

DISABILITY SUPPORT PROGRAM

IPSC TRANSITION GUIDEBOOK

MOVING TO A GOOD LIFE IN COMMUNITY

This document was created to provide a guiding framework for DSP staff supporting individuals as they transition to community-based supports. The guidance provided here is informed by the Key Directions outlined in the Human Rights Review and Remedy for the Findings of Systemic Discrimination Against Nova Scotians with Disabilities.

This document is also aligned with the principles of the Convention on the Rights of Persons with Disabilities (CRPD), specifically Article 19, which champions the right of individuals with disabilities to live independently and be included in the community on equal terms with others.

Convention on the Rights of Persons with Disabilities (CRPD)

Article 19 – Living independently and being included in the community

States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

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

TABLE OF CONTENTS

KEY TERMS AND ACRONYMS	1
INTRODUCTION	7
ABOUT THE IPSC TRANSITION GUIDEBOOK.....	7
ABOUT OPPORTUNITIES AND SOCIAL DEVELOPMENT (OSD).....	8
REMEDY GUIDING PRINCIPLES & SHARED VALUES	9
ABOUT THE REMEDY	12
BACKGROUND.....	12
REMEDY KEY DIRECTIONS	13
INTRODUCTION SECTION RECAP	13
TRANSITIONING TO COMMUNITY LIVING	14
PROCESS OVERVIEW	14
STAGE 1: GETTING TO KNOW EACH OTHER	15
STAGE 2: EXPLORING SUPPORTS AND COMMUNITIES.....	21
STAGE 3: TRANSITION PLAN REVIEW.....	30
STAGE 4: MOVING INTO THE COMMUNITY	34
STAGE 5: ONGOING SUPPORT	38
MOVING FORWARD AFTER THE TRANSITION	42
QUESTIONS TO SUPPORT THE TRANSITION PLAN.....	43

KEY TERMS AND ACRONYMS

Below is a list of key terms and acronyms that are relevant to understanding the Transition Guidebook, the Remedy, and the Disability Support Program (DSP).

As part of implementing the Remedy, some terms and programs listed here will be phased out or redefined over time. The language associated with current and new programs will continue to evolve as we work towards supporting life in the community.

A

Accommodation under the CRPD, refers to necessary and appropriate modification and adjustments not imposing an undue hardship, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms. Accommodation seeks to eliminate barriers in the workplace, allowing an employee, with a physical or mental disability, the opportunity to apply their skills and abilities in the workplace.

Adult Capacity and Decision-Making Act (ACDMA) is Nova Scotia legislation for adults who cannot make some or all decisions for themselves and allows another person to make some important decisions for them.

Adult Residential Centre (ARC) is a facility funded under the Disability Support Program to provide support to participants who need high levels of supervision and structured supports to enhance the development of their interpersonal, community oriented and activities of daily living skills to support their transition to a community-based option. Staffing is provided 24 hours/7 days a week.

Alternate Family Support Program (AFS) provides an approved, private family home, where support is provided for up to two persons who are not related to the AFS provider. Participants may receive varying levels of support with activities of daily living, and routine home and community activities.

B

Board of Inquiry is an independent administrative tribunal conducted separate and apart from the Nova Scotia Human Rights Commission. The Board of Inquiry Chair is the adjudicator and is appointed after the complaint has been referred to a Board of Inquiry by the Board of Commissioners.

C

Community Living Facilitator (CLF) is a role reporting to the Regional Hubs. This role would focus on new and innovative support option development, such as, Home Share recruitment, identifying innovative housing options in the open market and supporting users and families to develop bespoke options.

Community Outreach Assessment Support and Treatment Team (COAST) is a clinical team within Nova Scotia Health that provides services for persons with both intellectual disability and co-occurring mental illness issues. These services include, assessments and recommendations, short-term treatment and support, collaboration with family physicians and other community health care providers to facilitate the recovery of individual clients.

Community Transition Program (CTP) is a facility with an integrated care approach between the Department of Community Services Disability Support Program and Nova Scotia Health designed to address the needs of individuals experiencing mental and physical health issues and behavioural challenges that are impacting their ability to live successfully in the community.

Community-Based Living refers to housing and support options that enable people with disabilities to live in their own homes or in the community rather than in institutions. This model emphasizes independence, inclusion, and the ability to make choices about where and with whom to live. It supports individuals in accessing services and participating fully in community life on an equal basis with others.

Complex Case refers to situations requiring collaboration of inter-departmental and other resources to address the support needs of a DSP applicant/participant. Particularly when their support needs cannot be met by one of the levels of support provided in programs under the mandate of DCS, Seniors and Long-term Care or the Nova Scotia Health Authority.

Continuing Care provides a range of home and community care, and long-term care services administered and delivered by Nova Scotia Health and funded by the Department of Seniors and Long-Term Care.

Convention on the Rights of Persons with Disabilities (CRPD or UNCRPD) is an agreement under the United Nations that sets out principles that countries must use to ensure that disabled people have the same rights as everybody else. The CRPD was ratified by Canada in March 2010.

D

Day Activity/Programming refers to social, recreational, educational, and vocational/employment activities that individuals with disabilities participate in. These may include organized activities under programs funded by DSP, such as My Days.

DCS, see Department of Community Services

Department of Community Services (DCS) is one of the Departments of the Government of Nova Scotia. DCS delivers a wide range of social services to Nova Scotians, including the Disability Support Program (DSP).

Developmental Residence (DR) provides 24-hour residential support and supervision for four (4) or more persons with intellectual disabilities who need moderate support with activities of daily living and high support with routine home and community activities.

Direct Family Support for Children (DFSC) is a program offered by DSP that provides funding to families to support their child with an intellectual or physical disability at home.

Disability Support Program (DSP) is a division under the Nova Scotia Department of Community Services providing support and services to eligible individuals with disabilities.

DSP Applicant is a person with a disability, who applies for financial assistance and support from DSP.

DSP Participant is a person with a disability who has undergone financial and functional assessments, is determined eligible for the DSP, and receives support and services offered through DSP.

F

First Voice refers to the views and ideas of individuals with lived experience, in this case, of disability. Also, that there is an expectation that first voice individuals are involved in and play a primary role in decision making processes that involve them. Families, and others in close support networks, also have a valuable voice given their lived experience. Family voice is important but does not supplant the need for first voice.

G

Group Home (GH) provides licensed residential living supports for individuals with disabilities offered under DSP. Locations support 4-12 individuals.

H

Home Share refers to a program or arrangement where community members share their home and provide support to individuals with disabilities who choose to live with them. This can also include arrangements where support is provided in the individual's own home, offering flexibility and ensuring the living arrangement aligns with the person's preferences and needs.

I

Income Assistance Program (IA) is a division under the Nova Scotia Department of Community Services providing financial support to eligible Nova Scotia's in financial need.

Independent Living Support (ILS) is a community-based option offered by DSP that offers support (up to 31 hours per week) through and approved service provider for individuals to live independently in community.

Individualized Funding (IF) refers to direct allocations to individuals with disabilities (or families where appropriate) to be used to purchase services and support directly. Funding connects to each person's individual person-directed plan and disability related need.

Intensive Planning and Support Coordinator (IPSC) is a role using person centred planning to support individuals to set up or connect with individualized supports and services across domains (housing, community inclusion/employment, health etc. as well as generic community and informal supports). They are responsible to support those returning to community from institutional facilities, new people entering the system with significant support needs, and those facing major or complex transitions or changes in support needs or wishes.

L

Local Area Coordinator (LAC) is a role which provides individual planning and coordination supports in local communities across the region to individuals who identify as having a disability and those currently in the system with less complex needs and support arrangements. This includes those waiting to enter the system, persons with disabilities who may not qualify but are seeking information and assistance to connect with their community and non-funded services, and those seeking less complex changes to their support array. LACs would be based in communities across the regions and have a strong emphasis on individual, family and community capacity building and partnerships with local services.

M

Multidisciplinary Teams are clinical teams currently operating out of DSP institutions that provide consultative services offering assessment and recommendation, particularly to address behavioural concerns, to individuals living in community.

N

Nova Scotia Health (NSH or NSHA) is a Health Authority that operates hospitals, health centres and community-based programs providing health services to Nova Scotians and some specialized services Atlantic Canadians.

NSH or NSHA, see Nova Scotia Health

O

Office of Addictions and Mental Health (OAMH), is an office under the NS Department of Health and Wellness responsible to fund mental health and addictions services (outpatient, inpatient and crisis support) and work with community partners on programs for youth and adults, including programs for pre-school age children with autism and children, youth and adults impacted by sexual violence.

