



MODELS FOR  
HOUSING AND PROGRAM SUPPORT  
FOR ABORIGINAL PEOPLE  
WITH  
DEVELOPMENTAL DISABILITIES



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**Disclaimer**

The Ontario Federation of Indian Friendship Centres (OFIFC) respects the teachings and discussions brought to us by our Elders and Traditional People. However, we are not responsible for the content of their words, as delivered at OFIFC workshops, conferences and other meetings. The OFIFC itself promotes respectful approaches and an open and inclusive environment which is free of harassment or discrimination



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# INTRODUCTION

*"By creating an environment that enables individuals to reconnect with their identities as members of their Nation, the path of the individual and that of the Nation are inseparable"*

Findings from Phase 1 AHWS Longitudinal Study

The Ontario Federation of Indian Friendship Centres, in operation since July 9, 1971, is an administrative body representing the collective interests of twenty seven (27) Aboriginal Friendship Centres located in towns and cities across the Province of Ontario.

The OFIFC administers a number of programmes, which are delivered by local Friendship Centres in areas such as: health, justice, family support, and employment and training.

Local Friendship Centres also design and deliver local initiatives in areas such as: education, economic development, children and youth initiatives and cultural awareness.

A culturally appropriate Code of Ethics is the cornerstone to the OFIFC's award winning culture-based approach to communication, lobbying, training and programme support.



The Friendship Centre Movement believes strongly in cooperation, tolerance of differences, equal opportunity for participation in society, and acting with pride and dignity that the heritage of all Aboriginal people demands.

This belief is not based on political or legal distinctions and the Friendship Centre movement continues to advocate for and deliver services to all Aboriginal peoples, be they Indian, Métis, Inuit or non-Status.

The Friendship Centre approach is to serve all Aboriginal people and support their right to define and express their identity as they see fit.

This approach ensures that urban Aboriginal people, and therefore all Aboriginal people who seek services from the Friendship Centres, will be afforded the opportunities to keep their cultures strong and vibrant, regardless of origin.

## OBJECTIVES

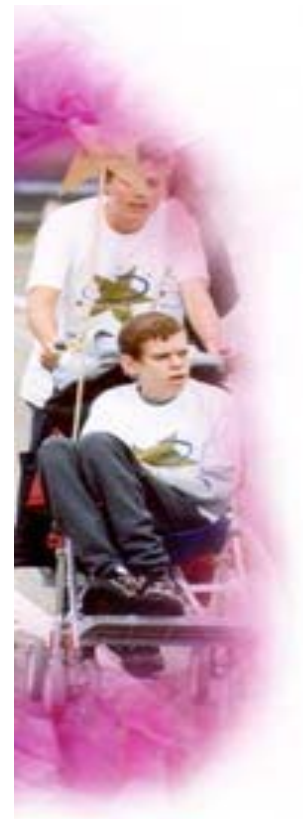
**The Ontario Federation of Indian Friendship Centres** has commissioned this report to explore the housing and program support requirements for Aboriginal people exhibiting developmental disabilities.

The intent of the paper is to focus on the unique programming needs for Aboriginal clients in order for them to receive effective and appropriate housing services, which will allow them to live valued and meaningful lives with dignity and a sense of self-worth, in safe, culturally appropriate, caring and supportive environments of their own choice.

While there is little specific research available on Aboriginal adults with developmental disabilities, there is research available on non-Aboriginals, and certain principles and findings in those studies may be of some assistance in arriving at various findings in this report.

Statistics and/or evaluation studies of current housing models do not seem to exist in Ontario. The information in this report is based on secondary research and information obtained from informants working in the housing and health fields.

Various models are proposed for consideration.



## DEFINITIONS

During the research for this paper it was discovered that various studies or reports use different terms including Aboriginal, First Nation, and Métis. For the purposes of this report it is important to understand exactly what these terms mean.

**Aboriginal Peoples:** The Canadian Constitution recognizes three groups of Aboriginal people, namely Indians, Métis and Inuit. They are the descendants of the original inhabitants of North America (Turtle Island) and each have unique languages, cultural practices, spiritual beliefs and a rich history.

**First Nation:** A term widely used to replace the word "Indian." Often used to include both Status and Non-Status Indians. It is frequently utilized to replace the word "band" in the name of a community.

**Inuit:** Aboriginal people occupying northern Canada including Nunavut, the Northwest Territories, Northern Quebec and Labrador. In the Inuit language of Inuktitut the word "Inuit" means "people." A singular Inuit person is an Inuk.

**Métis:** Although no universally accepted definition exists these are generally considered people of mixed heritage, from First Nation and European ancestry. Their distinct culture draws on diverse ancestral origins and may differ from one region to another.

