# Community Transitions:
# Manitoba Developmental Centre's Guiding Principles

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# Introduction

In January 2021, as part of a critical step to increase the quality of life and community inclusiveness for individuals living with an intellectual disability, the Manitoba government announced the transition of residents from Manitoba Developmental Centre (MDC), located in Portage la Prairie, to community living over a three-year period. This decision was based on best practices in Canada and around the world. It was also based on provincial legislation, which supports a shift towards community living for individuals living with an intellectual disability.

The process of transitioning individuals to the community itself was person-centred, focusing on residents' likes, dislikes and needs, ensuring they had a voice in decisions about their new home. The process involved the residents, their families, substitute decision makers (SDMs), staff at MDC, their care team, community service workers (CSWs) and community resources all working together to find a safe and supportive home in the community that was suited to the needs of each resident.

This process included the use of *"The Right Way: A Guide to Closing Institutions and Reclaiming a Life in the Community for People with Intellectual Disabilities"* (March 2010), developed by People First of Canada-Canadian Association for Community Living Joint Task Force on Deinstitutionalization.

"*The Right Way"* refers to foundational guiding principles and values, stating that: "Renewed efforts to assist people to leave institutions must be guided by those values and principles that are known to achieve positive outcomes."

Deinstitutionalization must be about more than simply closing large institutions, about more than simply replacing large institutions with smaller ones, about more than creating networks of group homes, and ultimately about more than substituting isolation outside the community for isolation within the community. A deinstitutionalization plan must ensure that people have:

1. The right to choose where they will live, and with whom;
2. Services/programs that are directed and controlled by the person and that are respectful of that person's right to make choices and take risks;
3. The right to individualized living arrangements and control over the required individualized funding;
4. The necessary disability related supports needed to fully participate in the community;
5. Support, as necessary, from friends/family/advocates to assist in decision making (supported decision making);
6. Services that meet all of their needs and are of high quality, portable and accessible."

These Guiding Principles and Values, as well as the 10 Key Elements of Successful Closure Plans strongly informed the province's work as it collaborated with residents, their family members, and other key stakeholders, agencies and advocates.

# "The Right Way" and the Manitoba Developmental Centre

The following summarizes the 10 Key Elements of Successful Closure Plans outlined in *"The Right Way",* including examples from the MDC transition process to show how these recommendations were adopted to create real homes in the community for individuals transitioning from MDC.

## 1. Involve Champions for Community Living

*"The Right Way"* recognizes the importance of "Involving Champions for Community Living", noting that,

- What has happened in Canada shows that the decision to close an institution and embrace community living requires vision, passion, leadership— and champions…
- These champions have come from every part of society— from the volunteer sector, advocacy organizations, from community living agencies, from inside the institutions, from within government and political parties.
- Champions will come from different sectors in each jurisdiction. It is important to engage a variety of champions and allies to build a united approach to achieving institutional closures.

To do this, the province established a Community Transition External Advisory Committee. Committee members included:

- Persons with lived experience
- Special Advisor on Disability Issues
- Community Agency representatives
- Family members of current and past residents from MDC
- Southern Chiefs Organization
- People First Manitoba
- Community Living Manitoba
- Inclusion Winnipeg
- Community Living disABILITY Services (CLDS)

The first committee meeting was held on June 29, 2021 and meetings continued monthly. The committee provided advice, comments, and feedback on the MDC

Transition Project through a community inclusion, person-centered, rights-based perspective.

In addition to the Community Transition External Advisory Committee, several other committees, with specific roles related to transition, were also established. These included an Internal Advisory Committee, the Workforce Adjustment Team, and the Resident Transition Team.

The Resident Transition Team was comprised of representatives from MDC, Abilities Manitoba, the Public Guardian and Trustee Office and the Department of Families including Community Living disABILITY Services (CLDS) Community Service Workers. The Team worked on developing and carrying out a strategic transition plan based on individuals' needs and available resources.