P

Person Directed Planning (PDP) is a service contracted by DCS with community organizations that offers individuals with disabilities the chance to work one-to-one with a facilitator to discover their values, dreams and goals and support to connect to community resources that align with their goals.

Personal Directives Act (PDA) is legislation that allows Nova Scotians to create a personal directive relating to personal care decisions and name a delegate if they should become incapable of making personal care decisions in the future. The PDA also provides a hierarchy of statutory decision makers for decisions relating to health care, placement in a continuing care home, or home care services for individuals who are incapacitated and have not named someone to make decisions for them.

R

Reconciliation refers to efforts of Canadians, individually and collectively, to advance reconciliation and renew the relationship with Indigenous peoples, based on recognition of rights, respect, cooperation and partnership.

Regional Closure Teams include a Regional Closure Specialist (**RCS**), Intensive Planning and Support Coordinators (**IPSC**) and a Community Living Facilitator focused on supporting individuals with disabilities in institutional care to plan and transition to community supports.

Regional Hub refers to the new main hubs located in each region as the primary resource point for individuals and families seeking disability supports, for facility closure projects and liaison with clinical services and other government programs.

Regional Rehabilitation Centres (RRC) refers to a DSP facility that provides support to participants who need a range of support including those with significant behavior challenges. An RRC provides both rehabilitation and developmental programs to participants to support their transition to a community-based option. Staffing is provided 24 hours a day, 7 days a week.

Residential Care Facility (RCF) is a facility that provides participants with residential living support, minimal support with their activities of daily living, routine home and community activities. Participants are provided with limited direct support/supervision and generally do not have major medical or behavioral support needs.

S

School leavers refer to youth with disabilities preparing to leave the school system and are planning for valued roles, community life and supports after graduation.

Self-Managed Care is a program that provides funding to people with physical disabilities to hire their own care providers. The program is funded through the NS Department of Seniors and Long-term Care.

Seniors and Long-Term Care (SLTC) is one of the Departments of the Government of Nova Scotia. Seniors and Long-Term Care oversees long-term care facilities and homecare agencies throughout the province.

Service Provider An organization or person that is contracted to provide support services to participants in the Department of Community Services DSP.

Service Request List (SRL) is a record of the eligible DSP applicants and participants waiting for a DSP service or program.

Shared Services combines the services of DSP and programs offered through SLTC to provide support in community for individuals with high personal care and nursing.

Silo refers to the effect of individual government departments working independently with limited contact with each other rather than collaboratively aligning their work and efforts.

Small Option Home (SOH) provides residential home support for three to four participants with varying types of disability.

Social Assistance Act is Nova Scotia law regulating the provision of social assistance in the province. Statutory Entitlement refers to a benefit provided by law.

Supervised Apartments Program (SAP) is a legacy program of the Disability Support Program where DSP participants are supported by a service provider to live independently.

Supported Decision Making (SDM) is the right to use support to make decisions. Supported decision making provides the supports and accommodations an individual needs to express their decisions, will and preferences. These supports may be human support, technical aids/devices to assist with communication or other forms of support.

Support Network refers to the group of people, including family, friends, and community members, who provide emotional, physical, and practical support to an individual with a disability. The support network plays a crucial role in helping the individual navigate daily challenges, make important life decisions, and achieve their personal goals. It is an essential component of a person-directed approach to care and support.

Support Provider (generic) refers to an individual(s) or hired organization that provide disability and daily living supports to a DSP participant which can be formal or informal supports that assist individuals to live their best life in community.

T

Temporary Shelter Arrangements (TSA) are ad hoc arrangements where individuals are supported, typically 1-1 by service provider staff. This option is only considered by DSP in emergency situations and when all other options have been exhausted.

The Disability Rights Coalition (DRC) is one of the parties that filed a complaint against the Province of Nova Scotia (NS) for the failure to provide persons with disabilities the supports and services they need to live in the community. The DRC is an advocacy group made up of people with disabilities, their friends and family members and dedicated professionals.

W

Wind-Up (legal term) refers to closing the operations of an organization, selling off assets, paying off any debts, and distributing any remaining assets to the owners. Once the wind-up process is complete, the dissolution step comes into play and when the organization under law ceases to exist.

INTRODUCTION

ABOUT THE IPSC TRANSITION GUIDEBOOK

The Transition Guidebook has been developed to support the transition of individuals from institutional settings to community-based living as part of the broader Remedy efforts. This guidebook provides a framework to assist IPSCs in supporting DSP participants transition to community-based supports.

The development of this guidebook was informed through consultations with subject matter experts and direct engagement with participants. This collaborative approach ensures that the guide reflects the lived experiences of those undergoing transitions and incorporates best practices from across the field. By drawing on a wide range of perspectives, the guidebook is designed to be a practical and participant-directed resource in supporting transitioning to community-based living.

ABOUT OPPORTUNITIES AND SOCIAL DEVELOPMENT (OSD)

The Department of Opportunities and Social Development helps people live more independent and healthier lives by providing a range of social services. The department works with organizations across the province to deliver social programs, including employment support and skills training, income assistance, housing and youth and family supports.¹

OSD is also responsible for child protection services, the foster care system, and disability support programs. The department has approximately 1,500 staff in 30 offices across the province.

OSD RESPONSIBILITIES

- Helping to make sure that children receive care essential for their wellbeing
- Providing employment support and income assistance
- Working with other departments and community housing organizations to provide supports for people experiencing or at risk of homelessness
- Providing programs to help youth at risk
- Managing the Nova Scotia Child Benefit Program, which helps low-income families with the cost of raising children
- Supporting Nova Scotians with intellectual disabilities, long-term mental illness and physical disabilities to live more independent and self-reliant lives
- Providing research and policy advice to the government on equality, fairness, and dignity for women in Nova Scotia, and supporting the work of women-serving organizations in the community (through the Status of Women Office)

OSD PRIORITIES

- Helping individuals living with disabilities become more independent through increased community-based programming
- Providing employment support, skills training and funding for post-secondary education to help people get the skills and experience they need for work
- Improving the way the department supports people in need
- Working with partners and communities to find ways to reduce poverty and address homelessness throughout the province
- Working with partners to support recommendations and plans from the Restorative Inquiry on the Nova Scotia Home for Colored Children
- Continuing to expand placement options for children and youth in the child welfare system

¹ “Department of Opportunities and Social Development,”
<https://beta.novascotia.ca/government/community-services>

OSD AND THE REMEDY

OSD leads the Province's work to transform the disability support system in Nova Scotia through the implementation of the Remedy for the Findings of Systemic Discrimination Against Nova Scotians with Disabilities. This includes closing institutions and ensuring individuals with disabilities have access to community-based supports and opportunities for independent living. For more information on the government's work to transform the disability support system in Nova Scotia, visit <https://www.dsp-transformation.ca/>.

REMEDY GUIDING PRINCIPLES & SHARED VALUES

The Remedy is about more than just closing institutions. It is about championing social and cultural change to better support persons with disabilities and promote inclusion in communities across Nova Scotia.

The Disability Support Program's Shared Values were developed by the DSP Advisory Committee to guide the implementation of the Remedy and provide the foundations for interacting with each other throughout the Remedy process.²



Figure 1: The DSP Shared Values

Below are explanations as to what these values mean and what they look like in practice.

² John Cox et al., "Shared Values" (presentation, Rebuilding Hope Conference 2023, multiple locations, NS, November 4, 2023).