**Status Indian:** An Indian person registered under the Indian Act of Canada according to government defined criteria.

**Non Status Indian:** An Indian person not currently registered under the Indian Act of Canada.

Métis sash: National Park Service, US  
Department of the Interior



Picture from Wikwemikong Indian Festival

<http://www.picture-newsletter.com/indians/index.htm>

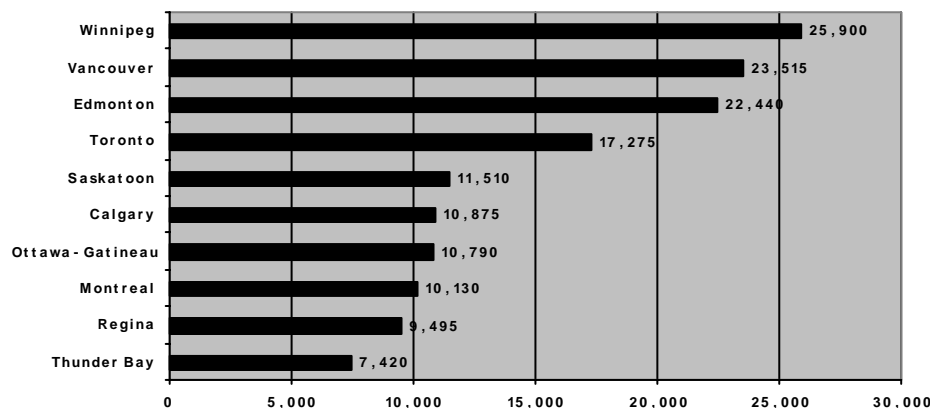
## BACKGROUND

### General Statistics

The 2006 Census of Population reporting an Aboriginal identity produced the following pertinent statistics:

- ◇ Over one in five Aboriginal people in Canada live in Ontario
- ◇ Ontario had the largest Aboriginal population at 242,495 people, out of a total of 1,172,790
- ◇ The Aboriginal population in Ontario increased 68% between 2001 and 2006
- ◇ The Aboriginal population has grown faster than the non-Aboriginal population. Between 1996 and 2006, it increased 45%, nearly six times faster than the 8% rate of growth for the non-Aboriginal population over the same period
- ◇ First Nations people comprised 60% of the 1,172,790 persons who identified themselves as an Aboriginal person in the census
- ◇ Censuses in both 1996 and 2006 found that about three-quarters (76%) of the off-reserve First Nations population lived in urban areas
- ◇ Almost 7 out of 10 Métis (69%) lived in urban centres in 2006
- ◇ In Ontario, the province with the largest number of First Nations people, 70% lived off reserve
- ◇ Censuses in both 1996 and 2006 found that about three out of every four people (76%) in the off-reserve First Nations population lived in urban areas

Top 10 census metropolitan areas with the largest number of First Nations people, 2006



Source: Statistics Canada,  
Census of Population, 2006

# HOUSING

The Aboriginal Peoples Survey, 2001 reported 1 in 5 Aboriginal households in core housing need. Core housing need means that housing falls below at least one of the adequacy, suitability or affordability standards and the resident would have to spend 30% or more of their before tax income to pay the median rent of alternative local housing to meet all three standards

According to results from the 2001 Census, approximately 24% of North American Indian households were in core housing need, as were 19% of Métis households and 22% of Inuit households. O'Donnell, Vivian & Ballardin, Adriana, Aboriginal Peoples Survey 2001, Statistics Canada, 2006, p.3

*Table 1: Summary of Off-Reserve Housing Conditions by Aboriginal Identity*

Households	Number of Households	Share of Aboriginal Households	Ownership Rate	Percentage in Core Housing Need		
				Total	Owners	Renters
Métis	128,400	43.2%	57.7%	20.6%	10.7%	34.2%
Status Indians	127,500	42.9%	43.1%	28.4%	12.4%	40.5%
Inuit	13,100	4.4%	32.8%	31.9%	20.7%	37.3%
All Aboriginal Households	297,300	100%	49.8%	24.8%	11.8%	37.8%
Non-Aboriginal	10,508,300	Not available	67.4%	15.6%	8.5%	30.1%

Source: CMHC, Census-Based Housing Indicators and Data 2001

While the numbers of urban Aboriginals increases annually, their housing needs (adequate, suitable and affordable) remain largely unmet.

The crisis is even greater for specialized housing for unique Aboriginal population groups with supplementary requirements, such as those with developmental disabilities.

