current and future clients needs, and to develop alternative approaches that will better meet these needs.
- Deloitte was engaged in 2021 to perform a review of residential supports and services in NL. The review focused on the needs of three specific client groups, as set out in the Project Charter:

Residential Supports in Canada

- A 2018 report by the Canadian Association of Community Living described the lack of access to housing and supports across the country as "institutionalization by default", even for those living at home¹.
- For example, an estimated 10,000 adults with intellectual disabilities across Canada under the age of 65 are living in hospitals, nursing homes or long-term care facilities because they cannot get the personal supports they need in the community².
- Another 13,200 adults aged 30 and older with developmental disabilities live with their parents because *an appropriate residential option does not exist* in the community at this time, including options designed for intellectual disabilities that are inappropriate for autism spectrum disorder^{3,4}.
- At least 235,000 adults experience some form of homelessness, including 25,000 to 35,000 each night, which results in \$1.4 billion each year in costs to the health care, justice and social services systems. Of these, an estimated 41 to 45% report previous involvement with the foster care system and difficult transition to adulthood⁵.
- An estimated 25 to 50% of homeless people live with a chronic, persistent mental illness⁶.

¹ Source: Canadian Association of Community Living (2018) <https://inclusioncanada.ca/wp-content/uploads/2018/07/CACLNHSubmissionJN8-FINAL.pdf>

² *Ibid.*

³ *Ibid.*

⁴ Source: CMHC National Housing Strategy Project <https://www.cmhc-schl.gc.ca/en/nhs/nhs-project-profiles/2020-nhs-projects/housing-through-an-autism-lens>

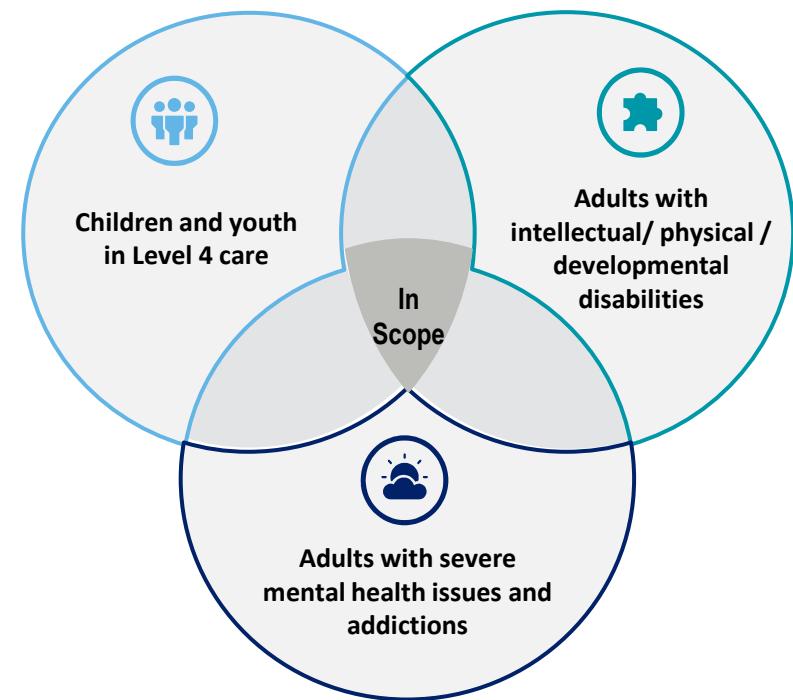
⁵ Source: 2009 Report from YouthWorks "Raising the Roof" -- YOUTH HOMELESSNESS IN CANADA: THE ROAD TO SOLUTIONS <https://www.homelesshub.ca/sites/default/files/attachments/qbwqaz.pdf>

⁶ Source: Statistics Canada 2021 <https://www150.statcan.gc.ca/n1/pub/82-003-x/2021001/article/00002-eng.htm>

Executive Summary (cont'd)

Project Scope and Approach (cont'd)

- *Adults with physical, intellectual and developmental disabilities*, including autism and fetal alcohol spectrum disorder;
- *Adults living with chronic and persistent mental illness and/or addictions*, including long-term residents of the Waterford Hospital; and
- *Children and youth in care* of the Manager of Children, Seniors and Social Development, under the *Children, Youth and Families Act*¹.
- A Steering Committee was formed to make day-to-day project decisions, and included the Director for Regional Services, Community Support Services, HCS; the Director of Mental Health and Addictions, HCS; the Director of Children and Youth in Care and Adoptions, CSSD.²
- Deloitte performed several key activities in this review:
 - A comprehensive needs analysis for the clients of and the families and caregivers of selected residential services and supports, primarily three client groups described in the diagram on this page;
 - Client data analysis (non-identifying) obtained from NL's Client and Referral Management System ("CRMS") and CSSD's Integrated Service Management ("ISM") to better understand the demographics, needs and placement type for clients currently receiving residential supports through HCS or CSSD in key program areas (described in box on next page);



¹ CSSD's continuum of care features 4 levels of care, from kinship homes (Level 1) to staffed residential placements (Level 4). Level 4 placements are in-scope for this project. All statistics in this document refer to Level 4 clients only

² The names of Steering Committee members are located in [Appendix A](#).

Executive Summary (cont'd)

Project Scope and Approach (cont'd)

- High-level document and information review on the living arrangements of individuals receiving supports through HCS or CSSD today;
- Jurisdictional scan, which assisted in identifying up to three (3) jurisdictions which have implemented innovative models, and which formed the basis for 'deep dive' explorations;
- Academic literature review, and other desk-based research which assisted the review team in identifying innovative, evidence-based models of residential support and services; and
- Several collaborative workshops were held with departmental program staff, RHA representatives and others, to provide feedback, input and information to this process.
- A detailed program review and/or funding model review was out of scope for this project.
- However, some high-level program information, including financial summaries, were reviewed for selected CSS programs (displayed in the box to the right) to provide context for stakeholder comments and feedback.

Residential Supports... by the numbers

- Deloitte's analysis indicates that at time of writing¹, there were a total of **3,749 children, youth and adults** receiving residential supports across Newfoundland & Labrador.
 - *Residential Supports for Adults.* Adults with disabilities and chronic mental illness currently receive a range of residential services across the province.
 - Nearly 3,600 adults receive supports across NL, about 71% of which are adults with disabilities supported by HCS Community Supports and Services programs, whereas the remaining 29% are supported by HCS Mental Health and Addictions programs.

¹ It is the nature of residential services (particularly for CSSD's child protection and in care programs) that the number of clients receiving supports will fluctuate over time. Statistics represent the current demographic profile and program populations as of May 2021. For the purposes of improving the understanding of client needs and residential options in this review, greater precision is not required, however these population statistics should not be assumed to predict demand for future residential services as a trend analysis was not performed.

Needs Analysis of Current Clients of Selected Programs

The needs of residential support clients were assessed for the following in-scope programs:

For adults²:

- Alternate Family Care ("AFC")
- Cooperative Apartments
- Community Care Homes ("CCH")
- Individualized Living Arrangements ("ILAs")
- Funding supplements provided to individuals to live with relatives or non-relatives (e.g. Board and Lodging subsidies)

For children³:

- Group Homes ("GH")
- Individualized Living Arrangements ("ILAs") / Shared Living Arrangements (SLAs)
- Emergency Placement Homes ("EPH")

Out of scope

- Detailed program and financial review
- Analysis of supply / demand and provider capacity

Executive Summary (cont'd)

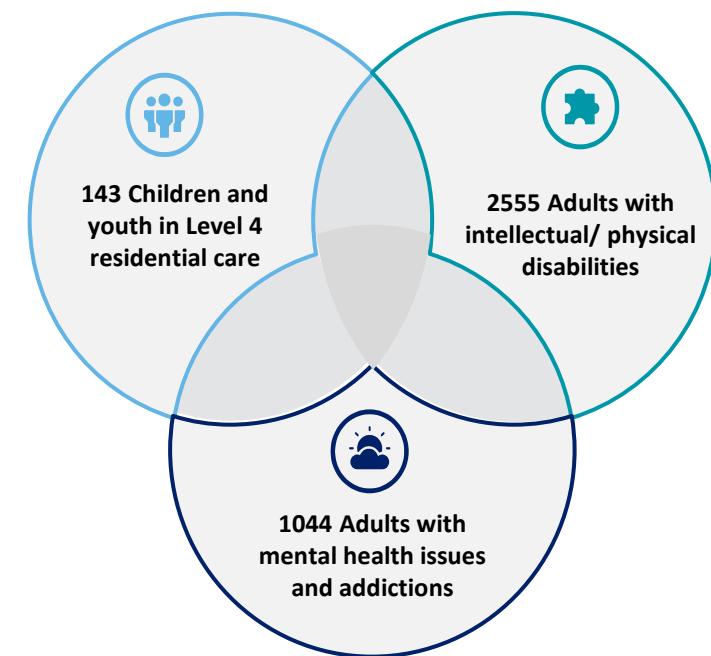
Residential Supports... by the numbers (cont'd)

- Fewer than 60% of adult clients live in Eastern Health region. About 18% live in Central Health, another 18% live in Western Health region, and the remaining ~6% in Labrador Grenfell Health.
- Program design, policy direction and operating standards are established by HCS' Community Support Services ("CSS") or its Mental Health and Addictions division ("MHA") divisions.
- While there is no official "system" of supports, residential services programs as described on the previous page are primarily delivered by the four Regional Health Authorities in partnership with the Department, community-based non-profit organizations, service providers, private landlords and others.

○ *Residential Supports for Children and Youth: Children and youth in care receive residential services* in CSSD's three regions of the province: St. John's Metro, Central-West and Labrador.

- At time of writing¹, **143 children and youth in care** are currently living in staffed residential placements ("Level 4 placements") across the province.
- About 48% of children and youth in Level 4 placements are located in St. John's Metro, whereas the remaining 52% are evenly split between Labrador and Central-West regions.
- CSSD establishes policy direction for its In Care program and has ultimate accountability for the protection and welfare of the children and youth in care.
- CSSD contracts third-party services provider to deliver Level 4 residential settings.
- It also partners with HCS as needed to support youth transitioning to the adult community support system, as well as with external health professionals including Child and Youth in Alternate Care (CAYAC), and with the Janeway Hospital for in-patient psychiatric care.

Clients receiving supports today



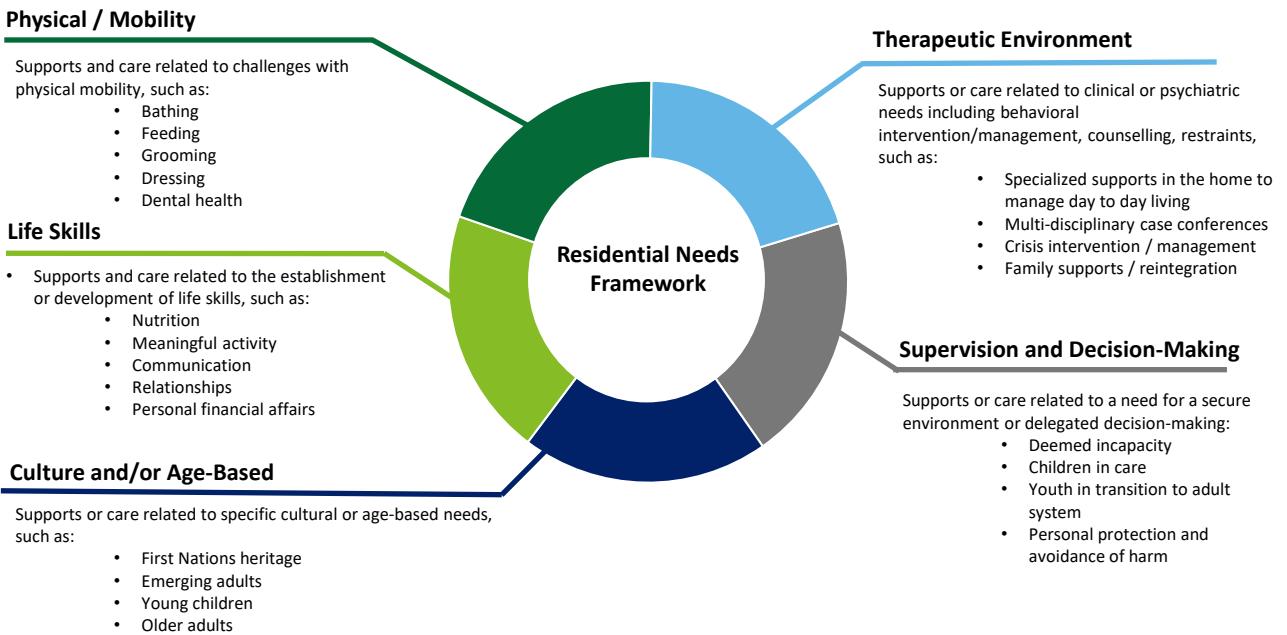
¹ The review only considered children and youth in Level 4 staffed residential placements, by decision of the Steering Committee. Out of scope are Levels 1-3 placements (e.g., foster homes, kinship homes, and specialized foster care). At time of writing, a separate project is underway in CSSD to review the continuum of care across all four levels of care.

Executive Summary (cont'd)

Summary of Residential Needs Analysis

- A key objective of this review was to improve the understanding of the needs of current clients, their families and caregivers, as well as to understand the landscape of supports across the province.
- Deloitte worked with the Steering Committee and program representatives to design a framework (displayed to the right) and an Excel-based evaluation tool to capture client needs.
- The methodology for this activity is described in a later section, however in general, social workers were invited to share their clinical impressions as to the level of support, and nature of support, required by a sample of their active caseloads.
- Several themes emerged, including:
 - Nearly 60% of adult clients across different program areas share a common need for life skills and supervision/decision-making supports. Many also share a high level of need for a therapeutic environment.
 - Over one-third of MHA clients have a high level of need for physical or mobility support.
 - Nearly 90% of children and youth in Level 4 care have a high need for a therapeutic environment, yet the remaining 10% may not be appropriately placed in this environment as a result of their unique family circumstances.
- These themes are described in a later chapter of this document.

A Framework to Assess Residential Support Needs



Executive Summary (cont'd)

Summary of Stakeholder Engagement and Themes Emerging

- Deloitte engaged with a wide range of stakeholders¹ to solicit input, feedback on the current array of supports and services, and to better understand client needs and preferences. Where available, the review team also sought to capture ideas for new models and opportunities to improve residential services.
- Stakeholder engagement activities included:
 - An online survey of **248 individuals** with lived experience, current clients, families and caregivers to assess met and unmet residential needs in NL.
 - More than **110 one-to-one interviews** were conducted over telephone and video conference call with:
 - *Twenty-five (25) families, caregivers and individuals with lived experience* including former youth in care, and current clients receiving residential supports;
 - *Forty (40) program representatives and front-line social workers* from NL Department of Health and Community Services; NL Department of Children, Seniors and Social Development; and the four Regional Health Authorities (RHAs);
 - *At least twenty-two (22) community-based providers* that serve either adults or children and youth; and
 - *At least twenty (20) representatives* of non-profit organizations, advocacy groups and other agencies of government including Newfoundland and Labrador Housing Corporation.
- Sixteen themes arose in these discussions and through feedback from the online survey (see diagram shown right). They are described in detail in [later chapter](#).

Key themes emerging from stakeholders

Clients and Families Do Not Feel Heard	Aging Families	Unmet Needs	Community-Based Treatment Options
Shared and Congregate Settings	Too Few Beds Available	Escalating Client Complexities	Unclear Outcomes / Cost-Benefit
Existing Options no Longer Meet Needs	Wraparound Supports are not Enough	“Bumpy” Transitions Across Lifespan	Unclear Plans for Waterford Patients
Oversight and Accountability	Stable and Specialized Workforce	System is Fragmented and Hard to Coordinate	Policy Confusion Between RHAs

¹ Stakeholders that participated in this review are listed in [Appendix A](#).

Executive Summary (cont'd)

- Consultations surfaced a number of residential models or options that do not exist or are not readily accessible for individuals in NL. These included but not limited to:
 - Temporary de-escalation facilities and crisis units, to avoid ER visits and placement breakdowns, for both children/youth and adults
 - Quasi-therapeutic stepped-down environments (e.g. “Not the Waterford, but not community either”)
 - Family-like communal home settings that provide varying levels of independence and support for adults
 - Customizable physical environments with on-demand supports, tailored to individual needs
 - Specialized adult foster care, with greater training and support available for providers
 - Environments to learn life skills (e.g. household management, cleaning, cooking, drivers license, bank account, managing one’s money, finding an apartment, finding a job, etc.)

Other Observations and Findings

- The intent of this review was to identify opportunities to improve NL’s current array of residential supports, as well as to identify innovative models of support that might meet the needs of current clients and those with an unmet need for residential support in future. It was intended to focus largely on client needs, and to provide guidance to HCS and CSSD on improving existing residential supports and services.
- However, in the course of performing this work, a number of striking observations were made at a system level. A diagram illustrating the current ‘system’ of residential support, and its many actors, are shown on next page:
 - Current options are poorly coordinated across government. There are multiple system actors involved with designing, planning, delivering, and monitoring the supports, despite the recognition by some stakeholders that these siloed systems serve many of the same clients.
 - Many of the current array of supports for adults have outdated or rundown physical environments, lack modern operating standards and do not generally feature embedded services and supports.

“Lacking skills to deal with ASD, I was eventually unable to manage my adult son’s needs and sometimes violent escalations.

Had help been available to me, I would not have been forced to make the heartbreaking decision to have him removed from my home.

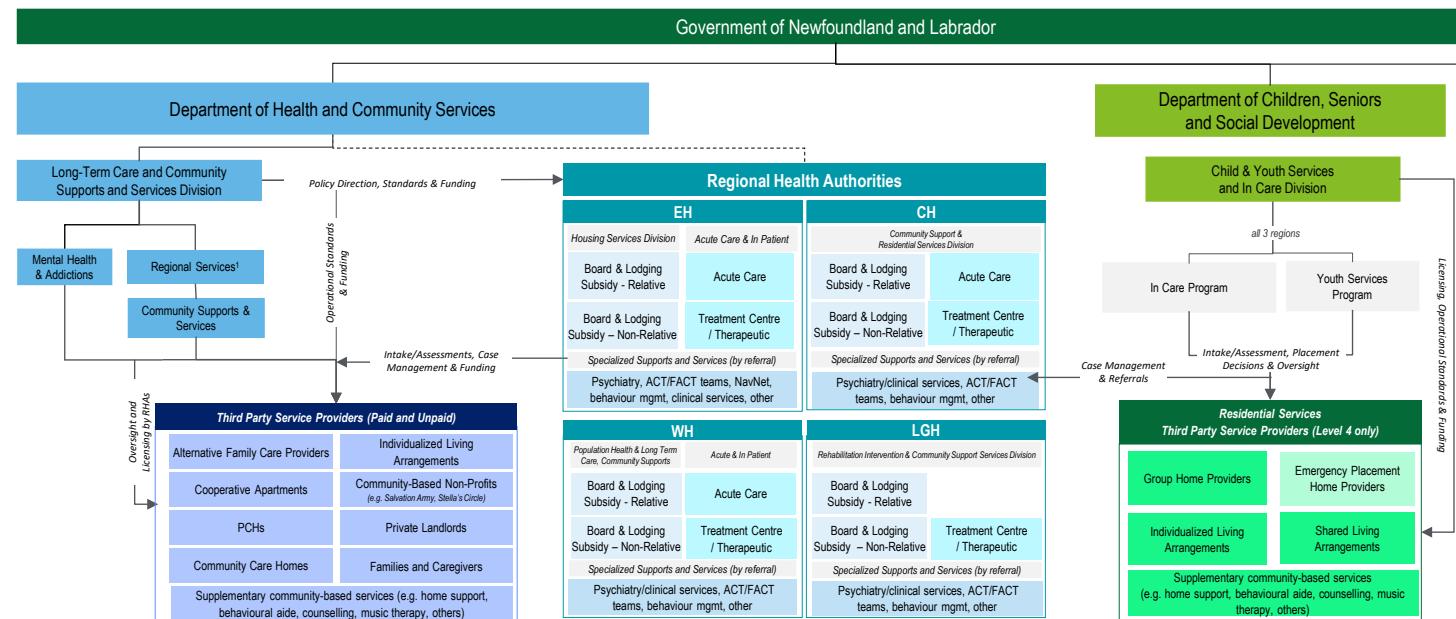
In the last two years, he has lived in two shelters and three apartments.”

*- Parent of adult son living with ASD
CBC News NL, 2018*

Executive Summary (cont'd)

- Despite good intentions and efforts, supports for adults are often difficult to coordinate and navigate. Points of entry, intake assessments, and clinical decisions are not coordinated or standardized across departments, programs and RHAs.
- Many programs rely on support from untrained or minimally trained service providers, without modern program design or operating standards, and do not set expectations for clients to achieve certain clinical outcomes.
- Housing decisions and referrals arise in different programs, departments and RHAs. Some program staff are in HCS, others are deployed by the RHAs, and still others are deployed in other government bodies.
- Programs often serve the same people (e.g. one client may receive funding from multiple programs). Alternatively, many programs serve clients with essentially the same needs for support, irrespective of diagnosis.
- Significant gaps exist in the array of options, particularly for clients that need a moderate or high degree of therapeutic support embedded in a long-term residential placement.
- Programs tend to be delivered independently, inhibiting system-level standardization, cost-efficiency, consistency and access, particularly for the clients with greatest need.

Illustrative Overview of NL's landscape of residential services and supports



Executive Summary (cont'd)

Innovative Models of Residential Support

This review also sought to learn from others and understand practices that work well in other jurisdictions.

A scan of academic literature and information in the public domain identified a range of interesting models that could be helpful in NL. The review team scanned the types of supports available for each of the three in-scope population groups across the country, and later selected British Columbia, Ontario and Nova Scotia for further review.

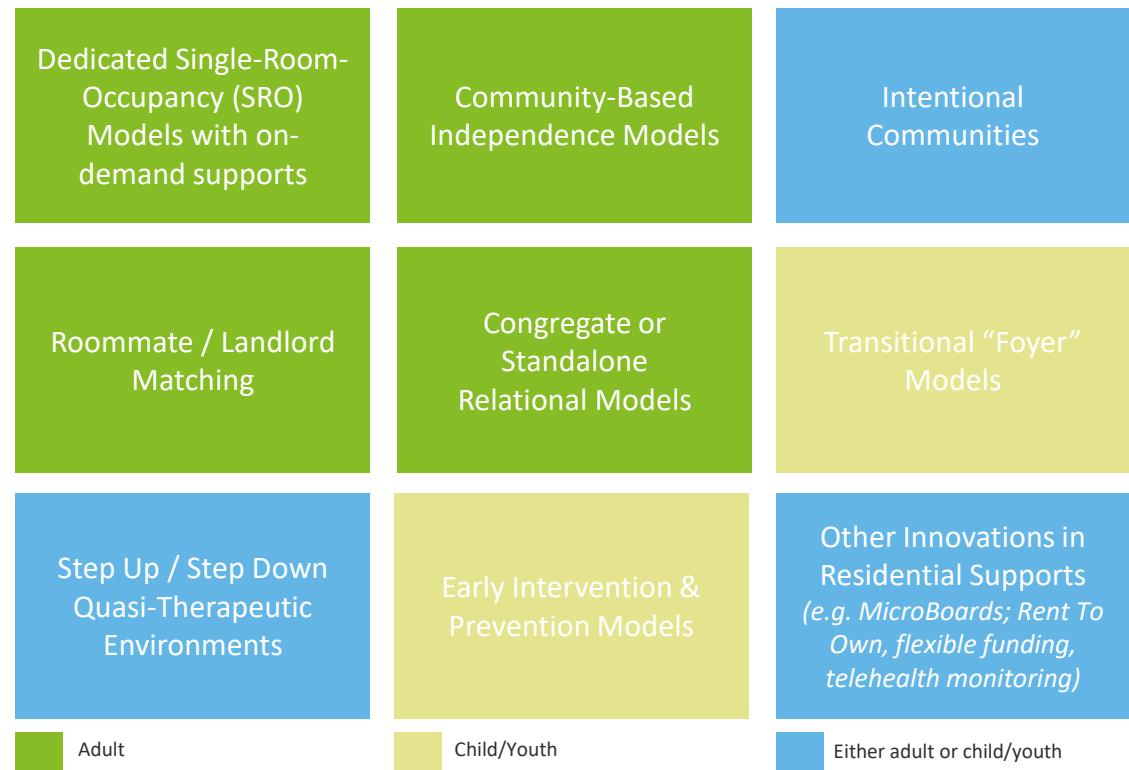
The review identified a broad range of innovative models and types of residential support. Jurisdictions around the world have been seeking alternatives to 'institutional care' for decades and have invested in options from co-locating multi-generational assisted living for seniors and young adults, to building 'tiny homes' for homeless and marginalized people in urban areas.

The intent of this review was to identify options and improvements for the current system to better address client needs. While these very unusual models might be of some benefit, it was decided that options more adjacent to the existing models of support would fill in gaps within the current continuum and be more cost-effective to the overall system.

A number of innovative models were selected for discussion (shown in the diagram, right). Options appropriate for adults are shown in **green**, whereas options for children or youth only are shown in **yellow**. Models that could be adapted for either group are displayed in **blue**.

Snapshots of each model are located in a [later chapter](#) of this document.

Selected innovations in residential support for adults and children/youth



Executive Summary (cont'd)

An unmet need for residential supports

- We believe the Government of Newfoundland and Labrador is committed to positive change and to improving the supports provided to adults with disabilities, mental illness, addictions, and children / youth in care. We also recognize the actions underway or completed in recent years that contribute to the betterment of residential services delivery which are summarized on the final page of this section.
- The purpose of this review was to better understand the needs of current clients of residential supports and services. Deloitte's analysis indicates many opportunities still exist to enhance the current array of options, and build upon foundational elements within the system to establish a new, cost-effective direction for residential supports in the province.
- It must also be acknowledged that the landscape of need extends beyond the clients who receive supports today. Numerous stakeholders pointed to an *unmet need* for residential support – that is, people living around the province who may need housing, but are unable to access or retain it. Identified reasons for this unmet need include:
 - **Marginalized people are often invisible to the system.** Some individuals with an unmet need for housing are not followed or linked up with any system in NL. They find accommodation wherever they can – on the street, in parks, in emergency shelters, temporarily with friends or other relatives. They are not tracked easily and are not reflected in the statistics contained in this report. Some examples are identified in the box to the right.
 - **Emergency shelters may underreport the actual number of shelter-seekers.** People in active addiction, with past history of violence, or those who are actively street-involved often do not meet the eligibility criteria and refused access to some shelters. Shelter-seekers unable to access services may not be reflected in reported data, and for that reason, official statistics have likely underestimated the current demand for services. Also:
 - In a 2017 study completed for HCS involving over 200 community-based organizations in St John's (including those operating emergency shelters), 50% to 60% of providers self-reported that they refused access to at least 50 individuals in the prior 12 months. Some estimated they refused access to over 100.

An unmet need for emergency shelter

- In St. John's alone, point-in-time shelter referral estimates for the City's 135 emergency shelter beds suggest that there are a **minimum of 800 unique individuals** with an unmet need for residential supports:
 - 80% are transitionally homeless
 - 10 to 15% experience recurring or periodic homelessness
 - 5 to 10% are chronically homeless
- At least **165 people were homeless** on April 19, 2018 (more than one for every shelter bed in the City), including 9% living in provincial correctional institutions.
- Outside of St. John's:
 - Only **11 emergency shelter beds** are available (8 in Happy Valley Goose Bay for men, 3 in Natuashish for youth). No emergency shelter is available for women.
 - Media coverage and stakeholder reports suggest there is a large group of single men being housed in a local motel while they await shelter.
 - Others shelter in tents outside or walk the trails around the town to keep warm at night.
- Most studies report these statistics as the *minimum* number of those experiencing homelessness, as many individuals in precarious housing situations are not visibly homeless (i.e., couch surfers, rough sleepers) and are undercounted, particularly in rural areas.

Executive Summary (cont'd)

An Unmet Need for Residential Supports (cont'd)

- Multiple stakeholders to this review expressed the need for more low-barrier shelter beds (e.g. those which are more permissive or tolerant of street and addiction behaviours), as well as the need for permanent accommodations that provide long-term support for those with active addiction and chronic and persistent mental health conditions. Providing housing only when people reach the stage of recovery does not reflect the reality of addiction and mental health, and exclude individuals who have the greatest need for support.
- Single men are disproportionately impacted by long waitlists for social / supportive housing.** At time of writing, NLHC reported a waitlist of 1,500 people across the province for social housing options including supportive housing. Priority is given to families, and several programs exist for women escaping domestic violence. However, the waitlist for social housing includes a disproportionate number of single men and those who have experienced homelessness. There have been very positive developments from federal and provincial investments in about 130 new shelter beds and social housing developments under The Gathering Place, as well as the Housing Hub in Happy-Valley Goose Bay. Even with such investments however, there remains a need for hundreds more beds to be made available, and for community-based housing options including supportive housing centres in downtown St. John's and elsewhere in the province.
- Strong intersectionality of chronic and persistent mental illness, addictions, and difficulties maintaining housing.** While there are many factors that impact homelessness and the difficulty in accessing safe and secure housing, academic literature and stakeholders consulted in this review emphasized that mental illness and active addictions often impact an individual's ability to consistently access and maintain residential supports, and to maintain healthy and appropriate relationships as a member of the community. Special consideration should be given to those individuals who are chronically evicted from residential placements due to disruption of the neighbourhood or other tenants, violence, street involvement and/or severe addiction.
- This review also identified a gap in residential support for those individuals who need high levels of therapeutic or clinical supports embedded in their place of residence, in order to be successful. This model of support is not broadly available in NL and as a result, there is a high churn of individuals with complex needs who are provided with residential placements but are unable to maintain them. Readers should be mindful that individuals who have difficulty accessing and maintaining housing may be amongst those with the most complex and challenging needs.



Executive Summary (cont'd)

Summary of Recommendations

- This report contains **32 recommendations** to Government, and has been produced with NL Health Accord recommendations as a backdrop. Our recommendations fully align with the direction of the Health Accord, particularly with the concept of integrated RHAs.
- These recommendations are intended to:
 - **Improve system-level coordination and governance** including the establishment of a new government agency to provide system level leadership, and the creation of a new provincial residential services strategy, a detailed supply/demand analysis;
 - **Modernize and improve existing residential support programs** for adults with disabilities and/or mental health and addictions challenges, children and youth in residential care, their families and those with unmet needs; and
 - **Expand the array of residential options for adults and children/youth**, including the adoption of several new models, transitional environments, and living environments with high-intensity therapeutic supports.

Implementation Roadmap and Timeline

- Any transformative change takes time and focus to achieve intended results. For the Government of NL, a re-imagining of the department-led programs to an integrated and coordinated provincial body and residential strategy is necessary to improve outcomes, reduce duplicative and inefficient spending, and enhance the quality of life for many adults and children.
- A high-level roadmap for implementation has been provided, with the following assumptions:
 - The timeline for implementation is assumed to begin upon acceptance of this report, and should extend over a 36-month timeframe.
 - Additional effort will be required to provide enough detail for system design and implementation. While we have provided high level recommendations in this review, further study particularly with regard to design of recommended models, system capacity and client needs/demand, is necessary.
 - The implementation roadmap identifies these projects and the sequence in which they should be rolled out.

Executive Summary (cont'd)

Work Already Underway in NL

- In any health and social welfare environment, the needs are constantly changing, increasing, and resources are finite. While this report is intended to point to gaps in the current system, challenges to be resolved, and make recommendations that will require investment, we fully acknowledge that several departments and agencies of the Government of Newfoundland and Labrador have already begun to improve community-based health and social service delivery including residential supports and services. Such improvements include but are not limited to:
 - *Health Accord for Newfoundland and Labrador* (2021)
 - *The Big Reset* (2021)
 - Provincial strategies and action plans within the Department of Health and Community Services, including *Autism Action Plan 2019-2022*, and:
 - Improvement within the Community Supports and Services, including a new levels of care framework, Provincial Home Support Program, alternative funding models for community-based care; and implementation of the Stepped Care model within the Mental Health and Addictions program area;
 - *The Way Forward: Toward Recovery Strategy* (2017) and *Towards Recovery: Mental Health and Addictions Action Plan* (2017-2022), which provided a system-level review, community-based service delivery improvements, including paving the way for the launch and continued development of Assertive Community Treatment (ACT) and Flexible Assertive Community Treatment (FACT) teams that support people with serious mental illness and concurrent disorders in the community;
 - *NL Action Plan on Home and Community Care and Mental Health and Addiction Services*, which provided the foundation for the Home First approach adopted by Newfoundland and Labrador, as well as palliative care options, and improvements to senior care including in-home dementia supports.
 - Provincial strategies and action plans within the Department of Children, Seniors and Social Development, including:
 - Proclamation of the Child, Youth and Family Act which improved child-centeredness and cultural responsibility;
 - Adoption of a new Innu Service Delivery Model (fly in/fly out) to better support two Indigenous communities in Labrador;
 - New service agreements with Nunatsiavut Government to increase the number of foster homes.
 - NLHC's *Social Housing Plan* (2009), and *Roadmap for Ending Homelessness in NL* (2014);
 - Various partnerships between two or more of HCS, CSSD, Nunatsiavut Government, Innu Round Table, as well as Miawpukek, Sheshatshiu, and Mushuau Innu First Nations to provide culturally-appropriate mental health supports and housing options for children and youth in Level 4 care; and
 - Various other improvements in community-based service delivery, including "*Bridge the gap*", an online resource of mental health supports for both adults and youth.

Introduction

Background to this report

The provision of residential supports and services by government

- The Government of NL is responsible for the delivery of high-quality services to children, youth and adults, including residential supports.
- Residential services and supports for adults are delivered by each of the four regional health authorities via the **Department of Health and Community Services' Community Supports Program ("CSS")** and/or its **Mental Health and Addictions ("MHA") program**. For children and youth in care, residential placements are provided by the **Department of Children, Seniors and Social Development ("CSSD")**.
- Government is working hard to modernize several areas of health and social service delivery. There are numerous examples of policy reform and community-based service improvement that touch on related aspects of disability support, mental health and addictions programming, and reform in the children's welfare and protection areas.
- NL Health and Community Services' policy direction is increasingly moving toward one which fully demonstrates several key elements:
 - *Choice and control*
 - *Person-centered practice*
 - *Least restrictive and inclusive*
 - *Access to and independence in home and community environments*
 - *A housing-first philosophy; and*
 - *Trauma informed, recovery and well-being, incorporating harm reduction principles*
- While there have been significant changes and improvements, the *NL Health Accord*, Dame Moya Greene's *"The Big Reset"* and a variety of previous child advocate reports, suggest there is significant room to improve coordination across government and design of many program areas. Residential services and supports are not unique in their need for modernization.



"The ways in which regular care from providers is received needs to change.

There was a focus on social determinants of health including... poverty, housing insecurity... and disabilities."

- Health Accord for Newfoundland & Labrador, What we heard from stakeholders, 2021

Newfoundland and Labrador's unique economic and social environment is the backdrop to the delivery of residential supports and services

- A series of confounding population health, demographic, and geographic factors in NL's current environment provide context for the provision of residential supports:
 - **Aging population.** Rapid aging of the population is perhaps one of the most important demographic challenges confronting the residential supports because of its impact of clients and caregivers alike.
 - **Small and disproportionately rural population.** NL has a significant segment of its population living in rural areas, which demands a new approach to service delivery.
 - **Population health indicators.** Research suggests that NL has a disproportionately high prevalence of dual diagnosis, such as mental illness and addiction, or anxiety and autism. In particular, the incidence of autism in NL's small population is higher than the national average. It also does not rank well on the social determinants of health¹, including lower than average performance in heavy drinking, obesity, smoking, and physical activity.
 - **Serious fiscal constraints.** Rising health care costs are forcing the four regional health authorities and community-based care providers to examine alternative methods of delivery, as a means to improving quality with fewer resources. Implementation of the *Health Accord* will take time and considerable resources.
 - **Transitions of service to community.** One way that NL is attempting to address soaring healthcare costs is to transition non-acute care from acute settings into the community. This is a long and complex process that has been in progress for some time.
 - **Support worker retention and recruitment.** The workers required to support clients in the community have not been historically well-paid, leading to high turnover rates and staff vacancies. Disruption of community-based supports places unnecessary stress on the workers themselves, as well as individuals, families and healthcare/community support workers, leading to burn-out and limiting respite for caregivers.
- While there have been efforts to add beds and placement options across the province, until now there has not been a concerted effort to review the current state of residential supports with a view of implementing improvement and innovations in the residential support system that would better address the needs of people in community.

Demographic highlights

- 47.4 is NL's median age – significantly higher than national median of 40.9
- 14.3% Patients in NL have 3 or more repeat hospital stays for mental illness in a single year (higher than the Canadian avg. of 12.8%)¹
- 42% of NL's population lives in a rural area
- 10% of NL's population is Indigenous



¹ Source: CIHI [https://yourhealthsystem.cihi.ca/hsp/inbrief?lang=en#!/indicators/007/repeat-hospital-stays-for-mental-illness;/mapC1;mapLevel2;overview;provinceC9001;trend\(C1,C9001\)](https://yourhealthsystem.cihi.ca/hsp/inbrief?lang=en#!/indicators/007/repeat-hospital-stays-for-mental-illness;/mapC1;mapLevel2;overview;provinceC9001;trend(C1,C9001))

² Source: CIHI <https://www.cihi.ca/en/an-in-depth-look-at-the-newfoundland-and-labrador-health-care-system>

Since the 1980's, most Canadian provinces have begun to modernize residential supports and services

NL's current residential support challenges are similar to those experienced by other provinces, however NL has not yet modernized

NL suffers a similar dark history as the rest of Canada

A stark history of institutionalization across Canada, including NL

- Large residential institutions and a medicalized model of disability support was commonplace across Canada and the US for generations.
- Beginning in the 1980s, most Canadian provinces began to downsize large residential institutions.
- These provinces improved residential settings, as social advocacy groups became more vocal and the public became more aware of the possibilities for other successful and appropriate models of support.

Provinces have also transitioned many support services into the community

- Provinces including NL have been moving more toward community-based supports including residential support arrangements.
- However, the changing needs of clients and demand for residential supports often exceeds supply, resulting in numerous constraints and limitations of the residential support system.

The need for supports and services for disabled people and marginalized populations have been well-documented publicly

- Media coverage (selected examples on the right) suggests a level of dissatisfaction and concern about NL's current array of residential options.
- Individuals with lived experience, families and advocacy groups are pushing for change, and for Government to adopt innovative housing alternatives for people with disabilities, mental illness, and to improve outcomes for children in care.

Media Perspectives on NL Residential Supports

Nfld. & Labrador

With no place for him to call home, N.L. mother pleads for help for son

Source: CBC, 2019

Nfld. & Labrador

Homeless in Happy Valley-Goose Bay remain plagued by lack of housing and programs

Source: CBC, 2018

Nfld. & Labrador · Critical Condition

Source: CBC, 2018

I am his only friend. What will happen to my son?

Nfld. & Labrador

N.L.'s Indigenous kids are still being taken away. But the foster-care system is slowly changing

Source: CBC, 2021

Need for Foster Parents Great in Province, says NLFFA

Source: VOCM, 2021

Nfld. & Labrador · Critical Condition

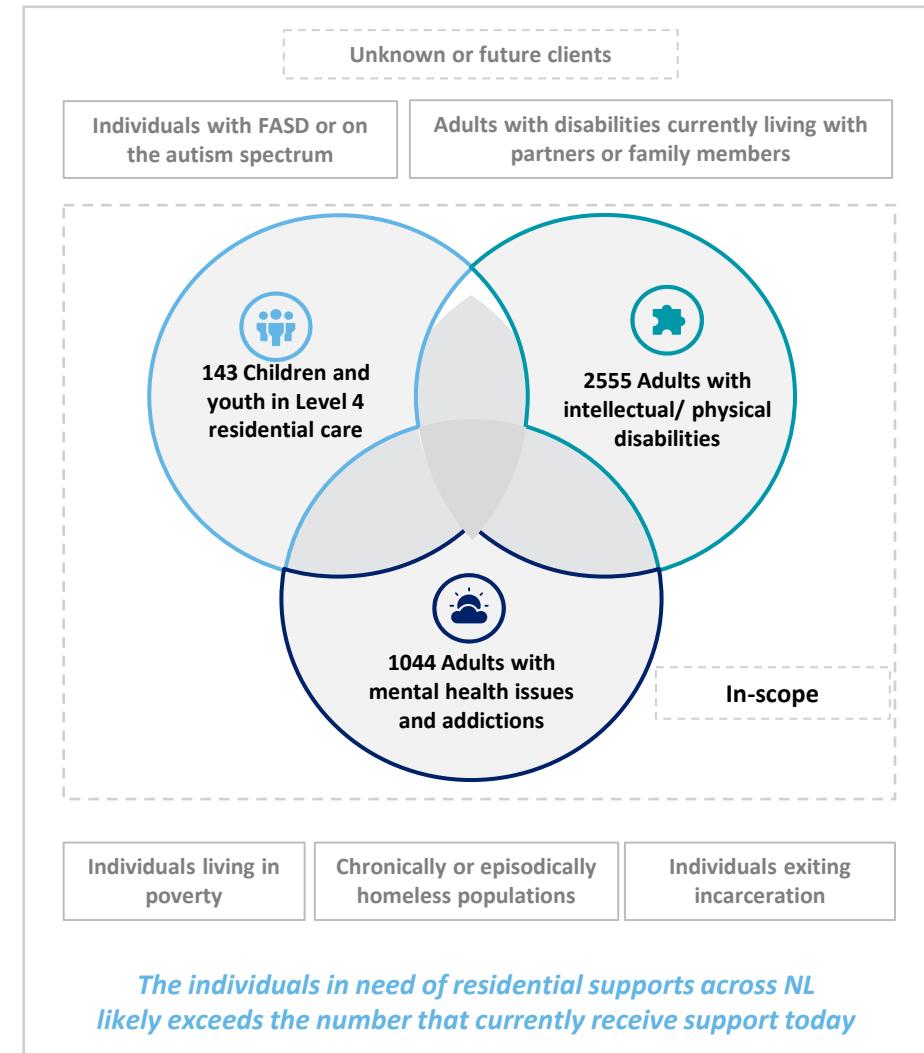
Source: CBC, 2018

Autism Society says adults living with disorder falling through the cracks

Deloitte was engaged to review the need for residential support across three populations

The Department of Health and Community Services (HCS) and Children, Seniors and Social Development (CSSD), have partnered to conduct a review of residential supports across the province

- In 2021, Deloitte was engaged by the Departments of Health and Community Services (“HCS”) and Children, Seniors and Social Development (“CSSD”) to conduct a review of residential services and supports in Newfoundland & Labrador.
- The scope of this work included a comprehensive review of residential supports for individuals who currently receive residential supports and services through HCS and CSSD, including:
 - **Adults with disabilities**, including developmental disabilities, autism and fetal alcohol spectrum disorder (FASD);
 - **Adults living with long-term mental illness and addictions**, including long-term residents of the Waterford Hospital; and
 - **Children and youth in Level 4 care and custody** of a Manager of CSSD, under the Children, Youth and Families Act.
- A key goal of this project was to improve the residential supports available for individuals, families and program representatives across the lifespan, including older adults cared for at home by aging parents. Also, as societal changes occur, new understanding is required for the supports needed for people with mental health and addictions challenges, and to consider adopting new models of support where appropriate.
- *Out of scope* activities of this review include:
 - Evaluation of Levels 1, 2 and 3 foster care placements;
 - Preparation of a services inventory across regions;
 - Detailed analysis of quantitative demand and/or supply; and
 - Detailed analysis of the staffing model, cost structure, funding model or rates.



The Project Charter outlined a needs-based approach (versus a program-oriented approach) for this review

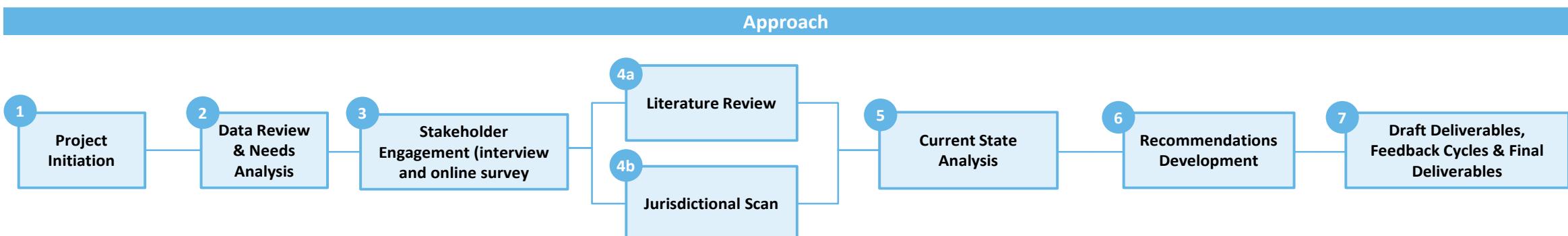
Key questions answered in this review:

- Who are the clients accessing residential services and supports today?
- Where do current clients live today?
- What do clients actually need from residential supports and services?
- What new models or improvements to existing models might better serve their needs?
- Is there an unmet need for residential supports and services?
- If so, how significant and who needs support – but isn't getting it?



Key project activities:

- Collected CRMS data from RHAs on all CSS, MHA, as well as ISM data for CSSD clients currently receiving residential supports;
- Engaged social workers to perform secondary data collection on a sample size of 25% of the clients identified above;
- Interviewed at least 110 individuals, families and caregivers, as well as program representatives across the province;
- Conducted online survey of 248 individuals with lived experience, current clients, families and caregivers to understand their needs;
- Performed research in the public domain about the continuum of models, services and supports across Canada, as well as in New Zealand and other jurisdictions; and
- Identified emerging and innovative models to examine and consider to address unmet needs in the NL residential supports continuum.



The review received inputs from a range of HCS and CSSD residential support programs

Definition	Selected Residential Programs and Supports ¹												
<p>What are residential supports?</p> <p>Residential supports are a cornerstone of the health and social programs in most Canadian provinces.</p> <p>Residential programs in NL include a broad array of services and supports ranging from:</p> <ul style="list-style-type: none">• The physical place where an individual resides or their living arrangement, as outlined in the table to the right• Financial benefits• Home/community inclusion support hours• Round the clock supervision• Other forms of care depending on the individual's level of need <p>Services can be provided in an individual's home, family member's home, an apartment, in a group or other supportive housing arrangement.</p> <p>In NL, residential support programs are delivered through three program areas:</p> <ul style="list-style-type: none">• HCS Community Supports and Services ("CSS")• HCS Mental Health and Addictions ("MHA")• CSSD In Care ("CSSD")	<p>Alternate Family Care (AFCs)</p> 	<p>Cooperative Apartments (Co-Ops)</p> 	<p>Personal Care Homes (PCHs)</p> 	<p>Individualized or Shared Living Arrangements (ILAs & SLAs)</p> 	<p>Board and Lodging - Relative (BLR)</p>  	<p>Board and Lodging – Non-Relative (BLNR)</p>  	<p>Personal Care Homes (PCHs)</p> 	<p>Waterford Hospital</p> 	<p>Community Care Homes (CCHs)</p> 	<p>Emergency Placement Homes (EPHs)</p> 	<p>Group Homes (GHs)</p> 	<p>Individualized or Shared Living Arrangements (ILAs & SLAs)</p> 	<p>Legend:</p> <ul style="list-style-type: none"> Programs accessed by adults with primarily physical and intellectual disabilities (CSS programs) Programs accessed by adults with severe and chronic mental illness and/or addictions (MHA programs) Programs accessed by children and youth with complex needs, in Level 4 foster care (CSSD programs)

¹ See [Appendix B](#) for definitions for each of the residential programs listed above, right.

The review process observed data challenges and confusion amongst stakeholders of different programs

Supplementary Services

- When reviewing residential support programs, it is important to note that many programs including those shown on the previous page are supplemented by a range of community-based supports such as home support staff, behavioural aides, and a variety of clinical professionals.
- For example, some clients may receive home support to enable them to live independently. Others may be supported by Behavioural Aides, see a counsellor for mental health challenges, or may be followed by an Assertive Care Team or Flexible Assertive Care Teams (ACT and FACT). Some clients may receive more than one of these kinds of supports.
- These supports are often referred to as “*wraparound services*,” although there is inconsistency across departments and program areas as to which types of services are considered ‘wraparound’.
- Such supplementary services were not assessed in detail. However, it must be noted that such services often not captured in program spending, and may be an underreported cost to the system.

Data Challenges

- Significant data quality issues were observed in this review, as described in the box on the right. Such issues contributed to debate and confusion in the review’s data analysis. For example:
 - Anecdotal stakeholder comments suggested that a relatively large number of adult clients receive funding from multiple program areas (e.g., an adult with chronic mental illness being followed by MHA, receives supports from CSS funding).
 - However, CRMS data only showed a small number of clients (>5) receiving both MHA and CSS funding. Stakeholders disagreed and felt this number was far too low, however it appears that CRMS does not clearly track which clients receive funding from different programs.
 - Similarly, we heard anecdotally about MHA clients living in personal care homes which do not typically support clients with mental illness. Unfortunately, CRMS data only identified 1 such client.
- It is likely that CRMS data underreports the number of clients who receive mental health supports.

Data Challenges

Issues related to the health system’s CRMS data quality and integrity were a significant challenge in this review.