A Community Transition Specialist role was also created to support individuals transitioning to the community from MDC. The Community Transition Specialist built partnerships between residents from MDC, their support networks (family, friends and staff from MDC) and the agencies who would be providing support to these residents in the community. The Community Transition Specialist also acted as a link between government program areas such as Community Living disABILITY Services (CLDS), income support programs, and other service providers in the community such as homecare.

The province also valued its continued partnerships with community living champions such as Inclusion Winnipeg, Community Living Manitoba and Manitoba Possible, to name a few. Partnerships like these were critical to continued efforts supporting adults living with intellectual disabilities and staff working in this sector.

## 2. Ensure that the Needs and Preferences of the Person Come First

The second key element in identified in *"The Right Way"* (page 10*)*, states that,

- The closure of an institution has to do with planning for each individual. It is primarily a process of creating responsive, individualized supports and services that will enable each person to live in his or her own home, to engage in meaningful activity in the community and make decisions about his or her own life.
- Each individual must be empowered to choose where and with whom to live, the resulting living arrangement must truly be that person's home.
- It must also be understood that an individual's preferences and needs may change once they are in the community. Planning should be seen as ongoing and not a one-time process.

When it came to supporting individuals from MDC throughout the transition, their needs and preferences were the priority. This included a focus on individualized, holistic and

person-centered planning. To support this, Inclusion Winnipeg offered education sessions at MDC to ensure that the residents transitioning from MDC benefited from the latest developments in person-centered planning.

Involving residents from MDC in person-centered planning for the transition meant asking the residents very specific questions about their personal wishes, support needs and preferences including cultural service provision. If a resident required assistance in sharing communicating their wishes, family members and/or their long-time support staff assisted in determining these decisions on behalf of the resident.

One example of how residents from MDC were involved in person-centered planning was through the development of a new communication tool. A member of the Community Transition External Advisory Committee with lived experience voiced concern for how residents who were non-verbal would be able to take part in person-centered transition planning. As a result, a booklet was developed that had visual cues assisting residents in making choices and identifying key elements such as:

- what was important to them,
- what kind of things do they like to do,
- who their friends were,
- where they would like to live, and
- who they would like to live with.

As part of person-centered transition planning, residents and their families had the opportunity to visit potential homes in the community (virtually or in-person). Once a potential home was selected, residents were able to decide how many visits they would have prior to moving, if they wanted to stay overnight at the home or to just have short day visits. The number of homes visited was different for everyone. Agency staff who worked at the home also had the opportunity to visit the residents at MDC to build a connection with them and to get to know their likes, dislikes and support needs before they moved to their new home.

Planning was viewed as an ongoing process with changes being made along the way. For example, one resident and their family had initially discussed a plan to move to Winnipeg to be closer to family, and as a result, options in Winnipeg were explored. A home was selected, and the resident visited the home a few times. The resident decided they did not want to move there and wanted to continue living at MDC. They stated that if they had to leave MDC, they wanted to live in Portage la Prairie. Options in Portage La Prairie were explored and a home was identified that met the resident's preferences, could support their needs and had suitable roommates. The resident visited the home a number of times, got to know the new staff and successfully moved into the home of choice.

A second family wanted their loved one to move to Churchill, the community they all thought of as their home. After the family had some time to talk about it, they decided

that the whole family would move to Western Manitoba for retirement. A home for their loved one in Western Manitoba was chosen instead of a home in Churchill, so they could all live in the same community together.

## 3. Respect the Experiences and Role of Families

According to the third key element from *"The Right Way"* (page 11) it is essential to respect the experience and roles of families:

- The views of families must always be thought about when starting to plan for an individuals move to their own home in the community…
- Families should be informed and involved from the beginning… Families will often be the best source of information about the person and be part of the person's support network....
- Families who have already been through the planning of a successful transition to the community should be invited to play a key role.

For the residents from MDC, the views of families were considered from the start. There was an understanding that the decision to transition residents from MDC to the community may be difficult for some families, bringing up a variety of emotions for them.