SHARED VALUE 1: OPEN TO NEW IDEAS

What It Means

- Creativity
- Open-mindedness
- Imagine better
- Flexibility
- Innovation

What It Looks Like

- Using our imagination to do something new and different
- Being ready to accept and explore new thoughts and opinions
- Dreaming of a better world
- Being open to change

SHARED VALUE 2: CHOICE

What It Means

- Self-determination
- Empowerment
- Person-directed
- Co-design
- Personal ownership
- Control over
- First voice
- You decide who supports you and how and who you live with
- Respecting choice even if you don't agree with it, allowing dignity of risk

What It Looks Like

- Persons with disabilities making choices and decisions about their own life
- Persons with disabilities being strong and confident to make decisions
- Persons with disabilities having a say in what happens in their life
- Working together with others to plan and make choices
- Persons with disabilities being responsible for our own decisions
- Persons with disabilities managing and deciding things
- Persons with disabilities' stories, needs, and preferences being important
- Persons with disabilities choosing the people who help them and deciding where and with whom they live
- Others accepting persons with disabilities' choices, even if they don't agree, as long as it's safe

SHARED VALUE 3: VALUING DIVERSITY

What It Means

- Celebrating differences
- Intersectionality
- Respect and acknowledge others' uniqueness
- Recognize and own your biases (prejudices)

What It Looks Like

- Being happy and proud that everyone is unique in their own way
- Knowing that people's race, gender, culture, and other parts that make up their identity impact their lives and experiences
- Respecting and acknowledging that we are all special in our own way
- Being aware of our own judgments about others and take responsibility for them

SHARED VALUE 4: INCLUSION

What It Means

- Citizenship
- Contribution
- Belonging
- Social responsibility
- Same as everybody else
- Promoting and supporting accessibility and inclusion of existing programs, not segregation or separate programs

What It Looks Like

- Persons with disabilities being a part of the community, just like everyone else
- Persons with disabilities doing things that help our community
- Persons with disabilities feeling part of a community
- Taking care of and helping others in our community
- Persons with disabilities having the same opportunities and rights as everyone
- Persons with disabilities accessing the same programs and supports as everyone else

SHARED VALUE 5: HOPE

What It Means

- Optimistic
- Positive
- Kindness
- Continued success

What It Looks Like

- Thinking good things will happen
- Looking for the good things
- Being kind of each other
- Doing more good things

ABOUT THE REMEDY

BACKGROUND

In 2014, three people with disabilities and the Disability Rights Coalition (DRC) sued the province of Nova Scotia over their right to live in the community. After a lengthy legal process, in 2021, the Nova Scotia Court of Appeal agreed with the DRC and said the Province was not supporting people to live in the community in a way that respects their human rights. This is called systemic discrimination. Systemic discrimination is when a wider group of people is treated unfairly, not just one person.

The Court found 4 main problems in how people with disabilities were being supported:

1. People with disabilities are living in institutions instead of their community.
2. People with disabilities don't get to choose where they live – they are often “placed” in a setting that might not be where they want to be or close to their family and friends.
3. People with disabilities who should be getting support are being told they can't have it.
4. People with disabilities who are able to get support are being told they have to wait (being put on a waitlist) for that support when the law says they should have access to support quickly.

To fix these problems, the Disability Rights Coalition (DRC) and the Province agreed to work together on a Human Rights Remedy – a plan that ‘remedies’ the discrimination against persons with disabilities.

The DRC and the Province hired two independent experts – Mr. Eddie Barnik (Australia) and Dr. Tim Stainton (British Columbia) – to look at the problems in Nova Scotia and come up with a way to stop the discrimination and change how the Province supports people with disabilities so their human rights would be respected.

The experts prepared a technical report with key steps, timelines, goals, signs of success, and results. It formed the basis of the court order and its requirements over a 5-year period, which will end on March 31, 2028.

REMEDY KEY DIRECTIONS

Six (6) key directions were identified as the pillars of the proposed Remedy:³



Figure 2: The 6 Key Directions of the Remedy

INTRODUCTION SECTION RECAP

The section provides an overview of the key roles and responsibilities of the Department. This section also provides an overview of the Remedy and key principles established by DSP to guide the Remedy implementation. Through fostering an inclusive culture and promoting choice and empowerment, this section underscores the importance of respecting the rights of individuals during every step of their journey in transitioning to community.

³ Mr. Eddie Bartnik and Dr. Tim Stainton, “Human Rights Review and Remedy for the Findings of Systemic Discrimination Against Nova Scotians with Disabilities,” last modified April 24, 2023, <https://novascotia.ca/coms/disabilities/human-rights-remedy-dsp-final-report.pdf>

TRANSITIONING TO COMMUNITY LIVING

PROCESS OVERVIEW

Transitioning from institutional settings to a home and a good life in the local community can be a significant and sometimes complex journey for individuals with disabilities. It requires careful planning, collaboration, and a deep understanding of each person's unique needs, preferences, and goals.

Section 2 of this guidebook provides a comprehensive overview of the transition process, offering detailed insights into each stage of the journey, while also providing guidance for the Intensive Planning and Support Coordinator (IPSC) to ensure that the process is supported throughout.

This section is designed to walk you through the key stages of the transition process, from the initial engagement with participants and their support networks to the final steps of ensuring sustained support in their new community-based environment. By following this approach, all those involved can work together to ensure that the transition is smooth, person-directed, and aligned with the participant's goals.

The transition process is organized into the following stages:

- Stage 1: Getting to Know Each Other
- Stage 2: Exploring Supports and Communities
- Stage 3: Transition Plan Review
- Stage 4: Moving into the Community
- Stage 5: Ongoing Support

Important to note that the title of these stages is reflected in different language for the participant and family/support network version of the transition guide, in recognition of different groups involvement and roles in the transition process.

STAGE 1: GETTING TO KNOW EACH OTHER

STAGE OBJECTIVES

- ❑ Review the participant's background: Familiarize yourself with the participant's history and existing documentation to build a starting point for understanding their needs and preferences.
- ❑ Identify areas to explore: Prepare a list of areas or topics to discuss, such as goals, support needs, and interests, rather than specific questions. Consider their communication style to ensure the conversation feels natural and comfortable.
- ❑ Plan for an informal introduction: Arrange for a casual, informal interaction with the participant as a first step. This could involve an outing, shared meal, or activity to help establish trust and begin to understand their communication preferences and interests.
- ❑ Document preferences and insights: After the initial interactions, begin documenting the participant's preferences, including communication styles, goals, and key aspects of their support needs.

The goal of this stage is to build a strong foundation by developing relationships with the transitioning individual and support network, understanding their preferences and needs. This stage involves initial meetings with the participant and their defined support network to gather key information and begin the transition process. It's important to listen, learn, and ensure that the participant's voice is central to the planning and decision-making process throughout.

KEY INSIGHTS

- Identify the participant's support network and understand their roles.
- For people without an existing informal network, this will need to involve finding people from their lives who have had a strong relationship with the person. This could include family members or friends who for many reasons may have drifted apart, ex-staff or staff, identified by the person, who have a long-standing relationship.
- Be mindful of potential conflicts within the support network (e.g., different desires from family members).
- Take time to build trust and avoid rushing the process.
- Prioritize the participant's perspective and support open dialogue

KEY ACTIVITIES

This initial stage of the transition process involves the first series of meetings and interactions with a participant and their support network. Understanding these fundamental steps will help IPSCs plan and manage the challenges of transitions effectively, ensuring a smooth and purposeful transition process right from the start.

GETTING TO KNOW YOU

Why is this important: Getting to know each other well is the foundation of building trust and understanding their unique needs and preferences. These initial conversations take time and multiple interactions, allowing both the participant and the support team to grow a meaningful relationship. This process ensures that the participant's voice is heard, and their transition is tailored to their individual journey. Taking time to truly connect helps ensure that the support provided aligns with the participant's long-term goals and comfort.

Examples (or some ideas) of what this could look like:

- Engaging with the participant, family, and their support network:
 - Schedule time to connect with the participant, their family, and/or their support network. This time should be tailored to the unique needs and preferences of the participant.
 - Use this time to introduce yourself, your role, and the upcoming changes. Building real trust will take time, so plan for multiple interactions that allow for relationship-building over time.
 - Ensure that the environment is comfortable and conducive to open communication. Ask the participant where they would like to meet, recognizing that preferences may vary across different meetings (e.g., their home, a coffee shop, a park). The location may also vary depending on who is attending, such as family members or other support networks.
- Establishing trust and rapport through interactions:
 - Spend time getting to know the participant.
 - Engage in casual conversation to make the participant feel at ease.
 - Learn about their life, hobbies, and preferences.

UNDERSTANDING PREFERENCES

Why is this important: Understanding the participant's preferences is essential for creating a person-centered transition plan. It's important to recognize that participants may have different communication styles and capacities, so the approach must be flexible.

Exploring and checking assumptions about their interests ensures that the support team truly understands what matters to the participant. This includes learning to accommodate varied communication styles—whether verbal, non-verbal, or assisted—and creating a space where all preferences, goals, and desires are thoroughly explored, no matter how they are expressed.

This may require giving the person opportunities to express their preference behaviourally while experiencing different environments and activities.

Examples (or some ideas) of what this could look like:

- Talking to the participant to understand what they want and need, ensuring they lead the process:
 - Ask open-ended questions to explore the participant's desires, goals, and needs.
 - Listen actively and validate their feelings and choices.
 - Encourage the participant to share their vision for their future living situation.
 - Document key aspects of their goals and needs to frame their transition plan.
- Using visuals or videos to help participants understand and express their choices:
 - Provide visual aids such as photos, videos, and diagrams to help explain different living options and supports.
 - Use these tools to facilitate discussions and help the participant visualize their choices.
 - Ensure that visual aids are clear, accessible, and relevant to the participant's interests and needs.
 - Do various activities with the person in different environments so they can show you what they like and dislike.
- Meeting support networks:
 - Identify, explore, and engage with all relevant support networks, including families, friends, staff support, and community partners to further understand the participant.
 - Know that this will take time and meetings will vary depending on who is attending the meeting, such as family members or other support networks.