# DISABILITIES

Type of disabilities among children aged 0 to 14 years with disabilities, by age groups, Canada, 2001

Type of disability <sup>2</sup>	Age groups					
	0 to 4 years		5 to 14 years		Total	
	Total number of children	Percentage of children	Total number of children	Percentage of children	Total number of children	Percentage of children
Hearing <sup>3</sup>	3,160 <sup>E</sup>	12.1	20,590	13.3	23,750	13.1
Seeing <sup>3</sup>	2,090 <sup>E</sup>	8.0	14,510	9.4	16,600	9.2
Speech <sup>4</sup>	...	...	66,940	43.3	66,940	43.3
Mobility <sup>4</sup>	...	...	21,150	13.7	21,150	13.7
Dexterity <sup>4</sup>	...	...	31,410	20.3	31,410	20.3
Delay <sup>5</sup>	17,820	68.0	...	...	17,820	68.0
Developmental <sup>4</sup>	...	...	46,180	29.8	46,180	29.8
Learning <sup>4</sup>	...	...	100,360	64.9	100,360	64.9
Psychological <sup>4</sup>	...	...	49,140	31.8	49,140	31.8
Chronic <sup>3</sup>	16,400	62.6	101,110	65.3	117,510	64.9
Unknown <sup>3</sup>	2,340 <sup>E</sup>	8.9	4,950	3.2	7,280	4.0

... Not applicable

1. The Canada total excludes the Yukon, Northwest Territories and Nunavut. The sum of the values for each category may differ from the total due to rounding.

2. The sum of the categories is greater than the population with disabilities because persons could report more than one type of disability.

3. Applies to all children under 15.

4. Applies to children aged 5 to 14.

5. Applies to children aged 0 to 4.

Source: Statistics Canada, Participation and Activity Limitation Survey, 2001.

## Prevalence of disability among adults aged 15 years and over, by type of disability, Canada, 2001

Type of disability <sup>2</sup>	Number of adults	Percentage of adults
Hearing	1,038,140	4.4
Seeing	594,350	2.5
Speech	362,720	1.5
Mobility	2,451,570	10.5
Agility	2,276,980	9.7
Pain	2,376,730	10.1
Learning	451,420	1.9
Memory	420,750	1.8
Developmental	120,140	0.5
Psychological	522,950	2.2
Unknown	96,180	0.4

1. The Canada total excludes the Yukon, Northwest Territories and Nunavut. The sum of the values for each category may differ from the total due to rounding.

2. The sum of the categories is greater than the population with disabilities because persons could report more than one type of disability.

Source: Statistics Canada, Participation and Activity Limitation Survey, 2001.

## Developmental disabilities, by age groups, Canada, 2001

Age groups	Developmental <sup>3</sup>		
	Total <sup>2</sup>	Males	Females
<b>Total - all ages</b>	<b>166,320</b>	<b>105,710</b>	<b>60,610</b>
<b>Total - aged less than 15 years</b>	<b>46,180</b>	<b>31,920</b>	<b>14,260</b>
0 to 4	...	...	...
5 to 9	22,040	16,380	5,650
10 to 14	24,140	15,530	8,610
<b>Total - aged 15 years and over</b>	<b>120,140</b>	<b>73,790</b>	<b>46,350</b>
15 to 64	109,060	66,030	43,030
15 to 24	26,010	15,420	10,590
25 to 44	38,280	22,270	16,010
45 to 64	44,770 <sup>E</sup>	28,340 <sup>E</sup>	16,430 <sup>E</sup>
65 and over	11,080 <sup>E</sup>	F	3,320 <sup>E</sup>
65 to 74	4,010 <sup>E</sup>	F	2,160 <sup>E</sup>
75 and over	F	F	F

1. The Canada total excludes the Yukon, Northwest Territories and Nunavut.
  2. The sum of the values for each category may differ from the total due to rounding.
  3. Not applicable to children 0 to 4 years of age.
  4. Applicable to adults 15 years of age or older only.
- Source:** Statistics Canada, Participation and Activity Limitation Survey, 2001.

## Developmental disabilities, by age groups, Canada, 2006

Age groups	Developmental <sup>3</sup>		
	Total <sup>2</sup>	Males	Females
<b>Total - all ages</b>	<b>190,310</b>	<b>115,600</b>	<b>74,710</b>
<b>Total - aged less than 15 years</b>	<b>53,740</b>	<b>37,660</b>	<b>16,080</b>
<b>0 to 4</b>	...	...	...
<b>5 to 9</b>	25,250	18,500	6,750
<b>10 to 14</b>	28,500	19,160	9,340
<b>Total - aged 15 years and over</b>	<b>136,570</b>	<b>77,940</b>	<b>58,630</b>
15 to 64	129,310	75,020	54,280
<b>15 to 24</b>	37,940	24,740	13,200
<b>25 to 44</b>	44,080	22,110	21,970
<b>45 to 64</b>	47,290	28,170 <sup>E</sup>	19,120 <sup>E</sup>
65 and over	7,260 <sup>E</sup>	F	F
<b>65 to 74</b>	3,740 <sup>E</sup>	F	F
75 and over	F	x	F
1. The Canada total excludes the Yukon, Northwest Territories and Nunavut. 2. The sum of the values for each category may differ from the total due to rounding. 3. Not applicable to children 0 to 4 years of age. 4. Applicable to adults 15 years of age or older only. <b>Source:</b> Statistics Canada, Participation and Activity Limitation Survey, 2006.			