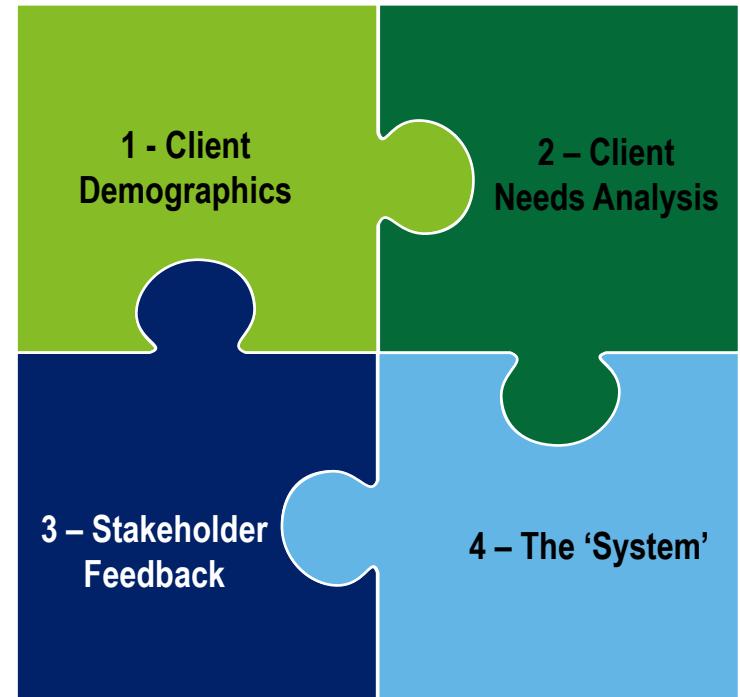
These issues limited the ability of the review team to identify high-level themes, and in some cases, to validate a fact base at the program and client level. For example:

- Data was not accessible from a centralized source. Systems used by HCS CCS, MHA and CRMS in RHA systems are not integrated, which cause difficulty mapping clients.
- Client data was only obtained from the four regional health authorities, some of which may use different data fields, or enter information that does not align with the data label.
- A large number of client records were missing basic demographic information, such as birthdate or sex, primarily in Eastern Health region.
- Regional health data in CRMS does not include details of a client’s case management information or the nature of the supports they receive, such as funding and/or services accessed.
- These quality issues led to perceived contradictions and confusion about ‘the facts’ which compromised the review’s ability to make definitive statements about current state of NL’s residential programs.

Residential supports in NL: a four-part overview

Introduction to this section

- In this chapter, we will provide details of the clients accessing residential supports and services across the province, their needs, the programs that support them by region, and the overarching ‘system’ of support that exists in NL.
- Each of NL’s four regional health authorities provided non-identifying data on active clients that receive residential supports and services today, in each of the programs offered within their respective region.
- A descriptive analysis was performed to answer the following questions:
 - **Client Demographics:** *Who accesses residential supports and services today?*
 - **Needs Analysis:** *What types of residential support do clients need? How significant are these needs, and are the needs being met?*
 - **Stakeholder Feedback:** *What can clients and their families tell us about residential supports and services today?*
 - **The ‘System’:** *How does the overall system of residential services and supports function?*
- Readers should note that CSSD and HCS do not share common regional boundaries. For that reason, we have separated the client group into *adult clients* (HCS’s community supports and mental health programs), from *children and youth in Level 4 care* (CSSD)¹.
- A portion of this review included collected information on the current living arrangements for individuals being supported by residential supports today, in the context of the overall programs (e.g., AFCs, ILAs, EPHs, etc.). However, it must be noted given the broad scope of this work and the focus around met and unmet client needs, this review did not include an in-depth analysis into each program area.
- The following pages outline a high-level descriptive analysis of each of the components of our review, as described in the framework on the right.



¹ For simplicity and clarity in the following sections, we will refer to adult clients with disabilities that are currently receiving supports through Community Supports and Services program as “CSS clients”, whereas we will refer to adult clients with mental health and addictions issues being supported by the HCS Mental Health and Addictions Program as “MHA clients.”

Residential Supports: Part 1 - Client demographics

- The following section contains a descriptive analysis of the client demographic information contained in CRMS (HCS/RHA) and ISM (CSSD).
- The key questions that were asked in this section include:
 - *Who accesses residential supports and services today?*
 - *What demographic characteristics can be identified from the Departments' data sources (e.g. age, sex, length of time in current living arrangement, type of living arrangement)?*
 - *What demographic patterns can be observed in the distribution of CSS, MHA and CSSD clients?*
 - *Where do clients live today?*

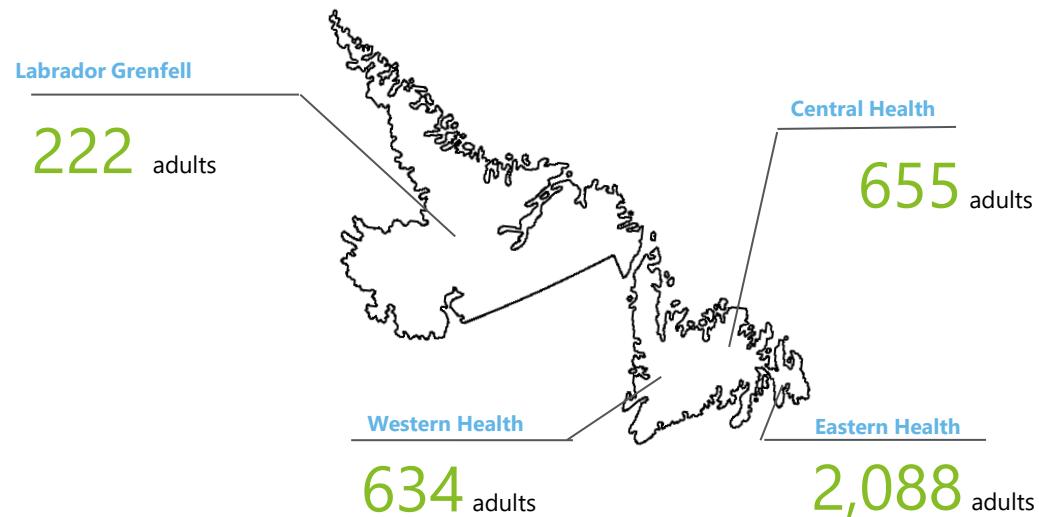


A total of 3,763 adults and children receive residential supports and services in NL at this time



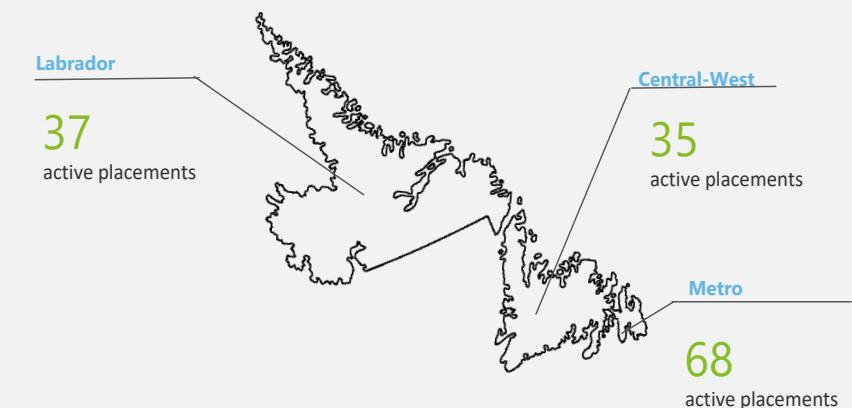
Adult clients with disabilities, and/or mental health and addictions (CSS and MHA clients)

- At time of writing, about **3,599 adults** were supported in residential placements around the province.



Children and youth in care (CSSD)

- At time of writing, **143 children and youth** in care were supported in active Level 4 residential placements around the province.



- The chart directly above reflects a breakdown of the number of individuals accessing residential supports, by health region. About 70.6% of all adults in NL that receive residential supports are CSS clients (e.g. adults with intellectual, physical and/or developmental disabilities), whereas 28.8% of adults receiving residential supports are MHA clients who may present with a range of chronic and persistent mental health challenges. A further 143 children and youth access Level 4 residential supports today through CSSD.
- It is important to note that CSSD's three service delivery regions are not directly aligned to HCS and the four RHAs. This limits the ability to directly compare regional variations and client needs across the lifespan. A few interesting points of comparison related to children and youth both populations that were observed in our analysis:
 - Labrador-Grenfell supports only 6% of adult clients, but 26.4% of children and youth Level 4 placements.
 - Eastern Health supports over 58% of adult clients, but only 47.5% of children and youth in care



From a regional perspective, residential supports for adults vary by health authority

Over 42% of CSS and MHA clients are supported outside of Eastern Health region

Distribution of adult clients by RHA and Program

- NL's population distribution is a known challenge to rural service delivery. Over half of adult clients are supported by EH (58%), whereas the remaining 42% are supported in other health regions. LGH supports only 6% of all CSS and MHA clients in NL.
- There is also regional variation in the proportion of MHA clients receiving residential supports:
 - Nearly 40% of clients receiving residential support in EH are MHA clients, whereas 7.9% of MHA clients receive residential supports in CH.
 - Nearly a quarter (24.6%) of clients receiving residential support are MHA clients in WH.
 - Only 13.5% of MHA clients in LGH access residential.
- The following pages outline client demographics for each RHA. It should be noted that limited tracking of MHA clients in RHAs may underestimate the supports accessed.

Adult residential support clients by RHA and Program

	Total # clients by RHA	# clients supported primarily:		% of total NL clients	Overlap in # of CSS and MHA clients ¹	% MHA clients, by RHA
		by CSS	by MHA			
Eastern Health	2088	1282	806	58%	1	38.6%
Central Health	655	605	52	18%	~55	7.9%
Western Health	634	478	156	18%	76	24.6%
Labrador-Grenfell Health	222	192	30	6%	1	13.5%
Total	3599	2555	1044			77%

¹ Overlap between in-scope populations

- It is understood that a significant portion of adults with disabilities that receive residential supports and services may be dually diagnosed or experience mental health issues in addition to physical or intellectual challenges, which is not adequately captured or reflected by the MHA program statistics or CRMS data.
- Some overlap between the program exists where an individual's case is managed by MHA but additional funding is provided through CSS. However, discussions with the two program areas has validated that the statistics presented in this report represent unique individuals unless otherwise specified, and that there has been no double-counting.



In NL, over 2550 adults with intellectual and physical disabilities receive residential supports through CSS programs



50%

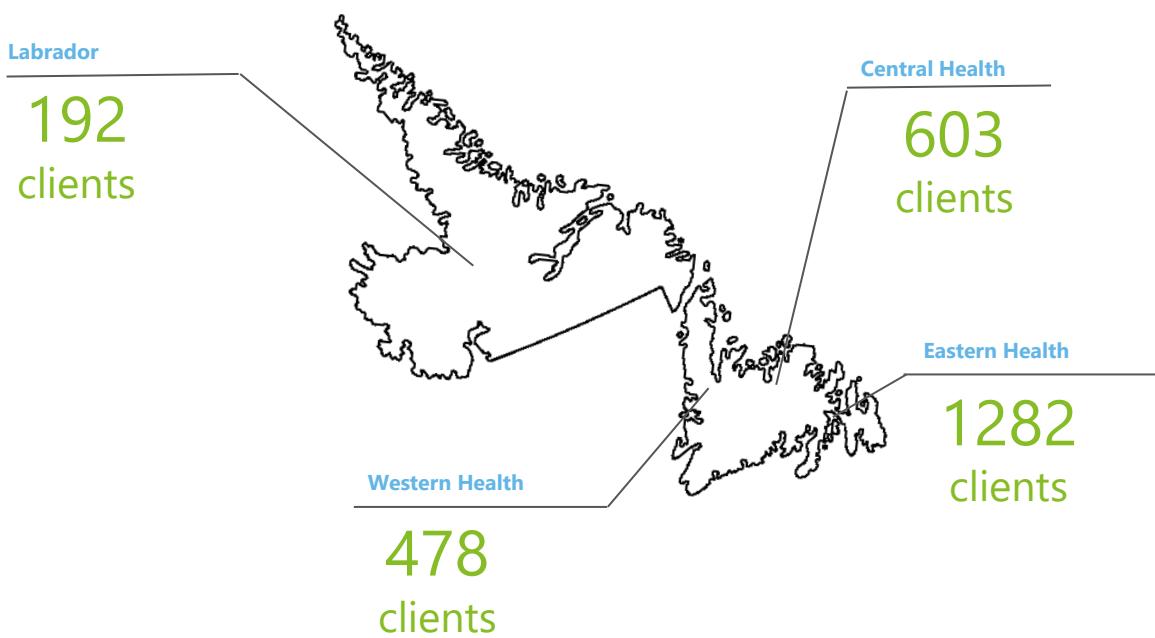
of adults with disabilities live outside EH

57%

of adults with disabilities are male

40%

of adults with disabilities are between 30-40 years old

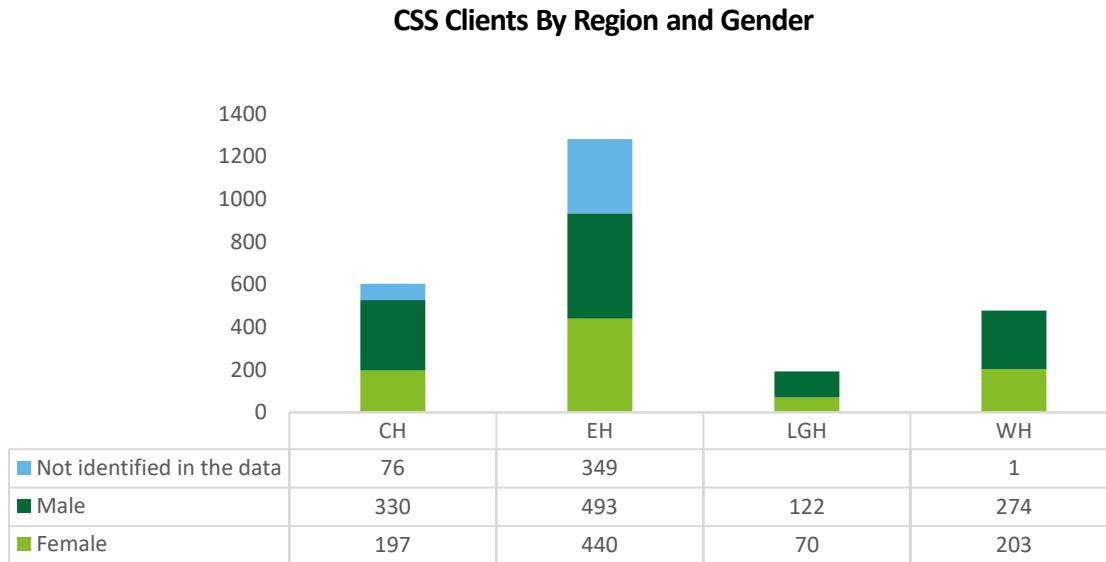


Adults with disabilities

- Clients receiving residential supports and services through the CSS program area are typically adults with significant intellectual, developmental, and physical disabilities. They may present with a wide range of diagnoses such as, but not limited to:
 - Developmental disabilities (e.g. autism, fetal alcoholic syndrome)
 - Down Syndrome and other intellectual disabilities
 - Acquired brain injury, spinal cord injuries, cerebral palsy, other physical/mobility disabilities
- Even for clients with a common diagnosis, readers should understand that the need and nature of support needed may be different. It is also important to note that there may be more individuals needing residential support than available data might suggest.

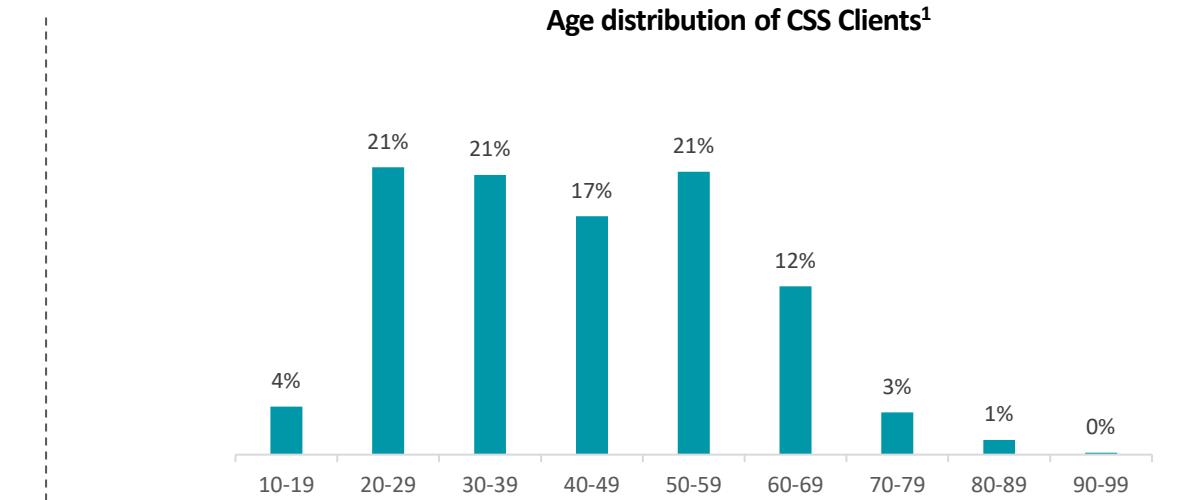


Of all CSS clients, about 57% are male; nearly half of CSS clients are under 40



Key Takeaways

- 50% of CSS clients (adults with disabilities) across the province access residential supports through EH
- Of 2129 CSS clients whose gender was identified, 1219 (57%) were male, and 910 (42%) were female
- There are 1.33 males for every female with a disability across the province. This gender balance is consistent across regions, with Central Health and Labrador-Grenfell having a slightly higher concentration of male clients (63% and 64%, respectively)



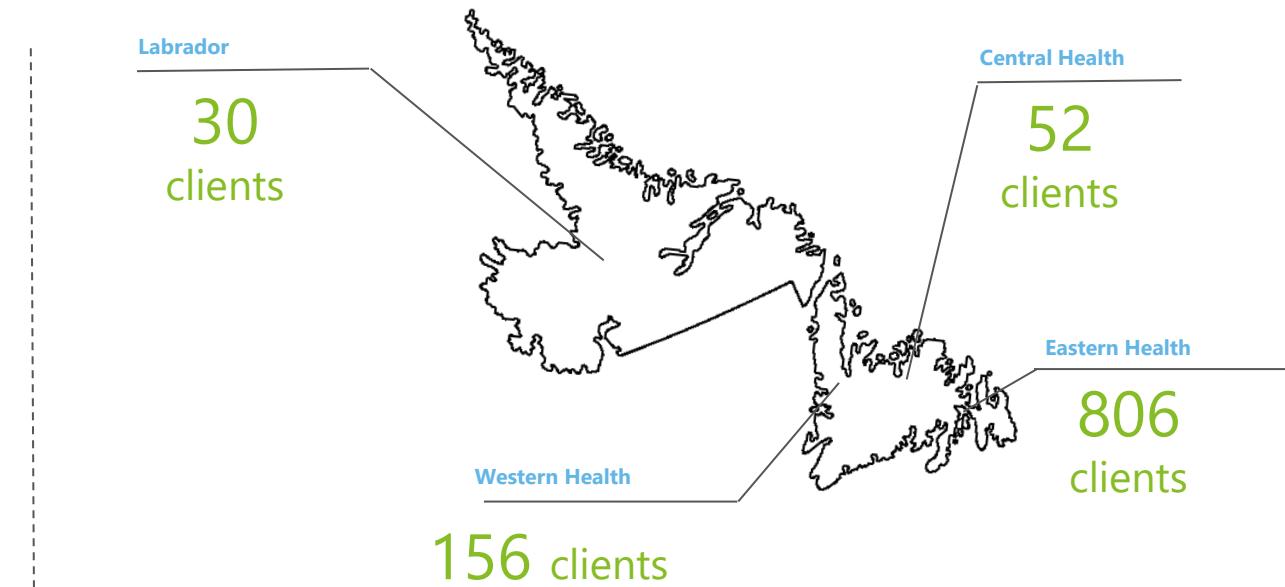
Average age: 43

Key Takeaways

- Deloitte's analysis (not shown) suggests that about 46% of CSS clients in NL are under age 40, whereas the average age of CSS clients is 43 across RHAs
- Age was not identified in the data for over a quarter (345) of adults with disabilities in EH
- CH supports the youngest group of adults with disabilities – with an average age of 42. About 65% of their clients are 50 or younger
- LH's CSS clients are the oldest on average at 44 years old, but Western Health has the highest concentration of adults 50 or older (40%)



In the MHA program area, over 1000 adults with mental health and addictions receive residential supports in NL

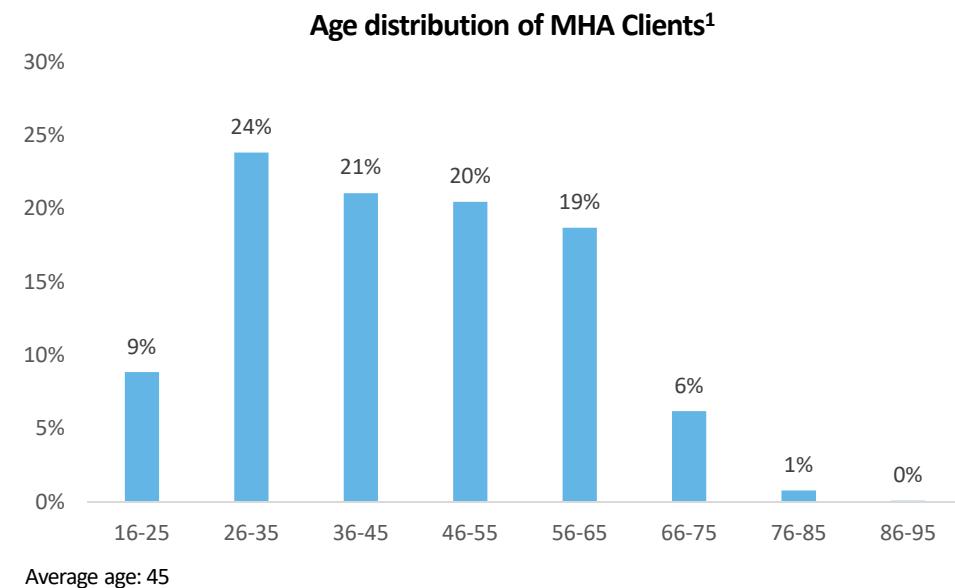
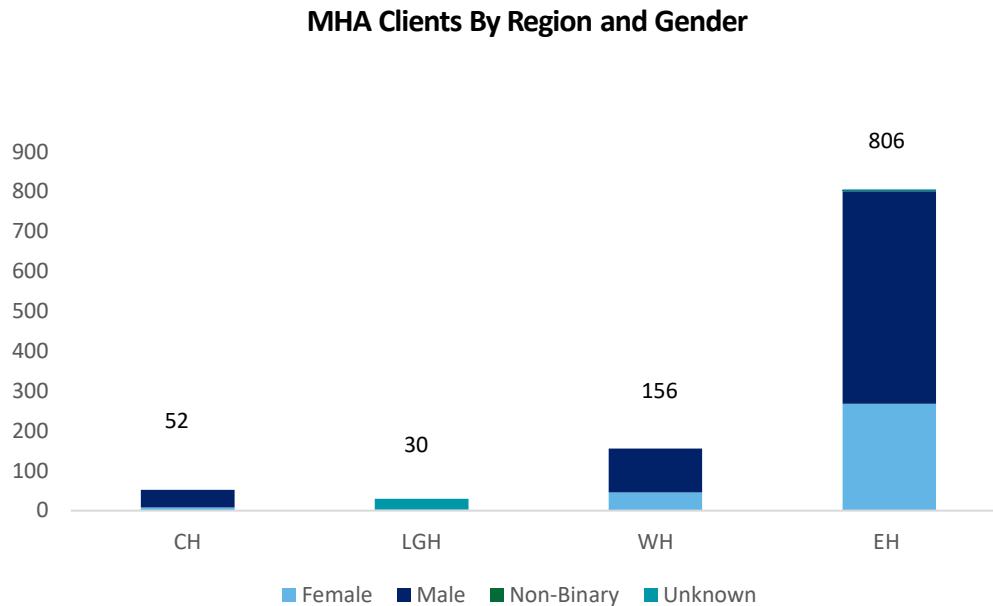


Adults with mental health and addictions issues

- Adults accessing residential supports and services from MHA programs live in a variety of residential placements. Typically, MHA clients present with:
 - Chronic and persistent mental illness including but not limited to schizophrenia, bipolar disorder, obsessive-compulsive disorder, post-traumatic stress disorder
 - Chronic and severe addictions
 - Other physical or intellectual impairments, in addition to long-term mental illness
- Even for clients with a common diagnosis, readers should understand that the need and nature of support needed may be different. It is also important to note that there may be more individuals needing residential support than available data might suggest.



Of the 1044 MHA clients in NL, nearly 70% are male and over half are under the age of 45



Key Takeaways

- Of the 1044 MHA clients accessing residential supports across the province:
 - A significant majority of clients (77%) are based in Eastern Health
 - Most mental health and addictions clients are male
 - Of clients whose gender is known, 68% identify as male

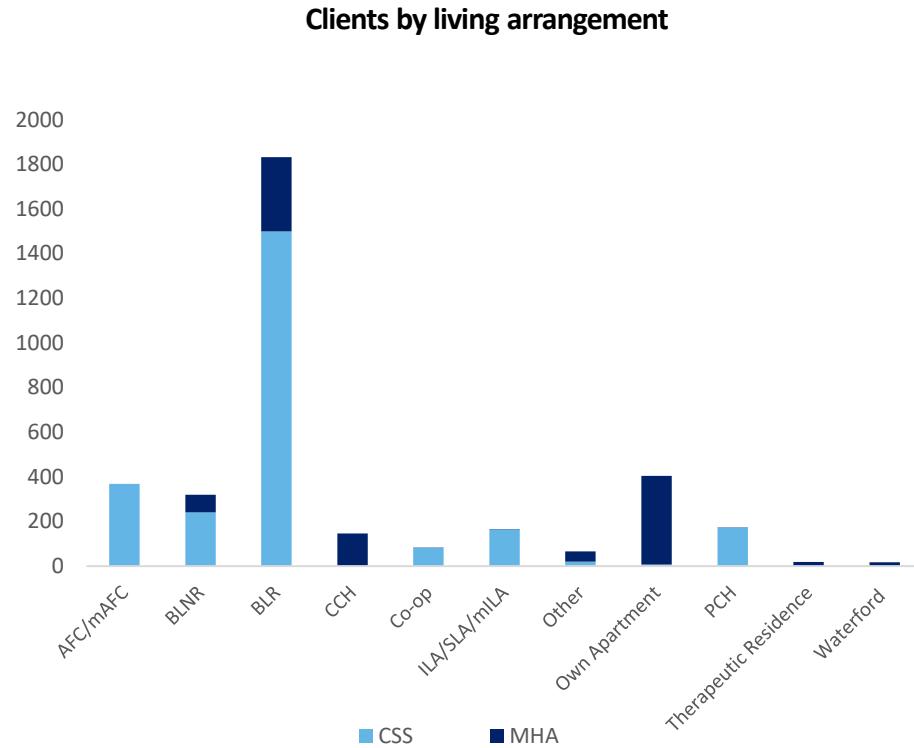
Key Takeaways

- Of the 1044 MHA clients across the province:
 - Provincially, the average age is 45
 - More than half of all MHA clients are under the age of 45
 - Only 7% of all MHA clients are over 65 today
- Deloitte's analysis (not shown) indicates some variation in the average age of MHA clients by region: 38 (CH); 46 (EH); 42 (WH)



CSS and MHA clients are supported in a variety of living arrangements across the province

44% of clients across regions and programs are supported through the BLR funding subsidy



Key Takeaways

- Most commonly across the province, adults with disabilities are supported to live with family members through a Board and Lodging – Relative subsidy.
- About 60% of CSS clients are supported in BLR.
- About 70% of MHA clients receiving residential supports access a funding subsidy which allows them to live with non-relatives including in their own apartment or with a landlord (BLNR).
- The second most common living arrangement is Alternative Family Care (AFC), in which 12% of CSS clients are supported across regions.
- However, there are several models that are not consistently used across regions. Several gaps in housing options were identified:
 - No Modified AFCs exist in LGH, whereas they are utilized by very small numbers of clients in Central and Western. Over 60 EH clients are supported in this arrangement.
 - Clients are only supported to live in their own apartment in LGH, albeit a very small number of clients.
 - Modified ILAs only exist in Western.
 - Shared arrangements only exist in Central and Labrador.



Across the province, there is variation in the residential programs available to CSS and MHA clients

Data from RHAs and CSSD outline the living arrangements for clients receiving residential services and supports; Community Care Home services are only available in Eastern Health

Historically, the programs available to provide residential support have varied by RHA.

Recognizing the population size differences between RHAs and CSSD regions, it is perhaps unsurprising that most clients accessing residential supports are located in the Eastern Health region (see program population statistics on next page).

However, the diagram to the right also indicates that living arrangements are not consistently available across the province.

A key variation in the provision of residential supports relates to Community Care Homes. These living arrangements are typically provided to MHA clients, and are only available in Eastern Health.

However this review has demonstrated that at least 23% of MHA clients are supported outside of EH, and that clients that receive supports from CSS who also present with persistent mental illness, may be generally underreported across the province.

Further analysis of programs and services is provided in later sections of this report.

The following pages describe the distribution of clients by region.

Adults	Living Arrangements by RHA			
	EH	CH	WH	LGH
Alternative Family Care (AFC)	✓	✓	✓	✓
Modified AFC	✓	✓	✓	✗
Cooperative Apartments Program	✓	✓	✓	✓
Individualized Living Arrangements (ILAs) or Modified ILA	✓	✓	✓	✓
Shared Living Arrangements (SILAs)	✗	✓	✓	✓
Board & Lodging – Relative (BNL)	✓	✓	✓	✓
Board & Lodging – Non-Relative (BNLR)	✓	✓	✓	✓
Personal Care Homes (PCH)	✓	✓	✓	✓
Community Care Homes (CCH)	✓	✗	✗	✗



On a regional level, EH supports over 58% of clients receiving residential supports today

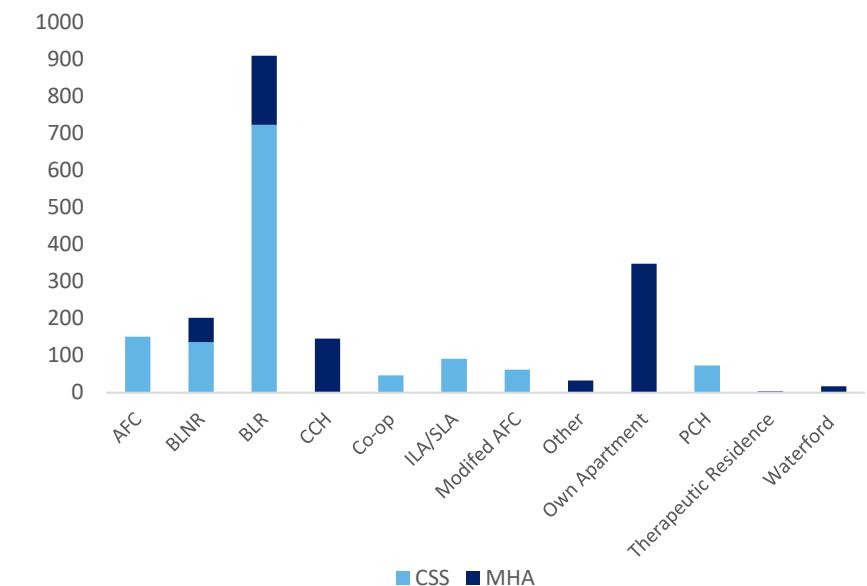
Snapshot of EH clients

- EH supports the largest proportion of clients receiving residential supports in NL today (2088 adults or 58%). Of these, EH supports 1282 adults with disabilities (CSS) and 806 clients through MHA programs (representing 77% of all MHA clients in NL receiving residential supports).
- Clients in this region are supported in a variety of living arrangements, which were described on page 26:
 - Adult clients supported through CSS most often live with relatives through the BLR program (44%).
 - Another significant population of CSS clients live in paid residential environments such as AFC (12%), or staffed residential placements in PCHs, ILA/SILAs, or cooperative apartments (2%).
 - Only 20% of MHA clients are supported to live with family through the BLR program. They are most commonly supported to live alone in their own apartment, or with a non-relative landlord (33%), or in a Community Care Home (CCH).
 - A small number of CSS clients are placed in PCH environments.
- Unlike other RHAs, EH's MHA program has a Housing Division to support clients with housing subsidies and rental top-ups. CRMS data suggests that the majority of these clients are living in their own apartments, as shown in the graph to the right.



of adults accessing residential supports across the province are located in EH

EH clients by living arrangement and program area





EH also provides in-patient MHA supports through the Waterford Hospital

The anticipated replacement of the Waterford Hospital in 2024 includes a planned reduction in in-patient beds, which will impact a group of long-term residents

Profiling the patients at the Waterford Hospital

- With the planned replacement of the Waterford Hospital in St. John's, a group of long-term residents will be transitioned to community-based living options. This population was identified as a group with a significant impending need for supports as part of this review.
 - There are currently over 150 mental health beds available for patients through the Waterford Hospital and its satellite/partner sites.
 - At any given time, there are **up to 20 long-term residents** with heightened care needs living in forensic, rehab or complex discharge units in the hospital.
 - Long-term in-patients are generally assigned to Unit N3A. They typically present with long-term mental illness, primarily schizophrenia. Patients exhibit a range of symptoms, including physical or verbal aggression, medical noncompliance, and to a limited degree, fecal smearing. Some also lack capacity to make decisions, understand appropriate boundaries, and exhibit sexual inappropriateness.
 - Some in-patients on these units are psychiatrically well, but chronically unable to maintain housing. Many are chronically and constantly admitted/discharged/re-admitted because they lack the life skills to live independently, due in part to lack of community-based "high support housing" which would provide an appropriate therapeutic environment and trained community support staff.
- There is a known population of Waterford in-patients that have lived on the units for over 30 years and lack the life skills and experience of living in "the outside world". All of these clients are slated for discharge in the next 12 to 24 months. At time of writing, discharge plans have not been finalized or reviewed by the review team.
- Given the potential for these long-term patients to revert to an unwell state, it is incumbent on HCS program staff to confirm that adequate and appropriate community-based supports and residential placements are confirmed in place prior to transitioning these long-term patients.
- While MHA clients have been successful in the community, several stakeholders report a gap in the residential options available with a high level of intensity and clinical services for chronically and severely unwell or addicted patients – including the long-term residents of the Waterford that are slated for discharge.

NAVNET Data for Service Utilization for clients over five years (2015-2020)

- NAVNET is an innovative collaboration to improve system approaches in supporting people with multiple and complex needs living in St. John's.
- These individuals are often the clientele who are admitted / discharged/ readmitted to the Waterford Hospital over extended periods.
- NAVNET engages in a wide variety of activities aimed at coordinating the response to individuals with complex needs, including case management, and supporting their housing needs.

- Over a 5-year period, 19 NAVNET clients have:

695 total Psychiatric Assessment Unit visits

198 inpatient visits at the Waterford Hospital

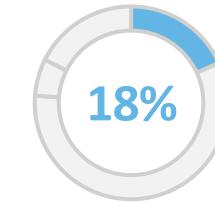
895 days living in the Waterford Hospital

2667 mobile crisis response calls



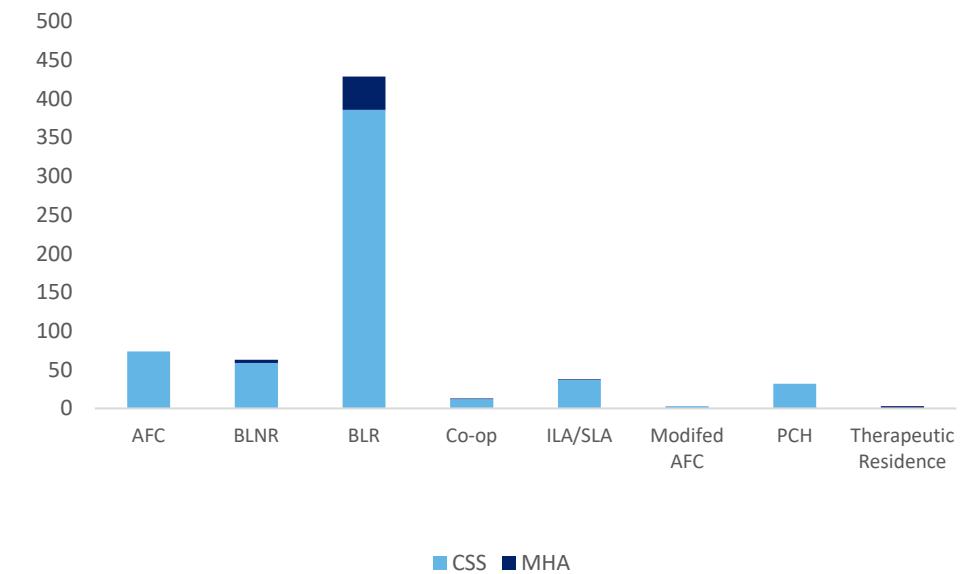
Snapshot of the clients in Central Health

- There are about 657 individuals receiving residential supports in CH, including 605 CSS clients and 52 MHA clients.
- We observed:
 - The average age of CH clients accessing residential supports is 42.
 - Of individuals whose gender was provided, 65% are male.
 - Anecdotally, RHA stakeholders estimate that approximately 15% of their clients experience chronic or persistent mental health and addictions issues, representing an overlap of approximately 55 clients whose cases are managed across program areas.
- The adult clients in Central Health region are supported in a range of residential options. Some observations:
 - Clients living with relatives receiving BLR subsidies is the most common (65%) living arrangement.
 - AFC arrangements are the next most common living arrangement supporting 11% of clients in the region, however none of the MHA clients are supported in this arrangement.
 - MHA clients are typically supported to live with relatives in CH.
 - There are no MHA clients supported to live in their own apartment in this region.
 - A small number of CSS clients are placed in PCH environments.
 - Community Care Homes are not available in this region.



of adults accessing residential supports across the province are located in CH

CH clients by living arrangement and program area

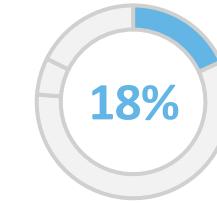


WH provides residential support to over 630 adults with disabilities, mental illness and addictions



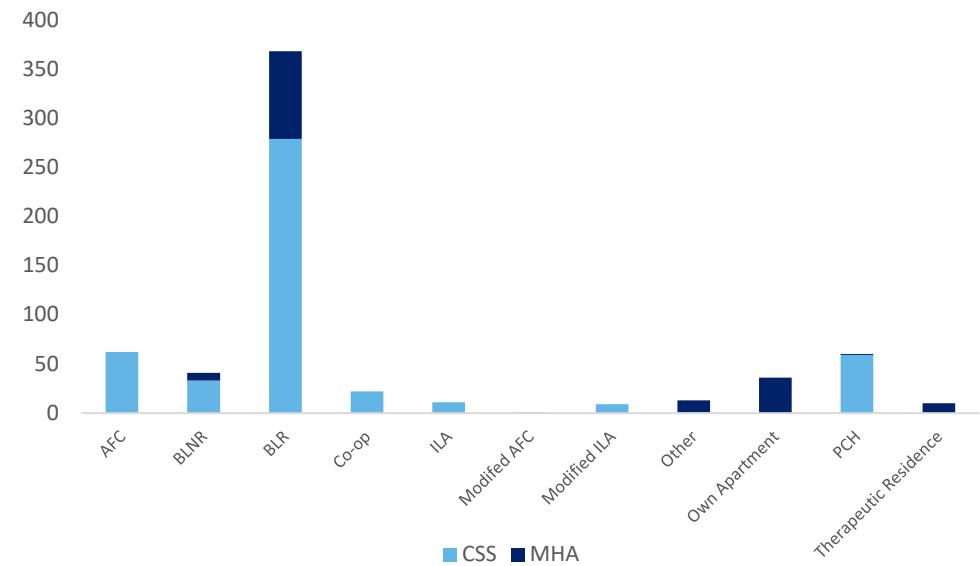
Snapshot of the clients in Western Health

- There are 634 clients being supported by residential supports in Western Region, including 478 CSS clients and 156 MHA clients:
 - Forty-three (43) is the average age of clients in WH that receive residential supports.
 - Similar to other regions, there are 3 males for every 2 female clients being supported.
 - Analysis by programs staff shows that there is an overlap of 76 clients that are listed on the caseloads of both CSS and MHA program areas. In some cases, funding for housing may be provided by CSS but case management is performed by MHA (e.g. FACT teams).
- The adult clients in WH are supported in a range of residential options. Some observations:
 - Clients receiving Board and Lodging - Relative subsidies are the most common (65%) living arrangement in this region.
 - AFC arrangements are the next most common living arrangement, supporting 11% of clients in the region.
 - There are no clients supported by Board and Lodging – Non-Relative arrangements in WH, however CRMS data indicates there are multiple MHA clients supported to live in their Own Apartment.
 - A small number of CSS clients are placed in PCH environments.
 - Similar to CH, there are no Community Care Homes in this region.



of adults accessing residential supports across the province are located in WH

WH clients by living arrangement and program area

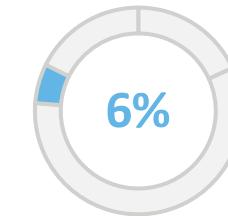




LGH provides residential supports to over 220 adults with disabilities, mental illness and/or addictions

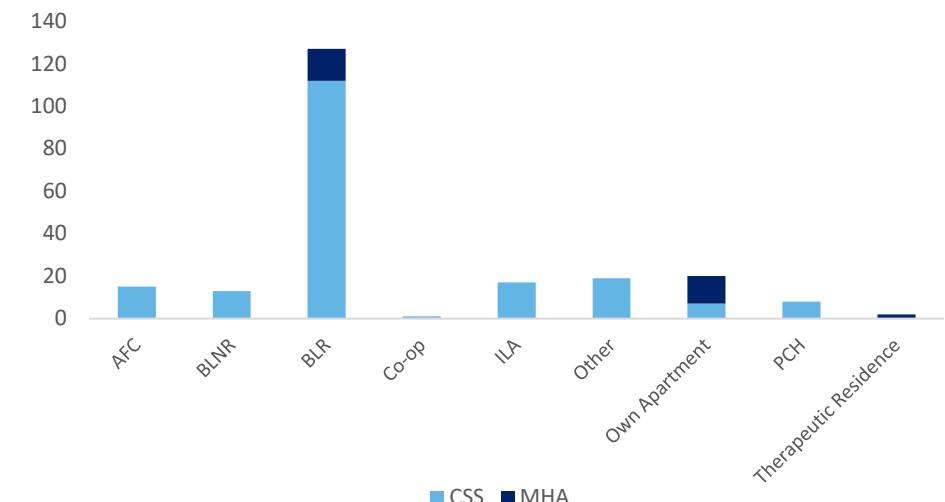
Snapshot of the clients in Labrador-Grenfell Health (LGH)

- LGH provides services to highly rural and remote regions of the province.
- There are 222 individuals currently being supported by residential supports through LGH, including 192 CSS clients and 30 MHA clients. Also:
 - The average age of clients who are currently being supported in LGH is 44; 63% of clients whose gender is known are male.
 - At the time of reporting there was only 1 client shared between CSS and MHA program areas, which is disproportionately low compared to the overlap observed in other regions.
 - A FACT team was introduced in LGH, concurrent with the preparation of this report. Additional case management may allow clients to qualify to receive residential supports where they were not previously eligible.
- The adult clients in LGH are supported in a range of residential options:
 - Clients supported by Board and Lodging - Relative subsidies are the most common (57%) living arrangement in this region.
 - There are no clients living in Cooperative Arrangements or Community Care Homes.
 - Partnerships have been developed with the Nunatsiavut Government, which delivers and supports residential options and interim shelters for clients that were previously unable or unwilling to access services through the RHA (i.e., Mokami Status of Women Council - Supportive Living Program)
 - CRMS data indicates that there is a higher percentage of MHA clients are being supported in their own apartments than in other regions, however it also suggests that virtually none are supported in a Board and Lodging – Non-Relative environment.
 - A small number of CSS clients are placed in PCH environments.



of adults accessing residential supports across the province are based in LGH

LGH clients by living arrangement and program area





About 1000 children and youth in NL are 'in care'

CSSD offers four levels of care for children and youth; only Level 4 residential placements are in-scope for this review

The children and youth in care of CSSD

- At any given time, there are approximately 1000 children and youth in care/custody in Newfoundland and Labrador across CSSD's four levels of care outlined to the right.
- In 2014, CSSD increased the quality and accountability of residential placements for children and youth in care. Around this time, a continuum of care strategy was introduced to better serve children and youth in care. It outlined four levels of placement ranging from kinship homes to foster care to specialized foster care, and staffed residential placements. The levels are shown in diagram to the right.
- All residential placements for children and youth in care align with this continuum.

Scope of this review

- The Steering Committee agreed that children and youth in care that are placed in Level 4 staffed residential placements are in-scope for this review. Level 4 staffed residential placements include: **Emergency Placement Homes, Group Homes, and Individualized Living Arrangements.** These options are designed to serve children and youth who cannot be supported in a family-based environment, due to a range of complex social, emotional, developmental, behavioural, and medical needs.
- The data presented in this report is only reflective of the Level 4 clients provided by CSSD.
- For some children/youth with highly complex needs, CSSD has relied on out of province placement options for children to receive assessment, treatment, or other therapeutic care when the necessary services have been unavailable in this province. These out of province arrangements are not in scope for this review.

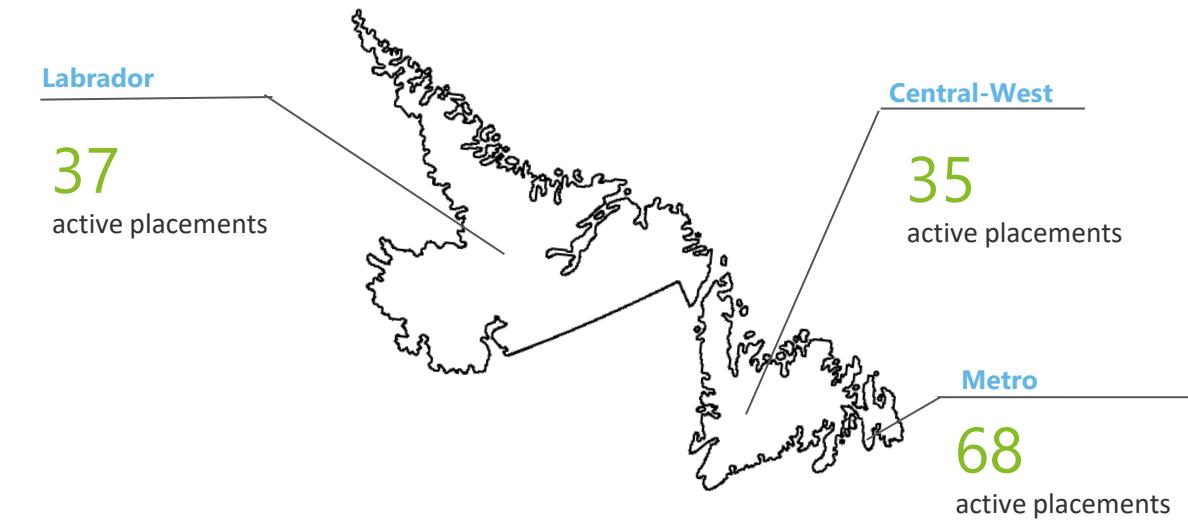
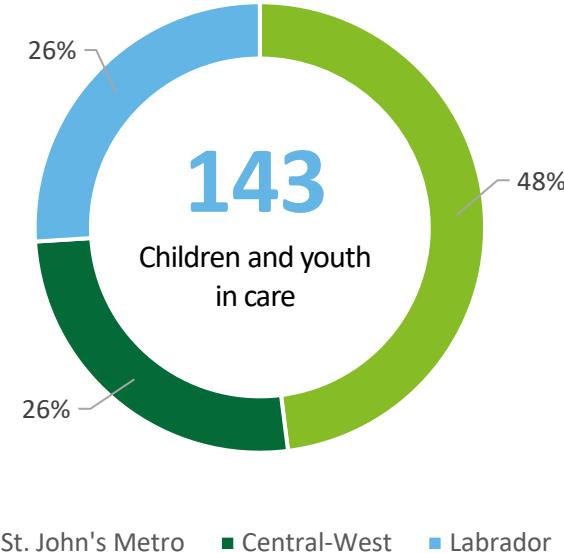
CSSD Continuum of Care Levels

Level	Description	In-Scope?
Level 1	The first level of CSSD's continuum of care which includes kinship homes, interim approved regular foster homes, and approved relative/significant other foster homes that have not completed PRIDE Pre-service sessions.	X
Level 2	The second level of CSSD's continuum of care, which consists of approved relative/significant other and regular foster homes that have completed PRIDE Pre-service sessions.	X
Level 3	The third level of CSSD's continuum of care, which consists of approved specialized foster homes.	X
Level 4	The fourth level of CSSD's continuum of care which consists of staffed residential placements resources including Emergency Placement Homes, Group Homes, and Individualized Living Arrangements.	✓



About 143 children and youth were placed in Level 4 options at the time of writing

Nearly half of Level 4 clients live in Metro region, however a disproportionately high number of Level 4 placements are in LGH



Children and Youth in Level 4 Care

- Children and youth who are unable to remain safely at home due to abuse, maltreatment or similar, may enter the care of CSSD when alternate family arrangements cannot be made.
- The children and youth in these placements typically have the most complex needs. Typical presenting concerns include, but are not limited to:
 - Complex mental health issues (e.g., depression, suicidal ideation, self harm, etc.)
 - Behavioural issues and/or disorders (e.g., ADD/ADHD, ODD, criminal involvement, etc.)
 - Cognitive/development delays (e.g., ASD, FASD, self care issues, etc.)
 - Substance abuse (i.e., drugs, alcohol)
- It is understood from stakeholders that a significant number of children and youth placed in Level 4 residential placements are likely to require residential supports and services through the adult system.