BUILDING TRUST

Why is this important: Building trust is a continuous process that involves consistent and meaningful interactions. Trust is the foundation of a successful transition, allowing open communication and ensuring that the best interests of the participant are always prioritized. Trust between the IPSC, the participant, and their support network enables transparency and clarity, especially as the transition process evolves and new challenges or decisions arise.

When trust is established, the participant feels more comfortable sharing their true preferences, concerns, and needs. This openness ensures that the transition plan remains person-directed and aligned with the participant's goals.

Examples (or some ideas) of what this could look like:

- Developing a strong relationship and trust through consistent and meaningful interactions:
 - Schedule regular check-ins and follow-up meetings.
 - Follow through on commitments and provide clear timelines where possible.
 - Show empathy and understanding, especially when the participant expresses concerns or fears.
- Giving participants time to get comfortable with making decisions and expressing their preferences:
 - Allow the participant to take their time in making decisions, ensuring they do not feel rushed.
 - Speak of past decisions - Engage the participant in conversations about previous decisions they have made. Allow them to reflect on those experiences, discussing what went well, what challenges they faced, and the outcomes of their choices. This can help

them gain confidence in their decision-making abilities and understand the importance of their preferences.

- Acknowledge that decisions may evolve and recognize that as participants move through the transition, their preferences or goals may shift. It is important to create space for these changes and let them know that evolving decisions are a natural part of the process.
- Revisit discussions as needed to ensure the participant is comfortable and confident in their choices.
- Making day-to-day decisions and expressing choices may be new for some participants moving out of institutional settings, so it will be important to provide space and support participants to gain confidence in this area.

HOW TO SUPPORT

Shared below are some key examples and tips to consider so the participant transitioning feels supported through the process.

Prepare thoroughly

- Review any available information about the participant to familiarize yourself with their background.
- Prepare a list of open-ended questions to guide the conversation and explore the participant's preferences and needs.

Create a supportive environment

- Choose a neutral and comfortable location for meetings, such as the participant's current living environment or a community space.
- Ensure privacy and minimize distractions to create a conducive environment for open and honest communication.
- Ensure the participant is aware of who is coming to the meeting and what the meeting is for. This helps the participant feel prepared and has a clear understanding of the purpose of the meeting, which supports transparency and trust.

Practice active listening

- Reflect on what the participant says by summarizing and paraphrasing their words to show understanding and validation.
- Check in with participants on others' opinions or statements related to their feelings. Run those by them to ensure they are at the center of conversations. It's important that people speak to the participant, not for them, and that this is made clear from the outset. This helps reinforce the participant's autonomy and ensures their voice is central in all discussions.
- Avoid overly making suggestions or options. Rather than asking, "Have you thought about a...?" use open-ended language like "Let's look at a whole bunch of options and make a list of what you like and don't like."

Practice cultural sensitivity

- Recognize the cumulative impact of discrimination through the lens of intersectionality and how these effects manifest in individuals and their support systems.
- Understand the significance of cultural identity for those you work with and adapt your methods to align with their cultural context, values, practices, and community.

Document the process

- Keep detailed notes of each meeting, including the participant's expressed preferences, concerns, and decisions.
- Use these notes to inform the development of the transition plan and to ensure continuity in future interactions.
- Avoid negatively framing the person in your notes (i.e. "Mary has a tendency to act inappropriately in some settings..."; instead, "Mary may need some help understanding how best to conduct herself in certain settings...").

Follow up consistently

- Schedule follow-up meetings to revisit discussions, address any new concerns, and continue building the relationship.
- Provide updates and check-in on the participant's well-being regularly to maintain trust and engagement.

Each person is unique

- Recognize that the process and cadence will look different for everyone.
- Understand and be considerate of the dynamics of their relationships and situations.

RECAP STAGE 1: GETTING TO KNOW EACH OTHER

Getting to know each other is focused on creating a strong foundation by developing relationships with each other, understanding their preferences and needs, and establishing trust. Note that this will take time, and it is important to be patient to allow the participant the necessary space and time to feel comfortable. Rushing this process can undermine trust and hinder the overall transition.

It is important to note at this stage that the person may have limited knowledge of possible opportunities. A key part of your job is to build a bigger vision of possibilities for your client by presenting information from a variety of sources.

Key takeaways

- Take initial steps to develop a strong and trusting relationship.
- Ensure that the participant's preferences and needs are well understood and documented.
- Regularly check in with the participant to maintain trust and support.

Move forward to Stage Two – Exploring Supports and Communities once the participant's initial preferences have been thoroughly explored, a relationship has been established between the IPSC and the participant, and the participant's primary support network has been identified.

STAGE 2: EXPLORING SUPPORTS AND COMMUNITIES

The support and planning that comes with building a path to community is a holistic process where understanding support needs, exploring living options, and evaluating support services happen together. Rather than following a strict step-by-step sequence, all parts within this stage are interconnected and can happen simultaneously. For example, while a participant is exploring living options, it is also important that they are thinking about their support needs and the services they'll require to thrive in their new community. Throughout this stage, conversations and decisions in one area will help to shape the other, ensuring the transition process is flexible, personalized, and responsive to the participant's evolving needs.

STAGE OBJECTIVES

- ☐ Work with the participant to understand their natural and formal support needs and community preferences.
- ☐ Refer to EFAC to conduct an InterRAI assessment with the participant.
- ☐ Explore and document potential living arrangements and community settings.
- ☐ Support the participant and their support network to evaluate and select services and providers that align with the participant's needs, preferences and goals.
- ☐ Work with the participant and their support network that the established funding proposal aligns with their vision for their future.
- ☐ Work with the participant and their support network to identify specific vulnerabilities and establish safeguards. This should include understanding past experiences, such as trauma or recurring health challenges, that may impact their well-being.
- ☐ Ensure that an individualized plan for Crisis Prevention and Emergency Response is developed with the participant.

The goal of this stage is to create a comprehensive plan that combines the support needs of the participant with their community preferences. This process involves understanding what services and supports the participant requires, aligning those with available community options, and ensuring support plans can evolve based on the participant's feedback, exploration, and needs.

KEY INSIGHTS

- The participant's preferences and needs guide the entire process, and ongoing conversations help inform both support and living options.
- Flexibility is essential as both support needs and living preferences may evolve during this stage.
- Building a living situation and lifestyle that aligns with what the participant wants their life to be like ensures the transition is focused on their personal goals.
- It is essential to assess both informal and formal supports to create a sustainable plan that involves family, friends, and service providers.

KEY ACTIVITIES

Planning for community living involves considering multiple factors simultaneously through understanding the participant's support needs, exploring potential living arrangements, and identifying services that will help them thrive in their new environment. These elements are addressed together, shaping a comprehensive and cohesive plan.

As participants think about where they want to live, they will also consider the types of help and support they will need in that setting. All decisions work in harmony to ensure the transition is flexible, personalized, and adaptable to changing needs. This stage emphasizes exploring and documenting the appropriate supports and community settings that align with the participant's desires. The participant's support network plays a crucial role in guiding them through the decision-making and planning process.

SUPPORT PLANNING – IDENTIFYING AND UNDERSTANDING SUPPORT NEEDS

Note: This section aligns with the Support Planning and EFAC process.

Why is this important: Identifying the participant's support needs ensures that their transition to community living is supported by the right services and providers. Support planning is key in the transition process where the participant's unique needs, preferences, and goals will be identified and incorporated into a comprehensive support plan. This involves completing key support planning steps, including integrating the InterRAI assessment process into a staged support planning approach, understanding emergency response considerations, and gathering a deep understanding of the participant's desires and circumstances to create a funding plan that is both flexible and tailored to their situation.

- **Developing an initial support plan:** Creating an initial support plan is a crucial step in the participant's planning process. This document captures the participant's desires, interests, and required supports, serving as the foundation for their personalized support journey. During this phase, the IPSC will work closely with the participant and their support network to prioritize their needs and aspirations, especially when key decisions arise. This approach ensures the participant's unique goals are accurately represented and advocated for in both the assessment and funding processes. ***For further details on Support Plan Development, see the IPSC Scope of Practice and associated templates.***
- **Involving the support network:** The participant's support network – including family, friends, and care providers – plays a key role in their support needs. Involving them in the planning will ensure a comprehensive and individualized support plan that will meet the person's needs.
 - Coordinate meetings with the participant and their support network to discuss the participant's plan.
 - Support the individual to address any potential conflicts or differing opinions within the support network, prioritizing the participant's perspective and wishes.
 - Collect input from all members of the support network and document how they can contribute to the participant's support plan.
 - Work with the support network to help align with the participant's goals.