*"The Right Way"* notes that, in the past, families were usually told that places like MDC were the best option for their loved one. For many families, MDC was the only home that their family members knew. It was expected that families would have lots of questions about the decision to transition residents from MDC to the community. Efforts were made to keep families informed and involved at every step of the process. Before the public announcement about the decision to transition residents from MDC to community living, the province contacted residents' families, including next of kin and SDM. The majority of families were first contacted by phone and provided with:

- information about the reason for the decision,
- changes in the models of support available for individuals in the community,
- what the transitions meant for their family member,
- the planning process,
- how they could be involved in the planning process, and
- how information would be shared with them along the way.

During the first phone call, families were able to express their concerns, feelings, views, and ask questions about the transition. Shortly after the first phone call with families, a letter was sent containing the information provided to them over the phone. The letter also had contact information if they had any other questions or concerns. Within the next few months, families were provided with an information booklet and a survey to fill out about where they would like to see their loved one live.

A virtual meet-and-greet was held early in the transition process to provide family members with the opportunity to learn more about: living in the community, Community Living disABILITY Services (CLDS), and community agencies; and to ask questions. Information about the agencies, along with the presentation, and the questions and responses from the meet-and-greet, were shared, in hard copy, with all families. Communication with families continued through quarterly and monthly transition updates.

Families were also encouraged to take part in person-centered planning and transition process for their family member, as well as further encouraged to connect with the Community Transition Specialist, Residential Coordinator or Clinical Coordinator at any step along the way.

Family members who had experience with planning transitions from MDC to community living were included as part of the Community Transition External Advisory Committee. They shared their experiences of successes and challenges with the committee so that the transition process could be better informed.

## 4. Facilitate Person-Centered Plans and Create a Real Home for Each Person

The fourth key element from *"The Right Way"* (pages 11-12) highlights that,

- Services must be based on the individual needs and preferences of the person being supported.
- The goal is to support the individual in ways that meet their needs and allows them to live in a real home, to participate meaningfully in community life, to make real choices and have their rights and wishes respected.
- The creative use of resources and protocols to address potential gaps or conflicts in community living supports should be addressed across all relevant areas of government.

Residents moving from MDC to the community had choices about where they would like to live and who they would like to live with. This information was presented through photos, videos, and/or a tour of the home in the community of choice. If an individual was not able to communicate their wishes, family members and/or long-time support staff assisted in deciding what would be best for that individual.

Once the agency who would support the resident in the community was decided on, detailed personal information about the specific needs and interests of the resident was shared. A checklist was developed to make sure that all information was shared with the new support team, including personal, medical, and care needs. This information was reviewed as part of the transition planning process. The information included things like medications, routines for bathing, communication styles as well as favourite items,

foods, activities, cultural and spiritual preferences etc. A transition plan was then developed with this information. The residents had opportunities to visit their new home before moving. Each resident decided on the number of visits to the new home before they moved in.

The following is an example of how person-centered planning helped in creating a real home in the community for residents from MDC. Two residents who lived together at MDC wanted to move into a home in the community with each other. Homes in the community that had space for these two residents to live together and that would meet their needs were found and then reviewed with the residents. After careful consideration, a suitable home was selected. Once the home was selected, a detailed transition plan was collaboratively developed, with the residents and the transition planning team (including the agency). To ensure a smooth transition, the residents had the opportunity to visit their potential new home before the move. This gave them a better understanding of what it would be like to live there and if it would work for them. Once they decided that this was the home for them, the moving date was set. On the day of their move to the new home, the residents received a warm welcome from a friendly neighbour who kindly shared cabbage rolls, creating a feeling of community for everyone in the home.