31%

of children and youth currently in care are Indigenous

75%

of children and youth present with behavioural issues and/or disorders

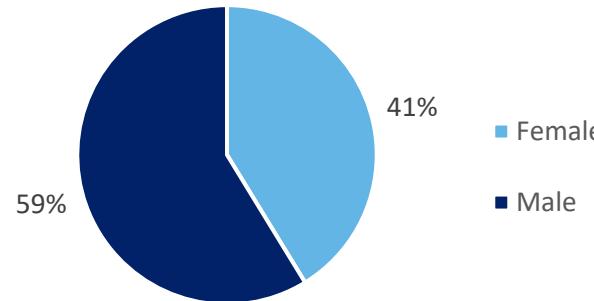
76%

of children and youth in Level 4 care are over the age of 13

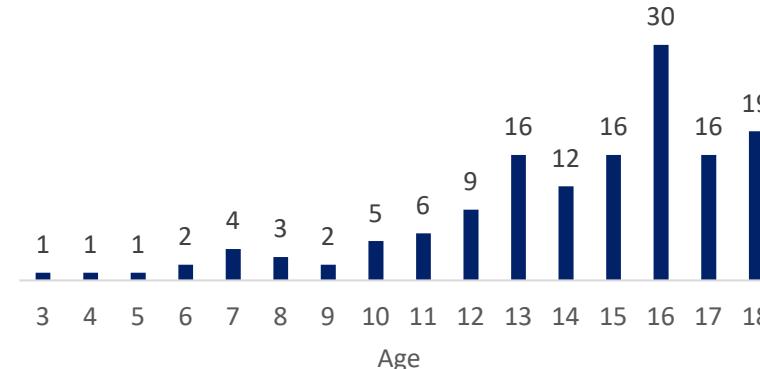
Nearly 31% of children and youth in Level 4 care are Indigenous, and are over-represented in LGH



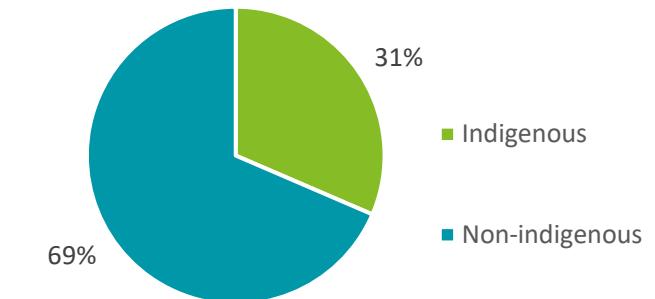
Gender balance of children and youth in Level 4 care



Age distribution of children and youth in Level 4 care



Indigenous children in Level 4 care



Gender by region

	Central West	Labrador	St. John's Metro
Female	15	20	24
Male	22	17	45

Average age by region

Region	Average Age
Central West	15
Labrador	13
St. John's Metro	14

Number of Indigenous children/youth by region

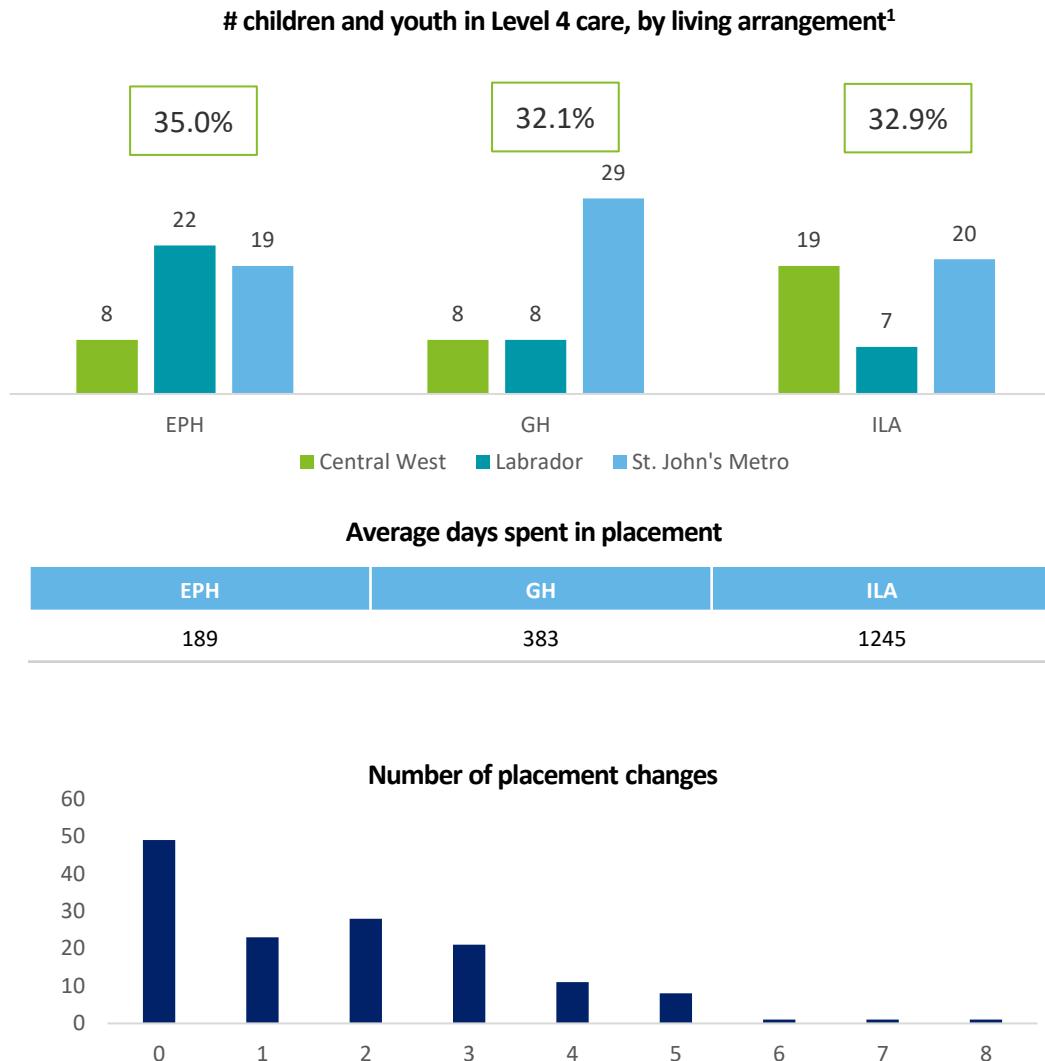
	Central West	Labrador	St. John's Metro
Non-Indigenous	31	5	62
Indigenous	6	32	7

Key Takeaways

- The provincial gender balance is a ratio of about 60:40 (male to females) in care. In Labrador, there are more females in level 4 placement than males (54%), whereas in St. John's Metro males account for approximately 65% of all children and youth in Level 4 care.
- Over three quarters (76%) of children and youth in Level 4 settings are over the age of 13, with an average age across regions of 14 years old. Children placed in Central West, on average are slightly older than the other regions, whereas children placed in Labrador tend to be slightly younger.
- Nearly one third (31%) of children and youth currently in care are Indigenous. Of those Indigenous children and youth, 71% live in the Labrador region. Indigenous children and youth represent 86% of all children and youth currently in Level 4 care in Labrador.



Of all Level 4 placements, ILAs are longest -- on average 3.4 years. EPH placements are commonly more than 6 months

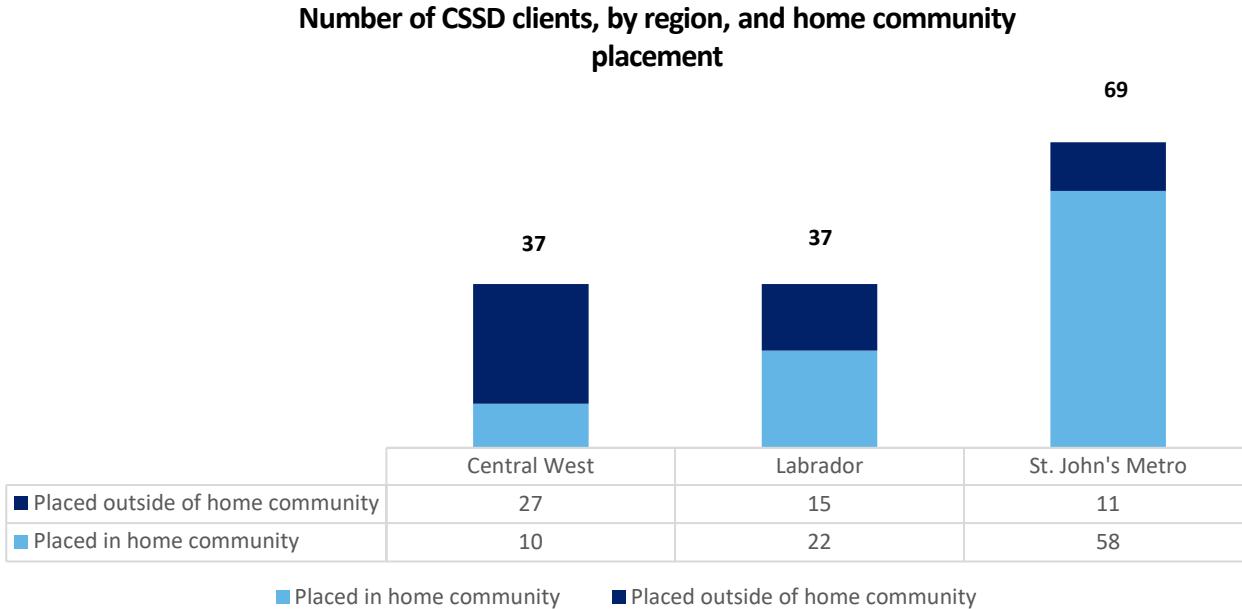


Key Takeaways

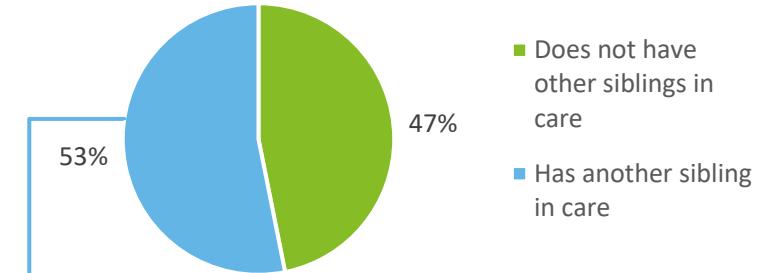
- There are three types of living arrangement for children and youth in residential care (not including those listed as “In Care - Awaiting Closure”):
 - Emergency Placement Homes (EPHs)* which represent 35% of Level 4 placements;
 - Group Homes (GHs)* which represent 32% of Level 4 placements; and
 - Individualized living arrangements (ILAs)* which represent 33% of Level 4 placements.
- Nearly 66% of clients have had at least one placement change while in care.
- EPH:** On average, children and youth placed in EPHs remain well beyond the 90-day maximum permitted by the provincial standards. Anecdotally, the review team was advised that some ‘emergency placements’ have been up to 2 years long. Long stays in EPH may create ‘bottlenecks’ and reduce the placement options available for social workers. EPHs represent 59% of the placements in Labrador.
- ILAs.** ILA placements are, on average, nearly 4 times as long as GH placements. For this reason, they become a *de facto* permanent placement, not a transitional or stabilization option as intended.
 - Just over half (51%) of all ILAs are placements in Central Western.
 - The use of ILAs in Labrador is lower than the provincial average (18% versus 29% in Metro).
- GH.** On average, children and youth in GHs stay for just over a year before moving on:
 - The majority of GH placements are in the Metro area of the province (64%)
 - Similarly, 43% of children and youth in Level 4 placements in the Metro area live in a GH.



Over a third of children and youth are placed outside of their home communities; most have another sibling in care



% of children or youth with one or more sibling(s) in care



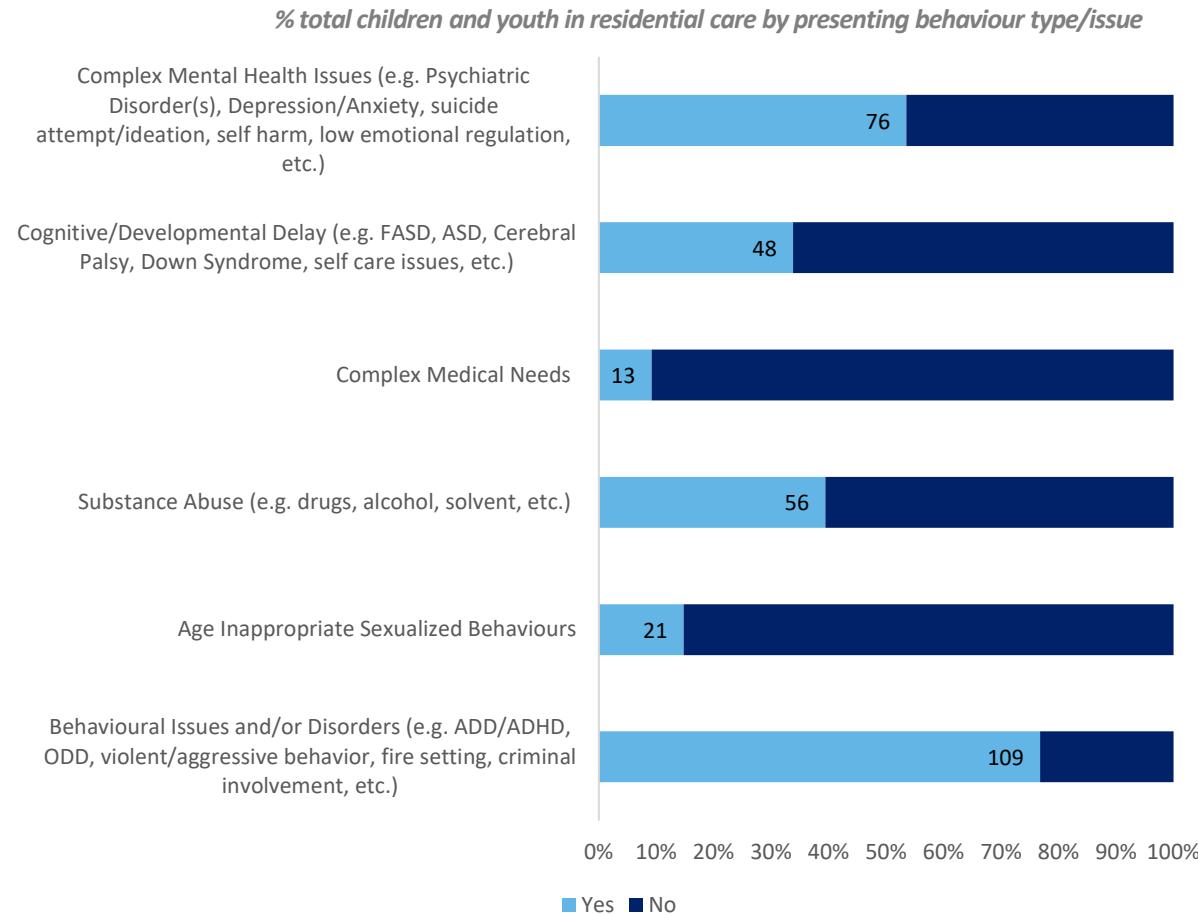
	Central West	Labrador	St. John's Metro
Not placed with sibling(s)	13	13	20
Placed with sibling(s)	6	5	19

Key Takeaways

- Nearly half (48%) of children and youth have been placed in St. John's Metro region.
- Over a third (37%) of children and youth in Level 4 placements are now living outside of their home communities. In particular:
 - 73% of children originating in Central West have been placed outside their home community
 - 40% of children originating in Labrador have been placed outside their home community.
- Over half of the children and youth in residential care (53%) also have another sibling in care; however, only 39% of these children are placed with a sibling.



Over 75% of children and youth in Level 4 placements present with complex behavioural, mental health and addictions issues



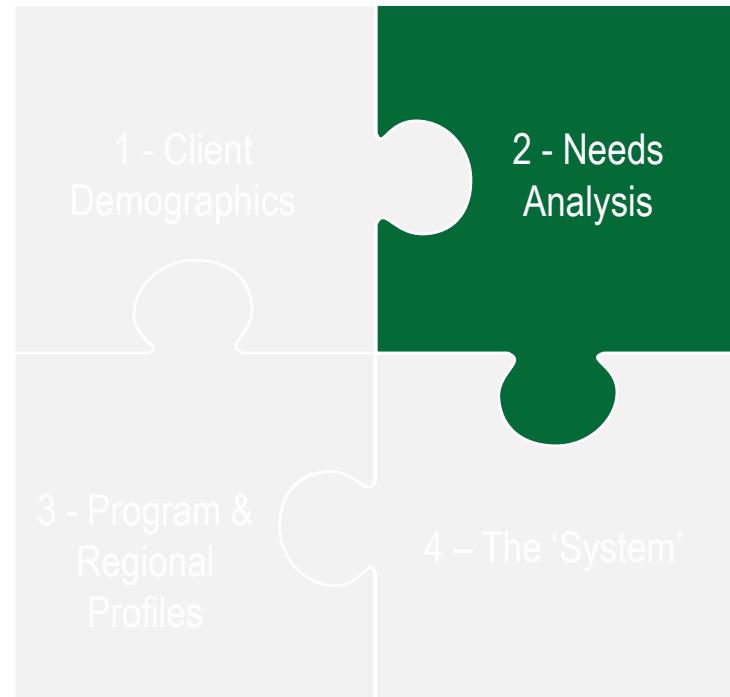
Key Takeaways

- Level 4 is considered “specialized” care
- CSSD’s ISM data indicated that **76% of children and youth in Level 4 placements** presented with significant behavioural issues and/or disorders (as outlined in the chart to the left).
- Of these:
 - The significant majority of this group (78%) presented with 2 or more complex issues and/or behaviours such as fire setting, violence, or criminal involvement
 - Over 53% presented with complex mental illness
 - Nearly 40% presented with problematic substance abuse or addictions
 - One-third (33.6%) presented with cognitive or developmental delay, such as autism or FASD
- It should also be noted that six (6) individuals were not found to have any behaviours or complex needs, despite their placement in Level 4 settings. It is understood that these children may be from a sibling group that have been placed together despite some children not requiring the higher level of care.

Residential Supports: Part 2 – Client Needs Analysis

To better understand the needs of clients supported in residential services, we worked with the Steering Committee to develop a framework and perform a client needs analysis

- The following section contains a descriptive analysis of client needs for residential support and services.
- The key questions asked in this section include:
 - *What needs do clients have, in areas such as to support physical needs, therapeutic or clinical needs, decision-making and oversight, life skills? Do some clients have a particular cultural need, or age-based need?*
 - *How do needs differ across client populations, geographies, and client demographics?*
 - *How significant are these needs, on a scale of 1 (low) to 3 (high), for each of the categories of residential need?*
 - *Do some clients need a greater level of support than they are currently receiving?*
- The framework on the next page illustrates how we defined five categories of needs for residential support, and the methodology used for evaluating these needs.



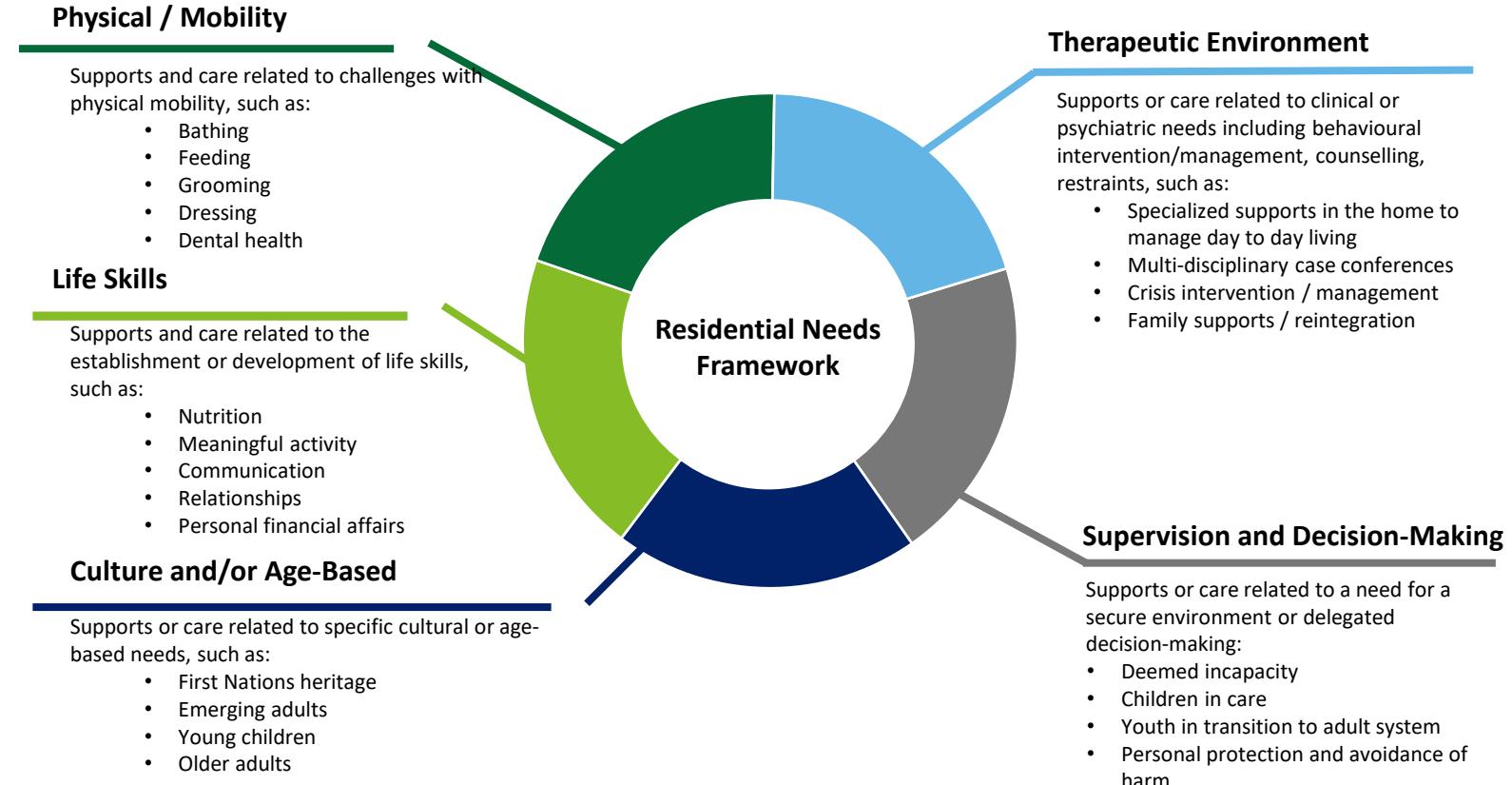


Deloitte developed a simple framework to assess current clients' needs for residential support

To better understand the needs of clients accessing residential supports in NL, we leveraged data from RHAs and CSSD, as well as engaged front-line social workers to provide a residential needs assessment

Assessment approach

- CRMS and other data pulled from HCS/CSSD/RHA systems was examined and found to lack sufficient detail to understand the needs of clients currently being supported in residential services.
- As a follow-up activity, Deloitte consulted with the Steering Committee, regional directors and others to design a secondary needs assessment. This new framework and definitions (see right) was developed as an outcome of those discussions.
- The methodology used to perform the needs analysis included:
 - Social workers were invited to report on a sample (min. of 25%) of their active caseload of residential supports client.
 - They were asked to provide their clinical impressions to rate the client's level of need in each of the five components, on a scale of 1 to 3 (low to high). This provided an indication of complexity and degree of need in each component.
 - 'Not applicable' was also offered as an option.



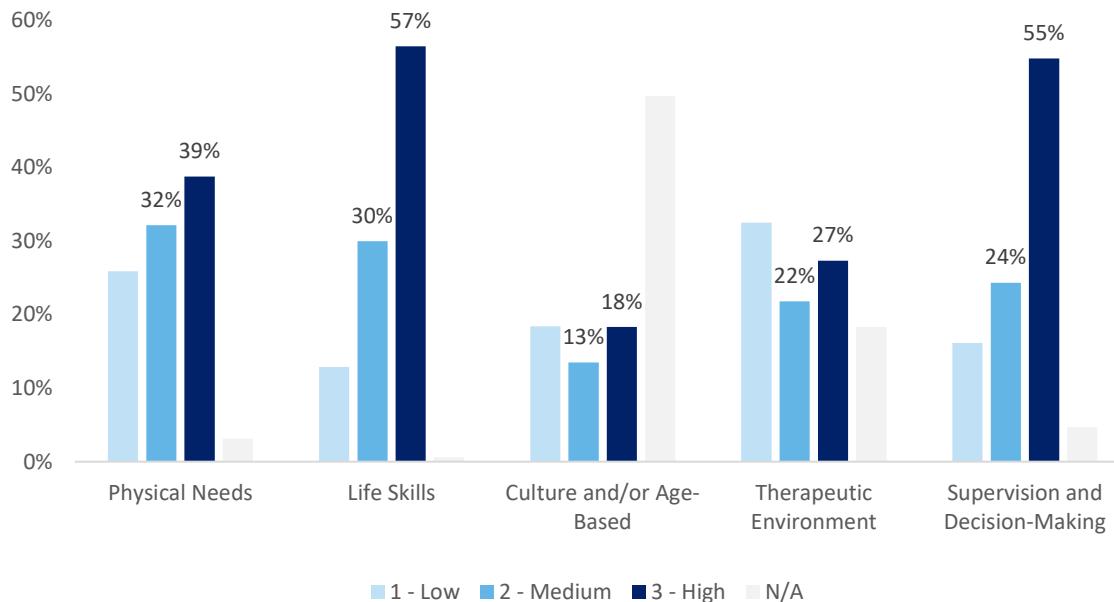


Adult clients across NL have an acute need for supports related to life skills, and supervision/decision-making

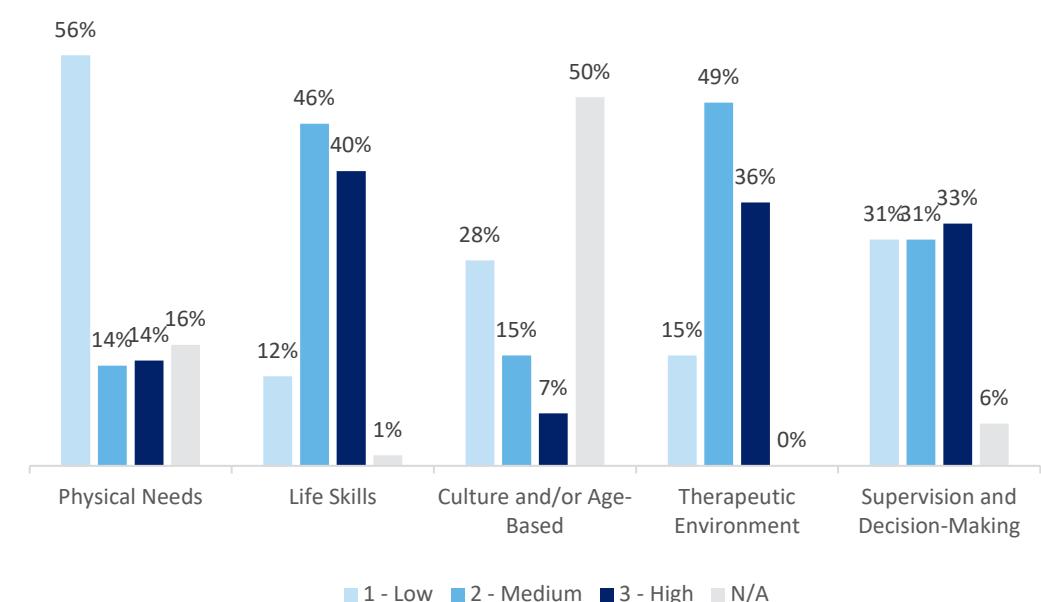
Understanding adult residential needs across NL

- The data provided from the client needs analysis was consolidated by region, program area, and by each of the five elements of residential support framework. Each client's assessed needs were added up to provide an overall score of complexity. Analysis was also performed by component across all clients. In general:
 - Over 85% of MHA clients across NL need moderate or high levels of both life skills development and a therapeutic environment.
 - Over 80% of CSS clients across require moderate or high levels of both life skills development and supervision/decision-making.
 - Both MHA and CSS clients also have a moderate to high need for a therapeutic environment.
- In many cases, clients are not placed in environments which fully address these pressing needs.

Assessed Residential Support Needs of CSS clients



Assessed Residential Support Needs of MHA clients





Over 80% of CSS clients across NL need residential environments with moderate to high levels of support in terms of life skills development, supervision and decision-making

Provincial Residential Needs Highlights

87% of adults with disabilities most need residential support in the area of Life Skills

79% of adults with disabilities have also have an acute need for support in Supervision / Decision-Making

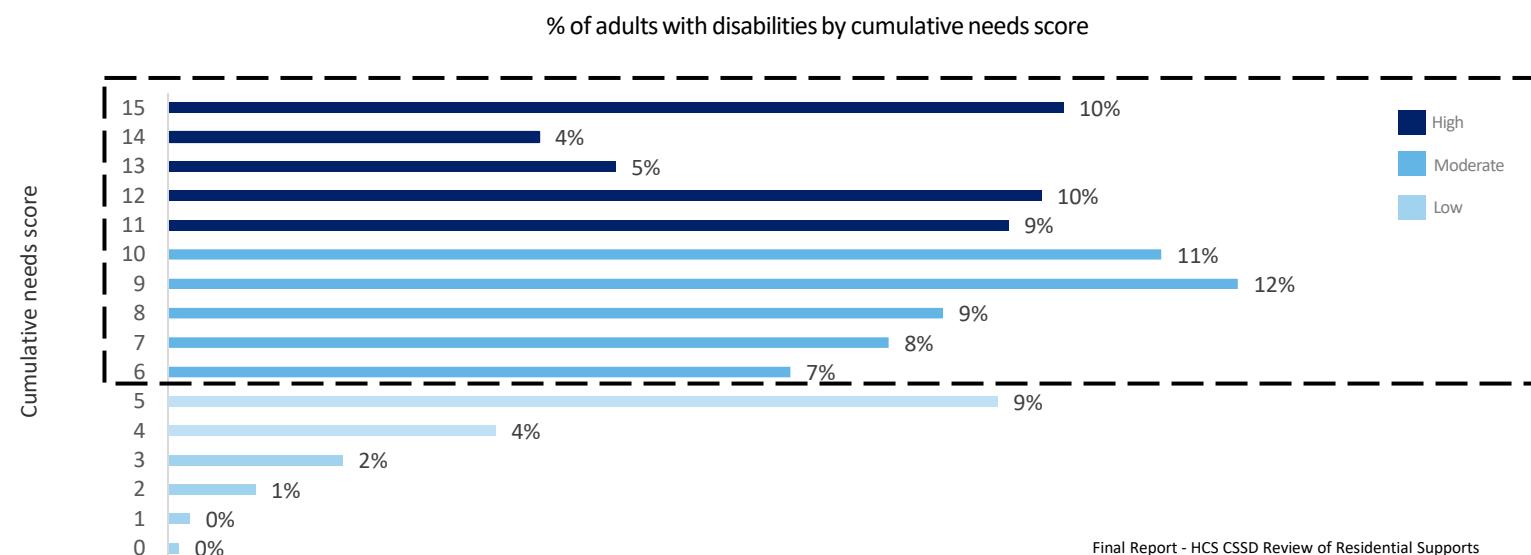
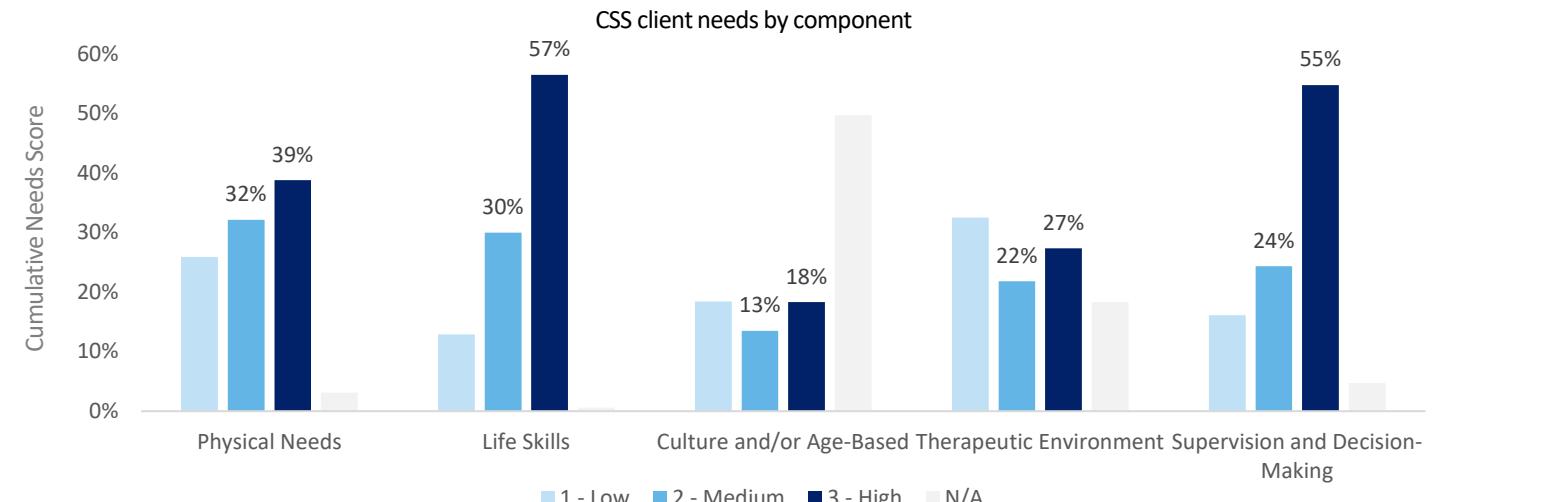
38% of adults with disabilities have exceptionally high complexity; a further 47% are assessed with moderate complexity



WHAT WE HEARD FROM STAKEHOLDERS

Unmet needs:

- Routine and structure
- Stimulation / activities
- Appropriate level of supports
- De-escalation supports
- Connections / social supports
- Independence (i.e., over-servicing)





For MHA clients across NL, over 85% need moderate to high levels of residential support, primarily in life skills development and a therapeutic environment

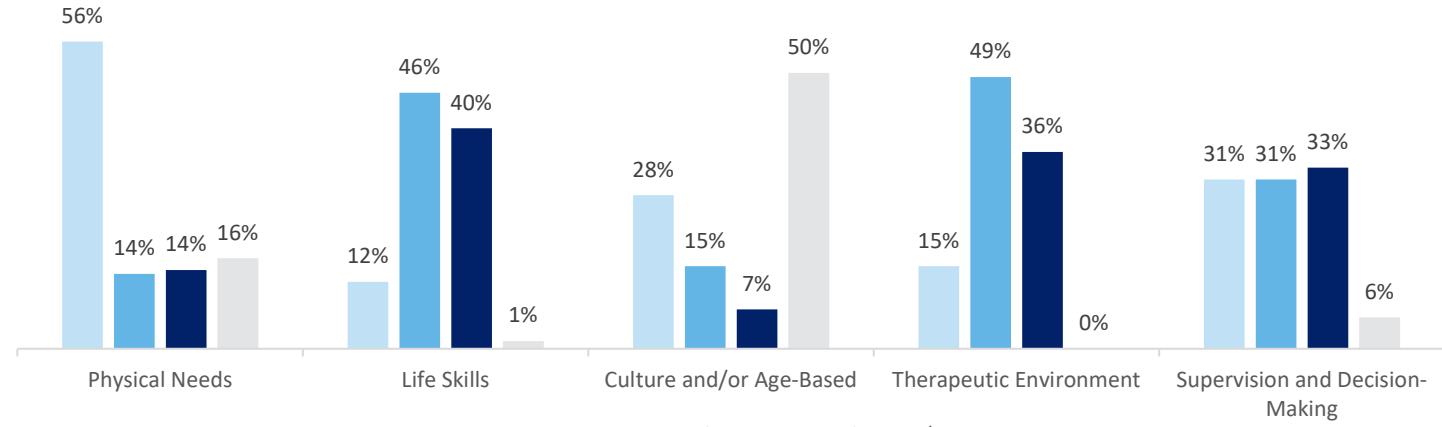
Provincial Residential Needs Highlights

86% of adults with mental illness and/or addictions most need residential support for Life Skills

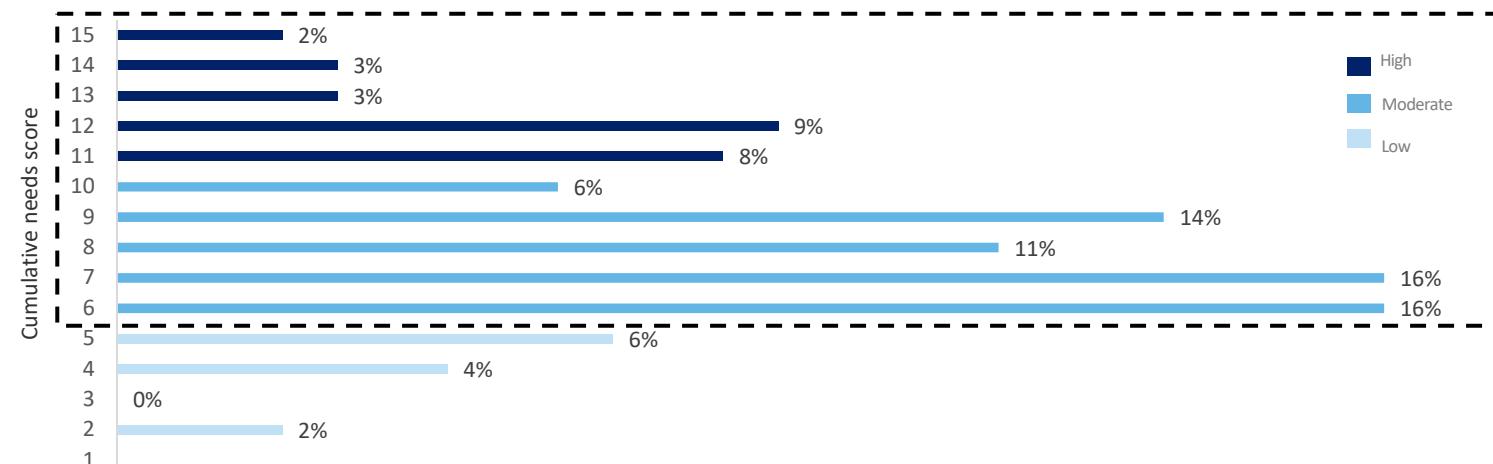
85% of adults with mental illness and/or addictions also need a highly Therapeutic Environment

25% of MHA clients have assessed residential needs of high complexity; a further 63% are moderate complexity

MHA client needs by component



% of MHA clients by cumulative need score



¹ Stakeholder themes are presented in the next section



Over 51% of children and youth in Level 4 care in NL are highly complex; at least 73% have an acute need for a therapeutic environment

Provincial Residential Needs Highlights

73% of children and youth have an acute need for a Therapeutic Environment

63% of children and youth have an acute need for Supervision / Decision-Making

51% of children and youth are in the top third of complexity

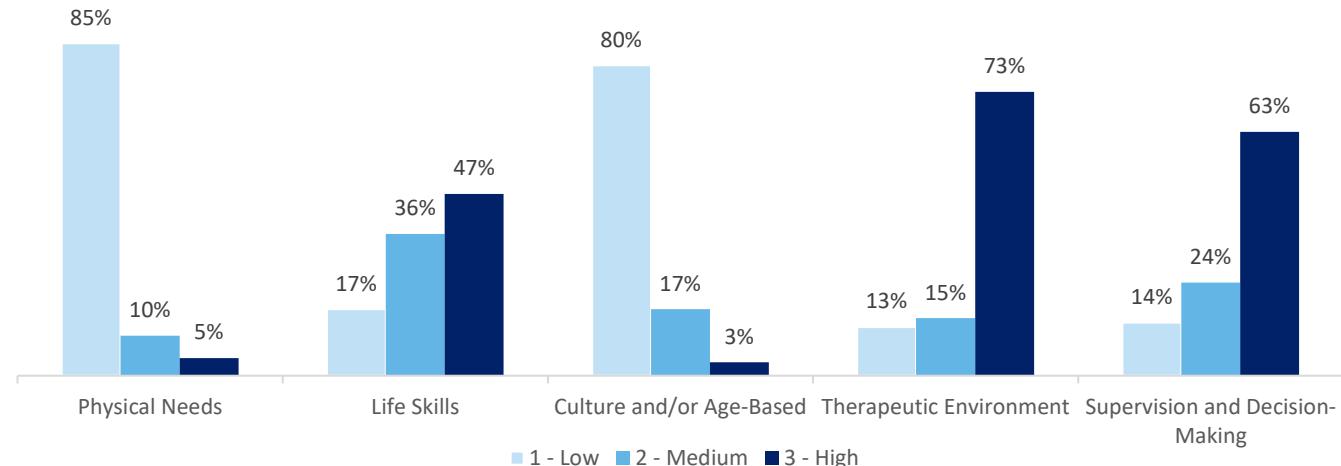


WHAT WE HEARD FROM STAKEHOLDERS

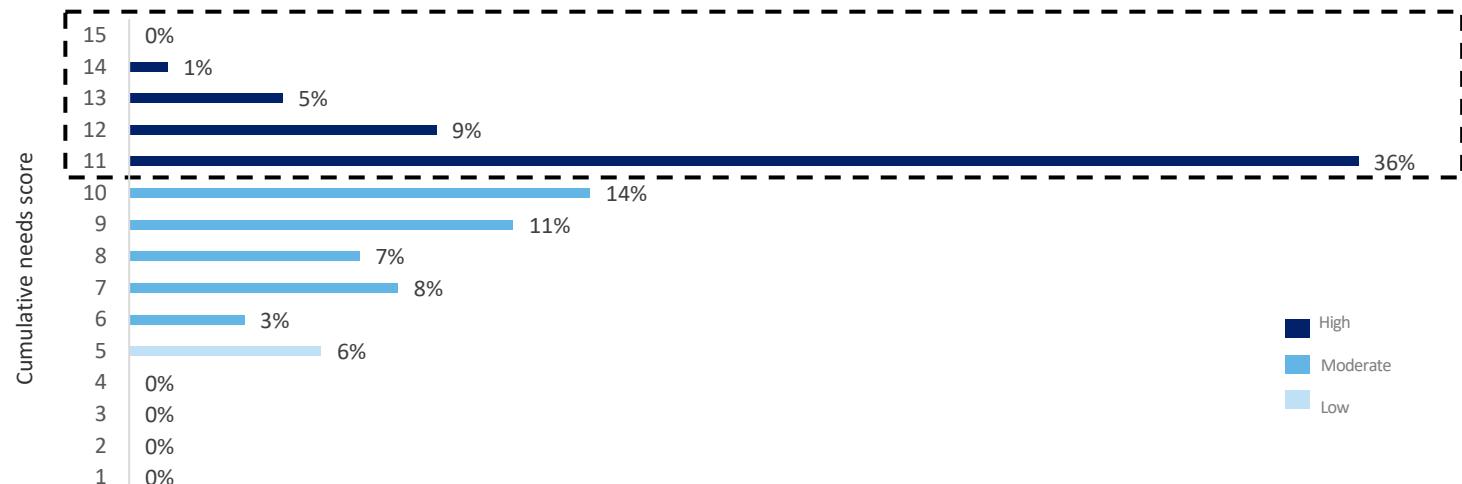
Unmet needs:

- Meaningful, trusting relationships
- Access to mental health supports
- Safe and secure environments
- Connection to culture and community
- Childhood 'amenities' (e.g., getting a dog) and life skills (e.g., obtaining drivers license, opening a bank account, managing money, etc.)

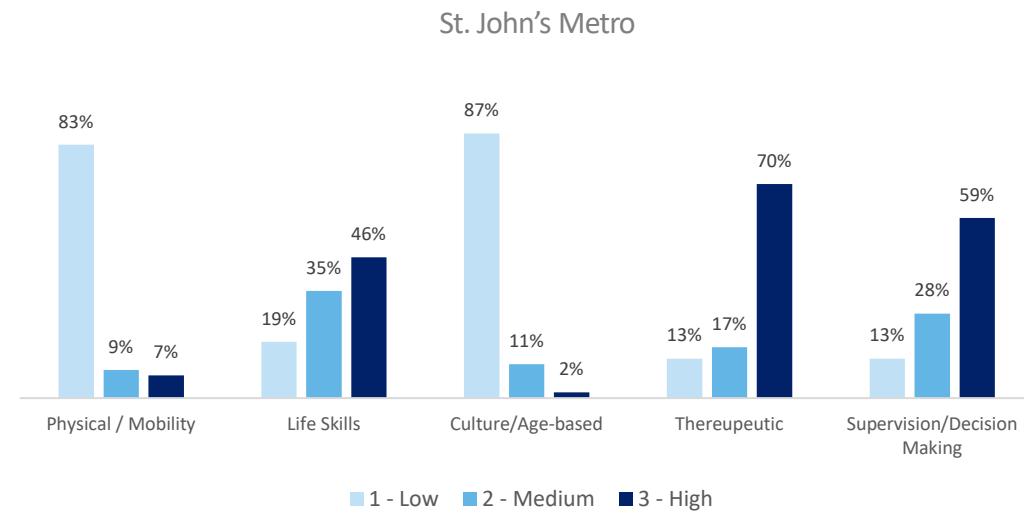
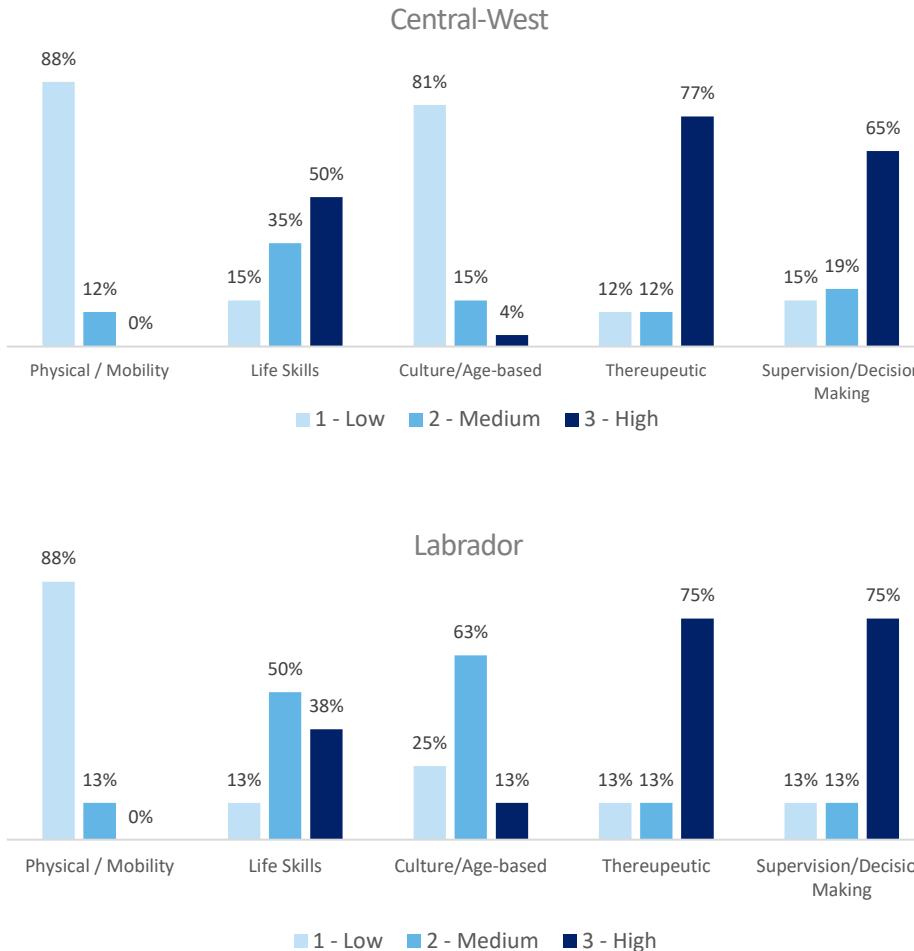
Children and youth needs by component



% of children and youth by consolidated needs score



Regionally, children and youth have an acute need for a therapeutic environment; Labrador's children in care have the greatest need for age/culturally appropriate settings



Key Takeaways

- The residential needs of children and youth are consistent across regions, with the greatest need being in a therapeutic environment (at least 70% in each region).
- Other exceptionally high needs are in terms of supervision/decision-making and in life skills development
- In Labrador, more children and youth have higher cultural/age-based needs than other region



Residential Supports – Part 3: Stakeholder Feedback

This section contains extensive feedback received from stakeholders through an online survey, interviews and group discussions

Summary of Stakeholder Consultations

- Consultation with key stakeholders on the met and unmet needs for residential supports across the province was an important source of information for the review team.
- The questions answered in this section include:
 - *How do individuals and their families feel about their current living arrangement?*
 - *What improvements are needed to better support clients in their arrangement?*
 - *What is missing from the living arrangement that clients or families need?*
 - *From a provider perspective, what feedback, challenges or concerns can be provided to Government on the different living arrangements?*
 - *What overall themes have emerged from our discussions?*
- In total, the stakeholder engagement process included over **350** unique individuals across the province.
- The following section summarizes the themes emerging from our discussions.





Stakeholder Engagement Approach

Direct consultations and online surveys were conducted to obtain input, feedback and ideas from over 350 stakeholders, including families and people with lived experience

- A comprehensive engagement process was designed to capture stakeholder feedback, insights and promote discussion in a constructive and meaningful way. Stakeholder groups are outlined to the right.
- Our approach included:
 - ***One to One Interviews and Small Group Interviews:*** Our team conducted **110 interviews** with stakeholders around the province. Given the COVID-19 environment, these consultations were performed by telephone or virtual video interviews (e.g. Zoom, MS Teams).
Most interviews were conducted on a one-to-one basis, however some discussions were held with small groups, where the participants were known to each other, had a common view of client needs and/or program opportunities (e.g. families, program staff, front-line social workers).
 - ***Online Survey of Client Needs:*** A confidential online survey tool was developed to collect structured and unstructured feedback from **248 stakeholders**, including marginalized individuals who may or may not be receiving residential supports.
In this case, individuals were supported by staff of community-based non-profit organizations to complete a survey. In other cases, surveys were distributed to the email addresses on file with RHAs.
- Consultations also solicited provider views on the current client needs, and to understand key challenges and feedback about the various living arrangements.
- The names of stakeholders who participated and provided feedback for this review are listed in [Appendix A](#).

Stakeholders consulted in this review

Stakeholder group	Interviews completed
Individuals, Families and Caregivers	27
Program representatives from HCS, CSSD and RHAs	41
Community-based residential service providers	23
Non-profit community and/or advocacy groups	19
Total interviews:	110
Surveys completed	
Individuals (completed independently)	80
Individuals (completed with support from community agency)	25
Individuals (completed with support from RHA staff)	18
Families and/or Caregivers on behalf of a person receiving residential supports	110
Other (i.e., completed with support from other individuals)	15
Total surveys:	248

Sixteen themes emerged from stakeholder consultations, related to gaps in support, service coordination, and oversight of supports

- The stakeholder engagement that was performed during this review met with tremendous uptake by clients, families and service providers.
- With hundreds of hours of consultation performed, and additional hundreds of online surveys returned, the comments, suggestions and feedback items were many. In some cases, opinions were universal. In other cases, there is disagreement.
- A clear and compelling point of view arose as one of this review's overarching themes: ***that RHA and program staff, service providers and social workers all mean well, work hard, and often make good decisions but are bound by outdated programs and inflexible policies, which lead to the concerns and frustrations that were expressed in these discussions.***
- In summary, sixteen themes were documented as described in the diagram to the right.