## DEVELOPMENTAL DISABILITIES

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**Developmental Disabilities (DD)** can have different definitions however it is generally a term that is used when a person has delayed or impaired adaptive function. Adaptive functioning is a broad term and includes all skills involved in daily living, ranging from basic eating, dressing to accessing public transportation, independently.

The [Developmental Services Act, R.S.O. 1990, c. D.11](#) defines a developmental disability as "a condition of mental impairment, present or occurring during a person's formative years, that is associated with limitations in adaptive behaviour."

The Ontario Ministry of Community and Social Services website states "A developmental disability is a life-long condition and can be accompanied by other physical conditions.

This disability varies greatly among individuals. A person with a developmental disability may have limitations in intellectual ability and difficulties in many common daily activities or life skills, such as personal hygiene and dressing, communication, learning, mobility, ability to live independently, and economic self-sufficiency.

Some people have what is referred to as a dual diagnosis. This term is used to describe someone who is diagnosed with both a developmental disability and a mental illness."


[http://www.mcass.gov.on.ca/mcass/english/pillars/developmental/questions/general/faqs\\_general.htm](http://www.mcass.gov.on.ca/mcass/english/pillars/developmental/questions/general/faqs_general.htm)

Developmental disability is a term used to describe life-long disabilities attributable to mental and/or physical or combination of mental and physical impairments, manifested prior to age twenty-two. The term refers to disabilities affecting daily functioning in three or more of the following areas:

- Capacity for independent living,
- Economic self-sufficiency,
- Learning,
- Mobility,
- Receptive and expressive language,
- Self-care, and
- Self-direction.

Usually people with mental retardation, cerebral palsy and various genetic and chromosomal disorders such as Down syndrome and Fragile X syndrome and Fetal Alcohol Spectrum Disorder are all described as having developmental disabilities

As children grow to be adults with developmental disabilities they have already suffered from a range of abuses. They are vulnerable to physical abuse, neglect, sexual abuse, psychological and emotional abuse, constraint or restrictive practices, financial abuse, legal or civil abuse, systemic abuse and passive neglect.



Other difficulties for people with developmental disabilities can be challenging behaviour, where they may exhibit aggressive, self-Injurious acts. Some are easily led into deviant or inappropriate actions such as attention seeking acts. Other problems often occur with management of finances. Also there are high rates of individuals taking of harmful addictive substances.

The interaction of behavioural and mental health problems with adverse environments leads to further problems, such as trouble with the law, called "secondary disabilities". Clark, Erica, Lutke, Jan, Minnes, Patricia and Ouellette-Kuntz, Helene (2004) Secondary Disabilities among Adults with Fetal Alcohol Spectrum Disorder in British Columbia

Many of the life challenges lead to unstable living conditions by being removed from residences or programming. This in turn leads to homelessness and often more criminal offences being committed.

Even though statistics are few, the following provides some context to the issues for Aboriginal people with developmental disabilities and associated disorders.


- ◇ A study conducted in the Yukon Territory and in British Columbia indicates that for every one Caucasian with FASD there are 10.9 Aboriginals with FASD. Boland, Fred and Duwyn, Michelle. (1999) Fetal Alcohol Syndrome: Understanding its impact. Queen's University (cited in FASD and the Incarceration of Métis and other Aboriginals by

Amanda Miller)

- ◇ It is projected that (20,697) of Aboriginal people 15 years and older living in Ontario suffer from a major mental disorder such as: depression, anxiety disorders and substance abuse. Health Status Report of Aboriginal People living in Ontario (2005) Dr. Chandrakant P. Shah, MD, FRCPC; Professor Emeritus Department of Public Health Sciences Staff of Anishnabec Health Toronto
- ◇ The Ontario government's *"A Shared Responsibility Ontario's Policy Framework for Child and Youth Mental Health"* recently produced and released by the Ministry of Children and Youth Services acknowledges the distinctive needs of Aboriginal people, stating;

*"Although research on the prevalence of mental health disorders in Canadian children and youth is limited, studies suggest that 15 to 21 per cent of children and youth are affected by mental health disorders that cause some significant symptoms or impairment - with significantly higher rates for aboriginal children"*

- ◇ In off reserve settings, although supports are available, infrastructure and funding mechanisms do not holistically exist to ensure the same kind of access and coverage that mainstream persons with disabilities see in similar settings. (AFN Comparative Resource Analysis of Support Services for First Nations People with Disabilities Dr. Rose-Alma J. McDonald)



Dr. Christine Loock, estimates that at least one in every four inmates in federal institutions are behind bars not because of conscious crime, but because of FAS. (Prisoners

With FAS - CTV National News "In Focus" Monday June 11, 2001)

Social disadvantage increases risks of individuals being developmentally disabled.