Facilitating person-centered plans and creating a real home for each individual sometimes required the creative use of resources to address potential gaps. For example, many residents who lived at MDC did not have photo identification, like a driver's licence, that could be used in the community. This was not a problem while they were at MDC because they were known in the community and could easily get library cards and participate in community recreation programs. However, when these residents transitioned to their new homes in different communities, it was possible that they could face barriers opening bank accounts and participating in activities that require photo identification. To solve this issue, the department collaborated with Manitoba Public Insurance to ensure the residents had provincially accepted photo identification before they moved to community.

## 5. Create Quality Supports, Services and Safeguards

According to the fifth element in *"The Right Way"* (pages 12-13),

- The need for increased capacity in the communities can be identified in a systemic and timely way, so that planning can occur, and supports are in place when individuals make the move to their homes in the community.
- Safeguards and monitoring plans should be included in the individualized plans for each person moving into the community.
- The main focus of the evaluation should be on the outcomes, how each person is doing and if they are happy with their life in the community.

The need for more residential resources, including Shift Staffed Homes and Agency Supported Home Shares, in the community to support individuals transitioning from

MDC was identified early in the planning process. Many factors were considered when identifying this need, for example:

- preferred location of home (identified by residents and/or their support network),
- support needs of the residents living at MDC,
- existing residential resources, and
- vacancy rates.

After reviewing these factors and comparing them to existing resources, it was found that approximately 80 - 100 residents at MDC would require new residential resources to be developed in the community. These resources would have to consider residents individual support needs which could be low, moderate or specialized in behavioural, deafblind and/or medically complex. As identified by residents' and/or their support networks preferences, most of these resources would need to be developed in Winnipeg and Portage La Prairie, with a few residents requiring resources in Western and Northern Regions.

Indigenous people who lived at MDC, and their families or support networks, were asked about moving back to their home communities. No one asked to go back at first, but it was an option that could be looked at for anyone who was interested.

It was recognized early on that the Community Living disABILITY Services (CLDS) sector capacity would need to be expanded in order to meet the needs of individuals transitioning to community from MDC. Government and agencies worked together to fill in these gaps by:

- expanding the locations where services were provided in,
- increasing the overall number of resident resources available,
- reviewing new resources for accessibility, and
- developing new residential services, specifically Purpose Built Homes (PBHs).

Some individuals transitioning from MDC had greater behavioural support needs, requiring staff skilled in conflict resolution and risk management. To meet this need in the community, PBHs were developed. PBHs were intended to be transitional placements where individuals were supported until they could move safely into other homes in the community.

Once this general need for resources was identified, government and agencies worked together to develop the resources and supports for specific individuals to transition to their home in the community. The relationship between agencies and MDC was supportive and focused on the person transitioning, ensuring they received quality supports and services.

Nurse Consultants and Occupational Therapists worked with the individual resident, MDC, and the agency, ensuring that the new residential resources met the needs of the individual who would be living there. While these resources and supports were being developed, residents continued to live and receive support at MDC. In some situations, staff from the agency - that would eventually be supporting the individual in the community - visited them at the MDC. They learned who the person was and what supports they may need.

Support for some in the community might have also included Home Care. To facilitate the provision of quality services and supports to individuals transitioning from MDC, discussions with Home Care about the increased service need in the community occurred. Home Care was also proactively engaged on an individual level to ensure a seamless transition for residents.

Each individual transitioning from MDC to the community had a specific CSW assigned to support them. The CSWs provided oversight, monitoring and support to individuals who transitioned to the community. They ensured consistency in care, identified issues, and followed-up to address them. The Resident Transition Team also provided an oversight function ensuring issues concerning an individual who had transitioned to the community were proactively addressed in a timely manner.

Additionally, an evaluation of the transition process is being conducted by a third party. The evaluation will consider the transition process and the outcomes for those who transitioned to the community, focusing on their health and quality of life. The evaluation is an added measure to ensure that residents from MDC have transitioned successfully to the community.