These 16 themes are further described in the following pages.
Direct quotes and commentary from stakeholders are denoted by the following icon:

Key themes emerging from stakeholders

Clients and Families Do Not Feel Heard	Aging Families	Unmet Needs	Community-Based Treatment Options
Shared and Congregate Settings	Too Few Beds Available	Escalating Client Complexities	Unclear Outcomes / Cost-Benefit
Existing Options no Longer Meet Needs	Wraparound Supports are not Enough	“Bumpy” Transitions Across Lifespan	Unclear Plans for Waterford Patients
Oversight and Accountability	Stable and Specialized Workforce	System is Fragmented and Hard to Coordinate	Policy Confusion Between RHAs

Stakeholder themes included not feeling heard by Government, and concerns about future plans aging families who care for disabled adults

- **Clients and families do not feel heard.** While the response to this review was generally quite positive, it is important to acknowledge that many clients, families and providers expressed frustration and reported that they feel they have not been heard in the past. Some clients and families report that they have shared their views in numerous previous reports. Some have taken their concerns to the media. Some have formed support groups or sought models of support on their own. They say they have tried to engage government in transparent discussion and have reported what “doesn’t make sense” but very few changes have been observed. They feel as though social workers make false promises but no plans are put into place.
- Parents and AFC providers also commented that ‘decision-makers’ in the system appear to have a limited understanding about the day to day strain of caring for a loved one 24 hours per day, often with no respite and bare minimum funding. Former youth in care expressed disappointment and resentment that they were dismissed as “problem youth” when they tried to engage social workers or reported concerns about their living environment or staffing issues.
- We also heard from non-profit organizations, advocacy groups, and service providers who have innovative ideas for change. They reported a range of efforts to engage government in discussion about alternative models of support. In several cases, they received no feedback or follow-up discussion on their proposals. Or they were advised that ‘the time was not right’ and they would have to wait. Stakeholders express they often feel powerless to influence policy decisions and approaches used to provide support. Proactive communications from program staff was also an area of concern.
- **Aging Families.** We also heard from clients, families, and program staff about family members well into their late 70’s and 80’s caring for disabled adults at home. These stakeholders expressed concern about the inadequacy and delay in developing transition plans for the long-term. These families need greater certainty about where their loved one will live once they are no longer able to provide care, however despite repeated efforts to establish plans, there appears to be no clarity about where their loved ones will be placed, few choices and options available, and confusion about when such a transition might take place. Many family members have already experienced health issues, and are fearful that a crisis or emergency may be the only way to prompt action.

“I’m getting tired of giving feedback to be honest.”

- Family member

“The only thing insecure about where I live now is my mother’s health. I don’t know what will happen to me if something happens to her. I have three brothers but only one seems to take an interest in me. He says he’ll help if my mom is not around. But I wonder if he actually realizes what my care entails.”

- Adult living at home with family

“Where is she going to go when we’re gone? I’m already 84 years old. There’s not much time left to figure it out.”

- Parent of an adult client

“They keep saying ‘don’t you worry my dear, your daughter will be taken care of’ but nothing ever happens.”

- Parent of an adult client

Stakeholders identified significant gaps in support, and unmet needs for housing and residential services

- **Unmet Needs.** Program staff, community agencies and other stakeholders expressed significant concern about homeless and unhoused individuals across the province. They reported numbers of individuals outside the system that they felt have an *unmet need* for residential supports or social housing, but which may not be reflected in the statistics generated for this report. We also heard about emergency shelters at capacity, as well as 1,500+ on the waitlist for social housing in the province – many of which are single men.
- In Happy Valley-Goose Bay, makeshift tents and temporary shelters can be seen throughout town or along surrounding trails. The local shelter is described as “bursting at the seams.” Many individuals are unable to access a bed and are supported at the Labrador Inn. Stakeholders reported that the waitlist for supportive housing is very long, and anecdotally, stakeholders report that “no one has received supportive housing in years” in that community.
- While actions have been taken by government and municipalities to expand shelter beds and partner with community organizations, a population may still exist who are at imminent risk, and are invisible to the system.
- A key challenge related to unmet needs is the ability to track individuals as they move through the system, particularly as they receive or are denied supports. Privacy and confidentiality policies are often cited as a barrier to sharing of important information between community based organizations, RHAs and other entities.
- **Community-Based Treatment Options.** Services are largely concentrated in urban areas, particularly for mental health and addictions clients. Stakeholders report limited choice in the array of housing options, particularly related to treatment options for adults and children/youth with more complex needs (e.g. autism, FASD, chronic and persistent mental illness), and for individuals transitioning to and from periods of acute illness. While some therapeutic programs may exist in NL, they are not well coordinated across government and are practically inaccessible for many individuals.
- Families, former youth in care clients, and providers expressed a need for community-based options where individuals will receive actual treatment – not management of their behaviours with workers in the home that may or may not follow the recommended care plan. They believe that clients would improve and be enabled to live more independently if there were some residential options that feature intensive clinical services, therapies, and assessments to ensure clients were receiving consistent care.

“We don’t really know how many are out there. Part of the problem is we can’t share information and name them.”

- Community service provider

“It’s a sin, all those fellas living out there in the winter.”

- RHA representative (Labrador)

“If they don’t agree to go [to a youth treatment facility], there’s nothing you can do.”

- CSSD social worker

“People’s needs change over time. Sometimes they are well, sometimes they’re not. We need places they can go to stabilize and maybe give the service providers a breather so the placement doesn’t break down”

- RHA representative

An option that some families wish to pursue is shared or congregate settings for adults; others describe a significant lack of capacity in the residential support system

- **Shared and Congregate Settings.** A significant number of families caring for disabled adults expressed a desire for shared living, or ‘family-like’ living arrangements. They express frustration that shared living (“group homes”) or congregate living arrangements are not available for adults, and believe this option has been avoided for reasons related to political sensitivity.
- However their view (which is shared by some but not all program staff) is that clients and families have the right to choose what is right for themselves or their loved ones – including whether they live alone, with a roommate, in shared accommodation, or in family-like setting. They seek options that have embedded supports that promote long-term personal relationships between their loved ones and paid caregivers, and allows their loved ones to ‘settle in.’ For some adults and youth, greater stability may allow for transition to a lower support environment over time.
- One group of families dissatisfied with the current array of options have banded together to form an advocacy group, and have submitted proposals to government to fund a new shared living option for their loved ones. They have a strong preference for a model of family-like setting known as L’Arche, and have provided extensive input to this consultation process.
- **Too Few Beds Available.** Program staff and social workers reported a significant lack of capacity in virtually all residential support programs, and expressed concerns about the impact this has on their placement decisions. Too often, stakeholders feel that a particular living arrangement is ‘not a great fit’ for the client, but felt they were forced to offer it to families because no alternatives are available. Or, a placement is made at a long distance from the natural family. This issue is particularly acute for children and youth who may be placed for long periods in emergency placement homes, which are typically limited to 90 days, but stakeholder report much longer stays.
- Service providers in several program areas report difficulty in obtaining respite, and the long distances they must travel to enable a family visit to take place. However, without enough capacity in the system, clients seem to be placed where ‘there is a bed’ and no matching of support needs, preferences, and even geography, can take place.
- Stakeholders also described the timeliness of access for adequate housing as problematic (i.e. the option may exist but its not available when you need it most). For those with disabilities, access is limited to universally designed, accessible units. For mental health and addictions clients, often units that are available are too large and are typically reserved for larger families in need.

“Why wouldn’t I want my son to live with other people and share a home? He’s been part of a family and living with other people for 43 years. It’s all he knows.”

- Parent of adult son living with significant intellectual and physical disabilities

“I hate the thought of someone being forced to live alone in an apartment, with only paid staff to come by every once in a while. To me, that’s inhumane.”

- Representative of advocacy group

“What options? There are no options... [laughs]”

- Social Worker

Client complexities and the number of dual and triple diagnoses have escalated in past decades, which have stressed the system

- A related challenge facing the system is the degree of manual effort required by service providers and RHA/department representatives to match clients with existing placement options, how provider capacity and operational needs are made known to the system and how social workers are able to access real-time information on available beds, particularly for the children/youth system.
- **Escalating Client Complexities.** Long-time service providers and RHA stakeholders have observed escalating client complexities over the past decade or two. They report that dual diagnoses, behaviours, aggressive episodes, and other complexities would have been exceptional in their caseloads in the past, but now are ‘the norm’. Many adult clients with disabilities exhibit concurrent mental health issues, such as OCD, anxiety and depression (whether or not they have been formally dually diagnosed), which may contribute to high behaviours. Individuals with complex needs and levels of acuity never seen before are challenging the existing system to respond with innovation.
- These stakeholders reported growing concerns about the adequacy and availability of supports available, such as behavioural management, and limited access to clinical services in rural communities outside of St. John’s.
- Social workers and RHA managers broadly report administrative hurdles and intensive interdepartmental or case management discussions required to manage the care of some clients with complex needs. Escalating residential program costs – as much as 76% of total annual budgets spent on wraparound supports, such as increased home support hours – are perceived as bandaid solutions which care teams add to existing supports to avoid placement breakdown. Yet, some stakeholders complain that the typical home support worker is not equipped to manage behaviours or complexities.
- Stakeholders also report frustration with clinical professionals particularly in the pediatric system who they feel dismiss self-harm, running away, or sexual acting out as “behaviours” that are not psychiatric in nature and therefore not appropriate for medical intervention. Stakeholders report being turned away with vague recommendations to obtain counselling, but that community-based supports are either practically inaccessible due to long waitlists, or insufficient for severely traumatized youth and young adults that need help.

“The complexities are off the chart.”

- Level 4 Care Home Service Provider

“Case management can feel like playing hot potato... and in the end no one ends up doing right by the client.”

- RHA representative

“[The clinical professionals] basically say the kid is looking for attention and close their file.”

- Level 4 Service Provider

Without enough options, stakeholders feel the default choice is to individualize a living arrangement at very high cost, but without expectations to achieve certain clinical outcomes

- **Unclear Outcomes & Cost Benefit.** For clients with complexities that exceed “normal” program protocols, stakeholders report a growing move to establishing customized settings or alternative living arrangements – often with exceptionally high staffing levels or physical environments that require frequent repair and renovation. Stakeholders reported that the cost to care for clients with complex needs can range anywhere from ten to hundreds of thousands of dollars a year. Clients may be receiving two-on-one or three-on-one care depending on their situations. Despite this high rate of pay, there is a prevailing sense that not every client is getting the same quality of level of support for the price that is being paid.
- For adults or child/youth that are sufficiently “complex” often with combinations of diagnoses, developmental delay, behaviours, mental illness, or other factors, and with families that can no longer cope at home, an ILA is increasingly the choice by default. Stakeholders report selecting this option because “there are no other options for them” or because they have exhausted available options in the community. It is not the preferred choice for most clients, as the living environment tends to prioritize safety and security over comfort and “home-iness”. In these cases, there are typically very high levels of support staffing required which further diminish the sense of home-like atmosphere.
- Other individuals¹ present with criminal justice system involvement, arson, pedophilia or a sufficiently high community profile such that special precautions are needed. Community-based housing for clients with anti-social behaviours are difficult to secure, and often depend on private landlords to source properties that avoid schools, victims, or which require arson-proofing. Media reports in 2020 report private landlords earning over \$1.1 million per year from such clients.
- For both groups, stakeholders reported that many customized arrangements are difficult to justify not only due to their cost, but because they are not designed with clinical outcomes identified, nor with expectations for reducing the level of support required.
- Program stakeholders questioned the relative benefit of these programs, where they felt costs paid to external service providers were exceptionally high, yet clients may still not be receiving the right supports. They also note that service providers (agencies) are not incented to support a client in gaining independence which could reduce the staffing levels required (and provider revenue).

“To be honest, I think we use ILAs because we don’t know what else to do.”

- RHA Representative

“I really worry about these kids who are being placed in ILAs. They’re going to be adults in ILAs someday. There’s no easy way to get them out of there.”

- Social Worker

“We sometimes really enable our clients to continue at their status quo...we need to start teaching our clients how to fish, not fish for them.”

- RHA representative

“And the cost! You wouldn’t believe how much some of these landlords are charging. But no one else will take them and we can’t have them on the street. What can you do? But... it bothers me.”

- RHA representative

¹ Some placements are considered Individualized Living Arrangements, which were reviewed as part of this report. Other placements (e.g. those established to support individuals as they transition from the justice system back to the community) are set up on a one-off basis in coordination with the Dept of Justice and Public Safety, and do not fall within existing program boundaries. They were not part of this review.

They feel many existing residential supports are simply not able to meet changing client needs

- **Existing Options No Longer Meet Client Needs.** Many of today's residential support programs have been in place for over a decade without change. While service providers are committed and willing to meet the need for ever-increasing complexity of client needs, many are working on a 24-hour basis but receiving funding well below what stakeholders perceive to be a fair and living wage. Examples include AFC and BLR.
- Stakeholders report a general sense of programs being "outdated" – including many of the physical living environments – and that they do not reflect the values, innovations, and most acutely, the flexibility required to participate in the modern world in which inclusiveness and independent living are prioritized. They also feel those options that rely on hourly workers lack permanency and stability.
- Some programs – including Alternative Family Care – are perceived as "dying." Service provider numbers are dwindling and there are fewer and fewer options to place disabled adults in family-like settings. Additionally, with smaller family sizes and more working parents, some stakeholders expressed concern that a financial subsidy (e.g. BLR) will be insufficient to support clients at home with a family member.
- They also describe a dearth of truly supportive living options in the community. For example, the inflexibility of funding and supports for physically disabled clients who do not need 24/7 live-in care, but may need support 'on demand' throughout the day or night. Current programs also do not allow for sharing of support staff between two clients, or for innovative approaches to supporting clients in the community.
- A key observation made by a small number of stakeholders, and by the review team, is that many RHA and program representatives involved in making clinical decisions appear to have difficulty describing the nuanced or specific residential needs; 'complex' or 'challenging' were often used as catch-all terms to describe a wide range of physical, social, or behavioural challenges which might impact where the individual should be living. The inability to truly define what a client truly needs as it relates to their living arrangement significantly impedes the ability to provide customized or tailored supports for the individual.

"I don't want someone in my house sitting in front of the tv 4 hours a day. I'm a grown man! I just need someone a few times a day. Maybe at night"

- 39 year old client with physical disabilities

"She's going to be living there day in, day out for the rest of her life. I want to know the place has some stability for her."

- Family member

"I love [the client] as my own...I will do this until I physically can't anymore... carry on as long as my health permits"

- AFC Provider

Supplementing with wraparound supports or services may not be enough for clients with the greatest complexity

- **Wraparound supports are not enough.** Most residential supports tend not to offer specialized workers, clinical services or supplementary supports that are embedded in the living environment. Across the lifespan, stakeholders reported that NL's residential services tend to provide the 'bricks and mortar' or the basic needs of life, but tend not to offer supportive living, programming, or therapeutic interventions that would enable the client to live well. For example, the board and lodging supplement provides only for rent, food, and community access. Private landlords are not perceived to provide a supportive living environment.
- Clients that require supports that do not exist in the physical living environment may be provided with supplementary support staff, home support, clinical social workers, and other services (sometimes called "wraparound services" although the definition of this term varies by program area). Such supplementary services might be brought into the home on a scheduled or appointment basis, or may be accessed in the community through clinical professionals funded by the health system.
- While these supports have merit, for some clients, wraparound services are perceived as being insufficient to effect meaningful change. Clients need more intensive and specialized supports, right there in the living environment, some of which might be available round-the-clock, in order to set and meet goals, obtain support when they need it, and make slow but steady progress.
- For some adults with disabilities, families express a need for a realistic view that their loved ones are not likely to improve dramatically and become capable of living independently. Instead, they seek living arrangements that reflect a long-term perspective, including that staffing is not "wraparound" which they perceived as unstable and temporary.

"Seeing a social worker on the doorstep a few times a week doesn't cut it. What's that going to do? There are 23 other hours in the day to get into trouble."

- Family member of a BNLR client

"I go to bed every night at 8:00pm when my caregiver leaves. That's a bit unnaturally early for a man my age.

- Adult client

"I would really like a couple hours alone in the home without staff."

- Adult client

Many transition points are not well managed particularly for youth to adulthood

- **'Bumpy' Transitions Across Lifespan.** Universally, we heard from stakeholders including clients, families and service providers that transitions across the lifespan are challenging. As previously described for aging parents and disabled adults, without a crisis to spur action, it may be difficult to plan and stage a transition from living with one's family to a staffed residential placement. Some stakeholders also referenced a small number of adults receiving residential supports who lack natural family and appear to have been 'passed on' from one program area to another without a substitute decision-maker identified. In these cases, health care decisions (such as related to vaccinations, surgical procedures, end of life decisions such as cremation versus burial) lack clarity.
- We also heard extensively from former youth in care, program staff and RHA representatives, that youth transitioning to the adult system have a very difficult time. Stakeholders noted there is little to no emphasis on transition planning as a child in care prepares to enter adulthood, particularly around housing and important life skills such as getting a drivers license, managing their money, or learning how to cook.
- Ideally, planning and support for this process begins well before the eighteenth birthday, and is an ongoing process – leveraging supports and resources from the adult system, as appropriate. However, some stakeholders have a view that some children are unwilling to commit to the transition and inhibits their success in adulthood.
 - While efforts are certainly made to plan and support youth into adulthood, such as the creation of the CSSD's Youth Services Program which extends residential support to youth in care age 21, too many youth fall through the cracks.
 - It is recognized that CSSD's Youth Services Program has been in existence for two decades and has successfully supported many youth through transition to adulthood,
- Across population groups, stakeholders reported there is often a trigger point which signals the need for alternative housing options or a change in placement (e.g. acute mental illness, recovery from mental illness and discharge from in-patient settings, caregivers health declining to the point they could no longer care for an adult with behaviours, escalation of challenging behaviour where the adult cannot safely remain in the house, transition to adulthood).
- An overarching gap that was identified was a lack of housing options that address these important life transitions or 'trigger points' in which clients may need more or less support than their 'steady state'.

"My parents aren't getting any younger."

- BNR client

*"They said I had to sign something so I could stay in the group home until I was 21. I told them to ** off and just left."*

- Former youth in care

Transition plans for former patients of the Waterford Hospital may be underway, but stakeholders prefer a step-down living environment that does not exist today

- **Unclear Plans for Waterford Patients.** Stakeholders shared that the biggest challenge when discharging these patients into community is not necessarily finding the physical ‘brick and mortar’ of a living arrangement, but rather ensuring the appropriate clinical supports are built around them to ensure a smooth transition from an acute setting to a supportive living option. With no housing attached to healthcare for mental health and addictions patients, this is often a challenge.
- For the 17 long-term patients at the Waterford Hospital slated for discharge, it is understood that transition planning is well underway, although at time of writing such plans were not available for review. It is assumed that NAVNET will support a number of the relatively less complex individuals when the acute beds close, however, there is limited understanding to the options that may be available through community to support the patients at the very top of the complexity pyramid.
- Hospital stakeholders suggest that the former Access House is the right model to support these patients in the near to medium term and assist them in acclimatizing to the community. However, Access House closed a number of years ago.
- **Oversight and Accountability.** Program staff, some service providers and families expressed concern about provider oversight, accountability and appropriateness of some accommodation operating standards. Stakeholders question provider accountability and adequacy of standards, for example, noting that BLNR has no minimum standards to assist in establishing a minimum quality of living arrangement (other than municipal requirements that apply to all rented accommodation). Many stakeholders identified the need to drive accountability for landlords and caregivers across the province who are charging outlandish fees. If housing options are available for a client, stakeholders feel they are rarely safe, high-quality, and affordable. Many community-based housing rented to mental health and addictions clients are reportedly substandard in terms of safety, physical environment, and cleanliness and rife with rodent infestations, broken appliances, and/or have foul odours, yet landlords are able to charge high rents - at times exceeding \$3000 per month.
- In other discussions, CCH operators, families and even program representatives commented on the fact that there is no accountability to Government for funding received, or for outcomes to be achieved. They feel there is limited ability for Government to set expectations, incent providers to enhance their service levels, or intervene when things go wrong. Additionally, some stakeholders commented that some of the PCH operating standards do not make sense for CCH providers, for example, related to equipment and staffing levels. Other Deloitte reviews have identified outdated PCH standards.

“Absolute filth.”

- *Family member, BLNR client*

“...deplorable conditions”

- *RHA representative*

“Doesn’t anyone want to know how my brother is spending his day? We’re giving them taxpayer money and no one knows what’s going on.”

- *Family member, BLNR client*

Challenges related to funding insufficiency and inflexibility were cited broadly as barriers to improved well-being, longevity of placements, and personal independence

- **Inadequate Funding.** We heard loud and clear from many stakeholders that they do not feel their current levels of financial support are adequate to appropriately meet today's evolving needs. Pay rates for most programs have remained relatively flat for many years (e.g. AFC), and while increases have been given on a case-by-case basis by RHAs, stakeholders feel a more thorough understanding of the operational realities, costs, and level of care needs are necessary to develop new reimbursement methodologies.
- Similarly, stakeholders reported that in several program areas (such as AFC, BLR), funding is perceived as insufficient to cover the actual costs of supporting the resident. They reported funding criteria and processes that make them "jump through hoops" to get legitimate expenses covered, and more hoops to be reimbursed for approved expenses and travel. While these caregivers indicate they will 'do it as long as they can', the pressures of financial hardship and their own advancing age, are mounting. These care providers are accessible 24 hours per day, 7 days a week with very few opportunities for respite, which further strains their financial situation.
- Some clients self-reported a desire to better leverage the funding available to them, either by pooling with other families, applying funds to other supplies or necessities that are currently not covered, or by reallocating unused funding to avoid 'losing it.' They expressed frustration that program funding rules are rigid and often fail to address the true need as they personally define it.
- Various restrictions on financial supports and subsidies were also cited as causing challenges for clients and families. For example, conflict of interest policies prevent family members from being hired as home support workers. Siblings are not eligible for funding to look after foster siblings.
- We saw evidence that providers could benefit from intensive training to avoid expensive mobile crisis team calls, police interventions, injuries, and ER visits. However, there is limited funding for provider training – and even the availability of training in the community, if funding were not a barrier – has been expressed as a concern. Some stakeholders suggest that behaviour management training should be provided to all service providers and families supporting clients with those needs. Also, they say any service providers working with youth in care, or adults with mental illness should be supported with trauma-informed training.

"Allow a family member to be approved for respite care to give my parents a break (hard to find non-relative and willing respite workers).

- Client

"Maybe all some they need is a simple bus pass but here we are spending taxpayer dollars on hospital stays, etc.."

- RHA representative

"More access to specialized services to support my needs, ie physical therapy, regular visits by a nurse"

"More funding for food, necessities, and funding for specialized equipment that supports my needs; ie adult wipes, mattresses "

- Client

"It's not really worth the hassle sometimes. Sometimes it takes 3 or 4 months to get paid back"

- AFC Provider

Stakeholders noted that the current workforce supporting individuals in residential environments does not lend itself to permanency, stability or building relationships – all of which may exacerbate behaviours

- **Stable and Specialized Workforce.** Many stakeholders mentioned having adequately trained caregivers would go a long way towards supporting their clients or family members with complex needs and behaviours. In many instances, caregivers are not prepared for behaviours and actions of these individuals. A supportive board and lodging provider indicated that whenever there is an issue, his first reaction will be to simply call the police – he is not always equipped or feels comfortable to manage the situation on his own.
- Other providers indicated that when behaviours are difficult to manage, the placement typically would break down. We heard several reports of providers or family members being injured on a routine basis by their loved one or client. The same providers and family members did not identify any previous training or education in management of complex needs and aggression. Conversely, some providers report they are fully equipped to manage the needs of their client/resident.
- Other examples included clients who are perceived as being ‘over-serviced’ – that is, individuals with admittedly complex needs who are supported by as many as five workers for 24/7 care, and yet still not receiving supports that meet their needs. They also reported instances in which clients with complex needs may be assigned workers who lack the skills and knowledge to provide appropriate support and structure. For example, they commented on home support workers that are rotated through a home or ILA of a client with complex needs, particularly those with developmental disabilities such as ASD or FASD. Stakeholders reported instances in which staff refused to follow a behaviour plan (when the plan is understood to exacerbate behaviours in the short term), or that transitory home support staff increase disruption and are not able to provide the sense of predictability and routine that will enable some clients to make progress.
- Service providers and clients noted the high turnover of staff supporting clients needs both in at-home or in staffed residential placements (e.g., child support worker, home support worker, etc.). Recruitment and retention challenges were cited broadly as barriers to continuity of care. A former child in care noted that the high turnover amongst staff prevented them from forming meaningful relationships. Others expressed concern that they could not bond with their workers because the workers might “disappear” or always be different than scheduled.
- Many clients and families spoke of the desire for a stable workforce and noted that support in one’s home requires an intimate working relationship which takes time to develop. Alternatives to hourly home support workers should be considered.

“I don’t think he means to hurt me. But he’s awfully big!”

- AFC Provider

“I felt the staff were uneducated and unwilling to intervene – any time I acted out, their first answer would be to call the cops..”

- Former youth in care

“I don’t think [some support staff] realized what they signed up for. They thought it was babysitting or simple oversight and were not prepared for violence, suicide attempts, aggression. It’s hard work.”

- Level 4 Service Provider

“I don’t blame the workers for leaving – you can just as much work as Walmart and feel much safer.”

- Service Provider

“Having staff know the schedule a little bit better as I have missed many appointments and many visits because staff were not aware.”

- Client

Stakeholders spoke of challenges navigating the ‘system’ of residential supports, coordinating across RHAs, and also identified housing options outside the scope of this review

- **System is fragmented and hard to coordinate.** Stakeholders reported that from a provincial perspective, the array of residential services and supports offered across the province are complicated, involve a wide range of actors, and vary in availability by region.
- Clients with exceptionally high complexities often have a multiplicity of needs and prior involvement with mental health services, the justice system, as well as other needs for support. Deloitte has previously commented on the gaps in service and poor coordination of services for the most marginalized of our community, for reasons including the mismatch of programs across government, community-based providers, and broader system of supports including housing. This often inhibits the marginalized individual’s ability to access the supports they need, for those supports to be available where, when and how they most need it, and negatively impacts their recovery and ability to achieve permanency.
- Even the selected residential services and supports in the scope of this review do not operate as comprehensive system. Program availability varies across the four regional health authorities. While policy direction is established by the departments, stakeholders report that clients eligible for a program in one region present very differently than those in other regions. Intake, assessment, and clinical decisions related to residential placements also vary by region. Coordination is particularly difficult when youth are transitioned to the adult system and require support.
- Stakeholders spoke of policy confusion between RHAs particularly related to clients with mental illness, noting several examples in which patients with complex mental illness that were unresponsive to treatment were denied a transfer to the Waterford Hospital, and indicating that RHA staff are “not allowed” to refer patients outside their region. Similarly, some clinical treatment settings for adults and youth may be operating below capacity, whereas other regions lack clinical treatment settings completely. Referral processes and policies may be unclear or contradictory within the four RHAs.
- The programs operated by HCS and CSSD appear to be only part of the housing continuum provided by government. NLHC has a large range of social and supportive housing projects but were not partners to this review so insights are limited as to the opportunities to improve. While this project was intended to consider the needs of current HCS/CSSD clients, we observed cross-over and lack of clarity with social / supportive housing options that were beyond our scope.
- The many conversations that were conducted in support of this review, coupled with extensive research into alternative options and how other jurisdictions address similar unmet needs, have illustrated many opportunities for growth and change in NL’s residential support services.

“One hand doesn’t know anything about the other!”

- Family Member

“People mean well... but... it’s painful sometimes.”

- CSSD social worker

“Services and supports need to take a needs-based lens – not a diagnosis based lens.”

- RHA representative

“We’re not allowed to transfer patients outside the region, It’s policy. That’s all I was told.”

- RHA program staff

Stakeholders also identified specific program improvements and gaps in options available today, as well as design considerations for future program development

Gaps in the current array of options:

- Temporary de-escalation facilities and crisis units, to avoid ER visits and placement breakdowns, for both children/youth and adults
- Quasi-therapeutic stepped-down environments (e.g. “Not the Waterford, but not community either”)
- Family-like communal home settings that provide varying levels of independence and support for adults
- Customizable environments with on-demand supports, tailored to individual needs
- Specialized adult foster care, with greater training and support available for providers

Program Improvements

- Community-based support and services for families and youth, to intervene earlier and prevent crisis / breakdown
- Improving supervision and security within residential placements for youth with highly challenging behaviours
- Increase in accessible units for physically-disabled adults
- Increase in respite options available for children and adults
- Recruitment of Level 3/ family-based foster care placements
- Increased number of social / affordable housing units, particularly options for singles
- Enhance training/structure/consistency in caregiver and staff skills (e.g., behavioural management, de-escalation, intervention, etc.)
- Availability of all residential options across province
- Greater program and funding flexibility, including options for clients to share support staff if desirable; choice of communal or individual living arrangements

Design considerations for future program development

- ***Routine and structure:*** Children and adults both require routine and structure to provide stability in their lives. Stakeholders emphasized that particularly for clients with mental illness, a daily routine reduces opportunities to engage in behaviours which may lead to placement breakdown or eviction. For adults with disabilities, routine offers a sense of certainty, predictability and purpose. Workers in the home create the atmosphere and living environment and must be part of establishing this routine.
- ***Access to culturally appropriate services and amenities:*** The inability to access culturally appropriate services and amenities is a significant barrier for individuals in this population group. Access challenges can be related to geographic location, eligibility, wait times for supports, and/or transportation (e.g., bus routes). A sense of belonging and meaningful contact with one's own culture is perceived by stakeholders as highly important.
- ***Connections / social contact:*** The need for social contact and a social network is no different than an individual without a disability, mental illness or addiction. However, such disabilities and disadvantages often present barriers to building and maintaining social relationships. Social networks can often be limited to family, staff members, and individuals with a similar diagnosis/condition, instead of clients being supported to move through the broader community as any other person.
- For children and youth in care, the ability to remain with sisters and brothers is tantamount, as these relationships may be the only familial or stable relationships in a child's life.

To engage with children and youth currently in care, CSSD social workers completed interviews on Deloitte's behalf

Describing current or past placements

- *"The group home setting in general and can be difficult with not having control over who moves into the home."*
- *"[The Foster Home] was a good home and that they met her needs but this ended because of her. I asked her about this and she commented that she was becoming a teenager and she had some behaviours that were too much for the foster parents."*
- *"He advised that [the group home] did not feel like a family and that they did not get things. He did not disclose any concerns, but stated that it was not a good placement."*

Is there something you need in your current living set-up to make you feel more comfortable? Or that you are not getting?

- *"We spoke about engagement in life skills and she feels like she needs more assistance with decision making and problem solving."*
- *"We spoke about it sometimes being difficult when dealing with other's crisis but that it's important to know that everyone deals with the trauma in different ways and that with some time hopefully they will be open to connecting with staff and their supports to learn more positive coping skills."*
- *"...wants a dog, wants to get a job, wants to learn to drive, sleepovers with friends..."*

If you could choose, would you want to live with more people? Fewer people? Different people?

- *"She spoke about how she is good with having roommates and that the ones here are good but that she couldn't see living with any more people."*
- *"He advised that he did not want to live with his siblings, or with younger individuals, but that it would be nice to have more people around to do things with."*
- *"...would rather live alone..."*

If you could wave a magic wand, what one thing would you want to CHANGE about where you live today?

- *"There wasn't anything she could think about [the Group Home] that she would change but that she did wish she was closer to her family. We spoke about how she is supported by staff and the department to visit with her siblings as she recently had a visit in Roddickton and we discussed working on getting her home to Natuashish for Aboriginal Days."*
- *"She commented that she does wish she was closer to her friends and family but over all she does feel positive about her placement."*
- *"....the amount of work that needs to go into getting a privilege like getting her nails done. She commented that she is expected to do chores for this."*
- *"He advised that staff would leave, sometimes staff he had known and been connected to, and they would leave without even saying goodbye. He talked about this being difficult on him, not knowing they were going and then they were gone."*
- *"No other youth to live in the home..."*

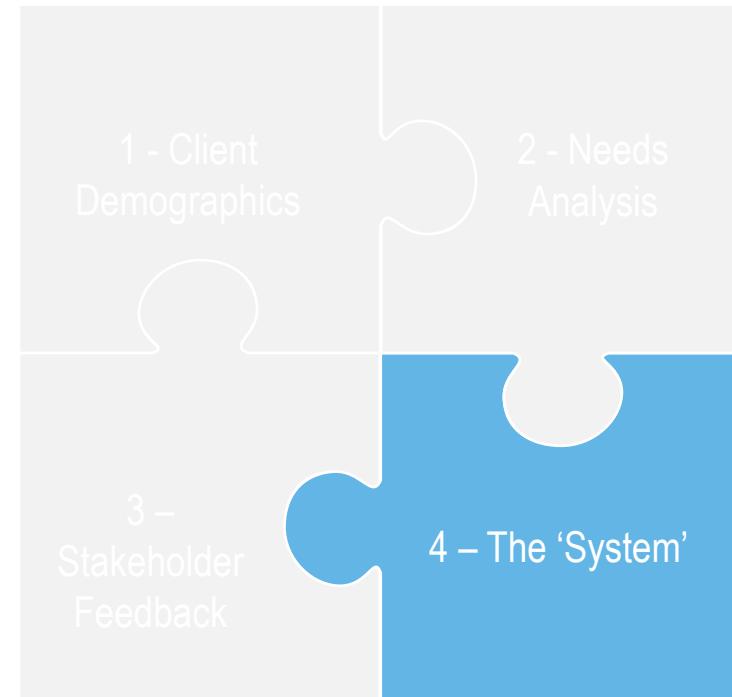
If you could wave a magic wand, what one thing would you want to KEEP THE SAME about where you live today?

- *"She spoke about having a good connection with staff and that she feels supported."*
- *"She would keep everything as it is as there was nothing she really thought that should change."*
- *"He advised that he likes the location of the house. He stated that it is close to things, being in the city – such as his physio, doctor, rugby, etc."*
- *"Child shrugged, eventually answered "the food."*
- *"Keep all of the workers..."*

Residential Supports – Part 4: About the ‘system’ of residential supports and services



- The following section contains a high-level perspective and our observations on NL's current array of residential programs and services.
- The key questions that were asked in this section include:
 - *How are residential supports and services organized today?*
 - *What entities are involved in residential services delivery?*
 - *How do clients access NL's residential supports and services, and are services well coordinated as clients needs change or increase over the lifespan?*
 - *Where do funding and policy decisions reside for residential supports and services?*
 - *How can the system be improved?*
- Some information related to the client demographics of selected residential support programs has been provided in earlier sections. More detailed snapshots for the programs are provided in [Appendix C](#).

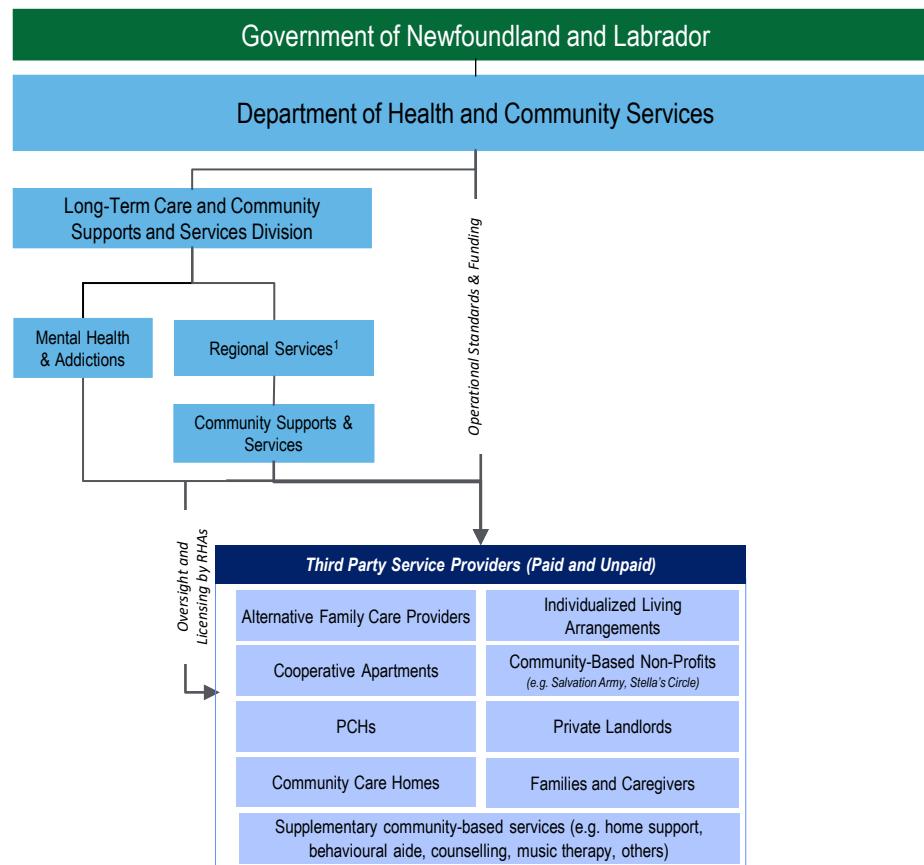




In NL, residential services and supports are designed and delivered by a number of different entities

Multiple government and semi-government entities have responsibility for policy-making, funding and administration of residential housing services. Third parties typically deliver services to the end-users in Newfoundland and Labrador.

Illustrative Landscape of NL's residential services and supports



Summary of Observations

To assist in helping readers understand the range of system actors, points of access/entry, pathways, and potential barriers, a simplified schematic diagram of the adult and child/youth residential services and supports is provided in the following pages. Readers should use these charts as an illustrative example of the potential barriers, pathways, and confusion that exists in the system – further levels of complexity are undoubtedly missing. Our observations include:

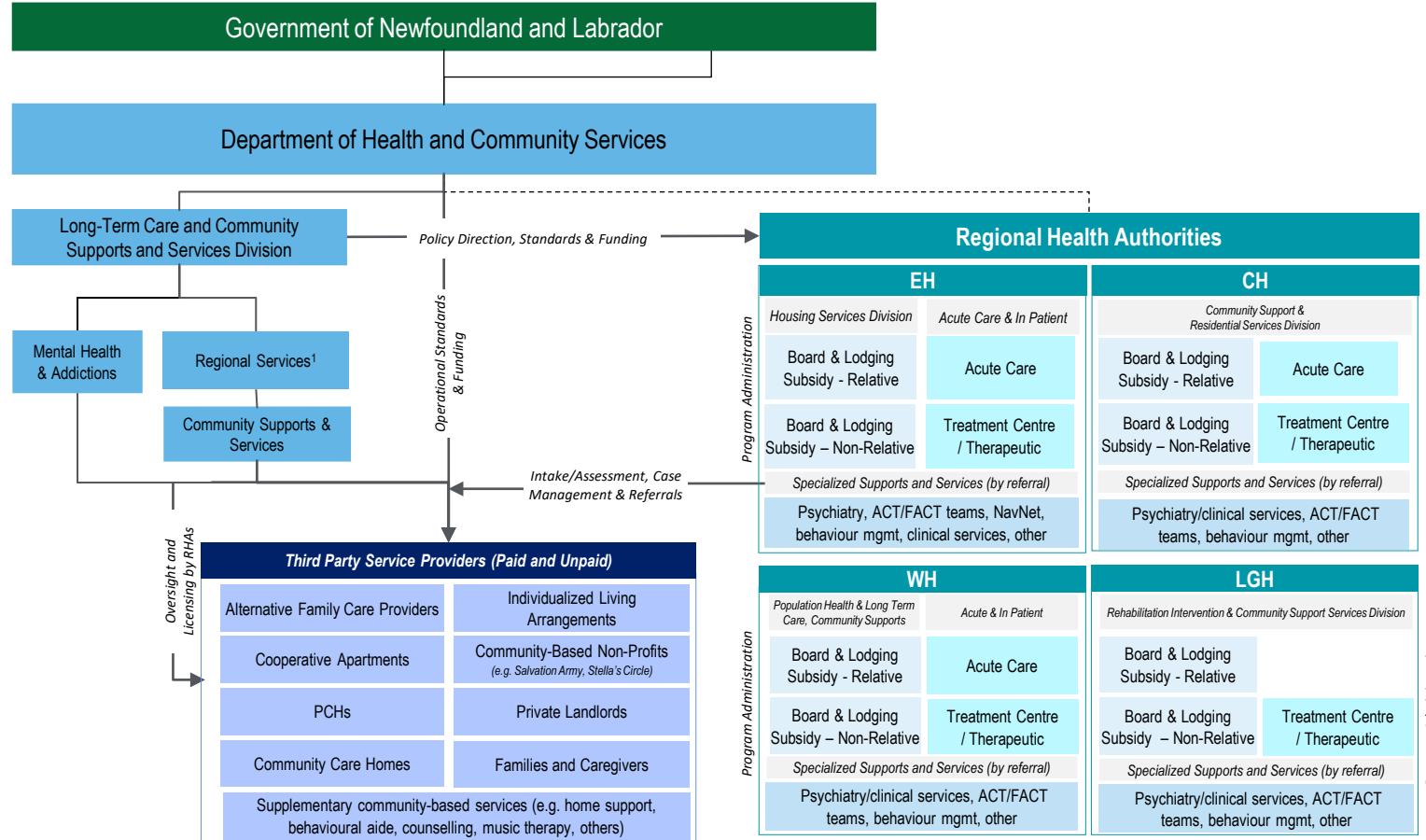
- HCS is the primary entity that has responsibility for designing adult residential services and supports today.
- CSSD has similar responsibility for designing and delivering programs for children and youth in care (shown later in this section).
- Within HCS Regional Services, at least two divisions (Community Supports and Services, and Mental Health and Addictions) provide policy direction and funding for a range of residential services programs.
- Program design, eligibility criteria, and development of operating standards for each program are the responsibility of the Department. Oversight of provider licensing and performance are performed on behalf of the Department, by RHAs.
- Residential programs of one division (e.g. CSS) are sometimes unavailable to clients of another division (e.g. MHA), and are not consistently delivered across the province (see next page).
- Contracted third-party service providers, as well as family members and private landlords, are commonly involved in the provision of living arrangements.
- A range of supplementary services and supports are also provided to assist clients in maintaining the living arrangement (e.g. home support) but may not be reflected in program budgets and may reflect 'hidden cost' to the system.
- Brief snapshots of NL's residential programs are provided in [Appendix C](#).

¹ Only relevant divisions and business units shown for simplicity.

The RHAs play a significant role in making referrals and delivering programs for adults



Each of the four RHAs maintain resources to assess client needs, make clinical decisions, and deliver residential programs in their region



- While programs are generally designed and approved at the departmental and division level, service delivery has been devolved to the four RHAs.
- Each RHAs has the authority to make service delivery decisions that suit the needs of their communities. While efforts have been made to coordinate services, the regional nature of service This has meant there are key differences in the types of services that are available in each region, and the capacity of the program in each region.
- Clinical assessments, intake and placement decisions are typically done within each of the four RHAs which have responsibility for program administration including program staffing.
- In certain circumstances and by exception, where client needs cannot be managed within the region’s programs or providers, the RHAs may coordinate resources to place the individual in another region. However clients are generally placed in the available programs within their “home region.”
- When required, referrals to specialized supports and services (sometimes known as ‘wraparound services’ depending on the program area) are made by each RHA to community-based, or to hospital-based professionals. Program staff within the RHA typically maintain a list of providers.

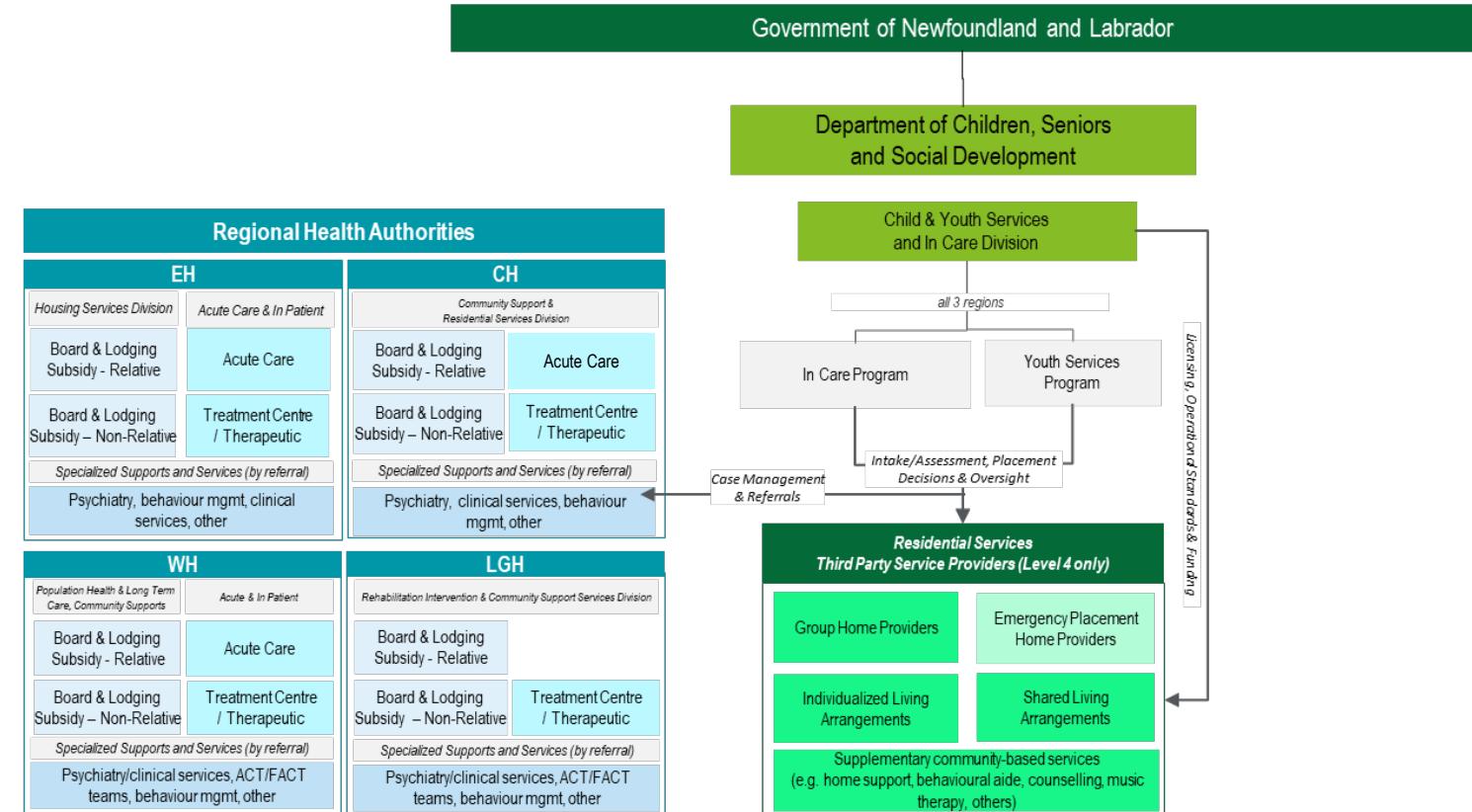
¹ Only relevant divisions and business units shown for simplicity.



For children and youth in Level 4 care, CSSD has authority to design and deliver programs

The children and youth in care system also relies on contracted third-party providers to provide residential settings

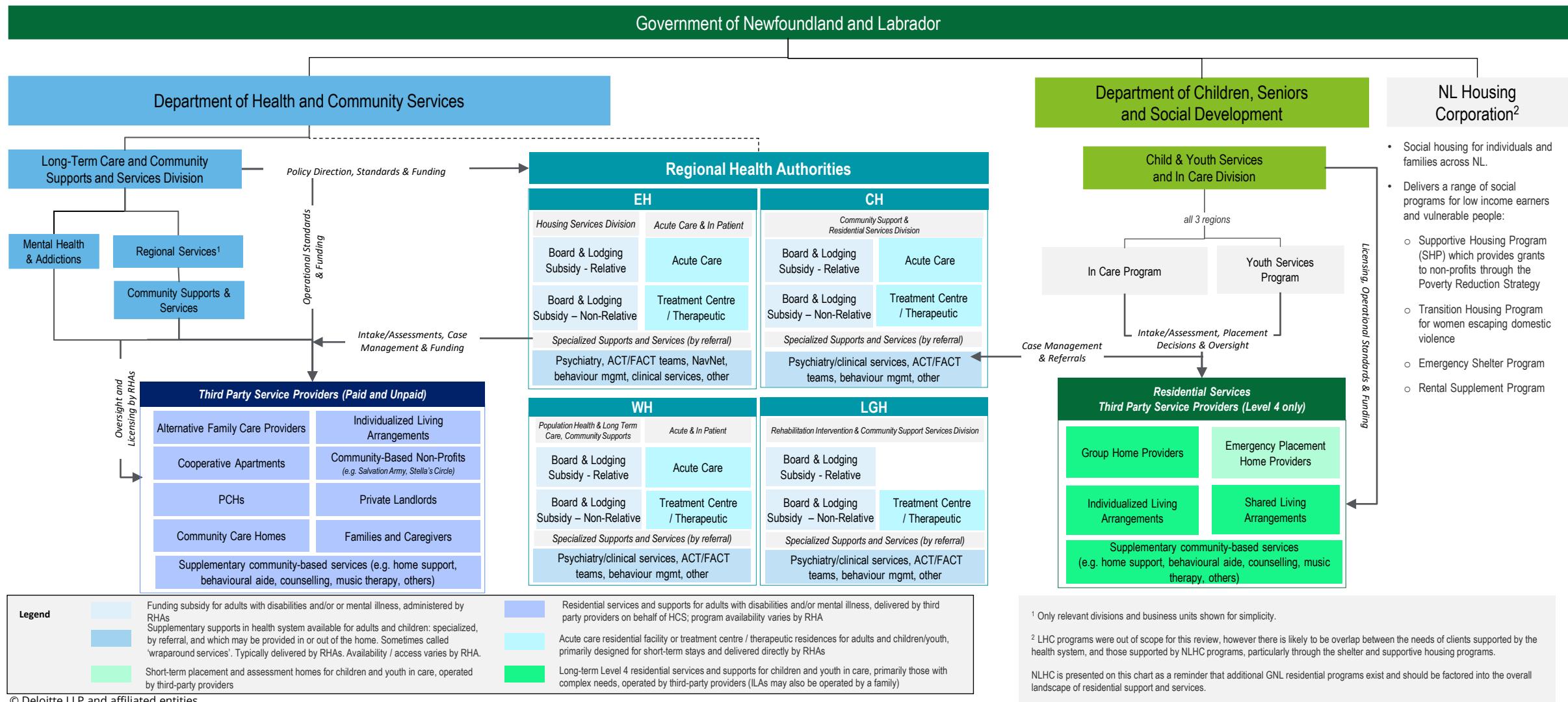
- CSSD has responsibility to design, oversee, contract and fund service providers to deliver its EPH, group home and ILA/SILA living arrangements.
- CSSD offers in-house behavioural management services and counselling services to children and youth in care. When required, CSSD may also contract for services from community-based third parties (e.g. counsellors, home support, other).
- It may also rely on services from the health system and make referrals to the Janeway Pediatric Hospital psychiatric and other clinical services, or to the North Star Child and Youth Advocacy Centre (CYAC).
- Wraparound or supplementary services are commonly provided by contracted third-parties or arrangement with the RHAs to provide supports such as behaviour management, home support, counselling. However these services are not embedded in the Level 4 environment.
- When children and youth in care are preparing for transition to adulthood, the Department offers a Youth Service Program available for youth 16 or 17, with an agreement with their social worker. This may also provide residential supports and funding up to age 21. These services may or may not be coordinated with the adult residential system, and may be stopped once the youth turns 21 unless other arrangements have been made.