(Sinason, 1992; Patton, Payne and Bierne-Smith, 1990; Simpson, 2001 (Carlson, Joyce Clouston, Travelling a Mirrored Pathway: Care of Children and Adults with Special Needs in Aboriginal Communities, Journal on Developmental Disabilities, Volume 12 Number 1, 2007)

Within the last few decades there has been a new trend as demands are being made for community inclusion, autonomous decision making, independent living, supported employment, career development and retirement planning for those with developmental disabilities. Those with developmental disabilities ... are living longer. (Walz, Harper, and Wilson, 1986; Harper, 1989, 1991) and residing in community settings in greater numbers (Wadsworth, Harper, and McLeran, 1995) (Harper, Dennis C., Journal of Rehabilitation, Jan-March, 1996 )

There appears to be a growing acknowledgement that community members, and particularly those who are affected by disability, have an important and legitimate role to play in determining how disability supports and services should be governed and operated. The move to community governance also recognizes that greater flexibility and accountability is needed in developing and implementing personal support plans. (Community Living British Columbia, Three Year Strategic Plan, December 2005 )

British Columbia is taking the lead in this area. In its February 8, 2005 Speech from the Throne, the BC Government reaffirmed its commitment to people with developmental disabilities and announced its intention to

*" build the best system of support in Canada for persons with disabilities, special needs, children at risk and seniors"*

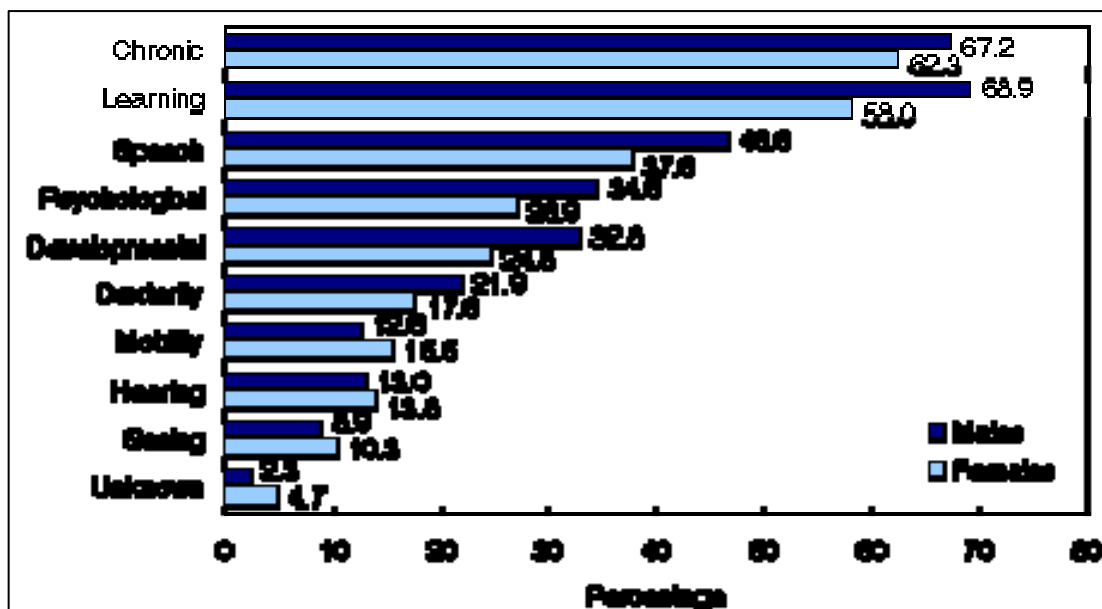
(Community Living British Columbia, Three Year Strategic Plan, December 2005 ) )

### **Developmental delay is the most common disability in children aged 0 to 4**

Among children aged 0 to 4, developmental delay is the most common disability. In 2001, nearly 18,000 children with a disability, or 68%, had a developmental delay, representing 1.1% of all children aged 0 to 4. In this group, 59% had a delay in their intellectual development, 54% a delay in their physical development and 38%, another type of delay such as speech difficulties (data not shown). It is important to note that developmental delay is identified by the child's parent/guardian and is not necessarily diagnosed by a health care professional. The identification of the disability is therefore based on the parent's perception of his/her child's development.