## 6. Recruit and Develop Qualified Support Staff

The sixth key element in *"The Right Way"* (page 13-14), states that, "one of the most important factors in the success of community living arrangements is the availability of skilled and knowledgeable employees to provide the individualized supports needed by individuals with intellectual disabilities in their homes and communities." It also says that, "virtually all communities go through periods where it is difficult to find and retain qualified support staff…this may be especially true where community support staff are not well compensated."

Service providers hired and trained staff in advance of an individual's transition from MDC to the community. Training included learning information specific to the individual being supported as well as system wide training for staff who support adults living with an intellectual disability.

The MDC transition plan included agency staff shadowing MDC staff. Agency staff, who would be supporting the individual in their new community home, received training by working alongside MDC staff in the resident's home while at MDC. This helped the

resident develop meaningful relationships with their new support team. It also provided opportunities for agency staff to ask questions to those who knew the residents well.

Training of agency support staff also included:

- Non-violent Crisis Intervention (NVCI)
- Epilepsy Education
- Adults Living with an Intellectual Disability Act (Formerly the Vulnerable Persons Living with a Disability Act- VPA), including topics such as the definition of abuse and mandatory reporting.
- Medication Management
- Personal Care
- Lifting and Transfers

Nurse Consultants took part in providing education to agency staff on written care plans (ex. bowel management, urinary tract infection (UTI) awareness, etc.) and occupational therapists provided assessments and training to agency staff on assistive adaptive equipment that individuals may benefit from. Behavioural Specialists took part in writing plans to guide agency staff to proactively engage with individuals and meaningfully support someone to de-escalate.

## 7. Establish Community Partnerships

The seventh key element identified in *"The Right Way"* (page 15) focusses on the importance of community partnerships:

- The successful closure of an institution depends on sound collaborative working partnerships between individuals, families, government and community agencies and any number of diverse allies.
- Partners must work together from the planning stages to the transition to the community to ensure that service planning is truly person-centered and individualized and that the rights and the choices of each individual remain central.

As noted throughout this report, community partnerships were made in different ways to make sure that each individual transition from MDC was truly person-centered. Oversight of the transition process from the Resident Transition Team, the Community Transition External Advisory Committee and the agencies themselves, worked closely together as a team helping to make each resident's transition to their new home as successful as possible.

Detailed plans were made for each person, setting up support in the community that was like what they had at MDC. This meant working with doctors, nurses, therapists,

behavior specialists, and other services like Home Care and pharmacies. These health providers were involved in the transition and were available for help afterward if needed.

As part of the planning process, partnerships were developed with agencies, like Life's Journey, to ensure services were provided by staff who have a cultural understanding of service delivery, and that the individuals' cultural needs were prioritized.

Advocacy organizations such as People First Manitoba, Abilities Manitoba, Inclusion Winnipeg, Community Living Manitoba and Manitoba Possible etc. were champions for community living and had supported the MDC transition process.

## 8. Establish a Clear Plan and Time Frame for Closing the Institutions

The eighth key element in *"The Right Way"* (page 15-16) states that government and community leaders need to make a clear, strong promise to close the institution and put resources into the community. They should also make sure each person living in the institution gets help to move to their own home in the community. It's important to have a set time frame for getting this done.

On January 29, 2021, the Manitoba government announced its commitment to deinstitutionalization by publicly stating that MDC would close within a three-year timeframe (March 31, 2024). The announcement explained why the decision was made, highlighting a promise to make sure community living resources would be accessible and inclusive. They also stressed that they would try to make the transition to the community as smooth as possible for both the people moving and the staff still working at MDC.

## 9. Communicate the Announcement Clearly and Effectively

According to the ninth key element in *"The Right Way"* (page 16), once the decision is made to close the institution, careful thought must be given to how the decision is communicated, at the beginning and throughout the process.

A plan on how to communicate that MDC was closing was developed, being mindful and respectful of how difficult the news would be for some.