In summary, a range of government entities and programs deliver residential services in NL

While out of scope for this review, it is also notable that NLHC provides low-income and social housing, which is often where CSS and MHA clients reside



Department of Children, Seniors and Social Development

Child & Youth Services and In Care Division

all 3 regions

In Care Program
Youth Services Program

Case Management & Referrals
Intake/Assessment, Placement Decisions & Oversight

Residential Services Third Party Service Providers (Level 4 only)

Group Home Providers
Emergency Placement Home Providers
Individualized Living Arrangements
Shared Living Arrangements
Supplementary community-based services (e.g. home support, behavioural aide, counselling, music therapy, others)

NL Housing Corporation²

- Social housing for individuals and families across NL.
- Delivers a range of social programs for low income earners and vulnerable people:
 - Supportive Housing Program (SHP) which provides grants to non-profits through the Poverty Reduction Strategy
 - Transition Housing Program for women escaping domestic violence
 - Emergency Shelter Program
 - Rental Supplement Program

Legend

Funding subsidy for adults with disabilities and/or mental illness, administered by RHAs
Supplementary supports in health system available for adults and children: specialized, by referral, and which may be provided in or out of the home. Sometimes called 'wraparound services'. Typically delivered by RHAs. Availability / access varies by RHA.

Residential services and supports for adults with disabilities and/or mental illness, delivered by third party providers on behalf of HCS; program availability varies by RHA
Acute care residential facility or treatment centre / therapeutic residences for adults and children/youth, primarily designed for short-term stays and delivered directly by RHAs
Long-term Level 4 residential services and supports for children and youth in care, primarily those with complex needs, operated by third-party providers (ILAs may also be operated by a family)

¹ Only relevant divisions and business units shown for simplicity.

² LHC programs were out of scope for this review, however there is likely to be overlap between the needs of clients supported by the health system, and those supported by NLHC programs, particularly through the shelter and supportive housing programs.

NLHC is presented on this chart as a reminder that additional GNL residential programs exist and should be factored into the overall landscape of residential support and services.

What we learned from others

Introduction to this section

- An important element of any review such as this is the identification and reflection involved in comparing and learning from others.
- We conducted a high-level scan of the types of supports available for each of the three in-scope population groups across the country. Additionally, several representatives from British Columbia, Ontario and Nova Scotia were interviewed.
- This section summarizes some of the key findings from those activities, from our supplementary research which included academic sources and information in the public domain.
- This section also identifies at high-level, some of the innovative models of residential support that were identified in the course of this project.
- It should also be noted that several of the models are ones that have been implemented by other jurisdictions. Other models may still be in the early stages of planning, however they appear to directly address the client needs outlined in earlier sections of this report and may be valuable to consider as alternatives or supplements to the current system.
- Further details are provided on each of the jurisdictions and innovative models in [Appendix D](#).



Highlights from the Canadian residential supports landscape

Newfoundland and Labrador has a similar mix of residential supports and housing challenges as other Canadian provinces, however system priorities and delivery models vary slightly across regions

Adults with disabilities

- Nova Scotia is the only province that continues to operate large residential centres, including one for children/youth which has been modernized but remains a traditional residential centre. The province has recently developed a plan to phase out larger institutional settings to allow people to move from larger facilities into community homes.
- Ontario is facing a housing crisis with 15,700 adults with developmental disabilities awaiting residential services in 2017. To address these issues, many people with a disability and their families are collaborating directly with local organizations, developers, and other families to develop long term solutions to the housing crisis.
- Manitoba and British Columbia have implemented Microboards™, which are a unique model in which a small group of committed family or friends joins with an individual with a disability to create a non-profit board to help direct the funding and care of the individual.

Individuals with mental health issues and addictions

- New Brunswick recently released its 2021-2025 Mental Health Action Plan which including the adoption of a Stepped Care Model to address gaps in the system. As it relates to housing, the creation of various forms of supportive housing for clients, including the implementation of a clinical consultation model was identified as a key priority area.
- In British Columbia, RHAs collaborate with BC housing and other non-profit organizations to match their mental health and addictions clients to the type of housing that will best support their needs. Housing options cover the full spectrum of housing options for licensed community care homes, supported housing and independent living to step-down therapeutic programs.

Children and youth in residential care

- Nova Scotia has a level-based continuum of residential placements in its child welfare system, supplemented by heavy investment in in- and out-of-home services for children not yet in care. Placements include Level 1 kinship/foster homes and more specialized contracted foster homes, Level 2 residential facilities and Level 3 secure care. Nova Scotia also provides emergency care arrangements that are not part of this level-based continuum. The province has made a commitment and heavily invested in early intervention and prevention efforts to assist families, before children are brought into care.
- In Manitoba, Indigenous children and youth make up 90% of children in care. In 2018, the Government of Manitoba commissioned a review to identify opportunities to improve the outcomes of their children and youth in care.

Key insights from additional jurisdictions

There are lessons to be learned from across the globe to enhance residential services delivery.

Insights for individuals with mental health and addictions from British Columbia



- People living with severe mental health challenges in British Columbia have an array of housing options available to them.
- Unlike other provinces (e.g., Ontario) who have devolved housing responsibility to municipalities, much of the programming is coordinated provincially through BC Housing, working with regions and non-profit organizations.
- Barriers to successful residential services delivery are consistent with other provinces including lack of decision-making frameworks, innovative funding models, and constraints on capacity (e.g., human resources, affordable housing stock, etc.).

Key takeaways:

- Strong central leadership and funding “authority” provides smoother collaboration between government departments, health authorities, and community providers to create solutions (i.e., developing targeted, purpose-built infrastructure for select population groups, overcoming ‘cherrypicking’ of clients)

Insights for adults with disabilities from New Zealand



- In 2018, the New Zealand Government released a new Community Residential Support Services Strategy, *Where I Live; How I Live*, aiming to provide disabled adults with greater choice, control and flexibility in where they live, while acknowledging that people’s own experiences will contribute to their level of desire to explore different living choices.
- Additional models of support aligned to living options for individuals with a disability were developed and are being implemented in regions across the country (e.g., local area coordination, enhanced individualized funding, self-assessment, Choice in Community Living, etc.)

Key takeaways:

- An increased focus on new models of supports and stronger accountabilities for adults with disability to allow information and personal assistance, support through tailored funding to needs rather than only program/services, and greater choice, control, and flexibility

Insights for children and youth from Scandinavian countries



- Several Scandinavian countries use a “family service” approach to supporting vulnerable young people, as opposed to a “child-protection” approach. Overall service delivery is described as a social pedagogy, combining elements of psychology, philosophy, and practical hands-on teaching methods in smaller group residential settings to create a home-like environment.
- The goal of the social pedagogical concept is to customize the different types of child and youth services even more precisely to the needs of the children and youth. Much of the children and youth residential care settings are outsourced to independent, not-for-profit, social care organizations.

Key takeaways:

- Highly trained and educated staff
- A holistic, program-focused approach to child welfare service delivery
- A goal-oriented approach to ensure children feel they have a safe place to stay, while preparing for successful independent lives

Leading models and innovative approaches

Recognizing that residential service delivery varies in different jurisdictions, it is important to consider emerging trends in this sector and their influence on the ability for individuals to live fulfilling lives in community

- Innovation can take the form of improving what exists today, or designing a completely new structure. On the pages that follow, we describe some of the approaches to residential supports and services that work well in other jurisdictions. These include:

1	Dedicated Single-Room-Occupancy (SRO) Models with on-demand supports	<ul style="list-style-type: none">• Dedicated congregate housing in which all or most of the residents have urgent need for stability and support. Residents enjoy their own bedroom, on-site supports, services and social activities that are typically embedded as part of the living environment. This arrangement is the foundation for increasing the likelihood of improved outcomes and opportunity to transition to other options.
2	Community-Based Independence Models	<ul style="list-style-type: none">• Purpose-built housing models which integrate individuals receiving supports with other types of individuals from community; supports are typically separated from the infrastructure
3	Intentional communities	<ul style="list-style-type: none">• Planned communities of support for individuals and their families who have chosen to live together or nearby, with a common purpose, sometimes shared supports, but with the intention of working cooperatively to create positive lifestyles and meet their collective needs.
4	Roommate / landlord matching	<ul style="list-style-type: none">• For individuals with mental health challenges or adults with disabilities finding either a landlord or an appropriate roommate can be a challenge, platforms and services have been developed to better facilitate this process.
5	Congregate or Standalone Relational Models	<ul style="list-style-type: none">• A model in which wraparound supports and caregivers are fully embedded in the living environment (either congregate or single home) and, are an active part of individuals day-to-day lives.

Leading models and innovative approaches (cont'd)

Recognizing that residential service delivery varies in different jurisdictions, it is important to consider emerging trends in this sector and their influence on the ability for individuals to live fulfilling lives in community

6

Transitional “Foyer” Models

- The Foyer model supports at-risk youth in a transition housing model, which focuses on supporting life skills development, employment outcomes, providing structure and wraparound supports.

7

Step Up Step Down Quasi-Therapeutic Environments

- Dedicated step up or down housing for individuals transitioning from acute care and/or incarceration to clients to re-integrate into community

8

Early Intervention & Prevention Models

- Proactive approaches to strengthening families and supporting children and youth with the goal of preventing children from entering the formal care and protection system.

9

Other Innovations in Residential Supports

- Residential supports extend beyond the bricks and mortar, and the care provided by a particular living arrangement, into how the supports are delivered and funded to better support an individual to live well in the community.
- Several examples of innovation have been identified, such as Microboards™, rent-to-own arrangements, flexible funding and telehealth monitoring.

Dedicated Single Room Occupancy (SRO) models with on-demand supports

Dedicated congregate housing in which all or most of the tenants are life skills supports as they re-integrate into the community; supports are typically embedded as part of the living environment, building skills and managing treatment needs while promoting a degree of independence

Description

SRO models provide chronically ill or addicted populations with options to build the foundation for their next chapter. Supports are typically embedded in the physical environment, where the focus is on harm reduction, realistic expectations for building life skills, socialization, and re-integration into the community. The building housing SRO units may or may not have separate shared cooking, bathing and toileting facilities for residents, however all residents enjoy the privacy of their own bedroom. Facilities are typically larger apartment style, condo or hostel settings and promote a continued degree of independence and responsibility for tenants. Within each model there is opportunity to embed different forms of supports and services to meet client needs (e.g., harm reduction supports, low-barrier access, life skills development, vocational support, etc.). Challenges with the model include the negative perception of 'ghettoization' in clustered communities, and access to funding.

Examples



The Portland Hotel Society (PHS) has converted hotels, condos and modular homes to provide single occupancy housing options for individuals living with severe or chronic mental health and addictions issues in Vancouver and Victoria, BC. The program features a harm reduction focus and operates its own safe injection site in the area. Funding is provided by the BC Housing Management Commission and the Vancouver Coastal Health Authority.

CMHA in Nanaimo, British Columbia partnered with the local health authority to develop a 19-unit single residency occupancy low-barrier, long-term housing option converted from a former hotel. The model was borne out of the closure of a psychiatric facility, with many of the former residents facing homelessness or inadequate housing.

Pacifica Housing is the housing operator and service provider for a purpose-built supportive housing complex in Victoria, BC – Camas Gardens. The complex has 44 units targeted for individuals at-risk of homelessness, with two staff on site 24/7, in addition to additional program staff available in the day to provide on-site programs such as cooking, grocery shopping support, walking groups, support accessing communities amenities, etc. The facility also operates a Community Work Program where residents are able to receive incentives for volunteer work perform (e.g., grocery vouchers).

Why it matters

- ✓ Responds to crisis needs
- ✓ Promotes some independence while recognizing the need for oversight and immediate interventions / support
- ✓ Encourages community integration and job opportunities
- ✓ Harm reduction focus, directly linked to housing
- ✓ Responds to need for permanency and stability for most vulnerable populations
- ✓ System partnerships to deliver on-site services tailored to resident needs (i.e., counselling, housing support)
- ✓ Maintaining resident independence with degree of oversight
- ✓ On-site, on demand supports available
- ✓ Built-in programming tailored to resident needs (e.g., life skills development)
- ✓ Combating Not in My Back Yard mentality through community integration

Community-Based Independence Models

Purpose-built housing models which integrate individuals receiving supports with other types of individuals from community; supports are typically separated from the infrastructure.

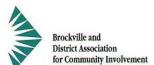
Description

A variety of purpose-built housing models have been tested for individuals with disabilities. These generally separate the supports from the physical infrastructure of the home. Models can be targeted for a select group of individuals, but often leverage mixed housing approaches to ensure integration as part of a broader community (i.e., preventing ghettoization through a scattered site approach).

Examples



UNITI-Chorus is an agency-driven purpose-built housing development in South Surrey, British Columbia. The initiative leverages underdeveloped property and capital assets to develop affordable rental housing, designed to meet the needs of people with intellectual or developmental disabilities who are able to live semi-independently, but also tenants without disabilities. The project leveraged a phased move-in approach to ensure persons with disabilities were well-adjusted to their new environments, as well as a “just enough support” model to provide on-call support to tenants as needed – preventing over servicing and promoting the creation of a community of unpaid supports.



Legacy Homes is a non-profit housing corporation in Ontario providing individuals with a developmental disability the ability to remain in the community they have always lived, even after their parents could no longer provide care to them. Legacy Homes acquires property and rents through a life-lease model, and supports for individuals are managed by other local agencies, as needed. Legacy Homes co-develops the circle of organic supports and plan itself with families and works with local service managers to obtain housing subsidies/allowances for tenants. Supports are separated from the home allowing for a family-driven model of care.



The Community Living Toronto Housing Initiative creates supportive housing for individuals with a developmental disability through partnership agreements with local developers and landlords to secure a number of apartments in existing or new buildings. Various partnership structures are used for their projects based on the developer (i.e., hybrid lease agreements, head leases, etc.). Community Living Toronto provides all paid in home supports.

Why it matters

- ✓ Inclusivity driven through integration into broader community
- ✓ Ensuring tenant readiness and appropriate supports in place
- ✓ “Just enough support” model to provide on-call support to tenants as needed – preventing over servicing
- ✓ Ability to remain for individual to remain in home community
- ✓ Circle of organic supports – including family members, friends, neighbors, and paid support workers
- ✓ Separation between the housing and the supports to allow for a family-driven model of care
- ✓ Inclusivity driven through integration into broader community
- ✓ Flexibility to tailor approach to individual needs and residents
- ✓ Strong relationships with housing partners (i.e., developers and landlords)

Intentional Communities

Intentional communities are planned communities of support for individuals who have chosen to live together with a common purpose, working cooperatively to create positive lifestyles and meet their collective needs.

Description

Intentional communities can manifest in many forms (e.g., co-housing, and intergenerational models) and with many adaptions of physical environment (e.g., shared land, cluster of homes, neighborhood). Intergenerational models typically bring seniors together with younger demographics, however other models have also been able to support children coming out of the foster system, as well as university-aged young adults with adults with disabilities. Co-housing communities are collaborative housing options in which residents actively participate in the design and operation of their own community, often living in separate homes, but share select resources including a community “common area”, in turn creating an informal network for all living there.

Examples



Snow Goose is a four-plex residence in Waterloo, Ontario. Snow Goose supports people with developmental disabilities to live in their own apartments with two students from the local university. The students live at Snow Goose rent-free and receive a full tuition scholarship for being “Good Friend and Neighbour” to the other tenants. They are not paid caregivers, simply by virtue of their presence and their commitment to be open to others, a social safety net is provided and real connections are made, reducing social isolation and loneliness. This is a form of intergenerational housing.



New Life Village, based in Florida, provides a supportive environment, within an intergenerational community for children in need of a safe, stable and permanent family experience. Seniors (and other foster families) are offered affordable housing as an incentive to care for children who’ve survived abuse, neglect and trauma. Senior citizens are also able to live and volunteer in the village as part of the wraparound programs and services also available (e.g., surrogate grandparents, tutors, and mentors).



Abundant Life Autism is a co-housing initiative in Alberta led by a group of families who have children/adults living with autism. Co-housing is a participatory process in which residents plan the community together to meet their needs – families are actively engaging with each other as this community forms. The community does not offer services, and families are responsible to bring in their own supports. The community is planned to have 25-30 homes, and will be designed to reduce isolation, increase safety, and promote social connection. This community will be targeted for those with adolescent children living with autism.

Why it matters

- ✓ Development of an organic social network
- ✓ Promotes independence for adult with disability
- ✓ Incenting roommate participation
- ✓ Approach to recruitment of foster families
- ✓ Building a natural community around the child, with appropriate supports and programs
- ✓ Resident involvement in decision-making
- ✓ Promoting social connections to build an organic circle of supports

Roommate / Landlord Matching

For individuals with mental health challenges, or for adults with disabilities, finding either a landlord or an appropriate roommate can be a challenge. Platforms and services have been developed to better facilitate this process, matching people with similar interests

Description

Residential supports can extend beyond the ‘bricks and mortar’ into technology solutions that assist individuals to access suitable, compatible roommates, housing options, and/or landlords. Several tools have been tested which allows people to find roommates or landlords that suit their unique personal preferences and needs. Roommates may also serve practice needs for individuals with disabilities, such as supporting with IADLs, or simply allowing for the natural support to build a social network and integrate as part of community. Landlord matching allows for individuals to access private rental market providers who are interested and willing to meet their needs, as opposed to strictly social housing and facilitates the improvement of tenancy skills.

Examples



Partners4Housing, is an American-based organization supporting adults with intellectual or developmental disabilities find roommates or partnering families to set up shared housing solutions. The organization supports families through the process by completing a comprehensive residential assessment to understand and clarify what “home” will look like for the client (i.e., support needs, benefits/services, locations, lifestyle, etc.) and then supports connecting like individuals with roommates or other families who are able to cost-share for their housing solution.



Rumi is a technology platform connecting individuals with disabilities (with a medical waiver) to “supportive” roommates who will be paid to provide support to the individual. The living arrangement varies from situation to situation; the supportive roommate can move into the individuals’ home or vice versa; alternatively the Rumi team can assist to find housing that meets their needs. Services include but are not limited to: 24/7 Assistance, Caregiver Living Expense, Housing Access Coordination, Transitional Services, Adult Companion, and Night Supervision.



The Doorway program delivered by Wellways in Australia provides integrated housing and recovery support designed to assist people with lived experience of persistent mental ill health who are at risk of, or experiencing homelessness. The program links consumers with private rental housing and psychosocial support while providing rental subsidies, and tenancy support. An independent evaluation of the program found that reduced hospital admissions and usage of acute clinical services totaled annual cost savings to government ranging from approximately \$1,150 to nearly \$20,000 per individual.¹

Why it matters

- ✓ Offers greater choice, options and flexibility
- ✓ Facilitates end-to-end support for families
- ✓ Client-centric approach to finding housing solutions
- ✓ Access to new range of informal supports
- ✓ Offers choice in identifying roommates who can specific supports if needed
- ✓ Natural partner to build social networks and access community
- ✓ Housing First approach
- ✓ Private rental market providers as opposed to social housing providers
- ✓ Development of tenancy skills and support building natural support networks

Congregate or Standalone Relational Models

Models of residential services whereby the wraparound supports/caregivers are fully embedded in the living environment (either congregate or single home) and are an active part of individual's day-to-day lives.

Description

Congregate or standalone relational models apply a relationship-based approach to housing by which the caregivers, providers, or staff represent a significant part of an individual's day-to-day life. This model is used for both children in care, as well as adults living with disabilities or mental health issues. Relational models can be formed organically through life-sharing or welcoming an individual into the home, or can be embedded within congregate models by embedding live-in caregivers as part of the day-to-day life. In the congregate model, caregivers are fully immersed in the living environment.

Examples



L'Arche creates communities for individuals with intellectual or developmental disabilities to share their lives with those that support them. The L'Arche delivery model seeks to breakdown traditional caregiver models by promoting live-in models of support. The relational model promotes interdependence and often wraps around day programming for the residents and others with varying levels of disability in community to build a more robust social network.



Josephine Schneider's House is a children's home based in Denmark for children ages 8-19. All staff at the home have completed a bachelor's degree and are highly respected professionals – because of this staff retention is high – allowing for lasting relationships to be developed with the children. The home takes a very familial approach, blurring lines between residential and foster care to instill a sense of 'hominess' (e.g., staff eat meals with children, meals prepared together, etc.).



Shared Lives Plus in the United Kingdom, is an innovative form of social care based around sharing home and family life for adults who need care or support to help them live well (e.g., adults with a range of disabilities, including developmental and mental health challenges). Shared Lives schemes match trained caregivers with individuals in need of living supports. The caregiver is meant to act as 'extended family' for the individual and develop real relationships.



The Breton Ability Centre in Nova Scotia has created a children's home providing 24-hour care to four children or youth with ASD and/or intellectual disabilities. The house allows children to continue their education, learn basic life skills and receive targeted supports. The centre includes significant outdoors green space, tailored interior color scheme and lighting, specialized recreation and leisure equipment, and private rooms with a common space for programming/activities (1).

Why it matters

- ✓ Life-sharing with caregivers to develop organic communities and friendship
- ✓ Embeds supports and programming into the environment
- ✓ High staff retention allowing for development of lasting relationships with children
- ✓ Focus on education and life skills development by highly qualified staff
- ✓ Highly trained, recruited, approved and monitored caregivers
- ✓ Caregivers are matched for compatibility
- ✓ Targeted, needs-based placement option tailored for specific population group

Step Up / Step Down Quasi-Therapeutic Environments

Dedicated stepped-down housing has been designed for individuals transitioning from in-patient environments, periods of being severely unwell, or from the justice system, allowing clients to better re-integrate into community and gain stability

Description

Stepped down environments are important models of support for individuals who may need more intensive support in the community, following lengthy hospital stays, periods of severe illness or incarceration. Such environments provide a therapeutic housing option for individuals who still require a level of support and supervision to maintain a home, that living in the community may not be successful. Other jurisdictions find that individuals who reside in this environment learn new skills, stabilize, and are sometimes able to transition into appropriate long-term living options – eventually, at their own pace. A quasi-stepped model enables increased discharge and bed flow in acute environments, while supporting individuals to more independent living over time, preventing homelessness, instability and further harm.

Examples



Coast Mental Health offers the Coast Transitional Cottage (CTC) program which on-site provides psychosocial rehabilitation, clinical assessment, treatment, counselling and support to clients who are transitioning from the Forensic Psychiatric Hospital into community. CTC supports 42 clients living in campus-based cottages, and modular units. The cottages are located on the ground of a former hospital. Outreach support is further provided for clients who transition on to semi-independent living apartments.



The **Transitional Rehabilitation Housing Program (TRHP)** is an Ontario Ministry of Health funded initiative implemented regionally to support community reintegration of forensic NCR patients that required increased transition support into communities within 12 -24 months. Communities developed local housing and community support models for complex discharge patients, as well as SLAs between hospitals and providers. The program has proven successful with research pointing to stable community functioning across time¹ for individuals who would have otherwise not been housed in community, and has now begun to target individuals with intellectual and developmental disabilities who have forensic involvement as well.



Youth Prevention and Recovery Care (Y-PARC) is a sub-acute youth residential service model implemented by Bendigo, as well as other Australian providers. The model provides up to four weeks of care for youth and young adults at risk of hospitalization due to their mental condition and/or those who are transitioning out of hospital units and back home or into community residential settings. High levels of satisfaction were reported and family members noted the model fills an important gap between community and acute hospital wards.²

Why it matters

- ✓ Provides options or community-based recovery program for forensic and justice-involved clients
- ✓ Transitional intent to reintegrate into more independent settings
- ✓ Continued support upon transitioning into community
- ✓ Responds to need for transition options for forensic patients and/or other acute care patients in community
- ✓ Transitional intent to reintegrate into more independent settings
- ✓ Improves stability for clients after long periods of institutionalization
- ✓ Promotion of autonomy and self-help
- ✓ Time spent with other young people with similar experiences

Transitional “Foyer” Models

The Foyer model is well-known housing and support model for at-risk youth extending the stay beyond traditional transition housing while embedding robust wraparound supports

Description

Transitional housing refers to a supportive, yet temporary and intermediate, type of accommodation that is intended to bridge the gap from homelessness to permanent housing. The Foyer approach was established in France to support large network of young people in search of work following WWII. This approach to housing has typically been geared towards youth but can also be extended to other populations in need of forms of transitional housing. The model provides life skills training, and the residential are generally employed, attending school or working. Some models are ran-through scattered site approach, while other are based in congregate living facilities. Foyers have been very successful at helping disadvantaged young people leaving care transition to adulthood and from dependence to independence, and can be targeted at specific population groups to ensure the delivery of culturally appropriate services and supports.

Examples



The Boys and Girls Club of Calgary (BGCC) provides a range of supports and services, including housing to adolescents and youth in Calgary, Alberta. The BGCC has become a national leader in housing first for youth (HF4Y) programming including their Infinity Project and their Home Fire project. Home Fire provides housing support for Indigenous youth aged 16-24 who are experiencing homelessness; the program focuses on providing a cultural home where youth can reconnect with family and culture and begin healing.



The Aberdeen Foyer provides supported tenancy to up to 80 former homeless and at-risk children and youth. Aberdeen engages in prevention work in the community to reduce future crisis situation with individuals and families, and also provides an array of programming for its tenants aimed at improving social skills, employable skills, and encouraging healthier lifestyle.

Why it matters

- ✓ Housing first approach
- ✓ Responds to the needs of children and youth experiencing homelessness
- ✓ Indigenous-led programming for culturally appropriate service delivery for Indigenous youth
- ✓ Improves downstream outcomes through prevention work in the community and with families
- ✓ Supporting individuals who are unemployed to learn new skills and gain opportunities
- ✓ Supporting positive mental health and wellbeing

Early Intervention & Prevention Models

8

Proactive approaches to strengthening families and supporting children and youth with the goal of preventing children and youth entering the formal care system.

Description

Investing in prevention and early intervention is a well recognized evidence-based approach that offers successful long-term outcomes for children and family. There are different models of intervention and prevention approaches for families with involvement with child welfare (e.g., home-visiting models, caregiving education, financial support, therapeutic interventions, etc.).

Examples



Alternative Family Care is a Government of Nova Scotia initiative aimed to keep children out of provincial care by offering financial help to extended family, such as grandparents, who are caring for the children. The program gives caregivers an initial influx of funding for the first children, and they then receive monthly payments, per child, to cover expenses like food, clothing, social programming, etc.



The Restoring the Sacred Bond initiative is a two-year indigenous designed and led pilot project matching Indigenous Birth Helpers with Indigenous mother who may be at risk of having their newborn brought into the child welfare system. The Birth Helpers bring Indigenous child birth/parenting techniques to support mothers in a traditional way. The program supports up to 200 at-risk expecting mothers before, during, and after birth. The program is financed through a social impact bond aiming to reduce the number of days that infants spend in care during their first year of life.



The Keeping Families Together (KFT) initiative led by the Corporation for Supportive Housing (CSH) and several partner agencies in New York provides supportive housing to vulnerable or homeless families who are at a high-risk of having their children removed. KFT targeted families with a history of recurrent shelter stays, or those deeply entrenched in poverty. The supportive housing units include case managers that support families in navigating the system to access critical services (e.g., mental health counselling, substance abuse treatment, parenting classes, etc.).

Why it matters

- ✓ Government commitment and investment to focus on prevention efforts
- ✓ Leveraging innovative financing mechanisms (e.g., social impact bonds)
- ✓ Culturally appropriate service delivery
- ✓ Promoting strong social outcomes
- ✓ Family preservation approach
- ✓ Individualized care management embedded in the housing to support system navigation and access to programming for families
- ✓ Housing stability and crisis management services

Other Innovations Related to Residential Support

9

We have identified a few additional innovations/initiatives related to residential services delivery that support the well-being of individuals who may be in need of supports.

A

Microboards™

- A unique model of care in which a small group of committed family or friends joins with an individual with a disability to create a non-profit board to help direct the funding and care of the individual.

B

Rent-to-Own Agreements

- Lease-to-own agreements where an investor/landlord purchases the home and continues to own the property and the tenant has the option to purchase the home.

C

Flexible Individualized Funding

- Clients are paid a lump-sum amount which they can allocate to purchase care needs, other supplies/equipment, recreation/social activities at their own discretion – therefore taking advantage of each of the dollars they are given.

D

Remote Monitoring/Telehealth

- Remote monitoring technologies, which can include cameras and two-way communications, are being leveraged to provide virtual oversight for their adults children or loved ones (e.g., on-site support during the day, virtual “remote” support oversight)

Recommendations

Key recommendations

- This review provided Government with an opportunity to shed light on, document, and identify better practices to improve outcomes. While government and sector stakeholders may agree that performing the review is a positive step, receiving the recommendations may be sensitive and difficult to digest.
- NL's residential supports and services share a number of positive factors, such as hard-working and committed RHA managers and front-line staff, as well as numerous service providers that have the best interests of clients at heart and ideas for effecting positive change. Most of all, we commend clients and those with lived experience, their families and caregivers for championing their needs and compelling action.
- At time of writing, HCS and CSSD may have commissioned other reports and implemented plans for policy reform in ways that will be complementary and will underpin the recommendations of this review.
- We recognize the actions underway or completed in recent years that will contribute to the betterment of community supports overall.
- However, we believe there are opportunities to enhance the status quo, and build upon foundational elements within the system to establish a modernized and cost-effective strategy for residential supports in the province.
- To that end, we make **32 unique recommendations**, which are intended to:
 - Improve, simplify and standardize the system of residential supports in NL across departments and RHAs;
 - Provide important new options for residential services and supports for adults and children/youth in Level 4 care; and
 - Modernize, expand and improve existing programs particularly to enhance oversight, efficiency and outcomes.
- The following pages provide the name of each recommendation, a brief explanation and a high-level identification of how implementation costs may be incurred (e.g. salary costs, technology costs, etc).

Key recommendations (cont'd)

ID	Opportunity Name	Description	Potential costs?
		Recommendations to Government of Newfoundland and Labrador – to improve the system of residential programs and service delivery	
01	Establish a provincial entity for residential services and supports in NL	<ul style="list-style-type: none"> In NL today, there are multiple departments, regional health authorities, community-based organizations, private service providers, and others involved in the delivery of residential supports for adults and children -- all of whom share a piece of this complex pie, and proceed with their own policies and direction. There are significant improvements to the level of support offered, as well as efficiencies that could be realized with clear system leadership, improved integration and alignment of <i>all</i> the province's residential supports and services. Other jurisdictions (e.g. BC) have moved to a single entity for at least adults, which integrates residential and support programs, and have seen greater coordination, standardization and efficiency. It is recommended that Government establish a new provincial structure (or select an existing government entity) that is mandated to: <ul style="list-style-type: none"> Lead and integrate system planning, integration, and standardized delivery of adult residential supports and services in NL, such that existing residential options currently owned by RHAs and/or government departments are transferred to the new entity, and new facilities / programs are established under its leadership and direction; Develop a provincial strategy to modernize NL's residential supports and services (see Recommendation 2, 4, 5, 6, 14-21) which establishes standards of care, modernizes existing programs, designs and implements new programs, and allocates financial resources as required to meet the needs of current and future clients (as well as children not in care but require residential care); Build an efficient and specialized team of dedicated provincial resources responsible for residential disability/MH supports, housing, and homelessness. Where dedicated housing-related resources exist in departmental programs or RHAs today, their roles should be transferred to the new entity; Engage with clients, families, indigenous communities, Regional Social and Health Networks (as outlined in the Health Accord), and community-based organizations for stakeholder input and program feedback as required (see Recommendation 3); Capture and analyze information on the residential supports system, and the clients that access it; and working with NLHC, improve and co-create social housing and shelter programs that better meet the long-term needs of the most complex, vulnerable and marginalized people, as described in this report (see Recommendations # 11, 12, 13). This new entity should be established with a governance structure (such as a board of directors) that oversees quality of supports, ensures forward-thinking and appropriate skill-sets are brought to bear, and performs meaningful engagement with key system partners, including HCS, CSSD, RHAs, NLHC, as well as clinical leadership in the health system. Consideration should be given how the new provincial organization aligns and fully integrates clinical and housing services with the single health authority, for which planning is now underway. The involvement of social housing authorities (e.g. NLHC) in this new provincial structure has not been evaluated, however we recommend that its role in residential services is considered. CSSD's oversight and involvement with service providers for children and youth services may present additional complexities however the goal should be to align youth and adult where possible. 	<p>Integration Costs</p> <p>Project Management</p> <p>Professional Fees</p>

Key recommendations (cont'd)

ID.	Opportunity Name	Description	
		Recommendations to Government of Newfoundland and Labrador – to improve the system of residential programs and service delivery	Potential Costs?
02	Develop an integrated, provincial strategy for residential services and supports	<ul style="list-style-type: none"> The 2022 Health Accord underscored the need for integration of health authorities and social service delivery to better meet the needs of Newfoundlanders today, and in future. For a relatively small population like NL's, the delivery of residential services and supports can (and should) be simplified and restructured to improve cost efficiency, client access, and better alignment of client needs with the appropriate support, while still providing a degree of flexibility at the regional level, and ensure that access to services is not dependent on geography. It is recommended that Government undertake a broad transformation of residential services in NL to implement modern service delivery practices, align with client needs, and increase support to clients in ways that are meaningful, outcome-oriented, and ensure that clients receive the right support at the right time. This requires a new provincial residential support and services strategy, to: <ul style="list-style-type: none"> Establish a common continuum of residential support, with pathways to, from and between each form of support. Today, residential options exist in a random and non-linear array of supports and services. Many gaps and issues have been identified, not the least of which is that supports tend to be focused on one client population, and/or variation across geographies. A new, needs-based continuum and program portfolio should be established to better support client needs, choice, companionship, and independence, as well as particular needs for permanency and stability, life skills development, transition or assessment, supportive living. Living environments and programs should be designed to diminish diagnostic, rural/urban and program boundaries. The continuum should also include treatment, clinical or high-acuity environments, while clearly describing client needs that each form of support will address. The strategy should also identify pathways across the lifespan, and provide flexibility as client needs change. Map existing department-specific “levels of care” to the common continuum. The three in-scope departments for this review do not share a common approach to residential support, nor a common language, although clients share common needs – this has been validated in this review. A mapping – if not full alignment – of the language used by the three program areas, to the common continuum of support, is a critical step in alignment and standardization. Consider whether there is greater efficiency in decoupling physical housing from clinical and case management (e.g. client placement decisions, client needs assessment, transition planning, etc.). It may be more efficient for a separate entity to construct and maintain the physical environments, whereas the health and social system delivers, oversees and is accountable for therapeutic programs, clinical decisions, and case management. In any event, a greater level of coordination between housing and clinical is required. Reflect the observations and findings from deep dive reviews to modernize existing programs and develop new programs, as described in later recommendations of this report. Community-based providers, clients, families, municipalities, private sector partners, and other relevant stakeholders should be heavily engaged in consultation on the integrated strategy, as well as on any other policy change related to this unique population. Equally critical will be the ongoing change management required at front-line across departments. 	Professional Fees

Key recommendations (cont'd)

ID	Opportunity Name	Description	Potential Costs?
		Recommendations to Government of Newfoundland and Labrador – to improve the system of residential programs and service delivery	
03	Establish an advisory group for residential supports and services	<ul style="list-style-type: none"> Stakeholders to this process expressed a strong desire for continued engagement with Government as residential supports are modernized around the province. In addition to deep insights about the supports they require, many of these stakeholders also had excellent ideas and were able to articulate concepts that would be helpful to Government. Their main priority, however, is to have meaningful engagement on such important topics as client access, safety and security, choice, inclusion, and funding flexibility. It is recommended that an advisory group for residential supports is established to provide feedback and a sounding board for Government as changes and improvements are designed and implemented. This advisory group may be part of the Regional Health and Social Network contemplated by the Health Accord, or standalone if timing or agenda topics are not aligned with the residential support agenda. Ideally, it will provide feedback directly to the new provincial entity contemplated in Recommendation #1, when it has been established. Regardless, the individuals providing advice to Government on residential supports and services must not be decision-making. Their role is to provide feedback and insight that program representatives from CSS/MHA and others may not have, and to have an opportunity for government to 'test' new models and ideas before rolling out the plan. The group should include a wide cross-section of relevant stakeholders that represent the populations in-scope for this review. We also recommend including a small number of selected community-based organizations and private agencies which have demonstrated good collaboration and ideas for improving service delivery. 	n/a
04	Further analyze demand/capacity for residential supports and services	<ul style="list-style-type: none"> Understanding the true demand for residential supports (now and in future) is critical to system planning. As an input to the integrated provincial strategy (Recommendation #2), it is recommended that Government performs an assessment on the residential supports 'supply and demand.' There remains a gap in information. A detailed quantitative and trend analysis should be performed to understand the distribution of clients, providers, and bed types across the province today. From a demand perspective, it will be important to understand how many individuals need which types of accommodation, in which communities, and how economic, population and demographic trends will impact this demand in the coming 5, 10, and 20 years. On the provider or supply side, Government must also assess how much capacity exists in the system today, where utilization should increase or decrease, and where investments will be needed to address future service gaps. This is a detailed and quantitative exercise that will be an important input to system-level planning. 	Professional Fees

Key recommendations (cont'd)

ID	Opportunity Name	Description	Potential Costs?
		Recommendations to Government of Newfoundland and Labrador – to improve the system of residential programs and service delivery	
05	Establish a centralized, specialized Intake and Assessment Centre(s) for residential services, with virtual capability	<ul style="list-style-type: none"> There are several examples of central intake in NL's mental health system, and other sources of referral. These resources provide value to the system and allow health consumers to navigate to the appropriate resources. However, it is clear that service capacity is an issue, coordination is difficult, and the complexities of many individuals exceed the ability of one healthcare domain to address. We are particularly concerned about the long-term outcomes and cost-benefit for supports provided to dually and triple-diagnosed individuals, adults and children placed in ILAs/SILAs, out-of-province residential placements, and adults / children supported to stay in the home with exceptionally high levels of complexity that may put providers, family or community at risk. These situations require a multi-disciplinary, specialized team approach to carefully evaluate, plan, implement and monitor clinical plans before a living arrangement can be properly identified. It is recommended that a centralized intake and assessment centre(s) is established to standardize assessments and clinical decisions with regard to residential supports. The centralized team should be composed of specialized, knowledgeable professionals that are accountable to develop / implement an evidence-informed management plan with the right appropriate supports. The centre should: <ul style="list-style-type: none"> Perform <i>community-based, in-patient and virtual intake and assessment processes</i> using evidence-informed tools, and common language, until such time as an appropriate placement has been determined; <i>Plan and implement appropriate interventions</i> to address an individual's unique array of challenges and needs – from residential, clinical, educational, and other needs – and <i>monitor until stability is achieved</i>; <i>Identify appropriate living arrangements and supports in the community of choice</i> for that individual, and <i>manage transitions</i>; <i>Maintain lists of qualified providers in a range of disciplines and locations, and make appropriate referrals for clinical services across the province</i>, including outpatient clinical supports, home support, behavioural support, and other services needed to stabilize and improve outcomes in the home; Low complexity clients may be assessed in community, or remotely if appropriate. However, for some clients with highly complex needs, in-patient assessment may be best, and may also require a lengthy stay to assess whether the intervention plans are effective before permanent placements are selected. For others, a faster transition may be possible. If internal resources are not available to staff such a centre appropriately, Government should consider qualified third-party partners (private or non-profit) which can provide this service on a contract basis and be accountable for performance standards and quality. The COVID-19 pandemic has demonstrated that virtual health and telecare assessments are a legitimate approach to assessing and providing services to clients. It is recommended that for low complexity or remote situations, virtual assessments should be offered routinely to ensure individuals and families can access services - and obtain a plan of action – without delay. 	Integration Costs Project Management Salary costs (if net new staffing)

Key recommendations (cont'd)

ID	Opportunity Name	Description	
Recommendations to Government of Newfoundland and Labrador – to improve the system of residential programs and service delivery			
06	Design and issue an Expression of Interest(s) for Community Partners	<ul style="list-style-type: none"> Like other jurisdictions, NL continues to be in the unenviable position of facing significant capital demands, growing demand for social housing and new residential support options, while post-COVID economic challenges increase in intensity. Once the provincial strategy for residential supports has been developed (Recommendation #2), and there is agreement on which new options are required (see Recommendation 8, 18, 19, 20, 21, 23, 31, others), it is recommended that the new provincial entity overseeing residential supports should design and issue an Expression of Interest in which private sector and non-profit partners can propose to Government how they can participate. The following information is recommended to assist proponents in designing their proposals: <ul style="list-style-type: none"> <i>Describes one or more residential living environments desired by Government</i>, the profile of clients that each will support, staffing skills and qualifications desired, and outlines high-level requirements for the construction and/or operations of the living environment; <i>Encourages consortium proposals</i> in which two or more private / public sector organizations partner to submit a bid, <i>which allows for a range of participants in development of options and service delivery</i> – from private sector partners, to community-based non-profit organizations; <i>Permits some flexibility and innovation</i> in the proposed partnerships and construction arrangements; and <i>Encourages proponents to propose new or alternative financing mechanisms</i> that will fund the design, development, construction and delivery of future residential supports. 	n/a
07	Validate transition plans for long-term Waterford Hospital clients	<ul style="list-style-type: none"> Transition planning is understood to be underway for remaining long-term residents of Unit N3A at the Waterford Hospital. It should be noted that confusion was reported to the review team about the responsibility for leading and managing the planning for these clients. This situation may now be resolved however, given the complexity of their needs, and anticipated high level of support required for this population, it is strongly recommended that transition plans including roles /responsibilities /oversight are validated well in advance of the proposed discharge date. A working group may be helpful to establish between HCS MHA, Waterford Hospital staff and the relevant community-based housing providers, to perform a detailed review and validation of each discharge and transition plan developed to date. If appropriate, the existing NAVNET structure may be the right place to host such discussions. If an appropriate place of residence has not yet been confirmed, it is strongly recommended that work begins on Recommendation #08 without delay. 	n/a

Key recommendations (cont'd)

ID	Opportunity Name	Description	
Recommendations to Government of Newfoundland and Labrador – to add important new options to the array of residential supports and services			
08	Immediately construct a step-up / step-down treatment-oriented, living environment for clients with long-term complex MH needs	<ul style="list-style-type: none"> Stakeholders including Waterford staff described a “therapeutic, step up/step down” treatment environment as being the most appropriate living environment for clients with exceptionally high levels of complexity (e.g. chronic and severe mental illness and other major challenges), including the long-term patients of the Waterford Hospital that are approaching discharge to the community. With the closure of acute beds at the Waterford and transition planning underway, in addition to general concerns expressed about the inadequacy of community-based living arrangements for the most complex and difficult clients, there is a pressing need to create a stable and therapeutic living environment to support people with complex mental health needs in the long-term. It is understood that long-term Waterford patients and other clients with highly complex needs all require intensive supports to gain the life skills, confidence, motivation, and achieve stability outside of acute care settings. It is recommended that Government immediately partner with health authorities to fund and establish a new step-up/ step-down facility to accommodate highly complex individuals in community, which should include designing an appropriate physical environment, clinical/social/life skills supports, staffing model, accountability and governance, as well as to agree on the transition criteria for how individuals move in – and out – of the environment to less intensive supports. To provide support in communities of origin and support bedflow across the province, the demand analysis process described in Recommendation #4 should identify additional step-up/step-down therapeutic housing supports required in other regions. 	Capital expenses Construction Project Management Professional Fees
09	Identify and begin transition planning for families that need stable, long-term support	<ul style="list-style-type: none"> Families with aging parents and adult children with disabilities are facing declining health and the ability to provide around the clock care. While assurances have been given that families will be supported in their time of need and that appropriate placements will be found, options are few. Transition planning may not have begun in earnest which increases the likelihood that a change in health status of the parents may create a crisis situation. It is recommended that clients and families in this unique situation are identified by RHA and departmental staff, with the support of community organizations including those serving mental health clients. A full needs analysis should be performed to understand client wishes, preferences, interests, and support needs, recognizing that the priority should be to secure long-term, stable and permanent supports including staffing which will promote stability and allow clients to feel secure. Some of these options might include existing options or new models of community living (see Recommendations 10, 21). Once a preferred outcome is agreed, timelines and transition plans should be put into place well in advance of the need materializing so that all family members are able to ‘settle’ into the new living arrangement. 	n/a

Key recommendations

ID	Opportunity Name	Description	Potential Costs?		
		Recommendations to Government of Newfoundland and Labrador – to add important new options to the array of residential supports and services			
10	Immediately fund the construction of one or more family-like living environments, such as L'Arche	<ul style="list-style-type: none"> The consultations performed in this review have illustrated a range of perspectives on safe, comfortable, desirable, appropriate and cost-effective, living arrangements – and where there are gaps. The desire for shared or congregate living is one particular gap that was identified by many stakeholders, particularly the clients who experience such loneliness and seek companionship, and their families who worry where their loved ones will live after they are no longer able to care for them. During our discussions, we heard loud and clear that for some clients, the right choice is a family-like, shared living environment with built-in supports, formal programming, live-in paid staff, and which take a relational approach to support, including socializing and involvement of other members of the community. Through this work, we have also engaged with several community organizations who expressed a strong desire to partner with the province to explore, pilot and develop these options. Some of the organizations included L'Arche which is a non-profit organization which has founded inclusive homes and communities of support for people with disabilities around the world, as well as NL's own Vera Perlin, Autism Society of Newfoundland, and private organizations. While shared living arrangements, congregate living, and family-like environments may not be the choice for every individual, this review confirmed that there is significant desire from individuals and their families for this style of living arrangement, and should be an option available for those who want it. Every individual wants a sense of belonging and acceptance in their community. The right to choose where, how and with whom one lives, as well as the opportunity for social interactions – both planned and informal – are fundamental to being a fully integrated part of society. Having a disability does not invalidate one's right to choose. The ability of some families to manage care into the future is diminishing. For that reason, it is recommended that Government immediately fund the construction of one or more family-like housing options, which suits the needs of several adults requiring residential supports, in a particular geography. The precise size, number and unique needs of clients supported by the home should not be a barrier to moving forward – its size can be determined by the number of families that wish to participate. While there is no specific client profile that would be best supported in this environment, families that wish to pursue this option represent clients that would be some of the last independent, and most physically and intellectually challenged. Matching clients to the living environment should take vulnerability into account and ensure that clients are appropriately protected and supported. 	Professional Fees	Capital expenses for construction and furnishing	Salary costs (for net new staff)

Key recommendations

ID	Opportunity Name	Description	Potential Costs?
		Recommendations to Government of Newfoundland and Labrador – to add important new options to the array of residential supports and services	
11	Validate demand of emergency housing options in Labrador and St. John's	<ul style="list-style-type: none"> While this review was not intended to address homelessness and precariously housed individuals, the need for additional shelter beds and longer-term supportive living options were identified in stakeholder consultations. Additionally, the challenges of people facing homelessness has been well-documented across the province, including in media coverage and through the efforts of community based organizations. However, understanding and quantifying the unmet need for residential supports and services proved to be, in this project, a difficult task. From siloed communications between service providers health system and government departments; disparate data sets maintained regionally which is not easily shared or integrated at a 'system' level; some clients having duplicate CRMS numbers; and concerns about potential 'double-counting' clients at the community level: there are many factors that impact the ability for anyone to truly understand how many people are without appropriate housing and other supports. Other reasons include transient and homeless populations, individuals not attached to the social system at all, and individuals opting-out of the social system. Of greatest concern to stakeholders of this project, are the individuals who are marginalized, addicted, unwell, and who are perceived to have 'fallen through the cracks'. Some of these include a disproportionate number in downtown St John's being served by community organizations, and a group of Indigenous people in Happy-Valley Goose Bay whose numbers have swelled in shelters and emergency housing since the start of the COVID-19 pandemic. Recent investments by the federal and provincial governments are understood to expand shelter capacity and social housing for families, however at time of writing, the unmet need for shelter and emergency housing remains unknown. It may be assumed that these investments while a positive step, will benefit only a relatively small number of individuals, particularly the single men who are disproportionately represented in emergency shelters or on long wait lists for housing. It is recommended that validation of the demand for emergency accommodations is reassessed in light of recent investments, and that any outstanding unmet need is analyzed. If demand remains, existing emergency accommodations (such as community-based shelters and motels used for 'overflow') could be acquired and converted to semi-permanent or long-term, single-room occupancy supportive housing. We recommend that the first priority should be given to expansion of existing community partners. For remote areas and where considerable net new capacity is needed. consideration should also be given to whether empty government-owned buildings could be acquired and repurposed to provide accommodations at a lower cost, and more quickly than constructing new facilities. 	Acquisition and conversion costs Capital expenses Construction Project Management