***A Profile of Disability In Canada, 2001 Statistics Canada***

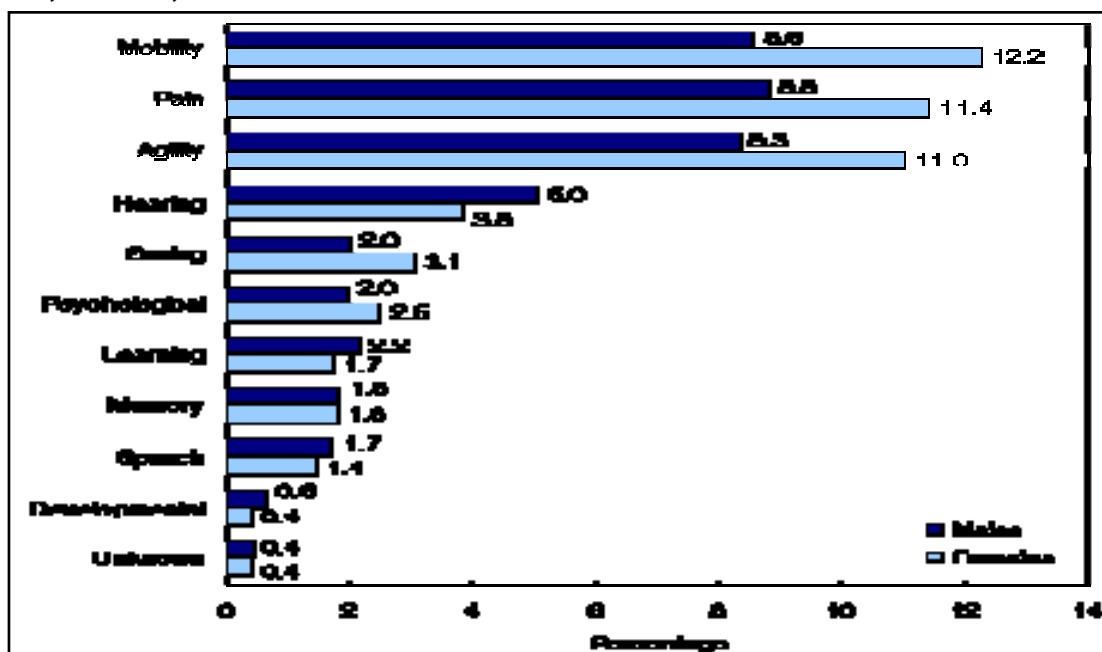
Types of disabilities among children with disabilities aged 5 to 14 years, by sex, Canada 2001<sup>1</sup>



<sup>1</sup> The Canada total excludes the Yukon, Northwest Territories and Nunavut. The sum of the values for each category may differ from the total due to rounding.

Source: Statistics Canada, Participation and Activity Limitation Survey, 2001.

Prevalence of disability among adults aged 15 years and over, by type of disability and sex, Canada, 2001<sup>1</sup>



<sup>1</sup> The Canada total excludes the Yukon, Northwest Territories and Nunavut. The sum of the values for each category may differ from the total due to rounding.

Source: Statistics Canada, Participation and Activity Limitation Survey, 2001.

The United Nations Convention on the Rights of Persons with Disabilities, passed on 14-25 August 2006 highlighted the issue by reporting that:

- ◇ Around 10 per cent of the world's population, or 650 million people, live with a disability. They are the world's largest minority.
- ◇ On average, 19 per cent of less educated people have disabilities, compared to 11 per cent among the better educated.
- ◇ In most of the Organization for Economic Co-operation and Development (OECD) countries, women report higher incidents of disability than men.
- ◇ Women with disabilities are recognized to be multiply disadvantaged, experiencing exclusion on account of their gender and their disability.
- ◇ According to UNICEF, 30 per cent of street youths are disabled.

Canada signed the Convention in March 2007. It is important to stress the following principles from the Convention as they should guide progress in this area:

## Article 3 General Principles

The principles of the present Convention shall be:

- a. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
- b. Non-discrimination;
- c. Full and effective participation and inclusion in society;
- d. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- e. Equality of opportunity;
- f. Accessibility;
- g. Equality between men and women;
- h. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Mr. Behring with Bui Thi Huyen, the Vietnamese girl he met in 2000, and whose joy at receiving a wheelchair helped convince him to start the Wheelchair Foundation





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## *Article 4 General Obligations*

1(f) To undertake or promote research and development of universally designed goods, services, equipment and facilities, as defined in article 2 of the present Convention, which should require the minimum possible adaptation and the least cost to meet the specific needs of a person with disabilities, to promote their availability and use, and to promote universal design in the development of standards and guidelines;

3. In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations.

## *Article 19 Living independently and being included in the community*

States Parties to this 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.