Before letting the public know that MDC was closing in a news release, it was shared with a variety of stakeholders including the residents, their families, MDC staff, the community of Portage La Prairie, other MDC community partners, agencies and advocacy groups. Written communication followed for many of the stakeholder groups in the form of formal notice letters, Frequently Asked Questions (FAQs) and answers for staff and information for resident family members.

Throughout the transition process, updates were regularly given to the residents, their families, or SDMs, and MDC staff. While planning for the transition was happening, the

Community Transition External Advisory Committee suggested that news about MDC closing and residents moving to the community should be shared widely with agencies, advocacy groups, and other service providers in the Community Living disABILITY Services (CLDS) sector. This would make the process more open and clear for everyone involved. As a result, updates were provided every three months which shared information about:

- The transition process,
- The development of new resources in the community,
- The work of the external advisory committee,
- The support for staff development, retention and recruitment,
- The continuation of care for residents at MDC, and
- The evaluation of resident transitions.

Once the transition process was well underway and after hearing more suggestions from the Community Transition External Advisory Committee, monthly updates were added to the three month updates. These updates gave more details about the resident transition process, the number of residents who transitioned to the community, the community they moved to, the agency supporting them and the date they moved. Future transitions to the community were also included. The monthly updates were shared with the residents, their families and/or SDMs, MDC staff and the sector (agencies, advocacy groups and other service providers).

As part of the communication process, the final evaluation report will also be shared publicly. The goals of the evaluation are to:

- Understand the community transition process during the closure of MDC, including stakeholder perspectives.
- Measure the short and longer term impact of community transitions on the health and quality of life of individuals who lived at MDC.
- Evaluate the impact of community transitions on families and care providers.

## 10. Carefully Coordinate/Support Each Persons Transition to the Community

The tenth and last key element recommended by the *"The Right Way"* (page 15-16) emphasizes the importance of adopting an individualized and person-centred approach::

- The planning of each person's transition to the community is highly individualized, many individuals have quick transitions to living in their new home, others may require a more gradual change.

- The people who know the person well will be in the best position to help plan the transition.

As mentioned throughout this document, the individual and their individual support needs were the priority throughout the transition to community living. The focus at all times was individualized, holistic, person-centered, and included such things as:

- Identifying individual needs, preferences and desires in a formal written plan.
- Ensuring regular and meaningful information sharing/communication occurred.
- Involving family members/support networks in the planning process as much as they wanted to be involved if the individual was supportive.
- Utilizing a team-based approach in decision making/planning.
- Working alongside new support staff to ensure a continuity of care and to provide an opportunity for individuals to develop relationships.
- Providing training to new support staff based on individual's needs.
- Ensuring all required community supports were in place prior to transition.
- Ensuring the individual's cultural needs were considered as part of the transition process.
- Developing a home visit plan that met the individual's needs/preferences.
- Identifying a specific move in date.
- Having a farewell party to say goodbye to friends and staff support.

## Conclusion

While the MDC transition to community living and closure announcement occurred on January 29, 2021, a lot of preparation and framework development occurred between February 1, 2021 - March 31, 2021, to make a plan of action.

MDC already had a process in place for transitioning residents to the community as this was something that happened even before the closure announcement. The announcement brought forward the need to review the existing process and ensure that all required stakeholders were involved in the transition plan going forward. *"The Right Way"* publication, developed by People First of Canada-Canadian Association for Community Living Joint Task Force on Deinstitutionalization, played a significant role in ensuring that MDC reviewed their discharge processes, using the 10 Key Elements of Successful Closure Plans as outlined above.

Indigenous perspectives, the Truth and Reconciliation Commission of Canada's Ten Principles for Reconciliation and the 94 Calls to Action were also taken into account throughout the transition process. Although the cultural lens is not addressed as a

separate element or guiding principle in *"The Right Way"* document, discussions occurred and were reflected within many of the key elements and shown with examples from the MDC transition process.

Throughout the process, the Manitoba government was committed to working with our community partners to ensure that residents of MDC transitioned to the community as soon as their homes were ready and their support needs could be met in the community.