- **Supporting the InterRAI assessment:** A detailed assessment is required to understand the participant's needs in various areas of their life, such as daily living skills, health, and social relationships, and to inform their associated funding level. The EFAC will lead this assessment. The outcome of the InterRAI assessment will define the individual's support level, which will help determine individualized funding bands.

The IPSC can provide support to participants during the InterRAI assessment based on their needs and preferences. For example, the IPSC can accompany the participant to the assessment, help clarify situations and offer context. It's important to note that the IPSC does not make any funding or assessment decisions.

- Use professional judgment to initiate the InterRAI assessment procedure with the EFAC. For DSP participants transitioning to community, some may be ready for the assessment to take place, while for others it may take more time and require a more developed relationship.
 - It will be important to introduce the participant to the EFAC and provide the required support and guidance as the assessment is conducted.
 - Inform the EFAC on the individual's communication styles, and preferences and support the EFAC in building a rapport before the InterRAI assessment.
 - This will look a little different for every participant so it will be important to allocate the required time to ensure the participant feels supported.
 - Allow space for other individuals in the participant's support network to attend the session if desired by the participant.
- **Understanding emergency considerations:** Supporting the prevention of and response to emergency or urgent situations for participants transitioning into community-based supports is important for ensuring stability. It's important to recognize that moving from institutional settings to community environments can be challenging for some individuals. Identifying potential triggers and providing targeted support can significantly reduce the risk of heightened reactions that require urgent support responses. ***For more details on Emergency Support Planning, please review the associated Crisis Prevention and Emergency Response within the participant's support planning document***
 - Incorporate an understanding of episodic mental health and physical health conditions that may impact the participant's well-being or decision-making abilities.
 - Have open conversations with the participant and their support network to understand what their expectations are about moving to community and what areas are causing them concern or worry.
 - Through conversation, understand what makes the participant feel safe, secure and comfortable and find ways to create those conditions in community.
 - Learn from the participant and their support networks what triggers or circumstances may lead to distress, specific behaviour or safety concerns. This can be learned through conversations with the participant's previous care coordinator, staffing support, and immediate support network

- **Developing a funding proposal and support plan:** Following the InterRAI assessment, the IPSC and participant will refine the funding proposal based on the assessment outcomes and determined funding band. During this stage, the IPSC will work with the participant to develop a detailed funding proposal that aligns with the participant's needs and goals as identified in the assessment and builds off the support plan. By refining the funding proposal together, the IPSC helps to ensure that the participant receives the appropriate level of support tailored to their specific support needs and established funding level. ***See IPSC Scope of Practice for further information on Funding Proposal.***
 - Develop a funding proposal and support plan that addresses the participant's individual needs, preferences, and goals, with a focus on their strengths and capabilities.
 - Include specific details about the participant's preferred living situation, desired community involvement, and necessary support.
 - Ensure the proposal builds aligns with the interRAI assessment
 - Work with the participant to define and confirm their funding proposal.
 - Ensure that the funding proposal is flexible and can be adjusted as the participant's needs or circumstances change.
 - Regularly review and update the plan based on feedback from the participant and their support network.
 - Incorporate discretionary funding options to allow the participant to explore potential living arrangements or services before finalizing long-term funding decisions.
 - Ensure that the plan includes a longer-term vision that supports the participant's growth and evolving needs beyond the immediate funding allocation.

COMMUNITY DISCOVERY – CONNECTING WITH, FINDING, AND BUILDING RELATIONSHIPS

Why this is important: Exploring potential living environments and situations allows the participant to experience different community settings firsthand, which is essential for making an informed decision. It helps the participant to understand the practical aspects of living in a new environment and ensures that their preferences are at the center of the transition process. This approach aligns with the principles outlined in the UN Convention on the Rights of Persons with Disabilities (Article 19), which emphasizes the right of persons with disabilities to live independently and be included in the community, with choices equal to others.

- **Research and understand preferred living environments:**
 - Allow the participant to express their community of preference, ask them questions to help guide the process and document specifics.
 - Use the participant's preferences to guide the search for suitable community settings and consider factors such as whether they prefer an urban or rural setting, proximity to employment opportunities, access to family, or desire to live within specific neighborhoods. Provide examples and discuss how each option might meet their unique needs and preferences.
 - Discuss different types of housing that could be a good fit, including apartments, home share arrangements, shared living spaces, or small option homes. Clearly explain the benefits and challenges of each option, ensuring the participant understands their choices.

- Initiate discussions about the participant's feelings and preferences for living with or near others. Explore their comfort level with shared spaces versus independent arrangements, and ensure these preferences are factored into housing searches.
- **Arrange community visits:**
 - Schedule visits to potential communities, ensuring the participant and their support network are engaged throughout the process.
 - Develop a clear plan for visits, identifying responsibilities among the participant's support network to ensure a seamless experience.
 - Note that DSP Service Providers and the participant's support network can access funding for transition activities, including site visits, with reimbursement available at provincial mileage rates.
 - Prepare the participant for each visit by partnering with their support network and adapting to their communication styles and support needs.
 - If the participant desires, consider attending community visits alongside the participant and their support network to provide additional support and insight.
- **Explore community resources and amenities:**
 - Ensure community visits include opportunities to explore surrounding public spaces and community resources, such as parks, shops, public transportation, and health services.
 - If an individual has accessibility needs or requires specific support, make sure to note the availability of supports or considerations within the community of preference.
 - Discuss how these amenities align with the participant's needs and lifestyle preferences.
 - Keep detailed notes on the participant's preferences, any concerns they have raised, and how each community or living arrangement aligns with their needs. This can be documented in a CCM note.
- **Finalize a shortlist:**
 - Work with the participant and their support network to create a shortlist of preferred living environments and communities. Make sure to note what about the community/area the participant liked in case secondary options need to be explored and considered.
 - Offer flexibility to ensure that the participant feels empowered to change their preferences as they explore more living options and take time to discuss the importance of making choices and their impacts.
 - If the participant cannot communicate verbally or has limited capacity, work with support networks to test assumptions and help establish a list of preferred communities and living arrangements.

SUPPORT EXPLORATION – UNDERSTANDING SUPPORT OPTIONS

Why this is important: Evaluating and selecting the right support options helps ensure the participant's transition to community living is successful and sustainable. The participant will lead this process with the IPSC providing assistance and guidance as needed. The emphasis is on putting the participant first, allowing them to explore and choose from a range of support options rather than deciding on their behalf.

- **Meeting with support providers:** Meeting with support providers allows for a detailed discussion about the participant's specific needs and preferences. It ensures that the selected provider can meet the required support levels and that there is a mutual understanding of the participant's goals.
 - Research and meet with support providers who can meet the participant's needs in their chosen community.
 - Take time to understand how formal and informal supports play a role in supporting a participant within their community of choice.
 - Identify support services in the participant's preferred community, including community activities, healthcare services, and social activities that align with their goals.
 - Discuss support options with the participant and their support network to ensure these services meet their long-term needs.
 - Organize meetings between the participant (and their support network) and potential Support Providers. Use these meetings to discuss the participant's support needs and introduce the support provider to the participant.
 - Document how the meetings go and the specific supports that providers offer which align the participant's needs and ensure that the participant's voice is prioritized during these discussions.
- **Exploring community opportunities:** Community opportunities play an important role in the participant's overall well-being and integration into the community. Understanding and finding appropriate support programs ensures that the participant can engage in meaningful activities that align with their interests and goals.
 - Research and visit resources and community activities that are available in the chosen community (e.g. community groups, job opportunities, clubs and activities).
 - Discuss these opportunities with the participant to gauge their interest and suitability.
 - Identify necessary allied health supports (e.g., physical therapy, counselling) and ensure they are accessible in the chosen community. Discuss these options with the participant and their support network to ensure they meet the participant's needs.
 - Coordinate meetings with allied health supports where the participant can meet health professionals in their preferred community.

- **Finding the right match:** Selecting the right provider is critical. Confirming a participant's preferred provider ensures that the participant and their support network feel comfortable and supported in their new living environment.
 - Confirm that the services provided meet both the participant's expectations and the financial allocations available based on the participant's established funding band.
 - Make sure the participant and their support network confirm the chosen provider in a way that does not select or introduce bias.
 - Reviewing providers should involve meeting with those who will be the direct support providers wherever possible rather than managers or other non-frontline staff.
 - Reiterate that more than one support provider can be selected by the participant and their support network
 - Conduct a final review with the participant and their support network to ensure that all selected services and providers are fully understood and agreed upon.
 - Once a provider (or providers) is confirmed by the participant and their support network, the IPSC will work with the designated provider to determine support logistics where necessary.