Key recommendations

ID	Opportunity Name	Description	Potential Costs?
Recommendations to Government of Newfoundland and Labrador – to add important new options to the array of residential supports and services			
12	Establish a 'by name' list of marginalized individuals	<ul style="list-style-type: none"> Privacy and confidentiality concerns have been cited as a primary barrier to sharing of personal and health data between system partners with the specific intent of matching individuals to supports and ensuring those who most need help receive it in a timely manner. Questions of privacy are not unique to NL, however other jurisdictions such as BC have recognized transparent information-sharing as a critical enabler of their ability to serve the most marginalized and vulnerable populations. For that reason, they have adopted a policy and practice to identify unique individuals at the community level, "by name" which is then used to track interactions with various system partners, support needs, and ensure that 'double counting' is not taking place. Without better insight into the actual number - and given name - of individuals accessing services or using shelters, Government and community partners will continue to observe unmet need in the community, and struggle to address it collectively. Individuals should be those accessing service through government, health authorities, community-based organizations such as shelters, and other organizations that serve marginalized people. It is noted that LGH has already implemented a similar process for identification and providing consent to share personal information. It is recommended that a 'by name' list of shelter users and other marginalized users is developed, in partnership with community organizations, as a key input to development of long-term strategies to address homelessness and poverty. 	n/a
13	Obtain informed consent to share personal and health information with system partners	<ul style="list-style-type: none"> Complementary to Recommendation #12, privacy and confidentiality matters must be taken seriously and breaches must be avoided. To ensure that individual's right to privacy is appropriately protected, it is recommended that Government develop an information-collection and information-sharing protocol for users of emergency shelters and other community supports, which will ensure that informed consent is obtained prior to the collection and sharing of information. Individuals should have full understanding of what their personal and health information is being collected for, who will receive it and how it will be stored. They should also be advised of the opportunity to be better understood and served by "the system" and that greater understanding between system partners about what people need is a positive outcome. Such consent should be recorded in EMRs, Meditech, HIFUS, CRMS, and/or other relevant systems used at the community level. Once consent to share information has been received, it is assumed that system partners (including RHAs and community organizations) will be in a position to share individual information, services accessed, health information and other relevant details that will enable them to obtain support in a more coordinated manner. 	n/a

Key recommendations (cont'd)

ID	Opportunity Name	Description	Potential Costs?
Recommendations to Government of Newfoundland and Labrador – to improve and modernize existing residential programs			
14	Develop and implement operating standards for Board and Lodging – Non-Relative	<ul style="list-style-type: none"> The Board and Lodging – Non-Relative program assists some individuals in living independently, sometimes with additional or wraparound supports. However, there are difficulties with this program as currently designed, particularly that it is simply a funding mechanism versus a true social support “program”. The need for good quality housing stock for individuals living in supportive board and lodging arrangements was repeatedly discussed by stakeholders through our consultation process. We heard from social workers about the constant struggle to ensure that living conditions are safe and clean, that basic living standards and client needs are being met in the home environment, as well as concerns from current clients and families that they are not able to self-advocate with difficult landlords or other residents. While it is important to have eyes on the ground to understand the state of the living environment, little can be done without accountability and oversight mechanisms. The current BLNR program has no provincial operating standards at all, which does not provide Government with any means of establishing minimum standards for living conditions, nutrition, or intervening when things go wrong. It is recommended that Government develop provincial operating standards that clearly outline the supportive environment that providers are expected to provide, as well as an accountability framework and governance model that will ultimately improve oversight of the program and service delivery. Standards should include minimum standards for the living environment, such as size of bedroom, egress, sanitary and safe conditions, nutrition and meal preparation, and ‘enjoyment of the home’ which should be included in the event of landlord intimidation or other interpersonal issues. Evaluation of the underlying funding model should also be considered. 	n/a
15	Encourage the establishment of family-based oversight boards for BLNR clients	<ul style="list-style-type: none"> Individualized funding models are already in progress for NL, which improve client choice and the flexibility in how support hours and subsidies are utilized. To further support this goal and further support families in making care decisions and self-advocating for support, it is recommended that Government explore other facets of family-led models, including the ability to support decision-making for individuals, and plan for innovative self-directed options in community. Several other jurisdictions including Ontario and BC have adopted family-based oversight boards (such as Vela Canada’s Microboards™ model), which typically establishes an incorporated legal entity with a board of committed family members and friends to support an individual in advocating for their needs, managing their funding and supports, and ensuring their overall ability to live fulfilling, independent lives. Where possible, a Microboard™ or a similar voluntary oversight body would be beneficial, even in the case of individuals without natural family or for whom care decisions are complex. 	n/a

Key recommendations (cont'd)

ID	Opportunity Name	Description	Potential Costs?
		Recommendations to Government of Newfoundland and Labrador – to improve and modernize existing residential programs	
16	<p>Perform in-depth program reviews:</p> <p>a. AFC</p> <p>b. Board and Lodging – Relative</p> <p>c. Cooperative Apartments</p>	<ul style="list-style-type: none"> For several residential programs, it has been a long time since standards and program design was reviewed and refreshed. With outdated operating standards, changing client complexities, and aging providers, it is strongly recommended that program reviews are performed on three of the existing residential programs in NL: <ol style="list-style-type: none"> The Provincial AFC Program has provincial operating standards that have not been reviewed since 2007. Very few new providers have been recruited, and an independent review of funding models has not been undertaken in years. While lack of financial support is the most observed frustration amongst providers, the ability to manage complex needs and behaviours of clients is another concern for families without the appropriate training or supports in place. Often referred to as an 'adult foster care' program, the AFC program may be able to draw upon the lessons learned and levelled approach to child foster care within CSSD, including the development of a tiered model for AFC providers which would allow for more specialized family care options for clients with more complex needs or behaviours. Such a tiering would include additional training and supports based on the level of care required. Renumeration for providers should be reviewed within this tiered structure. Board and Lodging – Relative. This funding support mechanism is the most frequently accessed in the province, most commonly by adults with disabilities who live with their parents and receive 24-hour support receive the least financial support of any clients. Given NL's changing social, economic and family structures, it is not clear that the current model is sufficient to maintain individuals at home with family members (who may be limited to immediate family members). Program design and funding model should be reassessed through a formal program review. Co-Operative Apartments is another program that has not been reviewed since 2007. Originally in place to support transition and development of life skills for adults with disabilities, individuals appear to be living permanently in this arrangement. We recommend HCS conduct an independent review of cooperative apartments with the intention to refresh operating standards and re-align on the purpose of the infrastructure. Additionally, there are lessons to be learned from co-ops operating successfully across the province (e.g. Central Residential Services Board), which could be leveraged to inform future opportunities. <p>Typically, such program reviews involve a balanced and objective assessment of service user demographics, provider demographics, program design, provider capacity / skills / training, refresh of standards, funding model / rates, program governance, provider oversight, performance, and/or compliance measures (e.g. adoption of Service Level Agreements), assessment of 'goodness of fit' of current clients, and the potential to introduce tiers of support or otherwise modernize the program to meet current needs.</p> 	n/a

Key recommendations (cont'd)

ID	Opportunity Name	Description	
Recommendations to Government of Newfoundland and Labrador – to improve and modernize existing residential programs		Potential Costs?	
17	Perform a program and financial review of ILA/SLA (adults and children)	<ul style="list-style-type: none"> ILAs are reportedly used when other options have been exhausted, however there also appears to be inconsistency in how ILAs are designed, eligibility criteria, staffing guidelines, and concern about the cost-benefit of the arrangement. There are also unclear client outcomes in both adult and children/youth ILAs. Without provincial operating standards for the adult ILA program, there does not appear to be any guidance to RHA and departmental staff on when and how ILAs should be established, how they should run, and where oversight is provided. Standards should be implemented when program review is completed. It is recommended that this review include detailed analysis of current ILA / SLA current client needs, program policies, client support staffing, governance, program costs, and current funding model. New funding incentives may be appropriate to support improved outcomes and incenting provider / worker behaviour to implement behavioural plans and similar techniques. Clinical assessment should also be performed on existing ILA/SILA client data to determine whether better outcomes are achieved with higher level of support. Anecdotal examples were offered for whom overservicing was confirmed, supports were reduced over time, and the client's behaviour improved dramatically. For that reason, it is recommended that careful efforts are made to identify the current status of adult and children/youth clients in ILAs that could transition to alternative models in the community to improve long-term outcomes, identification of outcome-based approaches, and to develop appropriate transition / behavioural / support plans to support this change. 	n/a
18	Identify and fund service providers in each region to provide for adults and children / youth: a) Short-term respite, and/or b) Short-term crisis stays	<ul style="list-style-type: none"> Respite beds. A significant challenge for providers and families alike is the lack of availability of respite support (either in the home or in a provider's home) for adults and children/youth. While respite has been considered in the standards for some programs (e.g. AFC), providers typically struggle to make a respite visit practically accessible, for example, travelling many hours and hundreds of kilometres for one night of respite. There is a need for respite accommodations for all clients, across the province. Adding respite beds in existing CCH/PCH or other facilities should be considered. Short-term crisis stays. Some individuals with mental illness and/or complex behaviours may experience transitory periods of aggression, self-harm, or where they struggle to maintain a reasonable level of functioning and relationships in the residential placement. The options for individuals and service providers to obtain extra support are inadequate. As a result, providers may rely on emergency room visits, calling the police, and have the individual removed for a period of time in which case they may be charged and jailed, or admission to in-patient acute care beds if available. While these options may be necessary in the moment, there are many cases which simply require a change of scenery and/or therapeutic support to avoid placement breakdown. Existing providers including CCH and PCH providers should be incented to open short-term crisis beds to provide relief to providers and families, and avoid justice system or acute care involvement. When a central intake/ assessment centre is available, it may be an appropriate provider of short-term crisis beds and/or respite. However, in the meantime, there are trained service providers in each region who may be able to perform this function. 	Funding for new service provision

Key recommendations (cont'd)

ID	Opportunity Name	Description	Potential Costs?
	Recommendations to Government of Newfoundland and Labrador – to improve the array of residential programs and service delivery		
19	<p>Review CCH program with a view to integration with Personal Care Home (PCHs)</p> <ul style="list-style-type: none"> The Community Care Homes program has been in existence for some time, but only exists in Eastern Health for individuals with mental health and addictions issues. While these homes have a place in the continuum of community-based options, it is inappropriate for them to operate without funding that is in alignment with reasonable expenses, and clear operating standards that reflect their small size and unique client needs. It is recommended that a program review is conducted with a view to refreshing the CCH program, and developing the appropriate provincial operating standards. Service level agreements should be considered for long-term relationships with providers. A key question for HCS will be whether (and if so, how) to integrate the CCH and PCH networks. We are sensitive to the efforts being made by HCS and PCH providers to modernize, and are reluctant to overburden PCHs with another 'new ask'. However, we are also sensitive that the PCH program represents a realistic, and potentially appropriate, supportive environment for people with long-term mental illness and/or addictions. We recommend that HCS pursue an independent and balanced review of CCH with a view to potential integration with PCH, including provider funding, and assessment of sustainability of the current portfolio of homes, if rationalization should occur. In the short-term, we recommend that HCS work with selected PCH providers leverage excess beds and bridge gaps in support for mental health and addictions clients. PCH staff may need additional training and support. Homes in critical locations or filling critical gaps may need additional support to update the physical environment, washroom and cooking facilities to achieve modern standards. It is recommended that regardless of whether integration is appropriate, some current CCH practices (such as shared bedrooms) are discontinued to reflect modern thinking in residential accommodations. Other practices may also be discontinued or adopted by the program following the review. Government should consider whether PCH and CCHs should be integrated into one program area however such an action should be informed by data on common client needs and provider capacity. The review team's view is that integration of the two programs is a policy decision of the Department. 	<p>Funding for new CCHs</p> <p>Transition costs</p>	

Key recommendations (cont'd)

ID	Opportunity Name	Description	Potential Costs?
Recommendations to Government of Newfoundland and Labrador – to improve the array of residential programs and service delivery			
20	Introduce selected new models of community living	<ul style="list-style-type: none"> The scope of this review included a high-level scan of innovative models of support for community-based living for adults with disabilities, mental health challenges and/or addictions. A number of interesting models were identified through their adoption or consideration by other jurisdictions, and through academic literature. These models prioritize embedded supports and Universal Design principles, and appear to address similar objectives as HCS/CSSD in terms of choice, person-centredness, and innovation: <ul style="list-style-type: none"> Intentional communities, to create purpose-built, supportive housing options that are designed to foster belonging, assist families with shared support needs, and foster independence (such as providing assisted living for younger adults, those in need of behavioural support, personal care). Intentional communities have been established around the world and vary in size and focus, but which respond directly to the needs of specific populations. Identification of these opportunities can be done once demand/supply and client needs analysis are completed. Transitional “Foyer” Model for emerging adults at risk of homelessness, particularly those that have recently transitioned from foster care and may have identified gaps in education, life skills, employment skills, or difficult histories that may create significant challenge to managing their lives as adults without support. Consideration may be given to <i>convertible leases</i>, and/or <i>scattered site approaches</i> which would allow youth to transition naturally to adulthood outside of an institutional environment. Purpose-built ASD housing options and modifications, to address issues of the physical environment which can trigger some ASD clients and exacerbate aggression, anxiety and behaviours. Of particular interest are ‘autism-friendly homes’, which embed certain features found to be useful for reducing anxiety and managing behaviours (such as a ‘walking loop’ and ‘connected home’ as adopted by Community Living BC). HCS/CSSD may wish to adopt one or more of these in future. However further due diligence should be performed to develop a specific design, and to assess ‘goodness of fit’ for current and future clients. As is being done in other jurisdictions, pilot projects should be considered to test operational design and measure effectiveness. 	Pilot project costs Construction / capital costs Funding for new facilities

Key recommendations (cont'd)

ID	Opportunity Name	Description			
		Recommendations to Government of Newfoundland and Labrador – to improve the array of residential programs and service delivery			Potential Costs?
21	Improve awareness and recruitment for key HCS/CSSD programs	<ul style="list-style-type: none"> The HCS/CSSD continuum of residential options includes a small number of programs for which recruitment has been a significant challenge, namely Alternate Family Care (AFC) for adults and Level 3 specialized foster care for children and youth. Public sector organizations around the world have successfully used strategic communications campaigns and public relations to achieve certain outcomes, such as increasing recruitment, generating community awareness of a particular need or opportunity, and enhancing acceptance of a future policy change. It is recommended that HCS and CSSD (together or independently) invest in a strategic communications campaign using a range of tactics and channels of communication, such as television, radio, newspaper, internal/digital media, social media, as well as volunteer networks and community-based providers to engage and increase awareness of the need for new service providers, how people can get involved, and to ideally generate interest in becoming a service provider. Ideally, HCS/CSSD will develop a mini-test that provider candidates can use to self-assess and match with various programs, based on their unique interest and potential to support different kinds of clients. Further due diligence on provider candidates before accepting them as providers is assumed however generating greater awareness and beginning the application process are important first steps. 		Advertising / marketing agency fees	Graphic design fees
22	Establish partnerships to expand existing capacity and pilot new models	<ul style="list-style-type: none"> As previously stated, the level of engagement and interest in this review suggests that there is no shortage of community-based interest in supporting innovation and piloting new models of residential support. Government is encouraged to think creatively about expanding the existing supply of residential options, for example, how existing public buildings and facilities may be repurposed to expand the province's supportive housing infrastructure. Beginning the discussion with key municipalities where capacity is needed may be helpful in identifying how to improve the impact of residential programs, in the current economic climate. There may be empty government-owned buildings or schools which could be converted to housing at minimal cost. Partnerships with municipalities, community organizations and the private sector should also be initiated to assist in planning, designing, operating, and financing newly identified community living models (see Recommendation 21). Community-based partners will be critical partners to HCS/CSSD in identifying and piloting alternative service delivery models, with a long-term goal of improving outcomes, maximizing funding efficiency and improving overall effectiveness of community living options. 			n/a

Key recommendations (cont'd)

ID	Opportunity Name	Description	Potential Costs?
		Recommendations to Government of Newfoundland and Labrador – to improve the array of residential programs and service delivery	
23	Develop and standardize new support roles and staffing models for community living	<ul style="list-style-type: none"> A key concern arising in this review was that existing home support workers and other support staff may not have the training, interest, skills or awareness of how to support clients with complex needs in the residential environment. They may inadvertently trigger behaviours or resist implementing support plans which may temporarily increase behaviours. Furthermore, stakeholders view the hourly basis staffing model as not providing the stability, long-term relationships and permanency that some clients require. As HCS/CSSD moves toward more long-term supportive housing options with embedded supports, Government is encouraged to reconsider the staffing arrangements for each, to ensure that clinical and other outcomes are achievable. Other jurisdictions use Community Living Support Workers, Mental Health Support Workers, Housing Support Workers, Behavioural Support Workers – all of which have a role to play in supporting people to live successfully. Other jurisdictions are also beginning to move beyond hourly wage workers and into more permanent staffing arrangements that incent providers to improve scheduling consistency and stability. It is recommended that Government work with the community college sector and/or other partners to assess the competencies required for each type of support environment, and develop the appropriate competency framework, training and role descriptions for the full range of community living support roles required in future. It is further recommended that Government evaluate alternative staffing models that will reduce disruption and turnover in residential supports, and which will align operational needs with target clinical outcomes. 	Funding model for new staffing arrangements
24	Formally partner with an external organization to accelerate learning	<ul style="list-style-type: none"> NL has been on a policy renewal journey for over a decade, and should be commended for its efforts to continue improvements. Given that there are Canadian and international jurisdictions that may be further along their journey to modernize residential supports and housing systems, NL may benefit from developing relationships with one or more organizations as a means to accelerate its understanding and design processes. It is recommended that NL develop formal partnerships with one or more of these organizations to share models, insights, expertise, as well as specific technical specifications, best practices, and lessons learned, which NL can use to inspire innovative thinking, and bring hands-on expertise to bear in the next chapter of its journey. Many jurisdictions have begun the residential supports transformation, and have adopted several of the models recommended for consideration by NL. These include British Columbia (Community Living BC; BC Housing), Ontario, New Zealand, amongst others. It is acknowledged that CSSD regularly engages with counterparts in other provinces and territories through the Director of Child Welfare Group and a placement subcommittee to that group. 	Net new staffing costs

Key recommendations (cont'd)

ID	Opportunity Name	Description	Potential Costs?
		Recommendations to Government of Newfoundland and Labrador – to improve the array of residential programs and service delivery	
25	<p>Explore innovative funding models, such as Social Impact Bonds or Investment Funds, to finance new models</p>	<ul style="list-style-type: none"> Affordable housing is an issue across the country, and is particularly acute for people with physical, intellectual and developmental disabilities, mental health and addictions issues, and youth transitioning to adulthood from the foster care system. In NL, the future is particularly concerning given the fiscal realities facing the province. When dollars are tight, alternative and creative funding sources should be considered. There are also emerging sources of alternative funding that are not grant-based, such as Social Financing. Social financing provides provincial and municipal governments with a means to raise low-cost capital for new projects, share risk, drive accountability and positive outcomes for community. In this model, jurisdictions identify a complex social outcome that needs to be addressed (e.g. chronic mental health issues, homelessness, recidivism), but which is funded by the capital markets instead of government and other traditional funders. Examples of social financing for disability housing or marginalized people, including the use of social impact bonds, include: <ul style="list-style-type: none"> Denver Supportive Housing Stability Bond, which raised \$8.6 million from 8 private investors to fund a social housing system for 250 of the city's most frequent users of the criminal justice system; Freddie Mac MultiFamily, which will provide \$230 million in social impact funding to build 1240 rental units for individuals with intellectual and developmental disabilities; and Positive Behavioural Support ("PBR") Social Impact Bond which was established to promote expansion in the community for children and youth with severe autism, through uptake of PBR regimes and achievement of specific outcomes Three affordable housing communities in BC and Ottawa, which were established through social investment from the private sector and are intended to achieve long-term stability and other social outcomes. <p>A short video on this subject may be viewed here: https://www.theinvisibleheart.ca/</p>	Professional Fees

Key recommendations (cont'd)

ID	Opportunity Name	Description	
		Recommendations to Government of Newfoundland and Labrador – to improve the array of residential programs and service delivery	Potential Costs?
26	Develop and launch technology app to match roommates and service providers	<ul style="list-style-type: none"> Individuals and their families struggle to navigate the residential supports system. By in large, clients and families do not have insight into what the options are, how people are selected to live together (if at all), or what their family members may be eligible to receive in terms of supports and funding. In other cases, families or individuals may wish to collaborate to create and operate homes for their family members – but lack the ability to do so in an organized way across the province. It is recommended Government develop and launch online resources and/or a technology application for families to support system navigation, which enable individuals to connect with like-minded potential roommates and service providers or landlord. Such examples of technology-enabled matching exist in other jurisdictions where shared accommodation is normalized, and where clients are supported to choose their preferred living arrangement and level of support. Potential roommates may offer support in exchange for accommodation, or may not offer support at all but act as natural, informal companions for the disabled person. In some jurisdictions, this resource has taken the form of a simple social media platform, and later developed into broader online networks with formalized tools and communication channels. Such a tool should be owned and managed by the new entity established in Recommendation #1. 	Software development costs Launch and marketing costs
27	Develop cloud-based database solution to manage demand/capacity of community living options	<ul style="list-style-type: none"> A key enabler of asset efficiency and resource management is the degree to which government departments, agencies and service providers are able to collect and report real-time data, understand, forecast and manage system capacity, utilization and availability. For example, clinical placement decisions would be significantly benefited by a tool to assist government in answering the questions, <i>How many beds are available? In which types of living arrangements? In which communities? Is that enough? Do we need more – if so, when do we need them?</i> There are no easy ways today for front-line social workers or senior leadership to obtain insight into the province's housing supply across all forms of living arrangements, the availability of beds, track vacancies, and how effectively beds are utilized. It is recommended that Government develop or leverage an existing platform to coordinate placements across the province, and serve as a key input to transition, and long-term planning. A mature tool could be used to drive additional transparency for individuals and families looking for placements to understand the queuing process as well. It is recommended that the provincial entity (Recommendation #1) explore the potential to implement a technology solution that is interoperable with existing technology systems as appropriate, and that allows service providers and RHAs to view availability of placements across multiple channels. 	Software development or acquisition costs Data migration Training

Key recommendations (cont'd)

ID	Opportunity Name	Description	
		Recommendations to Government of Newfoundland and Labrador – to improve supports and services for children and youth in Level 4 residential care	Potential Costs?
28	Accelerate action planning and investment in early intervention and prevention	<ul style="list-style-type: none"> By many accounts, CSSD has made very strong progress over the past decade to renew and reform the child welfare and protection system. Past child advocate reports have underscored the need for greater investment in early intervention and preventative support for families, as well as the disproportionate number of Indigenous children unnecessarily taken into care. Stakeholders to this project have identified numerous improvements in recent years, including greater focus on kinship placements, significantly greater investment and prioritization of prevention and family supports that ideally enable children to remain at home and avoid care. It is understood that a pilot project is underway with a community partner to develop early intervention and prevention programming, as well as CSSD Social and Economic Wellbeing Division's work in this area. CSSD's 2020-2023 Strategic Plan identifies early intervention and prevention as a strategic priority, however its timeline - completion by end of the fiscal year 2023 - is a long way away for those children who may not be in a healthy or nurturing environment in the natural family. It is recommended that CSSD accelerate its process to implement tangible actions that will funnel more dollars toward prevention and early intervention programming, aimed at keeping families together and improve outcomes prior to children coming into care. This action is in keeping with actions taken by other jurisdictions. While CSSD has made strides in improving Level 4 residential care in the province, ideally the number of children and youth in care will be decreased over time and the care system will be avoided altogether. 	Funding for net new staffing and program delivery
29	Expand in-home family supports and prevention programming	<ul style="list-style-type: none"> It is particularly important in Labrador where there is a need to continue educating and supporting professionals to enable culturally-appropriate placements and child protection decisions. Partnerships with community-based organizations have already been piloted to support families, prior to children being taken into care. Over time, these steps will represent considerable cost-savings to the child protection system, and more importantly, improved family preservation where appropriate, which is arguably the ultimate goal. This recommendation also supports earlier recommendations to re-consider and re-evaluate the use of residential arrangements such as ILA, which do not foster community integration, and incur high expenses with unclear outcomes. In this example, children (and potentially adults accessing residential services through HCS) may be prevented from becoming more complex, with appropriate, early interventions in the family home. Community-based partnership with the appropriate orientation and programming should be funded to expand their footprint across the province. CSSD should also explore opportunities to leverage other service providers and train them to provide in-home counselling and family supports. As with all interventions, specific attention should be paid to child and family outcomes, and monitoring over time to ensure ongoing appropriateness of this solution. 	Funding for net new staffing and program delivery

Key recommendations (cont'd)

ID	Opportunity Name	Description	
	Recommendations to Government of Newfoundland and Labrador – to improve supports and services for children and youth in Level 4 residential care	Potential Costs?	
30	Invest in life skills, developmental and therapeutic programming for youth transition period, and adults	<ul style="list-style-type: none"> In addition to supports provided through CSSD's Youth Services Program, and efforts to improve transition planning, some youth still 'age-out' of the child protection system, and are left to fend for themselves as they struggle with newfound independence and the lack of necessary life skills, resources and supports to transition successfully into adulthood. This is particularly acute for those youth that have more complex needs, such as addictions, emotional difficulties, behavioural challenges, or have become street involved at a young age. These young people are most at risk of difficult transitions and may struggle to maintain employment and housing. For young people, increased investment is needed in outcomes-oriented, intensive life skills development and enhanced therapeutic environments beyond what is currently available in many Level 4 homes. For adults with mental illness or addictions, developmental milestones and life skills may have been missed and need to be 'caught up' in addition to providing recovery. It is recommended that Government invest in living environments in which life skills are deliberately taught with a view to improving independence and reaching full adult potential. Such living environments should be available to youth between 18 and 21 as part of the Youth Services Program of extended supports, and for adults with appropriate need to improve life skills. Additionally, CSSD should encourage Level 4 providers to adopt a holistic, evidence-informed pedagogical approach (also known as a theory of change) for youth at risk that provides programmatic structure beyond the non-violence crisis intervention programs that are commonly referenced by providers as their 'program.' Examples include Therapeutic Crisis Intervention, Therapeutic Care, others. 	Funding for net new staffing and program delivery
31	Review children and youth in care "levels of care" continuum, including community-based supports available to Level 1 and 2 foster families	<ul style="list-style-type: none"> CSSD's current four-step levels of care continuum has been the subject of some discussion by stakeholders in this review, who express concern that the current four level continuum implies "Level 1 - kinship" is the least supported group in the continuum. If in-home supports fail or children are at high levels of risk, stakeholders believe that kinship placements are the next best option for placing that child. However, there appears to be minimal support, education, training and services available on balance to kinship providers. In some cases, elderly grandparents are caring for multiple children – some of which have complex needs – and have not received the training and paid supports that have been made available to third-party service providers. This review was focused on Level 4 placements, however there was considerable concern about the absence of Level 3 specialized foster homes, and the need for greater support at Levels 1 and 2. Ideally a comprehensive review of CSSD's entire child welfare/child protection continuum will be conducted to improve the understanding of children and providers at each level, gaps and opportunities. 	Professional Fees

Key recommendations (cont'd)

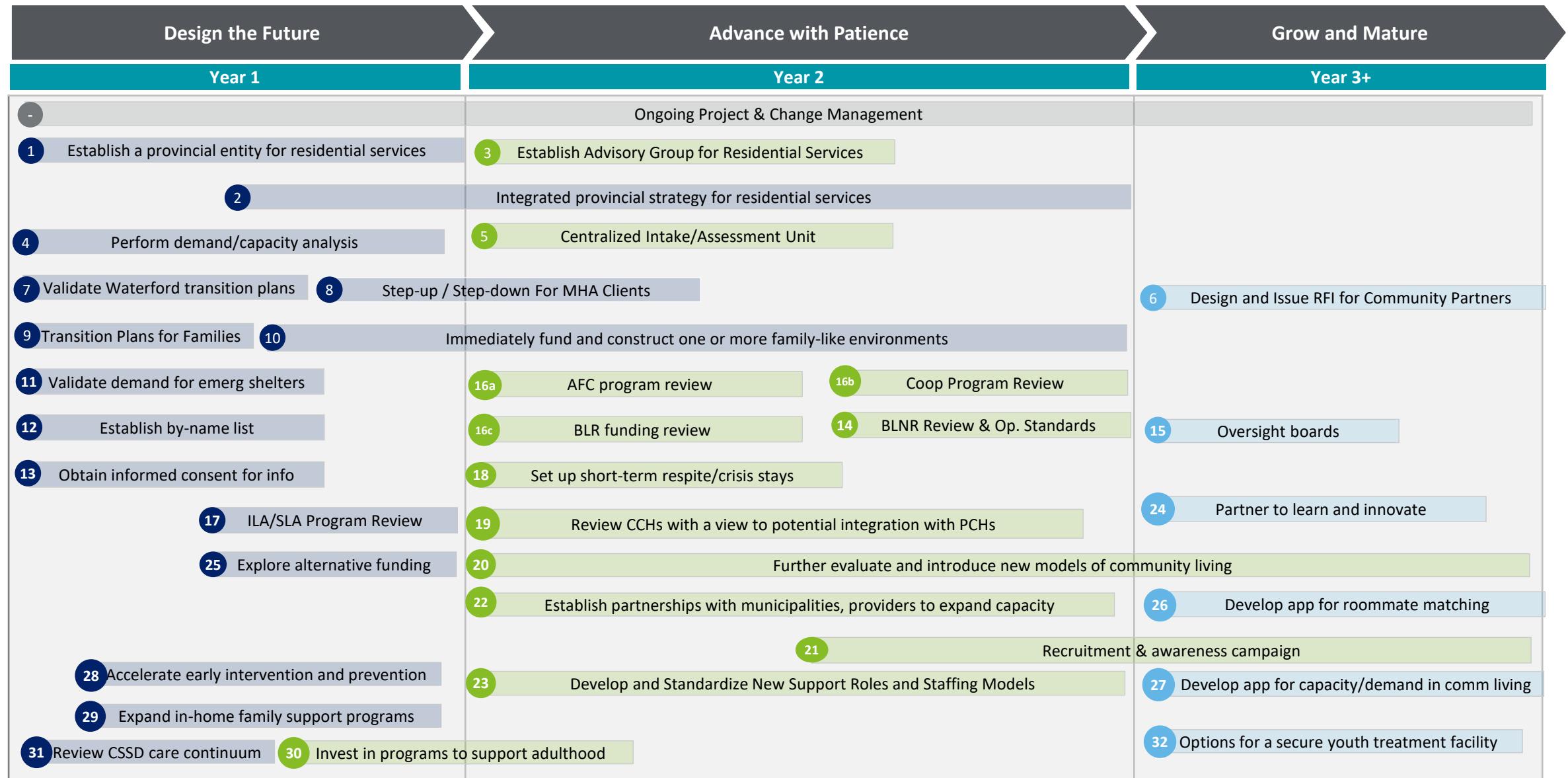
ID	Opportunity Name	Description	
32	Review options to establish a secure treatment facility for youth	<p>Recommendations to Government of Newfoundland and Labrador – to improve supports and services for children and youth in Level 4 residential care</p> <ul style="list-style-type: none"> In all aspects of this project, stakeholders report that the complexity and needs of some children, youth and adults have outstripped the ability of the current levels of care to provide safe, supportive care. Specific examples in the children's system included challenges in Level 1 and 2 foster care (out of scope for this review), as well as the absence of Level 3 foster homes, and extreme challenges in managing youth in Level 4 homes. While some children and youth may be appropriately placed in group facilities as currently offered across the province, there are a significant number of young people who engage in challenging behaviours, become street involved, experience substance abuse, become sex workers, or worse. Without the opportunity to keep them safe, it is difficult to imagine how good outcomes can be achieved. Similarly, we heard countless stories of adults with complex needs needing more support than families can provide – even some providers – and ending up with police being called, or being admitted to the psychiatric system. Moreover, in far too many cases, it appears that individuals with complex needs are only being <i>managed</i> and are not being <i>treated, intervened upon, and counselled</i> in such a way that will meaningfully improve long-term outcomes and mental health. That is, despite some living arrangements understood to have a therapeutic purpose, both stakeholders and providers report concerns that Level 4 and many adult residential arrangements usually do not offer an embedded treatment program or theory of change that orients department, staff and clients on a specific set of goals and intended outcomes, nor do they develop a therapeutic plan when difficulties arise that can be actively being pursued through evidence-informed practices and a clearly defined program of treatment. Similar situations can be identified for children or even adults living in highly-staffed or unstable ILAs which may not promote health and well-being, community integration, meaningful change and sustainability in the long-term. Given significant potential for lifelong instability and extremely poor outcomes for children, youth and adults with complex needs, it is incumbent on Government to consider options that balance risk, opportunity to invest in meaningful life improvements, harm to oneself and community – and do better. An appropriately governed, non-voluntary, secure treatment option may provide a supportive and restful 'pause' with appropriate clinical exploration that is currently lacking for children and adults who create harm to themselves. It is recommended that CSSD perform a review of its entire continuum of care. Additionally, the <i>Mental Health Care and Treatment Act</i> legislation is under review at time of writing. It is recommended that both entities consider opportunities to adopt a secure treatment option where individuals can receive appropriate and timely intervention. Ideally, such secure treatment will include a range of disciplines to perform intake and assessment, including but not limited to medical care, psychiatry, psychology / counselling, social work, youth workers, employment counsellors, remedial educational support, culturally-appropriate supports, etc. It is understood there has been considerable previous study and stakeholder participation within the children's system to learn from. Exploring the possibility of secure facilities as described is certainly sensitive. Such a recommendation is not made lightly. 	Potential Costs n/a

Implementation Roadmap

Introduction to Implementation Roadmap

- Implementation of the recommendations as outlined in the previous section of this report will require focus, patience, and support. The following section offers a high-level Gantt chart, outlining the relative timing and duration of each of the recommendations. In some cases, there are dependencies between the recommendations that will require deliberate sequencing and timing of activities.
- We have organized the recommendations into three categories for implementation:
 - **Short Term (first 12 months) – Design the future**
 - **Medium Term (12 to 24 months) – Advance with patience**
 - **Long Term (24 to 36 months) – Grow and mature**
- It may be helpful to scope and plan some recommendations (particularly #14-20: existing program reviews, #21 – new residential models, #23 - new support roles and staffing models) prior to the conclusion of #2 Integrated Residential Strategy, to ensure that the provincial strategy will be informed

Implementation Roadmap



Concluding Remarks

Concluding Remarks

- The Departments of HCS and CSSD, in partnership with the four RHAs have already invested considerable time and effort into the work of this review, and will continue to do as these recommendations are implemented.
- The analyses and recommendations laid out in this report set forward an ambitious future for residential supports and services delivery in Newfoundland & Labrador. We believe these recommendations allow for Government to be responsive to the identified needs – and unmet needs – of its citizens, and which align well with the principles underlying this work:
 - *Choice and control;*
 - *Person-centred practice*
 - *Access to and independence in home and community environments;*
 - *A housing-first philosophy; and*
 - *Trauma informed, recovery and well-being, incorporating harm reduction principles.*
- The suggested sequencing of recommendations provides a structured, and deliberate approach to building the necessary relationships to improve residential services delivery across the province.
- The implementation of these recommendations will require dedicated time, effort and collaboration from Government, RHAs, and community providers. Implementation and scale-up will not be easy, but is necessary to continue to lay the foundation for a shift in the way residential services are funded, delivered, and accessed by all population groups in need.

Deloitte wishes to thank HCS, CSSD, all four RHAs, and most importantly, the many individuals, families, caregivers, community agencies, non-profits, and subject matter experts for their honesty, engagement and enthusiasm.



“My son has the potential to build his self-esteem, feel valued, and lead a productive life”

- Parent of adult child with autism, CBC News
2018

Appendices:

A – Stakeholder Engagement

B – Program Definitions

C – Snapshots of Selected Residential Programs

D – Additional Detail from Jurisdictional Scan

E – Survey Results

Appendix A

Stakeholder Engagement

Appendix A – Steering Committee

Project oversight and guidance for the engagement was provided was provided by a small Steering Committee

Steering Committee Oversight

A small Steering Committee comprised of representatives from the Department of Health and Community Services, and Children, Seniors and Social Development provided guidance, oversight, and feedback. The members of the Steering Committee and their roles are listed below:

Name	Department	Role
Annette Bridgeman	Health and Community Services	Director, Regional Services, Community Supports and Services
Jennifer Sullivan	Children, Seniors and Social Development	Provincial Director
Niki Legge	Health and Community Services	Director, Mental Health and Addictions
Linda Warford	Health and Community Services	Youth/Emerging Adult Specialist
Sarah Hollett	Health and Community Services	Health Care Consultant, Community Supports and Services

Extended Oversight

Key directors from the program areas and RHAs were engaged to participate in key steering committee meetings.

Appendix A - Stakeholder Engagement - Participant List

The following individuals and groups were interviewed as part of this engagement:

Stakeholder Group	Geographic Area	Name	Role
Individuals, Family and Caregivers	Central NL	Jade Rodriguez	Caregiver - AFC
Individuals, Family and Caregivers	Central NL	Shawn Jarvis	Individual / Client - AFC
Individuals, Family and Caregivers	Central NL	Patty Callahan	Family Member / Substitute Decision Maker - ILA
Individuals, Family and Caregivers	Central NL	Gary Hennessey	Family Member / Substitute Decision Maker - AFC
Individuals, Family and Caregivers	Central NL	Bernadette St. Croix	Family Member / Substitute Decision Maker - ILA
Individuals, Family and Caregivers	Central NL	[Name withheld]	Individual / Client - Youth in Care
Individuals, Family and Caregivers	Eastern NL	Kaylynn Wadland	Individual / Client - Former Youth in Care
Individuals, Family and Caregivers	Eastern NL	Katie Curl	Individual / Client - Former Youth in Care
Individuals, Family and Caregivers	Eastern NL	Andrew Harnum	Caregiver - ILA
Individuals, Family and Caregivers	Eastern NL	Barry Pye	Individual / Client - Co- Op
Individuals, Family and Caregivers	Eastern NL	Brian Lewis	Individual / Client - PCH
Individuals, Family and Caregivers	Eastern NL	[Name withheld]	Individual / Client - Youth in Care
Individuals, Family and Caregivers	Eastern NL	[Name withheld]	Individual / Client - Youth in Care
Individuals, Family and Caregivers	Eastern NL	Wayne Holloway	Family Member
Individuals, Family and Caregivers	Eastern NL	Dave Holder	Family Member
Individuals, Family and Caregivers	Labrador	[Name withheld]	Individual / Client - Youth in Care
Individuals, Family and Caregivers	Labrador	Julie Giles	Family Member - B/L Relative
Individuals, Family and Caregivers	Labrador	Patsy Pittman	Family Member - ILA
Individuals, Family and Caregivers	Labrador	Daphne Eastman	Family Member - ILA
Individuals, Family and Caregivers	Labrador	Sheila Montague	Family Member - B/L Relative
Individuals, Family and Caregivers	Labrador	Daphne Eastman	Family Member - ILA
Individuals, Family and Caregivers	Labrador	Sheila Montague	Family Member - B/L Relative
Individuals, Family and Caregivers	Western NL	Albert Farrell	Individual / Client - AFC
Individuals, Family and Caregivers	Western NL	Albert Farrell	Individual / Client - AFC
Individuals, Family and Caregivers	Western NL	Lisa Gillam	Family Member - ILA
Individuals, Family and Caregivers	Western NL	Rochelle Lucas	Family Member / Caregiver - B/L Relative
Individuals, Family and Caregivers	Western NL	Wanda and Tanner Cormier	Family Member - Mental Health & Addictions
Individuals, Family and Caregivers	Western NL	Lisa Morris	Individual / Client - Mental Health & Addictions
Individuals, Family and Caregivers	Western NL	Kevin Hynes	Caregiver
Individuals, Family and Caregivers	Western NL	Beatrice Peddle	Family Member - Mental Health & Addictions

Appendix A - Stakeholder Engagement - Participant List (cont'd)

The following individuals and groups were interviewed as part of this engagement:

Stakeholder Group	Organization	Name	Role / Title
HCS, CSSD and RHA representatives	HCS	Deena Waddleton	Long Term Care Consultant
HCS, CSSD and RHA representatives	HCS	Annette Bridgeman	Director, Regional Services, Community Supports and Services
HCS, CSSD and RHA representatives	HCS	Lisa Baker-Worthman	Provincial Consultant – Child and Youth Community Health and Adult Disabilities
HCS, CSSD and RHA representatives	HCS	Sarah Hollett	Health Care Consultant
HCS, CSSD and RHA representatives	HCS	Niki Legge	Director, Mental Health & Addictions
HCS, CSSD and RHA representatives	HCS	Linda Warford	Youth and Emerging Adults Mental Health Specialist
HCS, CSSD and RHA representatives	Central Health	Mimie Carroll	Regional Director, Mental Health & Addictions
HCS, CSSD and RHA representatives	Central Health	Katie Barnes Prior	Psychiatrist
HCS, CSSD and RHA representatives	Central Health	Irene Pack	Director, Community Supports
HCS, CSSD and RHA representatives	Central Health	Greg McGrath	Community Supports RHA Representative
HCS, CSSD and RHA representatives	Eastern Health	Lisa Gilbert	Program Manager, Mental Health & Addictions, Community Care & Housing
HCS, CSSD and RHA representatives	Eastern Health	Melvin Layden	Regional Director, Long Term Care, Personal Care Homes, Community Care Homes
HCS, CSSD and RHA representatives	Eastern Health	Michelle White	Regional Manager, Personal Care Home Program
HCS, CSSD and RHA representatives	Eastern Health	Patrick Whelan	Regional Director, Health and Corrections
HCS, CSSD and RHA representatives	Eastern Health	Tana Green	Social Worker, The Waterford Hospital
HCS, CSSD and RHA representatives	Eastern Health	Deirdre Hunt	Program Manager, The Waterford Hospital
HCS, CSSD and RHA representatives	Eastern Health	Pam Parsons	Program Manager, ACT
HCS, CSSD and RHA representatives	Eastern Health	Cathy Williams	Social Worker/Case Manager, ACT
HCS, CSSD and RHA representatives	Eastern Health	Leslie Brown	Regional Director, Acute/Tertiary Care
HCS, CSSD and RHA representatives	Eastern Health	Janice Dalton	Regional Director, Community Supports
HCS, CSSD and RHA representatives	Eastern Health	Terry Mahon	Manager, Community Supports
HCS, CSSD and RHA representatives	Eastern Health	Laurie Sullivan	Manager, Community Supports
HCS, CSSD and RHA representatives	Eastern Health	Glenda Webber	Regional Director, Mental Health and Addictions - Community Division
HCS, CSSD and RHA representatives	Eastern Health, NAVNET	Brad Hunt	Mental Health Community Liaison
HCS, CSSD and RHA representatives	Eastern Health, NAVNET	Lisa Zigler	Project Coordinator
HCS, CSSD and RHA representatives	Eastern Health, NAVNET	Christina Tobin	Social Worker

Appendix A: Stakeholder Engagement: Participant List (cont'd)

The following individuals and groups were interviewed as part of this engagement:

Stakeholder Group	Program / Region	Name	Role / Title
HCS, CSSD and RHA representatives	Labrador Grenfell Health	Nadine Calloway	Director, Community Supports
HCS, CSSD and RHA representatives	Labrador Grenfell Health	Marina Brett	Program Manager, Community Supports
HCS, CSSD and RHA representatives	Labrador Grenfell Health	Lisa Dupre	Program Coordinator, Community Supports
HCS, CSSD and RHA representatives	Labrador Grenfell Health	Kelly Penney	Home Support/Special Assistance Coordinator, Community Supports
HCS, CSSD and RHA representatives	Labrador Grenfell Health	Amanda Pardy	Manager, Mental Health & Addictions
HCS, CSSD and RHA representatives	Labrador Grenfell Health	Ellen McDonald	Manager, Mental Health & Addictions
HCS, CSSD and RHA representatives	Labrador Grenfell Health	Shelley Cormier	Manager, Mental Health & Addictions
HCS, CSSD and RHA representatives	Labrador Grenfell Health	Sandy Penney	Regional Director, Mental Health & Addictions
HCS, CSSD and RHA representatives	Labrador Grenfell Health	Danika Parrill	Case Manager, Mental Health & Addictions
HCS, CSSD and RHA representatives	Labrador Grenfell Health	Kelly Miller	Case Manager, Mental Health & Addictions
HCS, CSSD and RHA representatives	Western Health	Michelle Skinner	Regional Director, Mental Health & Addictions
HCS, CSSD and RHA representatives	Western Health	Jennifer Wall	Manager, Mental Health & Addictions
HCS, CSSD and RHA representatives	Western Health	Natasha Jarvis	Community Supports Program Representative
HCS, CSSD and RHA representatives	Western Health	Debbie Lavers O'Neil	Director, Community Supports
HCS, CSSD and RHA representatives	CSSD	Jennifer Barnes	Former Director, In Care & Adoptions
HCS, CSSD and RHA representatives	CSSD	Jennifer Sullivan	Director, In Care & Adoptions
HCS, CSSD and RHA representatives	CSSD	Amanda Collier	Adoption Consultant
HCS, CSSD and RHA representatives	CSSD	Shaun Maclean	Regional Director, Labrador
HCS, CSSD and RHA representatives	CSSD	Robert Reid	Regional Director, Metro
	Child and Youth In Alternative Care (CAYAC)	Dr. Sandra Luscombe	Pediatrician
	Child and Youth In Alternative Care (CAYAC)	Dr. Leigh Anne Newhook	Pediatrician

Appendix B: Stakeholder Engagement: Participant List (cont'd)

The following individuals and groups have been interviewed as part of this engagement:

Stakeholder Group	Program / Region	Name	Role / Title
Other Government	Disability Policy Office (CSSD)	Krista Hutchings	Program and Policy Development Specialist
Other Government	Newfoundland & Labrador Housing Corporation	Melanie Thomas	Executive Director
Other Government	Newfoundland & Labrador Housing Corporation	Colin Hipditch	Manager, Supportive Housing Services
Other Government	Newfoundland & Labrador Housing Corporation	Stephanie Battcock	Regional Director, Labrador
Other Government	Newfoundland & Labrador Housing Corporation	Deborah Moynes-Keshen	Regional Director, Western & Interim Central
Other Government	Newfoundland & Labrador Housing Corporation	Jacqueline Carey	Social Worker
Partnerships	Nunatsiavut Government	Michelle Kinney	Deputy Minister, Nunatsiavut Government
Partnerships	Nunatsiavut Government	Nicole Burton	Nunatsiavut Government Representative
Partnerships	Nunatsiavut Government	Megan Russell	Nunatsiavut Government Representative
Partnerships	Nunatsiavut Government	Sean Lyall	Nunatsiavut Government Representative
Community Organizations	L'Arche Avalon	Sheilah MacKinnon Drover	Chair of the Board and Family Member
Community Organizations	L'Arche Avalon	Lewis Andrews	Vice-Chair of the Board and Family Member
Community Organizations	L'Arche Avalon	Lorraine Angelopoulos	Secretary of the Board and Family Member
Community Organizations	End Homelessness St. John's	Doug Pawson	Executive Director
Community Organizations	Autism Society of Newfoundland & Labrador	J. Paul Walsh	Chief Executive Officer, ASNL
Community Organizations	Autism Society of Newfoundland & Labrador	Tess Hartmann	Chief Operating Officer, ASNL
Community Organizations	Autism Society of Newfoundland & Labrador	Sarah White	Manager, Client Services
Community Organizations	Vera Perlin Society	Roger Downer	Executive Director, Vera Perlin
Community Organizations		Joanne Thompson	Former Executive Director, The Gathering Place

Appendix A - Stakeholder Engagement - Participant List (cont'd)

The following individuals and groups have been interviewed as part of this engagement:

Stakeholder Group	Program / Region	Name	Role / Title
Service Provider – Children and youth in care		Kathy Blanchard	Program Director, Blue Sky
Service Provider – Children and youth in care		John Whelan	Executive Director, Blue Sky
Service Provider – Children and youth in care		Heather Modlin	Executive Director, Key Assets
Service Provider – Children and youth in care		Leslie Goodyear	Program Manager, Key Assets
Service Provider – Children and youth in care		Jaime Lundrigan	Program Manager, Key Assets
Service Provider – Adults with disabilities		Lori Moulton	Executive Director, Central Residential Services Board
Service Provider – Adults with disabilities		Sandy Hoffe	Executive Director, Mokami Status of Women Council
Service Provider – Adults with disabilities		Chad Perrin	Executive Director, Momentum
Service Provider – Adults with disabilities		Winston Morgan	Supportive B&L Provider - Eastern
Service Provider – Adults with disabilities		Suzanne Blackwood	AFC Provider - Eastern
Service Provider – Adults with disabilities		Joan Elliot	AFC Provider - Eastern
Service Provider – Adults with disabilities		Ada Weir	AFC Provider - LGH
Service Provider – Adults with disabilities		Goldie Hardy	AFC Provider - Western
Service Provider – Adults with disabilities		Dianne Alexander	AFC Provider - Western
Service Provider – Adults with disabilities		Ada Short	AFC Provider - Western
Service Provider – Adults with disabilities		Michele Woodford	PCH Operator - Eastern
Service Provider – Mental health and addictions		Martin Hefferman	CCH Operator – Eastern
Service Provider – Mental health and addictions		Ina Tilley	CCH Operator - Eastern
Other Jurisdictions	BC Housing	Will Valenciano	Senior Manager, Coordinated Access and Assessment
Other Jurisdictions	Nova Scotia	Jill Barkhouse	Child Protection Coordinator, Department of Community Services
Subject Matter Experts	Cornell University	Martha Jane Holden	Senior Extension Associate, Project Director, Residential Child Care Project, Bronfenbrenner Center for Translational Research
Subject Matter Experts	Deloitte	Josh Hjartarson	National Human Service Leader

Appendix B

Definitions of NL's residential programs

Appendix B: Residential Program Definitions - Adults

Residential Program	Description
Personal Care Home (PCHs)	PCHs are privately owned and operated residential settings providing care and accommodations for seniors and adults who require support with Activities of Daily Living (ADLs). Clients are seniors and adults with disabilities that have generally low care needs but need assistance with Activities of Daily Living. Client needs are categorized as Level I, Level II, Level II Enhanced, and Level III (awaiting LTC placement) using a provincial PCH Level of Care Framework. There are 172 adults with intellectual/physical disabilities placed in PCHs across the province.
Cooperative Living Arrangements (Co-Ops)	Co-Ops are residences with 24-hour support for two or three residents who are diagnosed with an intellectual disability. The program is designed to address individual behaviours and teach life skills to enable the individual to live in other less restrictive community settings. Cooperative Apartments assist individuals to attain their fullest personal potential and achieve functional integration and acceptance into the community.
Alternate Family Care Homes (AFCs)	An AFC is a private residence that provides room and board, supervision and personal care to an unrelated adult with an intellectual disability. The program is designed to meet the needs of individuals who cannot live independently or chooses not to and can benefit from a family environment. This option is a flexible living arrangement that enables an individual, with extensive support needs and/or challenging behaviours, to live in a family environment. The Community Support Program approves and monitors Alternate Family Care Homes to ensure that a high quality of care is provided.
Community Care Homes (CCHs)	Community-based supportive housing program for individuals who require support as a result of a severe and persistent mental illness. Community care homes are privately owned and operated with the majority being located in the Conception Bay South area. The Regional Health Authority is responsible for monitoring and licensing the homes according to the Provincial Personal Care Home Operational Standards.
Individualized Living Arrangements (ILAs) for Adults	Residential Arrangements for people with complex mental health needs are established when no other service option is available or appropriate for an adult with an intellectual disability, developmental delay, and/or mental illness, who meets home support criteria and is unable to reside with their natural family. Clients are adults with a range of complex needs who require significant support with Activities of Daily Living and/or Instrumental Activities of Daily Living, and who may present a risk to their own safety or the safety of others. Supports and services are determined through a clinical assessment completed by home support coordinators and clinicians employed by the RHA. ILAs are provided by external private or non-profit service providers.
Board and Lodging - Relative & Non-Relative (BLR & BLNR)	A Board and Lodging Supplement is a funding supplement that is available, based on assessed need, to an adult with psychiatric, physical and/or intellectual disabilities, 18 years of age and older, who reside with either relatives (BLR) or non-relatives (BLNR). These adults have identified needs and require a higher board and lodging rate to live in these arrangements than is usually allowed. The basic rate of board and lodging is available through HCS and the supplement is available through the RHAs.
In-Patient Acute Settings	Inpatient placements (such as the Waterford Hospital) where an individual is admitted to hospital in order to provide intensive clinical intervention and treatment for a temporary period of time.