## *Article 23*

### *Respect for home and the family*

3. States Parties shall ensure that children with disabilities have equal rights with respect to family life. With a view to realizing these rights, and to prevent concealment, abandonment, neglect and segregation of children with disabilities, States Parties shall undertake to provide early and comprehensive information, services and support to children with disabilities and their families.

4. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. In no case shall a child be separated from parents on the basis of a disability of either the child or one or both of the parents.



5. States Parties shall, where the immediate family is unable to care for a child with disabilities, undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting.

Photo: Courtesy World Health Organization

## *Article 28*

### *Adequate standard of living and social protection*

1. States Parties recognize the right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate food, clothing and housing, and to the continuous improvement of living conditions, and shall take appropriate steps to safeguard and promote the realization of this right without discrimination on the basis of disability.

2. States Parties recognize the right of persons with disabilities to social protection and to the enjoyment of that right without discrimination on the basis of disability, and shall take appropriate steps to safeguard and promote the realization of this right, including measures:

- (a) To ensure equal access by persons with disabilities to clean water services, and to ensure access to appropriate and affordable services, devices and other assistance for disability-related needs;
- (b) To ensure access by persons with disabilities, in particular women and girls with disabilities and older persons with disabilities, to social protection programmes and poverty reduction programmes;
- (c) To ensure access by persons with disabilities and their families living in situations of poverty to assistance from the State with disability-related expenses, including adequate training, counselling, financial assistance and respite care;
- (d) To ensure access by persons with disabilities to public housing programmes;

### *Article 30*

### *Participation in cultural life, recreation, leisure and sport*

4. Persons with disabilities shall be entitled, on an equal basis with others, to recognition and support of their specific cultural and linguistic identity, including sign languages and deaf culture.



Photo: Courtesy World Health Organization



In Ontario the Ministry of Community and Social Services has indicated that it,

*"remains committed to transforming the way it delivers services to people with developmental disability and to continuing the expansion of opportunities for community living with the closure of the Province's remaining three residential facilities for adults with developmental disabilities by March 2009."*

Results-based Plan Briefing Book 2006-2007, Ministry of Community and Social Services, ISSN 1718-6269

It has stated that its transformation activities will continue to focus on building a strong community-based service system. It announced funding increases of more than \$80 million in 2006-07 for new residential and community supports. The Ontario government seems committed to creating a new vision for a fair, accessible and sustainable developmental service system in Ontario.

Despite the United Nations Convention and commendable pronouncements by some provincial governments, finding residential and program support for an adult with developmental disabilities becomes a significant challenge.

For Aboriginal families trying to find housing with appropriate cultural supports, the supply is virtually non-existent. Often the only assistance for Aboriginal people with disabilities is usually the family, or friends. However, this creates obvious strains. Housing units are often over populated with tenants, there tends to be a lack of training and resources for family members to care appropriately for the person with Developmental Disabilities or there is a lack of access to cultural supports. On occasion an elderly family member supporting a person with disabilities suffers from poor health as a result of the demands for care.

In the Ottawa Final Report for the Urban Aboriginal Task Force, released in March 2007, one person in a focus group stated the following:

*"At Gignul housing we do counselling, social work, but there is a segment that we are not capable of helping as we don't have the capacity, and they don't have the skills to manage their home (Budgeting, rent, bills, food-general household management)."*

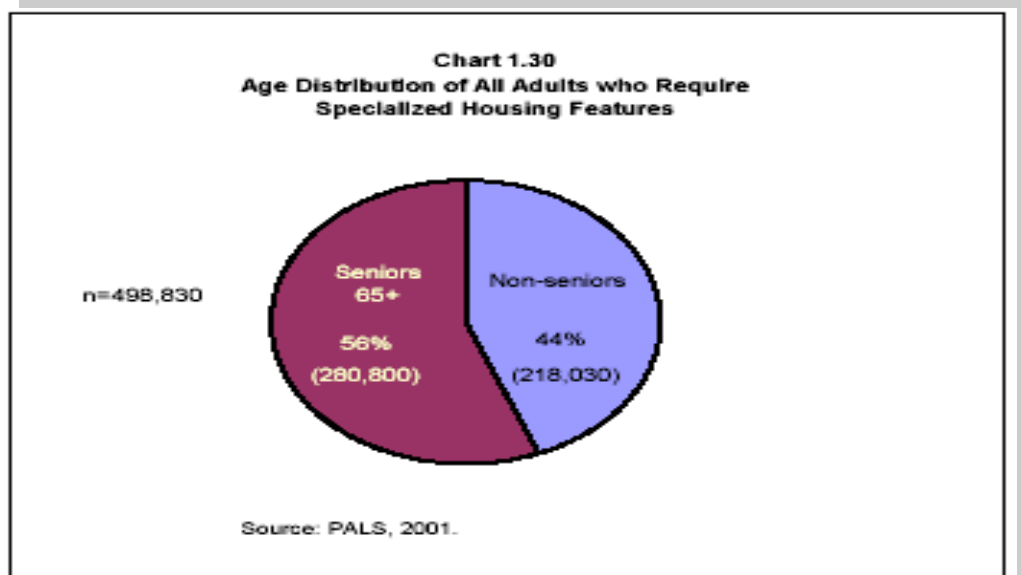
Ottawa Final Report, Urban Aboriginal Task Force, March 2007, OFIFC, OMAA & ONWA