HOW TO SUPPORT

Shared below are some key elements and tips to consider for the participant feels supported through the process.

Review and prepare resources

- Understand participant preferences: Familiarize yourself with the participant's goals, preferences, and previously gathered information. This may include past conversations, support needs, and any assessments.
- Create opportunities to showcase gifts, passions, and interests: Build ways for the participant to contribute their unique strengths and talents. This helps shape how they are introduced to others and creates opportunities for more meaningful connections.
- Compile a list of potential living environments, support services, and community-based resources that align with the participant's needs and desires.
- Ensure you have materials such as brochures, videos, or community guides to help the participant visualize the options available to them.

Create an engaging environment

- Whether meeting in-person or virtually, ensure the environment is comfortable and conducive to exploring possibilities. Keep distractions to a minimum to help the participant focus on the options being presented.
- When visiting potential living environments, make sure the settings are appropriate, accessible, and aligned with the participant's preferences.
- Let the participant be involved in deciding the timing and location of meetings or community visits, empowering them to feel in control of the process.

Facilitate active exploration

- Help the participant articulate their support needs by asking open-ended questions that encourage thoughtful reflection on their goals for community living.
- Provide opportunities for the participant to explore different community settings, either virtually or in person. Offer a mix of living environments and support providers to give them a comprehensive view of their options.
- Encourage the participant and their support network to be actively involved in every step of the process, from visiting communities to meeting with potential support providers.
- Keep them informed and engaged to build confidence in decision-making.

Maintain flexibility and be responsive

- Be open to adjusting the support plan or community options as the participant's preferences evolve through exploration. Make sure the process is flexible and responsive to their changing needs.
- Listen carefully to any concerns or discomfort the participant may have regarding potential living environments or support providers and address these promptly by offering alternatives or adjustments.

Document the process clearly

- Keep detailed records of the participant's thoughts, reactions, and preferences as they explore community and support options. Use this information to tailor the support plan and make informed decisions.
- As the participant selects support providers and community settings, document these choices clearly in the transition plan to ensure clarity and accountability moving forward.

Schedule regular follow-ups

- Schedule ongoing meetings with the participant to discuss their experiences with community exploration and support provider meetings. These allow for adjustments based on feedback.
- Keep the participant informed about any developments, such as new support options or living arrangements, so they remain engaged and empowered in the process.

RECAP STAGE 2: EXPLORING SUPPORTS AND COMMUNITIES

This stage is about building a future rooted in community and belonging, with a focus on understanding the participant's support needs, exploring living options, and fostering meaningful partnerships with families, networks, and communities. It emphasizes the participant's right to choose and actively shape their life in the community, while recognizing their unique gifts and contributions.

Key to this stage is the idea of co-creation: participants, families, networks, and service providers come together as partners to design a life that is personalized, sustainable, and inclusive. The process incorporates creativity, intentional safeguarding, and adaptability, allowing for flexibility as participants explore different options and evolve their vision of a good life.

Participants are encouraged to explore:

- Living environments that align with their preferences, such as independent apartments, home share options, or small option homes.
- Community resources that enable them to thrive, including opportunities to contribute, connect socially, and engage in meaningful activities.
- Partnerships that reinforce inclusion, reduce isolation, and establish a foundation of sustainable supports within their chosen community.

This stage is not only about making choices, but about imagining possibilities. It recognizes that families, networks, and communities play a vital role in supporting participants to explore and achieve their aspirations. By fostering hope, collaboration, and trust, the process helps participants see themselves as valued members of their communities.

Key takeaways

- Contributions and strengths: The participant's gifts, talents, and goals should shape the vision for their future, guiding both support plans and community engagement.
- Collaborative partnerships: Families, networks, and communities are essential partners in building a meaningful and sustainable life in the community.
- Exploration and flexibility: Participants explore different living environments and community supports, with a focus on finding solutions that adapt to their evolving needs.
- Shared responsibility: This stage requires shared effort across participants, families, IPSCs, service providers, and communities, fostering accountability and mutual trust.
- Planning beyond immediate needs: This process builds a foundation for long-term inclusion, balancing practical support needs with the participant's aspirations for a fulfilling life.
- Creative and personalized solutions: Support arrangements should be innovative, participant-led, and aligned with their vision of what makes a "good life."

By the end of this stage, participants and their networks will have identified and prioritized living arrangements and support services that align with their goals. Together, they will craft an initial transition plan that reflects their strengths, needs, and contributions while ensuring relationships and community connections are central to the participant's life. This plan will include a shared vision of a sustainable and inclusive future, supported by both formal services and informal networks. The participant, their family, and their network will also have clarity on the roles, responsibilities, and next steps needed to move confidently toward community living.

STAGE 3: TRANSITION PLAN REVIEW

STAGE OBJECTIVES

- ☐ Work with the participant and their support network to build a detailed transition plan.
- ☐ Confirm roles and responsibilities with all parties involved in supporting the transition, including facility operators and support networks.

The goal of this stage is to create a thorough plan for the participant's transition to community living. This includes confirming their preferences, documenting all necessary supports, and clearly outlining roles and responsibilities to ensure a successful transition. It is important to understand that the Transition Plan is different from an Individual Support Plan, as outlined below:

Transition Plan

- Focused specifically on the short-term process of supporting a participant in moving to community-based living. It ensures all necessary supports are in place during the transition period and highlights the milestones leading up to the participant's integration into the community.
- Details the specific steps, tasks, and timelines needed to make the transition smooth and successful. These can vary depending on the participant's specific needs and readiness.

Individual Support Plan

- Focused on what the participant wants for their life and building the required supports around them. The Individual Support Plan is an ongoing, living document that details the participant's needs, preferences, and services they will receive once living in the community.
- Guides the long-term provision of services and supports to help the participant achieve their goals and maintain their well-being as their needs evolve.

This stage builds upon the work done in Stage 2, where the community, living arrangements, and support options were confirmed with the participant and their support network. The Transition Plan ensures these are actioned, while the Individual Support Plan continues beyond the move.

KEY INSIGHTS

- The participant should lead the planning process, with their preferences and goals driving the decisions.
- Documentation of roles, tasks, and responsibilities is essential for clarity and successful coordination.
- Confirm and validate the Transition Plan with the participant and their support network multiple times throughout this stage.
- The plan should remain flexible and adaptable to changes in the participant's preferences or needs.
- Not everything needs to happen at once—avoid overwhelming the person.
- Building relationships and communication between all involved parties will take time and may involve challenges, so patience and ongoing support are key.

KEY ACTIVITIES

This stage ensures the Transition Plan is confirmed and that all necessary supports, roles, and responsibilities are clearly defined and understood by everyone involved. Communication is crucial at this stage to avoid misunderstandings.

This stage will allow the participant and their support network to proceed with confidence, knowing that all necessary supports are in place, and the participant's preferences have been respected.

BUILDING THE TRANSITION PLAN

Why is this important: A detailed transition plan ensures that all necessary supports are in place and that everyone involved understands their roles and responsibilities. It ensures that the participant's transition to the community of their choice is flexible and well-coordinated. This process must be in alignment with the Remedy, ensuring the participant's rights and preferences are respected, and supports provided are tailored to their specific needs and goals.

Examples (or some ideas) of what this could look like:

- Create a detailed transition plan:
 - Create a detailed document that outlines the transition plan, including preferences, community support needs, and goals at varying stages of moving to community.
 - Build out the plan alongside the participant and their support network to allow ownership of the process.
- Define and confirm roles and responsibilities:
 - Clearly define who is responsible for each aspect of the transition (e.g. finding an apartment, packing up the participant's belongings, updating personal information, etc.).
 - Ensure everyone involved understands their roles and is committed to the plan.
- Review and adjust the plan with the participant:
 - Review the plan with the participant multiple times to ensure it aligns with their preferences and needs.
 - Adjust as necessary based on the participant's feedback.
 - Work with the participant and their support network to define timelines for the plan to ensure that the transition advances. Transition times will vary based on the needs of each participant as well as community readiness, such as availability of housing.
- Share the Transition Plan with the support network:
 - Distribute the plan to all relevant parties, including the participant's support network.
 - Ensure that everyone is aware of the timeline and their responsibilities.
- Build relationships with the support provider:
 - Ensure that the participant and their personal network have a clear understanding of who the support provider is and what their role will be throughout the transition process.
 - Clearly outline who from the provider's team will be attending to support the participant during different stages of the transition and ensuring consistency and reliability in the support provided.