Appendix B: Residential Program Definitions – Children and Youth

Residential Program	Description
Individualized Living Arrangements (ILAs) for Children and Youth	Residential Arrangements for people with complex mental health needs are established when no other service option is available or appropriate for an adult with an intellectual disability, developmental delay, and/or mental illness, who meets home support criteria and is unable to reside with their natural family. Clients are adults or children with a range of complex needs who require significant support with Activities of Daily Living and/or Instrumental Activities of Daily Living, and who may present a risk to their own safety or the safety of others. Clients generally require more than one home support worker at any given time. Supports and services are determined through a clinical assessment completed by home support coordinators and clinicians employed by the RHA. ILAs are provided by external private or non-profit service providers.
Group Homes (GHs)	GHs are staffed residential settings that provide group care for children and youth in care, that are 12 years old or older and who have complex social, emotional, behavioural and developmental needs that require a level of support that cannot be provided through a less structured, family-based care setting.
Emergency Placement Homes (EPHs)	EPHs are staffed living arrangements that offer 24 hour emergency care to children and youth for up to 60 days to either assess a child or youth's placement needs, or to transition a child or youth to a longer term placement. Emergency Placement Homes must have the ability to accommodate sibling groups, and accommodate same day placement. These complex needs may include, but are not limited to, the following: Fetal Alcohol Spectrum Disorder, Depression, Anxiety, Autism Spectrum Disorder, Substance Abuse, etc.
In-Patient Acute Settings	Inpatient placements (such as the Janeway Hospital) where an individual is admitted to in-patient psychiatric care in order to provide intensive clinical intervention and treatment for a temporary period of time.

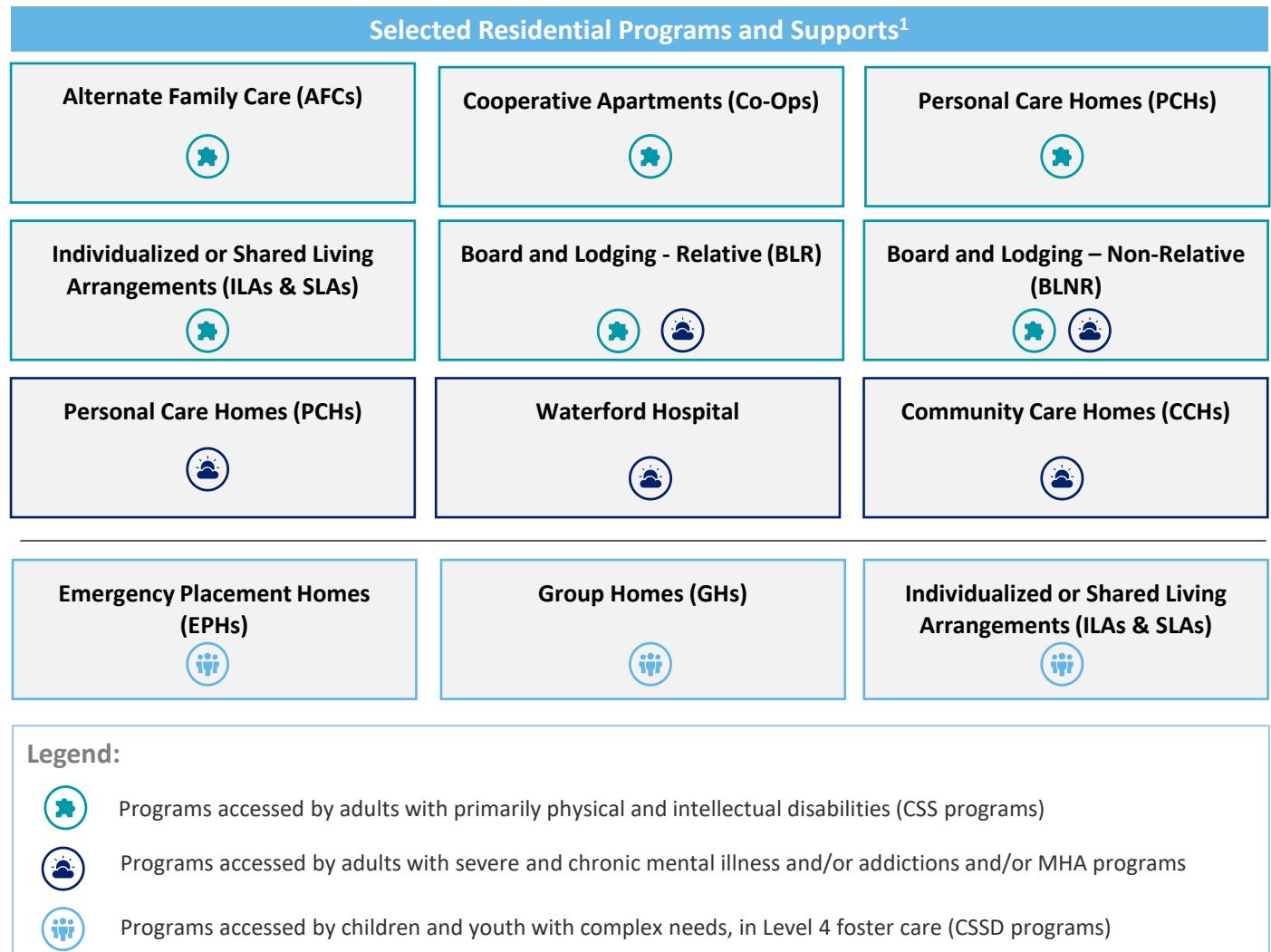
Appendix C

Snapshots of selected residential supports

Introduction to NL's Residential Supports and Services Programs

- Previous sections of this document have outlined a high-level overview of the selected residential programs funded by CSS, MHA and CSSD clients, outlined in the diagram on the right.
- This section of the report provides a brief program-by-program overview, where data was available.
- We have also provided relevant stakeholder themes for each program that emerged from our discussions.

NOTE: Only CSS financial information was provided. All financial statistics and cost information are only referencing CSS clients.



Program Overview: Alternate Family Care

Alternate Family Care homes are private residences that provide 368 adults with intellectual disabilities with room and board, supervision and social care.

About the AFC Program

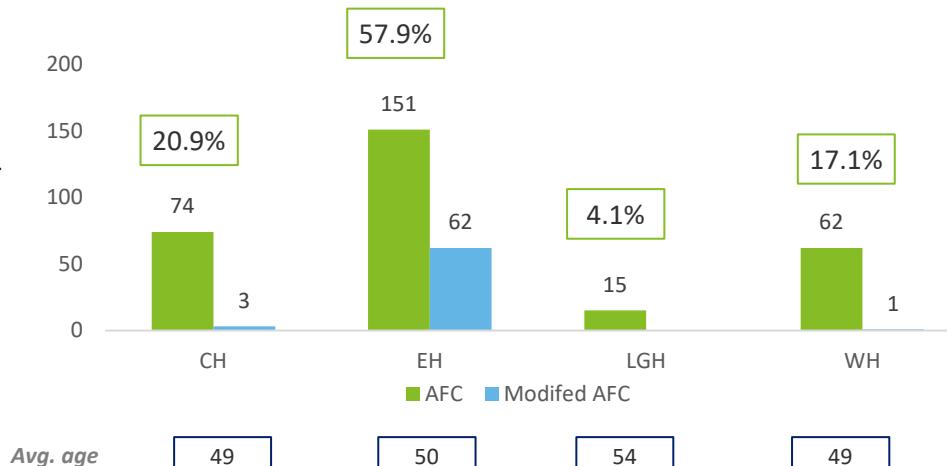
Program Description:

- An Alternate Family Care (“AFC”) is a private residence that provides room and board, supervision and personal care by paid service providers (non-family) to an adult with an intellectual disability.
- According to the Provincial Alternate Family Care Operating Standards (last updated in 2007), “it is a program based on the Foster Care Program for an adult with an intellectual disability who cannot live independently or chooses not to live independently and who can benefit from a family environment.”
- Modified AFCs have also emerged in two of the four RHAs, which are family-operated arrangements that provide staffing and other supports embedded.
- Stakeholder interviews also indicated that AFC providers are aging and program staff are very challenged to find new AFC providers.

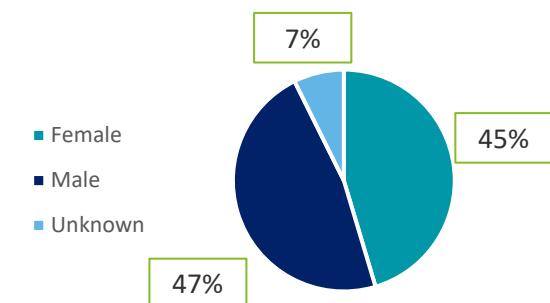
Clients:

- Based on data obtained from HCS CSS program staff, there are 368 clients living in AFC and Modified AFC placements across the province:
 - About 42% of AFC clients live outside of Eastern Health region.
 - Modified AFCs have emerged in three RHAs. These account for a smaller segment of total AFC clients (17.9%).
- Many AFC clients require additional home support and other clinical supports, in order to live successfully in this environment.
- Anecdotal stakeholder comments suggest that AFC clients are increasing in their complexity and require more and more supports to live successfully.
- Of clients whose gender is known, 47% are male. The average age for AFC clients across the province is 50 – with clients in LGH being slightly older than the provincial average.

AFC and Modified AFC Clients, by region



Gender of AFC Clients



Program Overview: Alternate Family Care (cont'd)

Program expenses for AFCs exceed \$30 million per year, however a considerable portion of program expenses are paid to home support and other workers – not to AFC service providers – which receive about \$2.00 per hour to provide 24/7 support.

AFC Program Expenses

- Total spending for the AFC program exceeded \$30.1 million in 2020.
 - Paid service providers receive a per diem payment and can sometimes claim additional funding, for example, for travel expenses, household appliances and furnishings.
 - However, home support and behavioural aide expenses accounted for over \$22 million in FY2020: nearly 72% of program expenditures, which represents nearly *three and a half times* the funding paid to service providers.
 - Embedding these services in the living environment may be more effective and efficient than bringing the services in 'as needed' where disruption and inconsistency may occur.
- The total average cost per AFC client is \$81,819¹ per year, however **only \$17,728 per client is paid to AFC providers**.
- Given that providers are required to support clients in their home on a 24-hour basis, this equates to *an average of \$48.56 per day, or \$2.03 per hour*.
- This puts AFC program spending per client at the lowest across all residential programs.
- Regionally, Eastern Health spends nearly double on a per client than AFC clients in Labrador-Grenfell and Central Health.
- Despite having less clients, Western Health is spending significantly more per client than Central Health (including social and recreational activities, behavioural aide services, and home support subsidies)

Source(s): CRMS Data submitted via RHAs, GNL Community Supports – Program Expenses (2019-2020)

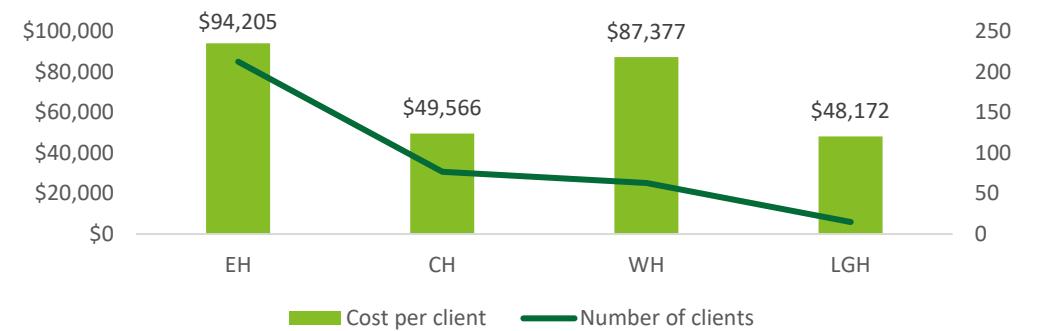
¹ Based on 368 AFC and Modified AFC clients across the province

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AFC Program Expenditures – FY2020

AFC Program Expenditures (all RHAs)	FY2020 P13 YTD	Percent of Total
Service Recipient Travel-Traceable	406,136	1.3%
Drugs/Medications	87	0.0%
Uninsured Medical Services	87,660	0.3%
Household Appliances and Furnishings	11,093	0.0%
Residential and Living Expenses	6,524,031	21.7%
Compensation for Damages	2,767	0.0%
Social and Recreational Activities	420,787	1.4%
Counselling/Parent Coaching	770	0.0%
Behavioural Aide Services	840,732	2.8%
Home Support Subsidy Fees	21,610,417	71.8%
Delegation of Nursing Function - Home Support Agencies	80	0.0%
Administration Bookkeeping Fees	204,488	0.7%
Miscellaneous	466	0.0%
Total Program Expenditures	30,109,514	100%

Average program spending per client, by region



Program Overview: Alternate Family Care (cont'd)

AFC providers report that funding levels have not changed in over a decade, yet clients are increasing in the complexity of their needs

Key Observations and Findings

Deloitte spoke to stakeholders including AFC clients and service providers to understand their feedback and insights on what clients need in this residential option. Beyond this group, other stakeholders also provided commentary on their past experiences with the AFC program as well.

- **Family-like, long-term placement.** Often compared to an adult foster home program, it is understood that the AFC program was born out of the closing of group homes across the province nearly thirty years ago. While interviewees often commented on the “family like environment,” it appears that specific arrangements vary by service provider. For some families, the AFC home is not “family-like enough” as some clients may be provided with a separate apartment in the provider’s residence where they live semi-independently. In other cases, AFC clients have a bedroom in the provider’s residence and live as part of the family. It was reported that several clients have lived with their AFC provider for over 30 years. These individuals have fully integrated into the family and participates naturally as part of the home.
- **Insufficient funding for 24/7 care.** AFC providers and RHA representatives commented on the lack of overall funding for AFC clients. Interviewees observe that the funding is insufficient to meet the ever-changing needs of their clients, and does not reflect the relative increase in cost of living over the past decade. The rate paid to AFC providers is “woefully low” – less than minimum wage. This level of funding also does not reflect the fact that AFC providers have the sole responsibility for supporting clients on a 24-hour, 7 day a week basis. Other types of service providers do not require this same life commitment to being a service provider.
- **Provider burnout and placement breakdown.** While some clients are able to successfully integrate into their AFC family, stakeholder reported that some placements will breakdown when situations get complex. For example, some clients present with aggressive behaviours and complex needs that exceed the providers’ ability to manage. Providers also attributed placement breakdowns to “burnout,” primarily as a result of lack of respite options available to them. For example, one provider described travelling over 200km to accommodate client respite periods, while another described not having a ‘day-off’ in years.
- **No required skills or formal training for providers.** AFC providers follow a formal application and approval process, however the program requires minimal criteria and no training for prospective AFC providers to be approved. AFC providers cited lived experience as primary means of understanding or managing client needs and their complex behaviours. There is no training provided for new AFC providers, and no training opportunities provided on a consistent basis. While “learning as you go” may have worked for some providers and clients in the past, the review team was concerned that some AFC providers disclosed that clients are frequently violent and/or aggressive. These providers tolerate such behaviour because they feel they have to (“where else will they go?”) or because it is what they’ve come to know and believe is their obligation.
- **A “dying” program.** RHA interviewees frequently commented on the ongoing difficulty in recruiting new AFC and respite providers in recent years. The aging caregiver demographic is of particular concern for AFC families as many individuals are retiring and/or beginning to have health issues of their own that could impact the quality of care they provide their clients. They state they will “continue as long as possible” however it does not appear that transition planning or “next steps” discussions have begun for most AFC clients, so any change in the providers’ health status could become an emergency placement situation¹.

¹ Deloitte did not perform a demand analysis or forecast of AFC program data. However based on anecdotal evidence and extensive stakeholder concerns, there may be a ‘bubble’ of AFC clients that will need alternative placements in the coming years.

Program Overview: Cooperative Apartments

Co-Ops are private residences (often rented apartments) with 24-hour support for two or three residents with an intellectual disability

About the Cooperative Apartments Program

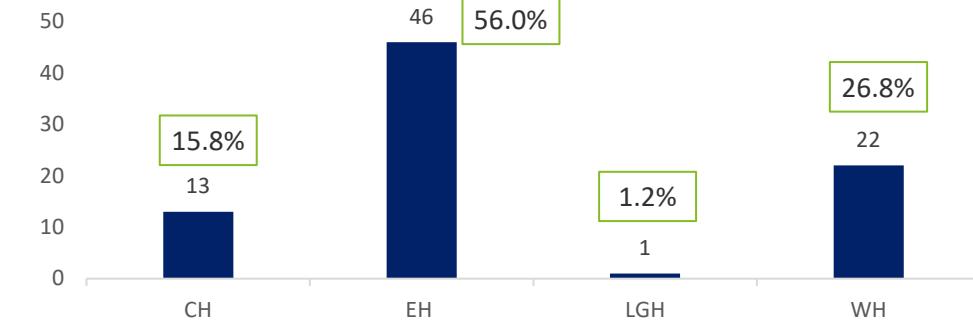
Description:

- Cooperative Apartments (“Co-ops”) are private residences with 24-hour support for two or three residents who are diagnosed with an intellectual disability. The program is intended to address individual behaviours and teach life skills to enable the individual to live in other less restrictive community settings.
- Cooperative Apartments are operated by Incorporated Community Residential Services Boards, which receive funding through the RHAs and are monitored for their compliance to provincial standards (last updated April 2007). The Boards are required to have a Program Committee which engages social workers and behavioural support through the RHAs, who collectively will make clinical decisions and establish a service plan to address client support needs.
- Each home is staffed by a live-in supervisor whose function is to ensure adequate supervision and support to the individual and to provide structured individualized programs. The supervisor may utilize co-operative apartment workers when individuals require intensive programming or supervision.
- *NOTE: Program financial information was only provided by LGH. No spending analysis could be performed for this program.*

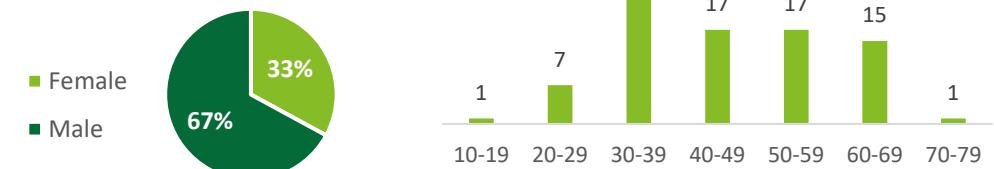
Clients:

- There are **82 clients** supported by the Co-Operative Apartment program across the province:
 - 54% of clients are currently living in Central and Western region, including 1 client living in LGH.
 - Two-thirds (67%) of clients living in Co-ops are male.
 - The average age of clients living in Co-ops is 45 – nearly 50% of individuals are between the ages of 30-50 and 40% of individuals are 50+.

Distribution of Co-Op Clients, by Region



Gender and age of Co-Op Clients



Program Overview: Cooperative Apartments (cont'd)

Co-Ops are a cost-effective and well-managed option for adults with disabilities

Key Findings and Observations

Deloitte engaged co-op clients, service providers and RHA representatives in discussion on the needs of cooperative clients, and collected their feedback on opportunities to improve. Some of the themes emerging from these discussions include:

- **Clear Accountability for Funding and Client Outcomes.** The Cooperative Apartment service delivery model requires that a non-profit entity is incorporated with a Board of Directors to oversee the delivery of supports and compliance with provincial standards. This model provides assurance to government, families and taxpayers that funds are appropriately managed and clients are being served appropriately.
- **Long-Term versus Transitional Placement.** Stakeholders reflected on the original intent of Cooperative Apartments, which was to better manage client behaviours and teach life skills to enable clients to move into less restrictive, more permanent community settings. However, it appears that clients reside in Co-op apartments on a longer term basis and the program now serves as more of permanent placement option.
- **Perceived “over-servicing”.** Stakeholders had mixed views on ability of Co-Ops to meet client needs across RHAs. Some stakeholders felt clients may be “over-serviced” at Co-Ops and could be successful in more independent options but that clients are perceived as “stable” and changes to the support plan and staffing model were not encouraged by co-op boards.



Case Study: Central Residential Services Board (CRSB) operates a range of residential placement options including:

- 7 Cooperative Living Apartments for adults with complex care needs who are unable to reside in other placements
- Respite placements for adults with intellectual disabilities living with natural families or alternate residential placements, if there is availability
- Transitional placements for adults with intellectual disabilities who are not residents of the co-operative apartment program
- Supported emergency placements for adults with intellectual disabilities in crisis or placement breakdown

CRSB seeks permanent housing that is owned as opposed to renting and hires residential managers with an understanding of basic property management concepts, and innovative placement approaches (e.g., split models providing different types of services while sharing resources, partnerships with MHA, etc.)

Program Overview: Board and Lodging (Relative)

A Board and Lodging Supplement is a funding supplement that is available to adults with psychiatric, physical and/or intellectual disabilities who reside with relatives

About the Board and Lodging (Relative) Program

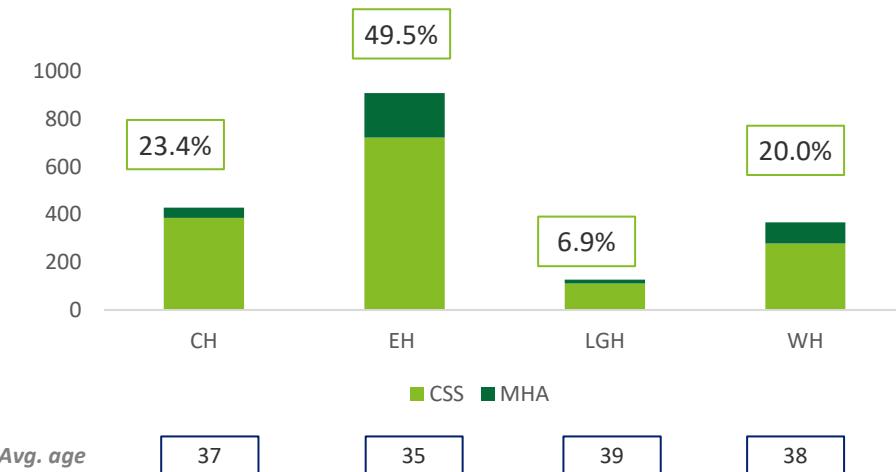
Description:

- While it is not a residential placement *per se*, a Board and Lodging subsidy or supplement may be provided based on assessed financial need, to an adult with psychiatric, physical and/or intellectual disabilities.
- Board and Lodging supplements can be provided to adults to live with a *relative* ("BLR") or with *non-relatives* ("BLNR").
 - According to Eastern Health's website, a relative caregiver is defined as "*specifically a child, parent, or grandparent and the relative is providing support. Clients residing with siblings will be assessed under the non-relative service.*
- Most clients are required to have a primary source of income such as Income Assistance in order to qualify for the Board and Lodging program which is provided through the RHAs.

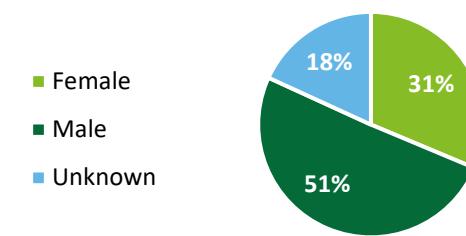
Clients:

- There are **1833 individuals** receiving BLR supplements across the province. Of these individual, 1500 are CSS clients and 333 are MHA clients.
- More than half of BNR clients live outside of Eastern Health region.
 - About a quarter are in Central, 20% in Western, whereas less than 7% live in Labrador.
- From a demographic perspective:
 - Males represent at a minimum 51% of the individuals living in BLR arrangements. Of clients where gender is known, males represent 61% of clients.
 - The average age of clients receiving BLR supplements is 36 – in LGH and WH clients are slightly older than the provincial average.

Distribution of BLR Clients, by region



Gender of BLR Clients



Program Overview: Board and Lodging (Relative) – cont'd

A Board and Lodging Supplement is a funding supplement that is available to adults with psychiatric, physical and/or intellectual disabilities who reside with relatives or non-relatives

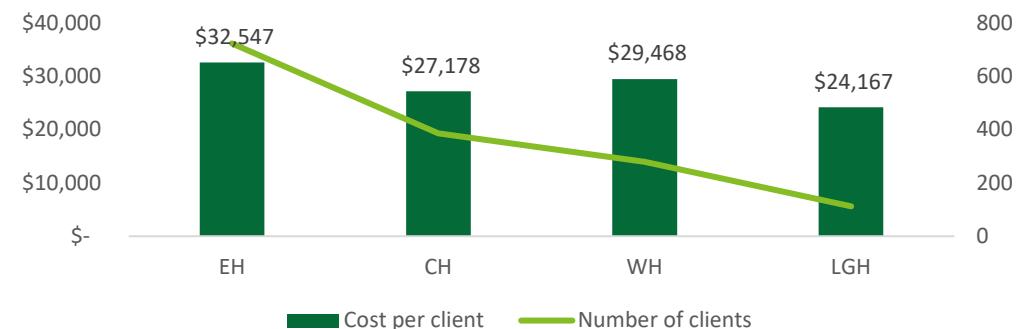
About the Board and Lodging (Relative) Program

Program Expenses:

- Program expenses in Community Supports Programs across the province were about \$45 million in FY2020¹.
- Also:
 - Total spending per CSS client, on average under the BLR program, is \$29,966 per year².
 - However many BLR clients also need home support and behavioural aide services to live successfully with their relative. These two 'wraparound services' exceed 76% of BLR spending – over \$34 million per year.
 - Only \$9.2 million is paid to the relatives that provide BLR clients with 24/7 care in their homes, which translates to *\$13.75 per day or \$0.57 per hour*.
 - When home supports and behavioural aide services are removed, the average spending per BLR client is reduced to \$5,020 per year.
 - Cost per CSS client data is inconsistent across regions – LGH spends the least per BLR client (~\$24K), whereas EH spends the most (~\$32.5K).

BLR	FY2020 P13 YTD	Percent of Total
Service Recipient Travel-Traceable	452,897	1%
Uninsured Medical Services	42,275	0%
Household Appliances and Furnishings	9,450	0%
Residential and Living Expenses	9,202,776	20%
Social and Recreational Activities	707,499	2%
Behavioural Aide Services	696,527	2%
Home Support Subsidy Fees	33,346,803	74%
Delegation of Nursing Function - Home Support Agencies	1,020	0%
Administration Bookkeeping Fees	465,057	1%
Miscellaneous	25,704	0%
Total Program Expenditures	44,950,008	100%

Average program spending per CSS client, by region



Source(s): CRMS Data submitted via RHAs, GNL Community Supports – Program Expenses (2019-2020)

¹ Does not include MHA BLR expenses as only CSS provincial data was available at time of analysis

² Does not include 333 MHA clients as part of the cost/client analysis

Program Overview: Board and Lodging (Non-Relative)

A Board and Lodging Supplement is a funding supplement that is available to adults with psychiatric, physical and/or intellectual disabilities who reside with non-relatives

About the Board and Lodging (Relative) Program

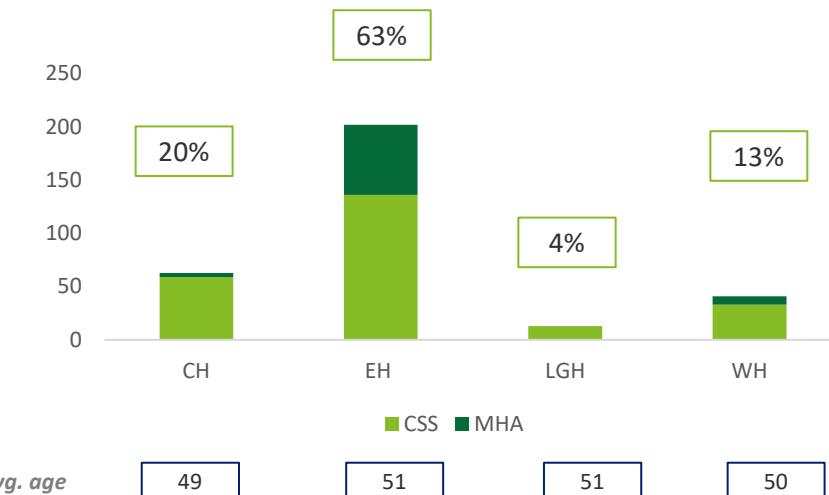
Description:

- The Board and Lodging Non-Relative program provides support to people with intellectual disabilities and chronic mental health issues, occasionally through extended family members (e.g. siblings), but primarily through private landlords in the community.
- Clients of the BLNR program are often those individuals without natural family, or those for whom living with relatives is not possible. They often have high levels of need, or a profile that prevents them from fully integrating into the community. They are sometimes supported by ACT and FACT teams in the community which provide intensive services in the home, as well as delivering medications and providing 'door-step' support on a drop-in or scheduled basis.

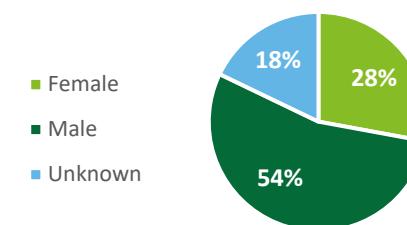
Clients:

- There are **319 individuals** availing of BLNR supplements across the province. Of these individuals, 241 are CSS clients and 78 are MHA clients.
- The majority (63%) of BLNR clients live in Eastern Health. It is assumed that many of the BLNR clients in this region avail of EH's Supportive Board and Lodging Program, which has approximately 60 placements in the region.
 - About a fifth of individuals are in Central, 13% in Western, whereas less than 5% live in Labrador.
- From a demographic perspective:
 - Males represent at a minimum 54% of the individuals living in BLNR arrangements. Of clients where gender is known, males represent two-thirds of clients.
 - The average age of clients receiving BLNR supplements is 51 – this is significantly higher than those availing of BLR supplements (36).

Distribution of BLNR Clients by region



Gender of BLNR Clients



Program Overview: Board and Lodging (Non-Relative)

For Board and Lodging with Non-Relatives, basic living expenses are about \$7,513 per client per year, however home support and other wraparound services make up 76% of overall program spending

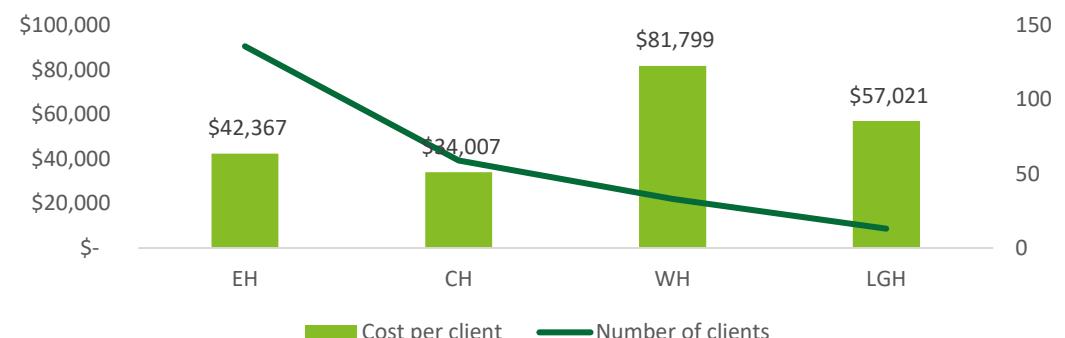
About the Board and Lodging (Non-Relative) Program

Program Spending:

- For the 241 CSS clients living in BLNR arrangements across the province, total program spending exceeds \$11 million¹
- The average cost per CSS client receiving non-relative home services is \$46,510²
- Home support and behavioural aide services represent about 76% of program spending, leaving \$2,396,817 for residential and living expenses – just over \$9,945 per CSS client.
- Western Health spends approximately 75% more per client receiving non-relative home services than the provincial average.
- Labrador Grenfell Health also spends over \$10K the provincial average per CSS client.

	BLNR	
Program Expenditures (all RHAs – CSS only)	FY2020 P13 YTD	Percent of Total
Service Recipient Travel-Traceable	100,459	1%
Uninsured Medical Services	13,414	0%
Household Appliances and Furnishings	2,173	0%
Residential and Living Expenses	2,396,817	21%
Social and Recreational Activities	152,789	1%
Behavioural Aide Services	71,236	1%
Home Support Subsidy Fees	8,365,847	75%
Delegation of Nursing Function - Home Support Agencies	160	0%
Administration Bookkeeping Fees	102,115	1%
Miscellaneous	3,954	0%
Total Program Expenditures	11,208,964	100%

Cost per CSS client, by region



Source(s): CRMS Data submitted via RHAs, GNL Community Supports – Program Expenses (2019-2020)

¹Does not include MHA BLNR expenses as only CSS provincial data was available at time of analysis

²Does not include 78 MHA clients as part of the cost/client analysis

Program Overview: Board and Lodging (Relative and Non-Relative)

BLR stakeholders are primarily concerned about the future for their loved ones; BNLR stakeholders express concern about 'the present'

Key Findings and Observations

Board & Lodging – Relative

- **Insufficient funding and inflexible funding model.** Families expressed frustrations with the funding arrangements for adult children who continue to live at home – more funding support is available if they were to leave the home and live in lesser arrangement with strangers. Numerous stakeholders commented that the funding received by parents is “the least” of all residential options for their adult children.
- **Stable, long-term need.** Relatives spoke of their need for adult children with intellectual disabilities to enjoy a stable living arrangement with minimal disruptions (e.g. staff changes). They expressed a concern that wraparound staffing (e.g. home support workers) does not provide the stability and security needed by their loved one, and that such changes in the environment create anxiety, confusion and behaviours that can be hard to manage.
- **Aging clients and families.** Many family members are growing older and expressed fears about how long their care arrangement can continue. Already, their adult children have not had the opportunities or challenges that typical adults would face when living independently. Parents expressed a strong desire to see their adult child be ‘settled’ in new accommodation before a parental health crisis occurs. They are being assured by social workers that their loved one will be cared for, however transition planning does not appear to have been initiated.
- **Impact on caregivers’ quality of life.** The impact on the quality of life for the parent or other relative should not be overlooked. Many families have given up their own freedoms and have spent their livelihoods to ensure their adult child is cared for appropriately – often without regular respite.

Board & Lodging – Non-Relative

- **No oversight or accountability.** While many providers offer a safe and stable living environment, stakeholders expressed strong concerns about high variability in the quality of accommodation and support provided by private landlords. Clients receiving board and lodging with non-relatives were viewed as some of the most vulnerable in the community, and at times, unwell or unstable.
 - Landlords are not required to provide an appropriate standard of living, beyond municipal housing requirements. They are generally expected to provide basic living conditions, meals, appointment reminders and may give medication, however there is no oversight of whether these activities are being provided.
 - Several “horror stories” were described, such as clients receiving moldy mattresses and pillows, living in damp basements, receiving only hotdogs and macaroni for their meals, being threatened by landlords, and worse.
 - Some ACT/FACT team members express concern that they are sometimes unable to view the living conditions or meet with landlords.
 - Others commented that BNLR providers are being paid for ‘tolerance’. Some BNLR clients can be highly disruptive, aggressive, and/or have limited ability to manage their personal care.
- **Undesirable or unsanitary conditions.** Families and RHA representatives also noted that such lack of accountability can also lead to deplorable living conditions and limited ability to confirm if client needs are truly being met, as they view clients living in these arrangements as the ‘least able to self-advocate’.

Program Overview: Individualized and Shared Living Arrangements (ILAs & SLAs)

ILAs/SLAs are customized living arrangements that are typically created for adults and children with complex needs, when no other service option is deemed available or appropriate

About Individualized / Modified / Shared Living Arrangements (ILAs / Modified ILAs / SLAs)

Description:

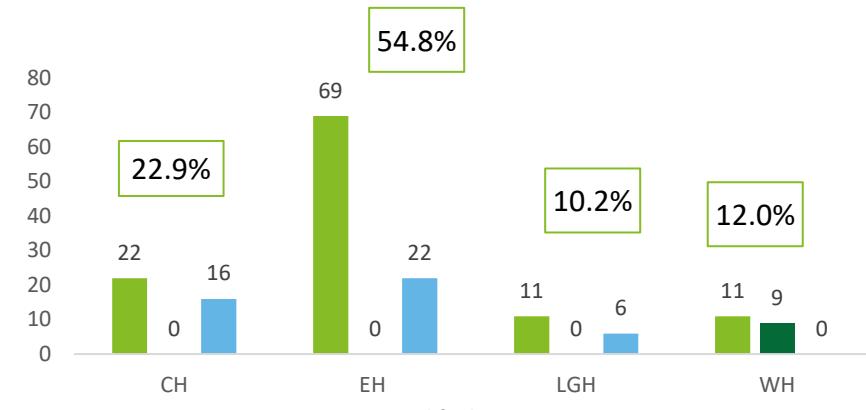
- The ILA / Modified ILA / Shared Living Arrangement program supports clients with complex needs, when no other service option is available. Clients are typically adults with an intellectual or developmental disability who meets home support criteria and is unable to reside with their natural family. In some instances, individuals with disabilities who require high level of home support may choose to share the cost of a living arrangement and home support staff (Shared ILA). Once established, the ILAs are managed by the paid agency service provider, or sometimes a family-led operating committee (Modified ILAs)
- Clients typically require significant support with Activities of Daily Living and/or Instrumental Activities of Daily Living with very complex care needs and may require more than one home support worker at any given time. Hours of care are determined through a clinical assessment, which is completed by home support coordinators and clinicians employed by the RHA.

Clients:

- There are 166 clients living in three types of one-off living arrangements across the province:
 - 113 clients or 68% live in ILAs
 - 44 clients or 26.5% live in SLAs
 - 9 clients or 5.4% live in Modified ILAs, all of which are in Western Health Region.
- From a regional perspective, 45.1% of all clients in these three living arrangements are supported by CH, WH and LGH. There was only 1 MHA client identified in the data provided by RHAs as living in an ILA¹.
- Clients in LGH (48) are, on average, 10 years older than clients in WH (38). The provincial average of clients living in these arrangements is 45.
- A minimum, male clients represent 55% of those living in ILAs and SLAs. Of clients whose gender is known males represent 64% of clients.

¹ While RHA data provided to this review was clear, the existence of only one MHA client may appear to contradict anecdotal evidence provided by stakeholders referencing MHA clients living in ILAs, and reflects potential data quality issues.

Clients by living arrangement, by region



Avg. age

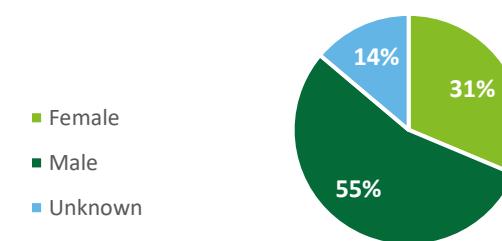
45

45

48

38

Gender Breakdown



Program Overview: Individualized and Shared Living Arrangements (ILAs & SLAs)

ILAs/SLAs are customized living arrangements that are typically created for adults and children with complex needs, when no other service option is deemed available or appropriate

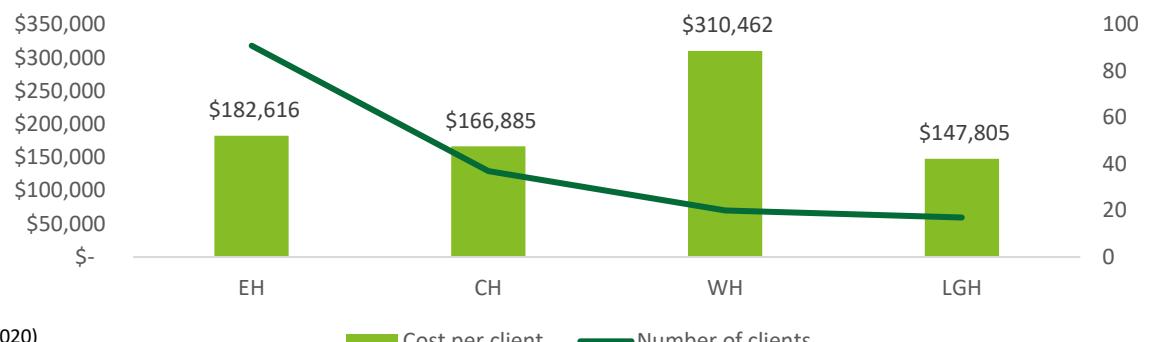
About Individualized / Modified / Shared Living Arrangements (ILAs / Modified ILAs / SLAs)

Program spending:

- Program spending for ILA/Modified ILA/ SLA living arrangements was in excess of \$31.5 million in FY2020 across the province.
- Also:
 - On average, total spending per client is higher than other programs, at \$189,847.¹
 - Of this, home support and behavioural aide services are in excess of \$27 million, or 87% of program spending.
 - When these two wraparound services are removed, program expenses are reduced to \$24,655 per client, per year.
- From a regional perspective, Western Health spends the most per client living in an ILA/Modified ILA/SLA arrangement, despite having the second least number of clients living in these modalities.

ILA Program Expenditures (all RHAs – CSS only)	FY2020 P13 YTD	Percent of Total
Service Recipient Travel-Traceable	72,288	0%
Uninsured Medical Services	22,249	0%
Household Appliances and Furnishings	-63,574	0%
Residential and Living Expenses	3,555,073	11%
Compensation for Damages	8,921	0%
Social and Recreational Activities	303,933	1%
Behavioural Aide Services	6,699,799	21%
Home Support Subsidy Fees	20,722,289	66%
Delegation of Nursing Function - Home Support Agencies	2,560	0%
Administration Bookkeeping Fees	55,734	0%
Miscellaneous	135,492	0%
Total Program Expenditures	31,514,764	100%

Average program spending per client, by region



Source(s): CRMS Data submitted via RHAs, GNL Community Supports – Program Expenses (2019-2020)

Program Overview: Individualized and Shared Living Arrangements (cont'd)

ILAs/SLAs for clients with complex needs are established when no other service option is available or appropriate.

Key Findings and Observations

Deloitte engaged with stakeholders to obtain insight and feedback on ILA/SLA living arrangements. Some common themes emerged:

- **'Institutionalization by another name.'** There is a view that many of the adults and children currently living in ILAs or Modified ILAs today would have been institutionalized at an earlier time, and while they are technically living "in the community", the current model of support is not appropriate or inclusive. One interviewee referred to it as amounting to "institutionalization by another name". Stakeholders with this view affirmed their support and respect for fully integrated, independent living for those individuals who can manage it, several commented that ILA clients are essentially alone 24 hours a day, except for paid service providers. Very few social opportunities or shared enjoyment of activities are commonly found in this living arrangement. Such isolated living was referred to as "inhumane."
- **Variable quality across different ILAs.** While families appear generally satisfied with these arrangements, other stakeholders raised concerns related to the actual benefit of such a model. They report that in many cases, clinical outcomes that not being planned or achieved in part due to limited oversight or accountability to achieve quality standards. In other cases, ILAs are very well operated but look different from each other. Non-standardized approaches to support are inefficient and difficult to oversee.
- **Funding approach promotes 'over-servicing' and disincentivizes improved outcomes.** Funding for ILAs is largely focused on the basis of number support hours. Therefore it is possible that paid service providers may be incented to maintain status quo, or even to increase hours by adding more workers, than the client truly needs. Some stakeholders including families questioned the current staffing model and worried that it had effectively become a permanent arrangement. They also commented on the lack of training/insight of support workers in these placements which may impact the quality of care being provided.
 - Of particular concern is that workers may be temporary and due to operational schedules by the agency, cannot adhere to a stable staffing schedule. This is in opposition to what clients most need from their living environment – stability and predictability - so the client cannot "get used to" staff and form relationships. These disruptions are compounded by the belief that many home support staff lack insight to their clients' unique needs and conditions, and sometimes do not follow through with behaviour management plans, as it can temporarily increase difficult behaviours.
- **Inconsistent policy and operating standards.** RHA and other system-level stakeholders commented on the number of ILAs that have been established in recent years, and that there appears to be some inconsistency in the underlying policy, particularly with regard to how ILAs/SLAs are established, and how they are intended operate. They noted exceptions to policy, and wondered where the oversight of ILA operations was being provided – by the families?
- **Unsustainable funding model.** Exceptionally high program spending was noted by RHAs as problematic. For example, stakeholders noted several clients who cost upwards of \$200,000 per year to support. Stakeholders also commented that for the total expense of an individual living arrangement, one might expect a very high level of care, and high likelihood of outcomes being achieved, however there is a pervasive feeling that what is happening on the ground is not delivering the quality one might expect.

Program Overview: Personal Care Homes (PCHs)

PCHs are privately owned and operated residential settings providing care and accommodations for seniors and adults who require support with Activities of Daily Living (ADLs)

About Personal Care Homes (PCHs)

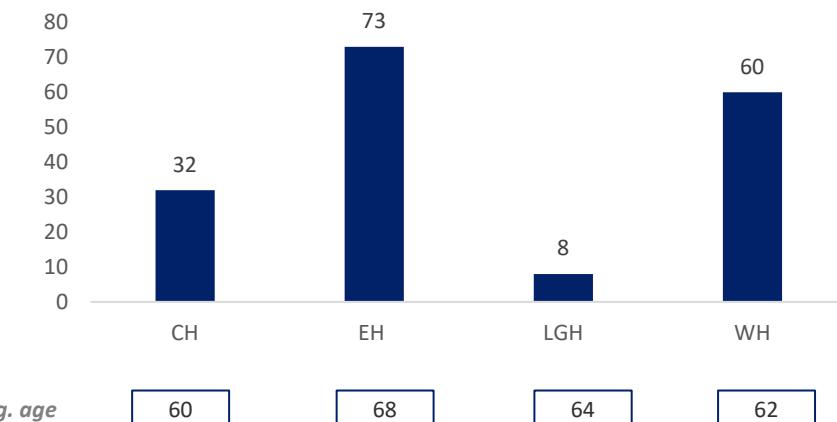
Description:

- PCHs are privately owned and operated residential settings providing care and accommodations for seniors and adults who require support with Activities of Daily Living (ADLs).
- Personal Care Homes operate under a set of provincial standards (last updated April 2007) to provide care and accommodations for seniors, and adults with physical/intellectual disabilities based on a PCH Level of Care framework. Client needs are categorized as Level I, Level II, Level II Enhanced, and Level III (awaiting LTC placement).¹

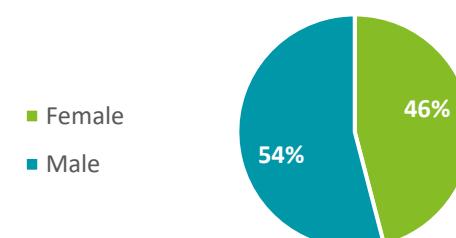
Clients:

- There are approximately 85 PCHs of variable capacity across the province, which support **173 adults** through CSS/MHA program areas.
- Anecdotally we heard from stakeholders that PCHs were increasingly used as living arrangements for MHA clients. However, data provided by RHAs listed only 1 MHA client as currently living in a PCH (based in WH).
- The majority of clients living in PCHs are male (54%)
- Clients receiving residential supports living in PCHs are older than the provincial average of CSS clients (i.e., avg. 64 in PCHs vs. 43 for all CSS clients)
- 29% of clients living in PCHs are age 60 or below

Clients living in PCHs by region



Gender of CSS/MHA clients living in PCHs



¹ A separate report has provided recommendations to HCS CSS on improvements to the PCH program, including funding model and which further align the program to the newly approved Levels of Care Framework.

Program Overview: Personal Care Homes (PCHs)

PCHs are privately owned and operated residential settings providing care and accommodations for seniors and adults who require support with Activities of Daily Living (ADLs)

About Personal Care Homes (PCHs)

Program Spending:

- Program spending for PCHs was in excess of \$44.4 million in FY2020 across the province.
- There are upwards of 2,000 individuals living in PCHs across the province, however, we are unable to determine the cost per client information given a small number of these individuals (173) were the adults identified by RHAs as receiving residential supports through CSS/MHA.
- Regionally, CH spends the largest portion of overall community supports expenditures on their PCH program, relative to other regions.