- Emphasize that the support provider is an integral part of the transition process, working collaboratively with the participant and their network to ensure that the participant's needs are met and that the transition is as smooth as possible.
- Maintain ongoing check-ins and accountability
 - Have frequent check-ins with the participant, their service provider(s), and the support network as this will check for any concerns that arise
 - Adapt the transition plan as needed, based on evolving needs or preferences. Ensure the participant feels comfortable voicing any changes or adjustments throughout the process.
 - Ensure clear accountability by establishing who is responsible for each task and recording it as it advances. This helps avoid any confusion or delays in the transition process.

HOW TO SUPPORT

Shared below are some key elements and tips to consider during this stage to help the participant feel supported through the process and ensure appropriate considerations are taken.

Prepare thoroughly

- Review all gathered information and previous meeting notes to ensure the plan is comprehensive.
- Prepare a detailed transition plan.

Collaborate with everyone involved

- Work closely with the participant and their support network to ensure the plan is aligned with their preferences and needs.
- Schedule regular meetings to review and validate the plan with all parties involved.

Adapt to changing needs

- Ensure the transition plan is adaptable and allows for changes based on the participant's feedback.
- Be prepared to adjust as necessary to accommodate evolving needs and preferences.

Document and share information

- Keep detailed records of all meetings, decisions, and changes to the plan.
- Share the transition plan with the participant, their support network and all relevant parties.
- Ensure all supporting documentation is accessible and shared with relevant parties.

RECAP STAGE 3: TRANSITION PLAN REVIEW

This stage finalizes the transition plan and clearly defines roles and responsibilities to ensure a smooth move to community living. The transition team—including the participant, their support network, the IPSC, and the participant’s service provider—works together to align responsibilities to support the participant as they move into community. During this stage, the confirmed service provider should become integrated into the participant’s support network, understanding their role in supporting the participant during and after the move.

It is important to note that a transition plan differs from an individual’s support plan and is focused on transitioning an individual to community-based support.

Key takeaways

- Build a comprehensive and detailed transition plan.
- Confirm roles and responsibilities with all parties involved.
- Share the plan with the participant and their support network.
- Ensure the plan is adaptable and allows for changes based on feedback.

STAGE 4: MOVING INTO THE COMMUNITY

STAGE OBJECTIVES

- ☐ Ensure all essential supports are in place and ready for the transition.
- ☐ Conduct regular check-ins with the participant and their support network.
- ☐ Observe the advancement of the plan and make necessary adjustments.
- ☐ Prepare for potential issues and have plans in place to address them.

Stage 4 focuses on implementing the transition plan alongside the participant's support network, ensuring all necessary supports are in place and that the participant is well-supported as they transition to community living.

Each person's journey is unique and has its own set of challenges. Recognizing the significance of this step – and its emotional impact on participants and families – is important, as providing consistent support will be key to a successful transition. The plan, developed in Stage 2, should be implemented by the participant, the IPSC and their support network, ensuring that all supports are ready and regular check-ins are scheduled to discuss how the transition plan is advancing and if adjustments are required. Being prepared for unexpected challenges with contingency plans in place will help ensure a smooth and supportive transition process.

KEY INSIGHTS

- Emphasize the importance of regular meetings and documenting of decisions.
- Prepare for potential issues and have plans in place to reduce risk.
- Ensure all supports are in place before the transition begins.
- Maintain open communication with the participant and their support network.

KEY ACTIVITIES

This stage is pivotal in the transition process, as it involves supporting and launching the established transition plan. The focus here is to ensure that all identified supports are in place, the participant is adequately prepared for the transition, and any potential issues are anticipated and addressed.

IMPLEMENTING THE TRANSITION PLAN

Why is this important: Implementing the transition plan is key for ensuring that the participant has the necessary supports in place to move to the community.

Examples (or some ideas) of what this could look like:

- Ensuring all supports are in place:
 - Verify that all identified supports and services are ready and available.
 - Confirm that housing arrangements, healthcare, and other essential services are in place.
- Conducting regular check-ins:
 - Schedule check-ins with the participant and their support network.
 - Use these check-ins to address any issues or concerns that arise.
- Remain flexible to changes:
 - Support the participant's transition process and make necessary adjustments to the plan.
 - Be flexible and responsive to the participant's needs and preferences.
- Prepare for potential issues:
 - Identify potential challenges and have plans in place to address them.
 - Ensure contingency plans are ready for any potential risks.
 - Document emergency plans and considerations.

SUPPORTING THE PARTICIPANT

Why is this important: Providing ongoing support helps ensure the participant feels comfortable and supported during the transition while building trust and confidence in their new living arrangement.

Examples (or some ideas) of what this could look like:

- Letting the participant lead the process
 - Some participants may need more time to feel comfortable with decisions, while others may move faster.
 - Break down the transition process into manageable steps, offering time to reflect after each decision. This ensures the participant doesn't feel overwhelmed and can make decisions confidently.
 - Build timelines that work for the participant. It is important to share that these timelines can evolve as needed to support the individual moving.
 - Determine how the participant will use the **Individualized Funding (IF) Backbone**, which plays an important role in coordinating funding. The IF Backbone also helps resolve funding-related queries, reducing the person's stress during the process.

- Provide continuous support and reassurance:
 - Offer ongoing support and reassurance to the participant throughout the transition.
 - Be available to answer questions and address concerns as they arise.
- Maintain open communication:
 - Keep communication lines open with the participant and their support network.
 - Use multiple communication methods to ensure accessibility and clarity.
For example, summarize discussions in writing and share them with the participant and their team.

HOW TO SUPPORT

Shared below are some key elements and tips to consider during this stage to ensure the participant feels supported through the process and that appropriate considerations are taken.

Prepare thoroughly

- Ensure all supports and services are in place and ready before the transition begins.
- Prepare contingency plans for potential issues or negative outcomes.

Provide active and ongoing support

- Conduct regular check-ins with the participant and their support network to understand how the transition is going. It's essential to check in on both the specifics of the move and the participant's formal and informal needs. Use these check-ins to address any issues or concerns that arise.
- This may involve close collaboration with the support network and the participant's support provider(s).
- Be open to receiving calls, whether it is for a full meeting or shorter check-ins. At this stage, check-ins should go beyond just a quick meeting; they should ensure that everything is advancing according to plan.
- Confirm that each member of the participant's transition team understands their role and responsibilities, and ensure this information is documented and shared.

Maintain open and accessible communication

- Maintain open communication with the participant and their support network.
- Use multiple communication methods to ensure accessibility and clarity.

RECAP STAGE 4: MOVING INTO COMMUNITY

This stage is focused on implementing the transition plan, ensuring all supports are in place for the participant's move to community living, advancing the plan, and making adjustments as needed. Regular check-ins and open communication with the participant and their support network are important during this phase.

Key Takeaways

- Ensure all supports are in place and ready for the transition.
- Conduct regular check-ins with the participant and their support network.
- Support the transition plan and make necessary adjustments as required.
- Prepare for potential issues and have plans in place to address them.

Move forward to Stage Five: Ongoing Support once the participant has moved to the community and initial support needs have been met.

STAGE 5: ONGOING SUPPORT

OBJECTIVES

- ☐ Conduct regular check-ins with the participant and their support network.
- ☐ Ensure the person and their network know who to contact and how if they have concerns or issues.
- ☐ Monitor implementation of the plan and make necessary adjustments.
- ☐ Respond to and address issues and other considerations as they arise.
- ☐ Ensure prompt contact and communication.

The main goal of this stage is to ensure that the participant's transition to community living is successful and that they feel supported and empowered in their new environment. This stage involves regular check-ins, advancing the plan, and making necessary adjustments to ensure ongoing satisfaction and support.

KEY INSIGHTS

- Regular check-ins are crucial for advancing the plan and identifying areas for improvement. These do not need to be overly formal or scheduled 'meetings' but may be simple catch ups over coffee, for example.
- Ensure the support plan remains adaptive and responsive to the participant's changing needs and preferences.
- Regular communication between the IPSC, support providers, and the participant should guide adjustments and service planning.
- Incorporate both professional judgment and participant preferences when making decisions about future steps.

KEY ACTIVITIES

As the participant settles into their new environment, the focus of this stage is on ensuring their well-being and making any necessary changes to the support structure. Flexibility is key, as the participant's needs may evolve over time.

CONDUCTING REGULAR CONNECTIONS

Why is this important: Regular check-ins are key for ensuring that the participant is settling well into their new environment and that any issues or concerns are addressed promptly. This helps to maintain a sense of support and stability.

Examples (or some ideas) of what this could look like:

- Schedule connections:
 - Arrange meetings with the participant and their support network to discuss what is going well and to address any concerns. Ensure that the meeting times and frequency are based on participant preferences.
 - Gather feedback and adjust the support and transition plans as needed.
 - Use informal check-ins and conversations to give the participant opportunities to share concerns
- Understanding of the change:
 - Be proactive in identifying and addressing any challenges that arise.
- Provide continuous support:
 - Offer ongoing reassurance and support to the participant throughout the transition.
 - Be available to answer questions and address concerns as they arise.

EXPANDING SUPPORT PROVIDER RESPONSIBILITIES

Why is this important: As the participant transitions into community-based living, the Support Provider becomes the primary source of daily support. It is important for the IPSC to maintain contact to ensure that the Support Provider is fulfilling their responsibilities, and the participant is supported in moving to their new community. This involves ongoing discussions, regular connections, and collaborative problem-solving to ensure the participant's needs are continuously met. The IF Backbone plays a critical role in ensuring seamless financial coordination between the participant and the Support Provider, enhancing accountability and transparency in service delivery.

Examples (or some ideas) of what this could look like:

- Support Provider roles:
 - Recognize that the Support Provider now assumes more responsibility, ensuring the participant's day-to-day needs are met based on the established support plan. Depending on the established support plan this may be a hired provider, family member, or friend.
 - Understand how the IF Backbone can support participants in coordinating funding arrangements and ensure the participant feels confident in the financial processes.
- IPSC support and engagement:
 - Conduct regular check-ins with the participant to discuss how things are going and to gather updates on their well-being.

- Engage with those supporting the participant to understand how the move to community is going for the participant and work with them to address any concerns.
- Keep open lines of communication between all parties, ensuring a collaborative approach to problem-solving and planning.
- Collaborative problem-solving:
 - Work collaboratively with the participant and all involved to resolve any challenges, ensuring that the support plan remains effective and responsive to their needs.
 - Encourage open communication between the participant, their support network, and the service provider to foster a supportive and transparent environment.

KEEPING THE TRANSITION PLAN FLEXIBLE

Why is this important: Making necessary adjustments to the plan ensures that the participant's needs and preferences are continuously met and that they feel supported and empowered in their new community. By actively engaging with the participant their support network you can support timely adjustments that reflect evolving needs and promote a positive and sustainable transition experience.

Examples (or some ideas) of what this could look like:

- Adapt the plan based on feedback:
 - Use the feedback gathered during check-ins to make changes in the support and transition plans as needed.
 - Ensure support and transition plans remain flexible and responsive to the participant's evolving needs.
- Maintain open communication:
 - Keep communication lines open with the participant and their support network.
 - Use multiple communication methods to ensure accessibility and clarity.

HOW TO SUPPORT

Shared below are some key elements and tips to consider during this stage that can ensure that the participant feels supported through the process and that appropriate considerations are taken.

Prepare for regular check-ins

- Prepare a schedule for regular check-ins and updates.
- Review previous meeting notes and feedback to inform upcoming check-in discussions.

Stay attentive and aware

- Be attentive to any signs of distress or dissatisfaction and address them promptly.

Remain flexible and adaptive

- Be prepared to adjust plans as needed.
- Ensure the participant's needs and preferences continue to be met.

Stay connected

- Maintain open communication with the participant and their support network.
- Use multiple communication methods to ensure accessibility and clarity.

RECAP STAGE 5: ONGOING SUPPORT – TRANSITION CHECK-INS

This stage focuses on ensuring that the participant's transition to community living is not only successful but also sustainable in the long term by providing active support and making adjustments as needed. It is essential to recognize that the participant's needs and circumstances may change, and that support plans should be flexible and responsive to those evolving conditions.

The IPSC relies on professional judgment to assess whether continued dedicated support is necessary or if the participant can transition to a less intensive support model. After the transition process, the IPSC assesses the participant's ongoing support needs in collaboration with the regional hub team to determine future DSP service requirements. For participants requiring external services (e.g., DHW, OAMH, SLTC), or those with a limited support network, extended IPSC involvement may be necessary. In these instances, transitioning to an LAC might be delayed ensuring the participant receives the appropriate level of care and support without the risk of resource limitations affecting their community integration.

Key Takeaways

- Schedule regular contact with the participant
- Check in with the participant's support network regularly.
- Update the support plan with any new information or adjustments as required.
- Continue to adjust the existing plan to address the participant's current needs.
- Determine if the participant can transition to a less intensive support model, working with an LAC (see scope of practice).

MOVING FORWARD AFTER THE TRANSITION

As we conclude the formal stages of the transition process, it is essential to recognize that the journey does not stop here. Transitioning to community living is a continuous process that requires ongoing care, support, and adjustments to meet the participant's evolving needs and preferences. The following key elements will ensure participants continue to have the person-directed support they need to live successfully and confidently within their community.

SUSTAINED SUPPORT AND PROFESSIONAL COLLABORATION:

Moving forward, the role of the DSP support team, including IPSCs and LACs, is to work together with the participant to ensure that the right level of support is provided. This involves professional collaboration, and determining the appropriate level of continued involvement based on the participant's support needs. Decisions about ongoing support are not made in isolation but rather led by the participant in partnership with their network.

TRANSITION IS A BEGINNING, NOT AN END POINT:

As people settle into their new life, new opportunities and interests may emerge that require changes to the support plan. The plan should be thought of as a living document rather than a fixed set of actions.

ONGOING TOUCHPOINTS AND FLEXIBILITY:

Sustained support involves regular check-ins and communications to ensure that the participant's transition to community living remains stable and successful.

FUTURE PLANNING AND RELATIONSHIP BUILDING:

The relationship between the participant and their support network extends beyond the initial transition. It's important to maintain strong connections, open communication, and a proactive approach to addressing any emerging needs. Future planning helps support the participant's long-term well-being and quality of life, allowing them to thrive in their new community.

For further information on continued support following the transition process please refer to the IPSC and LAC scope of practice

QUESTIONS TO SUPPORT THE TRANSITION PLAN

The following questions below can be used as starting points to guide conversations during the stage in the process of transitioning to the community. It is important to note that these questions are just ideas and prompts to build on as conversations and relationships evolve.

STAGE 1: INITIAL ENGAGEMENT – BUILDING TRUST AND UNDERSTANDING

Objectives

- Build trust and rapport with the participant and their personal support network.
- Understand the participant's goals, preferences, and support needs.

What to ask

- What are your goals for living in the community?
- What is important to you when making decisions about where you live?
- Who would you like to include in your support network throughout this process?
- How would you prefer to communicate with your support team (frequency, methods)?
- What are your biggest concerns or hopes for this transition?

STAGE 2: PLANNING FOR SUCCESS – EXPLORING SUPPORT AND COMMUNITY

Objectives

- Develop a comprehensive support plan.
- Explore community living options and support services that align with the participant's preferences and needs.

What to ask

- Where do you want to live?
- What would a day in your new community look like to you?
- Are there activities that you want to live close to?
- How do you feel about roommates?
- Do you have any friends that you would like to live with?

STAGE 3: FINALIZING THE PATH – TRANSITION PLAN REVIEW

Objectives

- Confirm the participant's preferred community and support options.
- Finalize the transition plan with all necessary roles and responsibilities defined.

What to ask

- Does the transition plan reflect your preferences and goals for moving into the community?
- Are you comfortable with the supports and services outlined in the plan?
- Are there any parts of the plan that you would like to change or adjust?
- Do you feel confident about the roles assigned to the people in your support network?
- Is there anything you are unsure about before we finalize the plan?

STAGE 4: TRANSITION IN ACTION – MOVING INTO THE COMMUNITY

Objectives

- Ensure a smooth move into the community.
- Support the participant as they settle into their new environment.

What to ask

- How are you feeling about the move?
- Is there anything we can do to make this transition easier for you?
- Are you clear on what is going to happen on move-in day?
- Who would you like to be present during the move to help support you?
- Is there anything you need help within the days leading up to or after the move?

STAGE 5: ONGOING SUPPORT

Objectives

- Conduct regular check-ins to follow-up with the participant.
- Make necessary adjustments to the support plan as the participant's needs evolve.

What to ask

- How are you feeling about your new living situation?
- Are the supports you are receiving meeting your needs?
- Are there any areas where you feel you need more or less support?
- Have you encountered any challenges that we should address?
- Is there anything we should adjust to help you feel more comfortable?