PCH Program Expenditures (all RHAs – CSS/MHA clients only)	FY2020 P13 YTD	Percent of Total
Service Recipient Travel-Traceable	1,935,907	4%
Medical and Surgical Supplies	600,076	1%
Medical Gases	132,029	0%
Uninsured Medical Services	609,293	1%
Residential and Living Expenses	41,217,399	93%
Total Program Expenditures	44,494,704	100%

Program Overview: Personal Care Homes (PCHs) – cont'd

There are a very high number of approved PCH beds across the province, many of which are not operating at capacity

Key Findings and Observations

Deloitte engaged with stakeholders to obtain feedback and insights about CSS/MHA clients that are currently living in PCH settings. A few common themes emerged:

- **High vacancy rates and province-wide footprint.** Many stakeholders across program areas and regions noted the high vacancy rates in PCH homes across the province. Given the need for mental health and other living arrangements, many stakeholders see repurposing PCH capacity as an opportunity to support more individuals, particularly in rural communities.
- **Changing client demographics.** Typically, PCHs accommodate older populations and those with physical support needs, however in recent years, many PCHs have seen an increase in younger individuals, and individuals with chronic mental health and addictions issues. Mental illness is becoming increasingly pronounced in the population of individuals above 65 and in rural areas where there may be excess PCH capacity.
 - Stakeholders express concern that client complexities are believed to be increasing dramatically.
 - Several PCH homes now accept MHA clients but stakeholders believe these exceptions are not in alignment with provincial standards, however they acknowledge that at times PCH environments are the only option available but feel the traditional PCH setting is not appropriate for younger clients placed with seniors, clients with limited physical care needs, or clients with chronic mental health and addictions issues.
- **Staffing and recruitment challenges.** It was also noted that hiring staff with the proper training/qualifications to meet the ever-increasing complexity of client needs is a continual challenge. In parallel, recruitment of general home support staff to fill these positions also continues to be a challenge. One PCH reported to the review team that they have a night position posted and available for over 5 years. Several stakeholders also questioned whether PCH homes are appropriately staffed or trained to manage mental health and addictions challenges, and to do so should require at least basic training for staff.
- **Significant change in PCH sector.** Following earlier program reviews and planned change in the personal care home sector, some stakeholders commented on the capacity of service providers to absorb additional change. Further modernization efforts should be tempered with the recognition that many PCHs have aging physical infrastructure and will struggle to meet existing operating standards and staffing levels, and to provide higher levels of support to clients that largely present with physical needs only. Adding further complexities (such as new client groups or demographics) may stretch this sector to breaking point, which is not in the best interests of the clients that they are intended to serve.

Program Overview: Community Care Homes (CCHs)

CCHs are a community-based supportive housing program for individuals who require support as a result of a severe and persistent mental illness. CCHs exist in Eastern Health region only

About CCHs

Description:

- Eastern Health runs a community-based supportive housing program for individuals who require support as a result of a severe and persistent mental illness.
- CCHs are privately owned businesses. Most were originally large family homes with the majority being located in the Conception Bay South area.
- CCHs are currently licensed under the Provincial Personal Care Home Operational Standards. The standards require that clients are provided with safe living facilities, meals, and basic living supports. Stakeholders report that bedroom accommodations are often shared, some bedroom areas separated only with a curtain for as many as three clients.
- Providers report that there is no money to improve the facilities, or upgrade common bathing and living areas. Some stakeholders and even providers themselves report that CCHs tend to be in poor condition and need significant physical improvement.
- While PCH standards may appear functionally similar in that they set out expectations of a clean, safe living space for clients that need a supportive living environment, it must also be noted that the clients served in CCH typically present with mental illness, whereas PCH clients tend to have predominantly physical needs.
- Annual program spending is approximately \$6.3 million dollars.

Clients:

- There are 146 clients living in CCH homes, all of which are based in Eastern Health. Clients are typically an older population relative to other MH clients with an average age of 61 compared to the provincial average age of MH clients (45).
- **Nearly 70% of the clients living in CCHs are male.**

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¹Assumes approximate yearly spend is \$6.3 million and 146 clients availing of CCHs

12 CCHs

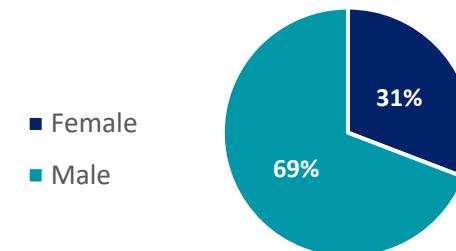
All based in Eastern Health

Average age:
61

146 clients

Total program spending (avg):
\$43,151 per client¹

Gender of CCH Clients



Program Overview: Community Care Homes (CCHs) – cont'd

CCHs have room to improve but are generally perceived as positive living options for MHA clients - albeit they only exist in EH

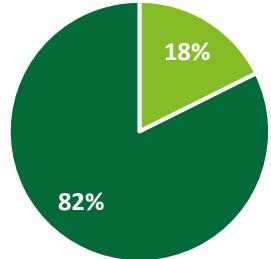
Key Findings and Observations

Deloitte engaged with CCH operators to obtain their feedback and insights about MHA clients that currently reside in CCH environments:

- **Complying with PCH Operating Standards.** CCH operators expressed frustration with the licensure arrangement under PCH Provincial Operating Standards. They report many of the PCH standards do not apply to their clientele or context, and there are gaps to what they see as more appropriate operating standards for mental health clients. The increased bureaucracy and confusion were also noted as a pain point for these private operators.
- **'Cherry-picking' clients.** As private operators, CCH homes are perceived as having the ability to 'cherry-pick' their clientele, which causes concern amongst some stakeholders about access and system flexibility. Some RHA stakeholders report that for some homes, once a client has been evicted / removed, the operator may "ban them for life" and refuse to consider re-entry irrespective of any improvements or changes in the client's behaviour. Stakeholders reported that several CCH clients have been forced into shelters/homelessness as a result of this policy.
- **'Low support' environment.** CCH homes typically provide low levels of care or support, typically aligning with the Level 1 support observed in Personal Care Home settings, which is a very minimal level of support approaching independence. Individuals that are aging with mental health conditions or dual diagnoses may develop physical health conditions earlier in life. However once a client's care needs exceed Level 1, there are limited living options for individuals who have been living in CCHs. Clients may be referred to PCHs or long term care settings, however stakeholders also report that these alternatives also do not align with client needs.
- **Inflexible, short-term funding model.** Stakeholders commented on the poor physical condition of some CCHs. While generally perceived as 'safe', some living spaces were described as "pretty old" or "tired". They also noted that some clients share bedrooms and only have privacy in their beds by separating them by a curtain. Limited privacy and independence was noted as a concern. However, adequate funding has been a long-standing issue amongst operators and makes the ability to perform home renovations difficult. Similarly, limited funding limits CCH operators' ability to recruit and retain quality staff. They often have low-skilled workers and cannot invest in training. Operators expressed an interest in sending their staff for additional training but wondered '*who's going to pay for that?*'
- **Expansion to other regions.** While there is room to improve the CCH program, many stakeholders perceive CCHs as a safe and cost-effective option for community living for those with mental health conditions. Some described CCHs as a missing resource in other parts of the province and believe that a CCH model would fill some gaps for clients with mental health and addictions issues in other regions, as there are no other housing options directly linked to MHA provincially.

Other living arrangements: In-patient Placements

Individuals with mental health or addictions challenges are sometimes admitted to hospital in order to provide intensive clinical intervention and treatment (e.g., The Waterford Hospital); some have become long-term or recurrent residents

About –In-patient Placements	Illustrative Diagnosis	Illustrative challenges/risks identified as part of discharge planning						
<p>Description:</p> <ul style="list-style-type: none">Individuals can be admitted to hospital in order to address episodes of acute mental illness. Such in-patient treatment environments provide a very high-level of clinical intervention and treatment needed to stabilize the patient before returning to the community.In some cases, an individual will reside longer in the acute setting until an appropriate community option is available.At any given time, it is reported that there are patients occupying acute beds in mental health units, who are clinically stable but waiting for appropriate community-based options.With the upcoming closure of the Waterford Hospital in 2024, it is understood that a cohort of 17 long-term patients are slated for discharge, ideally to community settings.Central Health and Western Health have small psychiatric units in their local facilities. There are no psychiatric inpatient units in Labrador-Grenfell Health.	<ul style="list-style-type: none">Chronic paranoiaSchizophreniaTourette's SyndromeSubstance abuseDementiaAnxietyNeuro-CognitiveAdjustment DisorderTraumatic brain injury	<ul style="list-style-type: none">Fecal SmearingRefusal of ServicesMedical noncomplianceProperty damageDisruptive noisesAggression (verbal and/or physical)Sexually inappropriateLack of insightLack of capacity						
<p>Clients:</p> <ul style="list-style-type: none">There are 17 individuals currently living full-time at the Waterford Hospital in complex discharge/rehab units. Data for individuals who might be living in other acute units across the province was not provided.The average age of these clients is 45.There is 1 female for every 4 males living full-time at the Waterford Hospital.Clients living in the Waterford range in complexity of diagnosis, as well as the challenges/risks that present when planning for discharge back into community.	<p>Gender Breakdown</p>  <table border="1"><thead><tr><th>Gender</th><th>Percentage</th></tr></thead><tbody><tr><td>Female</td><td>18%</td></tr><tr><td>Male</td><td>82%</td></tr></tbody></table> <p>Average age: 45</p>	Gender	Percentage	Female	18%	Male	82%	
Gender	Percentage							
Female	18%							
Male	82%							

Overview of Level 4 residential programs for children and youth in care

At time of writing, 143 children and youth have been placed in Level staffed residential options

The following pages provide high-level statistics on the three types of Level 4 residential placements that were in-scope for this review: Group Homes (GHs); Emergency Placement Homes (EPHs); and Individualized Living Arrangements (ILAs). Deloitte also engaged with a range of departmental staff and stakeholders, including youth formerly in care. Their views are summarized below:

Key Findings and Observations

- **Insufficient capacity.** Although it is a common issue facing the adult system also, front-line departmental staff and managers report having “no options” available to place children and youth. As a result, while ‘fit’ with the service provider is ideally prioritized, stakeholders report that more often than not, placements are made children where there is a bed which may not take into account factors such as client mix (e.g. placing young children with teenagers with complex needs), ‘domino effect’ (e.g. an incoming young person is so disruptive that existing residents must be moved to maintain safety), or that a client who was removed from a provider, may be returned to their care because there are no alternatives.
- **Lack of urgency with placements, particularly in EPHs.** Placement in EPHs are limited to 90 days. Stakeholders to this report confirm that policy is routinely breached, albeit reportedly as a result of sibling groups being placed in a location together. Not only is the EPH environment intended to be a temporary placement that is only an *emergency measure* while a suitable placement is being located, stakeholders reported they often feel transition planning for a more long-term option lacks urgency from the department. This is very concerning as the EPH environment often do not provide supports and services that could be expected in other placement types.
- **Non-secure environment.** A key concern for some stakeholders to this review, primarily service providers, is that youth in Level 4 programs sometimes lack the judgement to make good decisions and are a danger to themselves or others. Although not universal, some service providers are supportive of a secure treatment environment which could be utilized to manage acute situations where youth may runaway or harm themselves, however there is no secure facility available in NL. Some complex youth are transferred to out of province facilities which are understood to be secure treatment facilities.
- **Lack of treatment program for complex children and youth.** Level 4 does not provide an evidence-informed treatment program for these highly complex youth who need significant support to live effectively as adults. While there are treatment centres (e.g. Tuckamore and Hope Valley which are out of scope for this review, but which are understood to provide complex mental health treatment and/or addictions treatment, on a voluntary basis), there are high vacancy rates and most youth receive minimal treatment interventions. Higher levels of staffing that tend to accompany increased complexity does not necessarily result in improved outcomes. Some service providers seek the ability to implement a comprehensive treatment program for these complex children and youth, however the current funding arrangement does not allow for this approach and services are often cut as soon as young people are seen to be making positive progress.
- **Weak intake, case management, and youth transitions to the adult system.** Some departmental staff report limitations in their ability to effectively understand what a child or youth need, and rely on the service provider to ‘fill in the details’. There is no centralized intake process or team. Service providers express concern about incoming placements often have ‘wrong’ information or lack details about the child or youth’s actual support needs. Service providers report long periods where case management is not happening and few check-ins by departmental staff. They also express concerns about transitions to the adult system are frequently difficult.

Program Overview: Group Homes (GHs) for children and youth

GHs provide group care for children and youth with complex needs that cannot be met in a foster care or kinship setting. Group homes provide care for children, youth, and young people who are 12 years old or older, generally with higher levels of complexity.

About Group Homes (GHs)

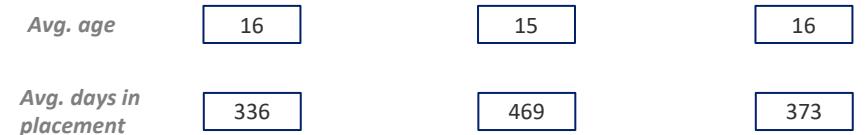
Description:

- Group Homes are staffed residential settings that provide group care for children and youth who are 12 years old or older who have complex social, emotional, behavioural and developmental needs and as a result require a level of residential service that cannot be provided through a less structured, family based setting.
- There are a total of 67 licensed GH beds across the province. While beds are always in high demand, there are often vacancies in GHs that are driven by the complexities of the children and youth that have already been placed there.

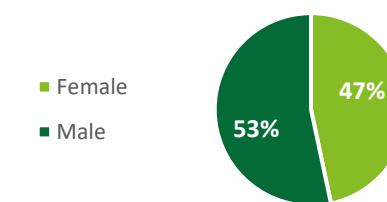
Clients:

- At the time of reporting, there were 45 children and youth active placements in GHs across the province. For every 10 children and youth in Level 4 care, approximately 3 are living in GHs.
 - The average age for children in group homes across the province is 16 – this number is consistent across the province.
 - The average days in GH placements for children and youth currently in care is 383 days – GH placements in Labrador tend to latest the ‘longest’ at 469 days.
 - The gender balance is relatively consistent across the province with 53% of children identifying as male, and 47% as female.
- Social workers involved with the young people living in group care assessed their needs as being much higher in terms of treatment and supervision. Stakeholders to this work report that young people in group care are extremely complex, and need more than the current level of support.

Children and youth living in Level 4 Group Homes, by region



Gender Breakdown



Program Overview: Emergency Placement Homes (EPHs)

EPHs are staffed living arrangements that offer 24-hour emergency care to children and youth for up to 90 days to assess the young person's placement needs, and/or to locate a longer term placement option

About Emergency Placement Homes (EPHs)

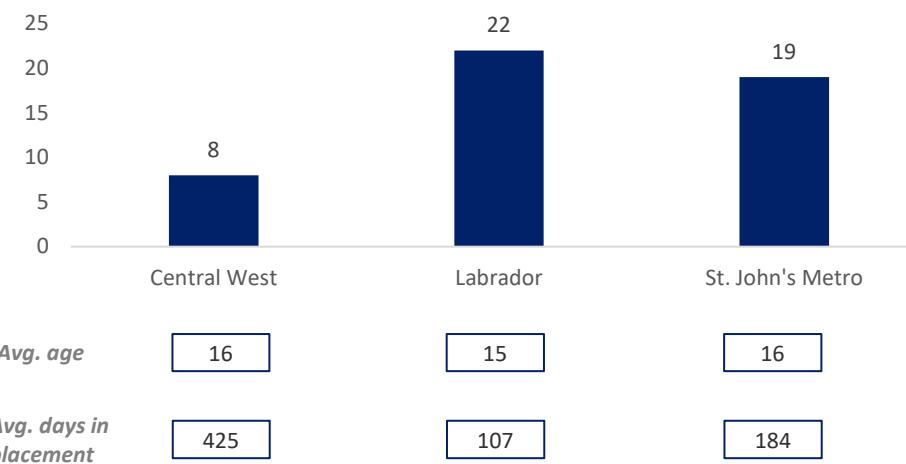
Description:

- EPHs are staffed residential placements that offer 24-hour emergency care to children and youth for up to 90 days. The intent is to assess a child or youth's needs, or to provide safety while a suitable placement is being located.
- EPHs must have the ability to accommodate sibling groups and accommodate same day placement.
 - Current EPH policy and operating standards limit placements of children and youth to 90 days.
 - A manager can approve an EPH placement for longer than 90 days where required, however average days in EPH placements for children and youth currently in care is 189 days -- more than double the timeframe permitted in the legislation.
 - In C-W, the average placement is well over a year (425 days).

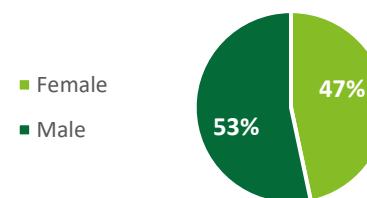
Clients:

- There are 49 children and youth living in Level 4 Emergency Placement Homes across the province – the most EPH placements are in Labrador with 22 (or 45%), conversely only 16% of the placements are in Central-West.
- The gender breakdown for children and youth living in EPHs is the same as those living in GHs (53% male and 47% female).

Children and youth living in Level 4 EPHs by region



Gender Breakdown



Program Overview: Individualized Living Arrangements (ILAs for children and youth)

ILAs are established on an as-needed basis for children and youth where another suitable placement is not available, and the child or youth has highly complex needs that cannot be met in another setting

About ILAs (Child/Youth)

Description:

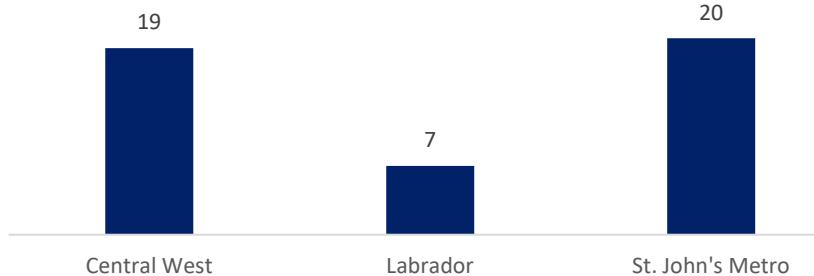
- ILAs are generally established for a child/youth where another placement is not available or when the individual has such complex needs that support cannot be provided in another setting.
- Sometimes ILAs are used to accommodate a large sibling groups, and/or are able to accommodate multiple clients (Shared ILA). ILAs are operated by licensed residential service providers and are considered a staffed residential placement.
 - In addition to any specialized staff that are required, clients generally require more than one Child and Youth Care Worker at any given time.
 - CSSD standards provide for staffing ratios of 2:1 maximum, whereas some adults in ILA arrangements may have as many as 5:1 staff.
 - When clients share a living environment, it is understood that staffing levels are shared.

Clients:

- There are currently 46 ILA placements across the province.
- The average length of stay in ILA placements is 1245 days or nearly 3 and a half years – children and youth in St. John's Metro are approximately 100 days under this provincial average.
- Two-thirds of children in ILA placements are male (67%) – a greater proportion of male children than other Level 4 placement options (GHs and EPHs).

Ideally, an ILA is a temporary placement environment in which specific goals can be achieved (e.g. reduced behaviours, return to school, etc.) however stakeholders report that treatment does not generally occur in ILAs and that once children or youth are placed in an ILA, this is where they will reside. Some stakeholders indicate that children placed into an ILA may continue to be in an ILA through their adult lives, at a very high cost of care to the province.

Children and youth living in ILAs by region



Avg. age

16

15

16

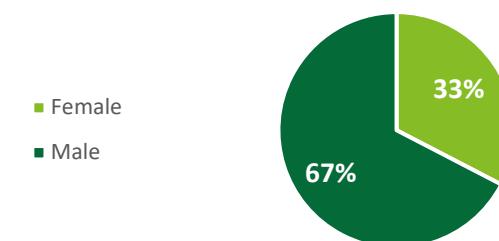
Avg. days in placement

1324

1313

1147

Gender of ILA Clients



Appendix D

Additional detail from jurisdictional scan

Jurisdictional Scan – British Columbia

BC has implemented a range of housing options to support people living with a mental illness or substance use problem in the province, and have also integrated social housing with disability and other supports under the purview of BC Housing

Topic	Details
Overview	<ul style="list-style-type: none">A total of 7,655 individuals were identified as experiencing homelessness in the 2018 Report on Homeless Counts in B.C. This included 219 children who were under the age of 19 and accompanied by a parent or guardian. The majority were sheltered (63%) and 37% were unsheltered. Indigenous populations are overrepresented with an estimated 38% of homeless population identifying as Indigenous.British Columbia has more than 11,000 subsidized units, rent supplements, and emergency shelter spaces for people who are homeless or at risk of homelessness.Its primary department for addressing homelessness, amongst other housing issues, is BC Housing. The provincial government does not operate the housing, non-profit organizations are responsible for this, but BC Housing does play a leading role in the provision of units
Living Options	<p>Collaborations between RHAs, BC Housing, BC Mental Health & Substance Use Services, non-profit organizations, local community agencies, and housing “cooperatives.” Housing options include:</p> <ul style="list-style-type: none">Licensed community careSupportive housing (i.e., dedicated site, mixed-site, scattered-site, transitional)Supported housingSemi-independent livingSubsidized housing & assisted livingEmergency sheltersHarm reduction housingLow-barrier housing
Highlighting Relevant Services	<ul style="list-style-type: none"><i>Forensic Community Care Transition Program – BC Mental Health & Substance Use Services:</i> Offers 41 beds divided amongst 9 cottages and 2 modular homes for individuals who need high levels of support following their treatment and conditional discharge from psychiatric units. An additional 104 beds are provided as additional transitional and supportive stepped-down options. (2)<i>Homeless Outreach Programs – BC Housing:</i> In addition to supportive housing in apartment-style buildings, BC Housing has two homeless outreach programs that may serve as the first point of contact with the provincial system of housing and support services for individuals who are homeless or at risk of homelessness and who may be in need of supports to maintain a successful tenancy. These programs compliment the work being done by ACT teams within the health authorities.
Challenges	<ul style="list-style-type: none">Constraints on capacityAffordable housing stock‘Not in My Backyard’

Jurisdictional Scan – New Zealand

New Zealand has developed a new model for disability support to promote greater choice, control and flexibility.

Topic	Details
Overview	<ul style="list-style-type: none">The New Zealand Government provides a range of funded disability supports (e.g., ASD supports, behaviour support, child development, community day services, community residential support services, equipment and modifications, hearing and vision services, home and community support, individualized funding, respite, supported living).In 2018, the NZ Ministry of Health released a new Community Residential Support Services Strategy, <i>Where I Live; How I Live</i>, aiming to provide disabled adults with greater choice, control and flexibility, while acknowledging that people's own experiences will contribute to their level of desire to explore different living choices.
Living Options	<ul style="list-style-type: none">Independent Living with Home and Community Support ServicesSupported LivingFlatting with others (e.g., house sharing)Community residential homesLiving at home with family + respite options
Highlighting Relevant Services	<ul style="list-style-type: none"><i>Local Area Coordinators</i>: work with disabled people to plan for key moments in their life and further connect within their own communities. A focus on information sharing and personal assistance to support transition planning.<i>Supported Self Assessment</i>: a new self-assessment form to assess need based on strengths and capabilities. Funding is then calculated based on the unmet disability support needs that have been identified.<i>Enhanced Individualized Funding</i>: enables greater choice, control and flexibility over the funding disabled individuals are eligible to receive and how they are able to use it.<i>Choice in Community Living</i>: an alternative to residential living placements to allow each disabled person the opportunity to live more independently in a home of their choice.
Challenges	<ul style="list-style-type: none">Healthy housing (e.g., environmental factors creating dampness and coldness in the home)Accessible housing for individuals with physical/mobility issuesYoung people transitioning to residential support services due to a lack of alternative support optionsWorkforce capability – the disability workforce has an older age profile and lower qualification levels

Jurisdictional Scan – Scandinavian countries

Child protection in the Scandinavian countries follows a “family service” approach to responding to parental maltreatment and protection issues.

Topic	Details
Overview	<ul style="list-style-type: none">The provision of children protection services in Scandinavian countries such as Denmark and Sweden follows a “family service” orientation, as opposed to a “child protection” orientation in countries, such as the United States and CanadaThe defining characteristic of the family service orientation is based around a more holistic system approach to child welfare, with little divide between child protection and prevention services. The Scandinavian systems are set up to respond to the needs of families.In Sweden, child welfare services are governed by the municipalities, with each council having a degree of autonomy and independence to respond to the needs of their communityThe workforce is composed of many professionals including social workers, health, education and psychology. Staff are well paid and well trained, requiring a bachelor's degree in Social Pedagogy and experience working with children in many group homes. Many workers have other forms of continued education as well, and come from a variety of backgrounds. People who work in the sector stay long term and the role holds a lot of prestige
Living Options	<p>The following models of residential care are leveraged in the Nordic countries. The list is not exhaustive because of gaps in evidence but provides an overview of types of service provision:</p> <ul style="list-style-type: none"><i>Reception facilities/children's shelters</i> – emergency or assessment placements for children entering care<i>Respite/part-time homes</i> – provide planned or emergency service on an interim-basis<i>Family group care</i> – live-in couples who provide ongoing care for small groups of children, supported by paid staff<i>Care for babies and very young children</i><i>Group care/children's home</i> – staffed residential placements group homes<i>Therapeutic/high-support units</i> – a therapeutic milieu providing therapy or specialist on-site support/education<i>Secure care/semi-secure care</i> – locked establishment for children deemed at risk to themselves or setting where there is ability to run away
Challenges	<ul style="list-style-type: none">Less risk aversion and more individual discretion to client needsToo much emphasis around the parent, potentially at the expense of needs of the child

Appendix E

Detailed Survey Findings

Survey results... by the numbers



- The survey was opened for distribution by RHAs and third parties beginning **July 21, 2021**, and closed on **August 8th, 2021**.
- Respondents primarily participated through the email link provided, however some respondents were supported to participate by phone call with a third party who filled out the survey on their behalf.
- It should be noted that respondents/individuals may or may not be in receipt of supports.

248 completed surveys

32% *self-administered*

44% *family members*

10% *third-party facilitated*

31% *receive no financial supports for their current living arrangement*

63% *prefer shared living arrangements*

20%
homeless or insecurely housed

¹ See Appendix B for the survey questionnaire.

Survey Results - Demographics

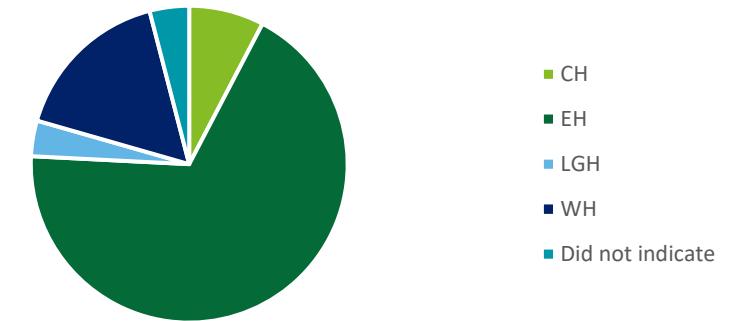
The survey was closed on August 8th with 248 completed surveys received, largely self-administered or completed by a family member

Information on the survey respondent

Who is completing the survey?

Family member or caregiver	110
I am on my own	80
Other	15
Somebody is helping me at a community agency	25
Somebody is helping me through my regional health authority (e.g., social worker, other)	18
Total	248

Geographic area

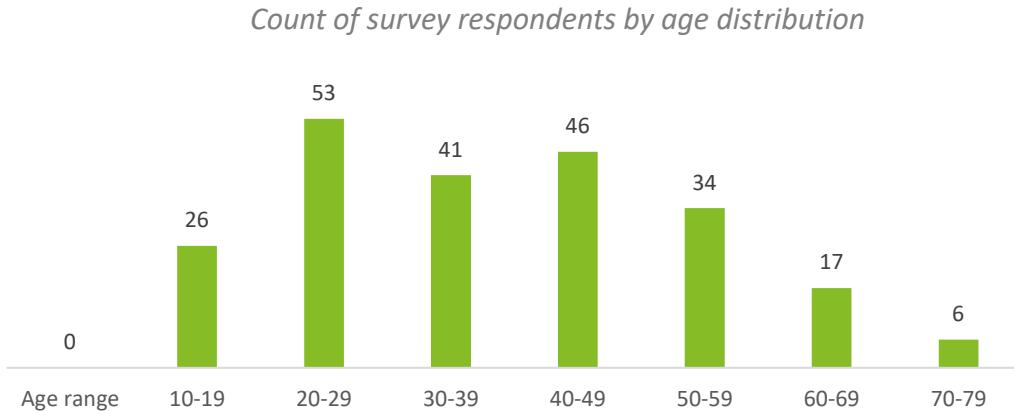


Geographical distribution of responses generally reflect the distribution of individuals across the province, however, slightly under represents the % total population in CH

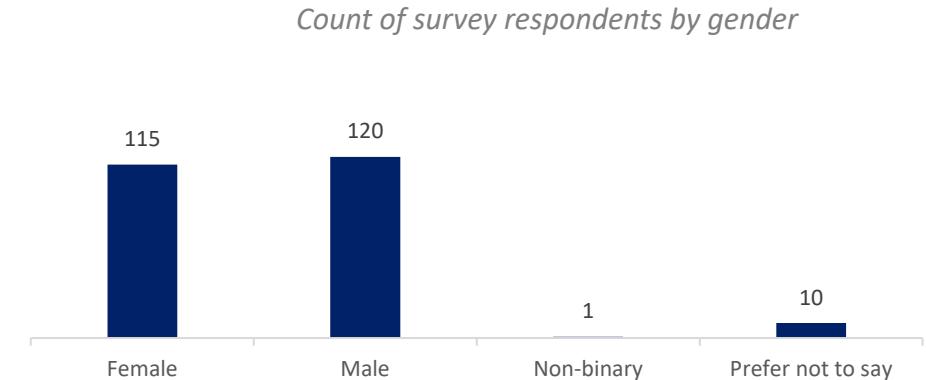
Region	Responses
Eastern Health	169 (68%)
Central Health	19 (8%)
Western Health	41 (17%)
Labrador-Grenfell Health	9 (4%)
Did not indicate	10 (4%)

Survey Results - Demographics

Gender distribution was relatively equal amongst respondents; average age of respondents is 38



- Over a third of survey respondents (35%) were between ages of 10-29 and just over a quarter (26%) of respondents are 50+
- The average age of respondents is 38 years old



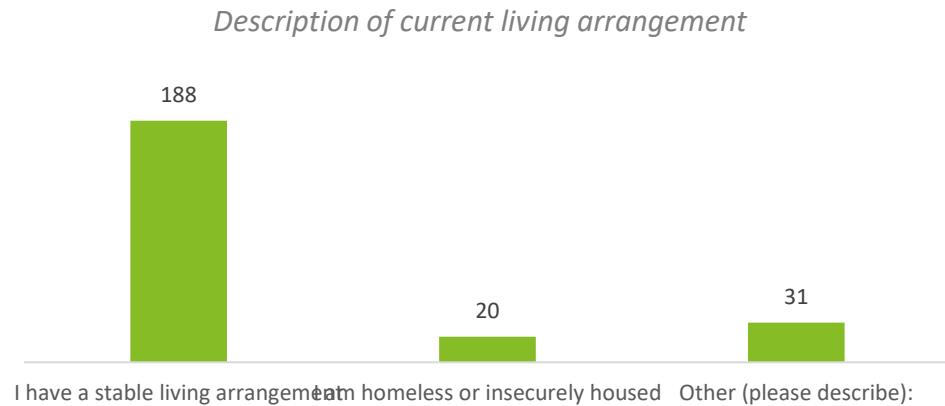
- Gender distribution was nearly equal amongst male and female survey respondents
- 49% of respondents self-identified as male and 47% of respondents self-identified as female
- 4% of respondents preferred not to indicate their gender

12% of survey respondents self-identified as Indigenous or a member of a First Nations community, and **4%** of respondents self-identified as new Canadians.

31% of survey respondents do not receive financial supports from the government to pay for their current living arrangement (table not shown)

Survey Results – Current Living Arrangements

Over 20% of respondents have unstable living arrangements. About 41% of individuals have been living in their arrangement for 10+ years.



- 79% of individuals described their current living arrangement as stable
- 21% of respondents indicated they are homeless or insecurely housed, or described their current living arrangement in another way.
 - 7% of individuals are homeless or insecurely housed
 - 14% of individuals describe their living arrangement as between “stable and homeless”

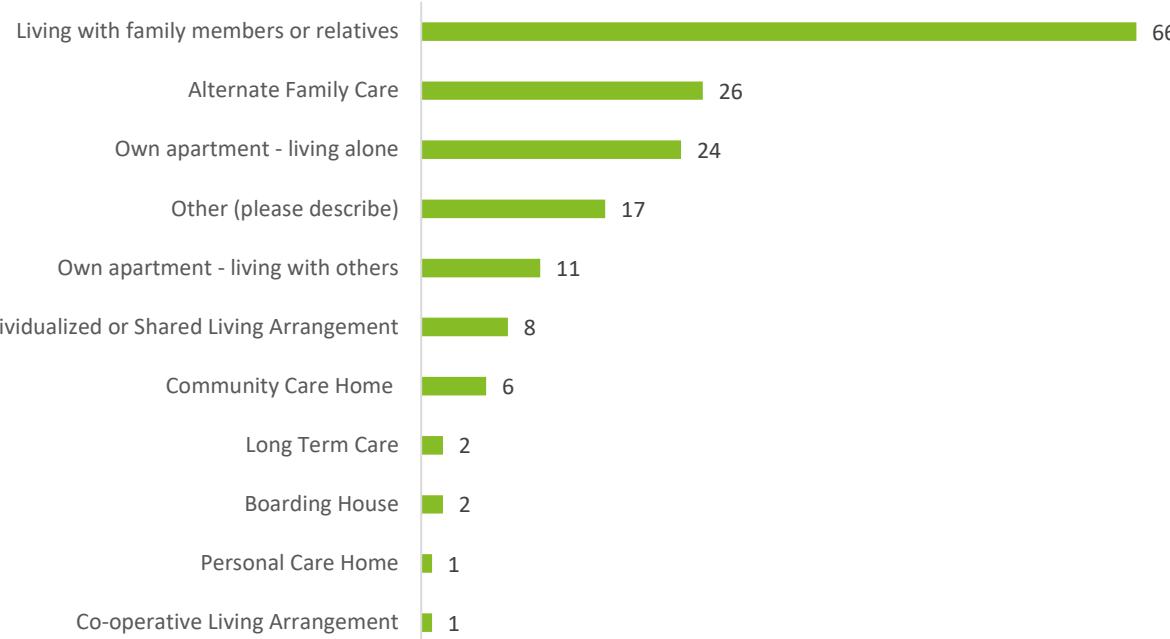
Current Living Arrangement	10+ years	1-5 years	5 - 10 years	Less than a year
I am homeless or insecurely housed	2	5	-	10
I have a stable living arrangement	71	40	29	25
Other (please describe):	14	10	1	6
Total	87	55	30	41

- 41% of individuals have been living in their current arrangement for over 10+ years and 45% of individuals have been living in their current arrangement for less than 5 years
- The majority of individuals who are homeless or insecurely housing have been in this situation for less than a year

Survey Results – Current Living Arrangements

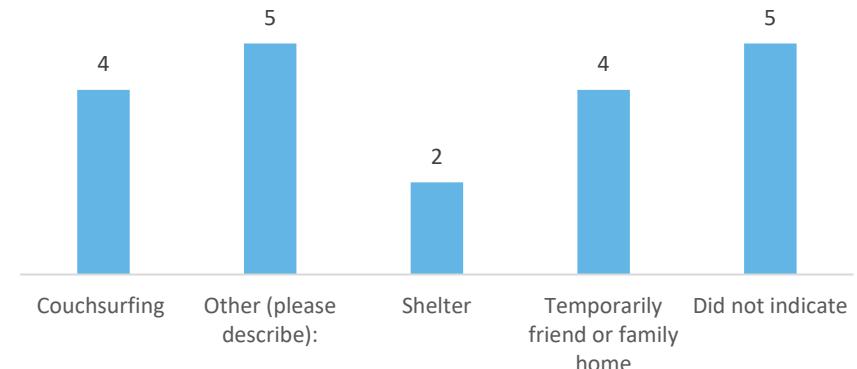
Over 40% of respondents with a stable living arrangement reside with family members or relatives

Count of current living arrangements (of individuals who live in a stable environment)



- 40% of individuals with a stable environment live with their family members or relatives
- Verbatim descriptions of living arrangements for respondents who selected 'Other' include: "Group Homes", "Apartment in parents home", "Living with caregivers", "Living with Foster parents", and "Family based carers"

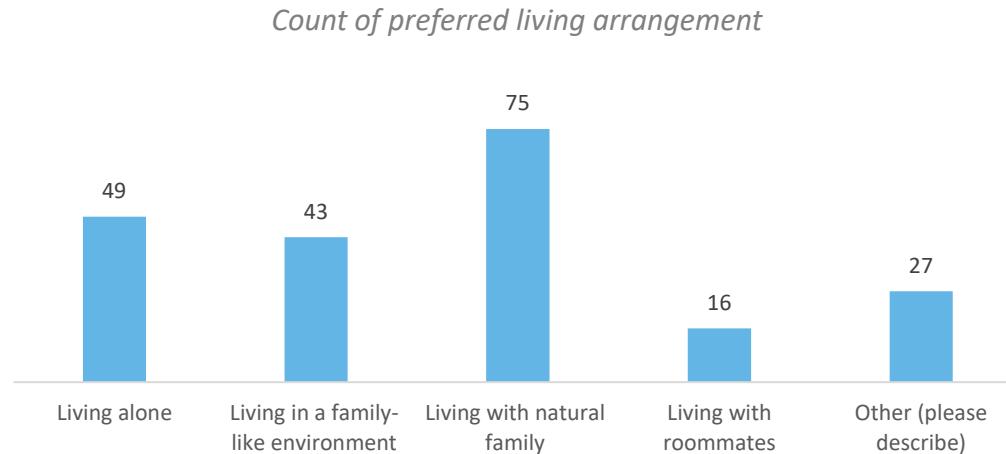
Count of current living arrangements (of individuals who are homeless or insecurely housed)



- 50% of individuals who are homeless or insecurely housed are couch surfing, living temporarily with a friend or family member, or living in a shelter
- Verbatim descriptions of living arrangements for respondents who selected 'Other' include: "I live in a transitional housing program", "In an apartment, might get kicked out", "Own apartment but am getting evicted"

Survey Results – Preferred Living Arrangements

Nearly 2/3 of respondents prefer shared living



There are mixed preferences on ideal living arrangements for individuals who may be in need or are already accessing residential supports:

- 23% of respondents prefer to live alone
- 20% of respondents prefer a family-like environment
- 36% of respondents prefer to live with natural family
- 8% of respondents prefer to live with roommates
- 13% of respondents selected 'other (please describe)' (see comments, right)

Sample verbatim responses of individuals who selected 'Other (please describe)'

"I would like to live with my family, and my staff and also a family that knows how to take care of me. So, more than one."

"Living in a support environment with several other. House mother to help with meals and supervision"

"Would like to have more companionship with others my age group"

"The options given would not necessarily be best. All of the above exist in some form or fashion now, but are not appropriate placements for reasons which I have already mentioned. A residence with a philosophy such as L'Arche provides the appropriate housing, programming and supervision required to provide a quote life for persons with special needs."

"Some assistance with meal planning in my own apartment."

"Do well with some supervision"

"I just want to have a nice rich family"

Survey Results – Qualitative Commentary

Respondents were asked to describe their living arrangements today; select verbatim comments from the responses are listed below.



What three words best describe where you live in today?

Really the house needs a lot of work	Stressful, Expensive, Good neighborhood	Fits my needs.	Pleasant, clean, and contented	Wheelchair Accessible , Close to amenities, In Need of upgrading
Expensive, temporary, uncomfortable	Home sweet home :)	small noisy damp	Really the house needs a lot of work	My favorite, inviting and busy street.
Safe, loving, comfortable	Stable, caring, boredom family living conditions	needs modifications	Home, comfortable, loving	Fine, A bit gross, I don't know
Comfortable , Lonely	Unstable, unsafe, scary	Lonely , Small Family minded living	Cold, Unstable, Convenient, mostly accessible but could have some improvements to make it more accessible	Independence, quality and perfect
quiet, boring, lame	Modern, Clean, Comfortable	Home, Nice, Comfortable	A house with 6 rooms	Accessible, small, old with my parents, it's the best
Inaccessible, expensive, triggering	Parents not good Happy, big bed, and got a roommate	Caring, loving, active	Unsanitary	Chaotic, no continuity of care, a lot of dictatorship. Unable to grow as adults.
Warm comfortable satisfying	Unsanitary, disrespectful, not a home environment	Not accessible or safe	***hole, dirty, gross	Great, "Finally what I need"
Supportive Family Home	Love my room!	Ugly, stupid, kind of good	my own home	basic, cold, plain scary, unsafe, temporary
Safe, secure, unaffordable	A hell hole	"Fine, that's it"	Comfortable, friendly, beautiful	it's his family, safe place, and where his best memories are.

Survey Results – Qualitative Commentary

Respondents were asked to comment on improvement opportunities for their living arrangements today; select verbatim responses are listed below.



What one thing should CHANGE or IMPROVE about where you live today?

Physical environment and accessibility

- Some minor renovations
- More up to date equipment - hospital bed and mechanical lifts are outdated.
- Plumbing/Sewer Repaired, General upgrading, Wider Bathroom Door
- Make more wheelchair accessible
- Give it more space
- More accessibility in the bathroom, especially, a walk in bathtub. More space for my washer and dryer, flooring tiles need to be safe
- Upkeep on the home

Service delivery and access to support

- More respite for the family I live with
- I would like to have a full-time caring, funny, intuitive worker who is as eager as me to develop a relationship with me.
- Medical access in a rural setting
- I would like to have programming available in my city, programming that give me a place to go to daily, where I can be with people.
- Having staff know the schedule a little bit better as I have missed many appointments and many visits because staff were not aware
- Although I have been given many chances, I would like time to prove that I can actually do this. I need this support.
- A more enlightened work force, who are responsible for determining the living space and programs for persons with special needs.

Independence, choice and companionship

- Couple hours alone in the home without staff
- To be living more of an independent life
- It would be good not to have to rely on my mother.
- To be able to make choices for myself.
- Be with people my age
- That I was back to myself and living without help
- Get more people here that actually talk to me
- More companionship with others like me
- Have friends live with me

Affordable housing and increased funding

- More funding for food, necessities, and funding for specialized equipment that supports my needs; ie adult wipes, mattresses
- Less expensive. Cost of living is very high given the area's cost for housing, food, heating and transportation.
- The cost of living: Housing is extremely expensive, food prices are ridiculously high and rising.
- Affordable rent and a safer neighborhood, that would help me feel like this place is my home instead of just somewhere I'm living until I have to move again.
- More money to be able to pay my full share of the expenses

Survey Results – Qualitative Commentary

Respondents were asked to comment on what they like about their living arrangements today: selected verbatim responses

What one thing should be KEPT THE SAME about where you live today?

Family environments and relationships

- Staff, they are my friends.
- My worker who has been with me a very long time
- My family (foster parents)
- To have people around me who care for me and love me.
- The love, the care, the connections with other people that happen in the home I live.
- Parents lived forever
- the good caring relationships with the people who care for and support me.
- Contact with my family.
- I like my caregivers
- There is one particular home support worker who goes above and beyond to help me and to guide me. My family wants him to stay with me.

...as well as the comfort and safety of the living arrangement

- How safe it feels
- Feeling safe
- Continued security to be able to stay in the home
- Living with family who understand my needs and provide a loving, secure environment.

Physical location and proximity to work

- Location to work - I live 3 minutes away from my place of employment. The commute enables me to be less stressed about daily routines and needs.
- at least keep the medical access in rural we already have as the medical transportation is very difficult, yet our gov't doesn't want us driving while on narcotics or certain medications.
- Like the walking trails close by
- We go to Corner Brook and Nova Scotia for a holiday every summer

Household amenities and features

- I'd like to keep my room the same.
- Keep our woodstove
- We have a dog - my nephew's dog lives with us.
- Like the physical supports that the EPH provides such as new clothing whenever needed
- My room.
- My dog to live forever
- My own room, my TV, and my computer
- House design
- Good food
- Keep my space for watching movies and having my own bathroom.

Survey Results – Qualitative Commentary

Respondents were asked to comment on what need to improve their lives: selected verbatim responses



What other supports or services would make your life better?

Enhanced recreation / social activities

- Access to transportation for ppl with special needs, more community activities for people with special needs
- Recreation activities outside the home and in the community. Continuous walks get old and the client will refuse to go. More variety.
- Would be nice to have something on a playground for people like me, in a larger, longer, form could use.
- People like me need meaningful day activities. We also crave, like most people, social connections. I particularly like to be among people, spending time together
- More ways I could participate in more social activities.
- More peer interaction. I go to Vera Perlin Summer Camp, but for 10 months of the year, I do not have that opportunity

Life skills and mental health supports

- Access to specialized services to support my needs, ie physical therapy, regular visits by a nurse
- Foot care, remove the red tape that government brings to situations
- Counsellor in adult services
- Supports around accessing mental health without crazy wait times
- Have a job coach that doesn't always change. I have had 8 job coaches over two years. I like to work my two shifts every week but can't work when they leave.
- To be able to get customized support....more person centered.

Staffing/caregivers

- Stable long term staff
- I go to bed every night at 8:00pm when my caregiver leaves. That's a bit unnaturally early for a man my age.
- More organization amongst staff so appointments and visits are not missed.
- Staff who have the interests of the family and what works best for them at the forefront.

Funding and respite

- More money to buy food
- Travel subsidies - cost of travel to my homeland and other places is very high given the rural isolation of the area.
- Have my cochlear implant supplies paid for by government. Have help with my dialysis and have more money for movies and entertainment.
- One change that could be made is his income support payment, as it has not increased since he was 18.
- Weekend and holiday respite
- Allow a family member to be approved for respite care to give my parents a break (hard to find non-relative and willing respite workers)

Household maintenance

- Help with snow clearing and household tasks like pressure washing ramp or changing lightbulbs. Homecare workers will often not do these tasks
- Financial support for home renos and better snow clearing

Survey Results – Qualitative Commentary

Respondents were asked to comment on what they like about their living arrangements today: selected verbatim responses



Any other comments about the place you live in today?

Positive comments

- *Have been in this home for 33 years - this is my family. Feel safe and loved here.*
- *I'm one of the lucky ones.*
- *I am comfortable and warm in my home, which is also clean. I understand that this is a huge privilege.*

Need for more support

- *I work full time but I still can't afford to pay for all of my living expenses. My apartment is not at all fancy, but rent is so expensive that I have to choose between groceries, heat/light, transportation to and from work, personal care items, etc. I usually end up borrowing money from family to get by. Something as simple as buying clothes just isn't an option for someone with my income and expenses. I have mental health issues and cannot live with strangers, but there are very few resources for people who are working full time - the income threshold for resources is too low.*
- *I live adjacent to people who use alcohol at least 5 days a week. They are always drunk on weekends and because of the cost of housing I can't afford to move. I hate it.*
- *We just got accepted into city housing after being wait listed 4 years....if we could change anything it would be the amount of time needing to wait and more accessible units for persons on with disabilities. We either have to accept the units or placed back on the wait list*

Aging families and caregivers

- *My parents aren't getting any younger*
- *The only thing insecure about where I live now is my mother's health. I don't know what will happen to me if something happens to her. I have three brothers but only one seems to take an interest in me. He says he'll help if my mom is not around. But I wonder if he actually realizes what my care entails.*
- *There is no other option. It is scary to think what would happen if for some reasons my family could not provide the 24~7 support that is needed. Persons with special needs do not survive in LTC placements, due to primarily staff lack of knowledge and knowing how to give appropriate care. Believe me I speak from lived experience.*
- *Current situation working well but concern about future as parents age.*

Choice and independence

- *Continuity of care is unacceptable especially for those with special needs and trust issues. Those in care should have a voice as to what they want to do and participate in daily. If taken to a movie it should be a movie age appropriate for those they are taking and one that the client would enjoy not the staff member.*
- *[It is difficult for her to articulate but she absolutely knows what she wants/likes and is able to let people know - if they are listening and aware. SMD. - sister]"*
- *I need to work for money not to just get it.. also for me to save my money and if I don't then its my fault.. and have a couple Chores here and there so I dont become lazy when I'm an adult and live on my own.. and learn to do new things for when I go on my own*

Survey Questions

Respondents answered the following questions as part of our stakeholder survey – all respondents had the ability to skip questions they were not comfortable answering.

Introduction

Thank you for your time to take this survey. We are interested in better understanding your housing needs. Your information will be confidential. It will be used as input to our report.

Tell us about you

Q1. Who is filling in this survey?

- a. I am on my own
- b. Somebody is helping me at a community agency
- c. Somebody is helping me through my health authority (i.e., social worker)
- d. Family member or caregiver
- e. Other

Q2. How old are you? [text field]

Q3. What is your gender?

- a. Male
- b. Female
- c. Non-binary
- d. Prefer not to say

Q4. Would you identify with any of the Indigenous or First Nations communities? Yes / No

Q5. Are you a newcomer to Canada? Yes/No

Q6. What town do you live in? [text field]

Survey Questions

Respondents answered the following questions as part of our stakeholder survey – all respondents had the ability to skip questions they were not comfortable answering.

Current housing and needs

Q7. What is your current living arrangement?

- a. I am homeless or insecurely housed [Branch to below]
 - i. Shelter
 - ii. Couchsurfing
 - iii. Temporarily friend or family home
 - iv. Street
- b. I have a stable living arrangement [Branch to below]
 - i. Own apartment – living alone
 - ii. Own apartment – living with others
 - iii. Living with family members or relatives
 - iv. Boarding House
 - v. Bedsitter
 - vi. Alternate Family Care
 - vii. Community Care Home
 - viii. Personal Care Home
 - ix. Long Term Care
 - x. Co-operative Living Arrangement
 - xi. Individualized or Shared Living Arrangement
- c. Other (please describe)

Q8. How long have you lived here?

Q9. Do you receive financial help to pay for your living arrangement?

- a. Yes
- b. No

Q10. What three words would you use to describe the place you live in today?

Q11. How satisfied are you with your current living arrangement? [LIKERT SCALE]

Q12. What living arrangement would you like best?

- a. Living alone
- b. Living with roommates
- c. Living with natural family
- d. Living in a family-like environment
- e. Other (please describe)

Q13. If you could wave a magic wand, what one thing would you want to CHANGE or IMPROVE about where you live today?

Q14. What one thing would you want to KEEP THE SAME about where you live today?

Q15. What are the other kinds of supports or services that would make your life better?

Q16. Any other comments you would like to share about the places you live in today.



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