## HOUSING FEATURES

Persons with disabilities often require specialized features within and around their homes. These often vary depending on the nature, extent and severity of the disability. For the purposes of this report it is important to understand the Issues facing people when it comes to determining what is proper and adequate housing for persons with developmental disabilities.

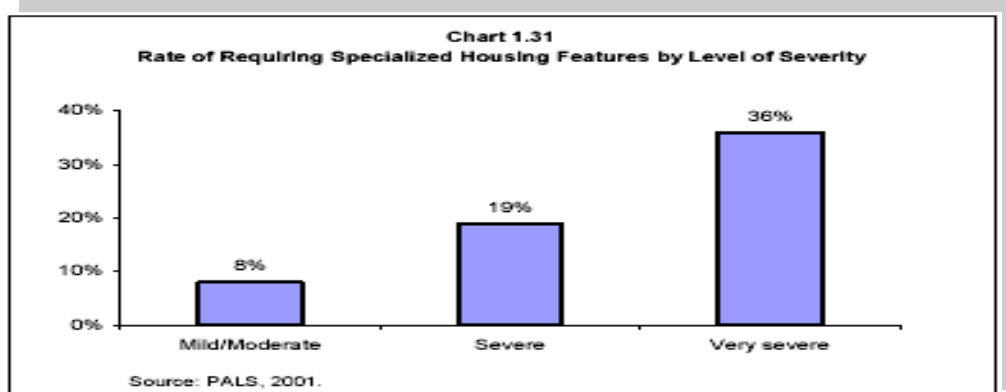
### *Magnitude and Nature of the Requirements*

Nearly 15% of adult Canadians with disabilities require specialized housing features. Over 50% of these are seniors.



### *Gender and Severity Level*

Women (17%) are slightly more likely than men (11%) to require specialized housing features. As well, the likelihood of requiring specialized housing features increases with level of severity of the disability.





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*Type of Disability*

<b>Table 1.12</b>		
<b>Percentage and Number of Persons Requiring Specialized Housing Features by Type of Disability</b>		
	<b>%</b>	<b>Number</b>
Agility	20%	448,430
Hearing	16%	172,900
Learning	16%	70,390
Mobility	19%	464,570
Sight	23%	138,870
Speech	25%	89,320
Memory	22%	92,460
Developmental	11%	12,780
Pain	16%	381,110
Psychological	17%	90,820
<b>Source: PALS, 2001.</b>		

*Which Specific Specialized Housing Feature is Most Required?*

The following Table encapsulates the requirements for specific specialized housing features in order of frequency as detailed in the PALS report, 2001.

<b>Table 1.13</b>		
<b>Requirements for Specific Specialized Housing Features Number and Percent of all Adults with Disabilities</b>		
	<b>Number</b>	<b>Percent</b>
Grab bars/bath lift	353,580	10%
Ramps/street level entrance	210,610	6%
Other	138,640	4%
Elevator/lift service	135,040	4%
Automatic door	122,930	4%
Widened doorway/hallways	100,610	3%
Visual alarm/audio warning device	67,680	2%
Lowered counters in the kitchen	39,560	1%
<b>Source: PALS, 2001</b>		

### *What is the Unmet Need for Specialized Housing Features?*

Despite the need for certain specialized features in housing for persons living with disabilities it is clear that there are unmet needs. The following table illustrates those unmet needs as evidenced by the 2001 PALS survey.

<b>Table 1.14</b>				
<b>Met and Unmet Needs for Specific Specialized Housing Features</b>				
	<b>% Needs Unmet</b>	<b>% Needs Met</b>	<b>% Total Need</b>	<b>Total Need Number</b>
Grab bars/bath lift	25%	75%	100%	353,580
Ramps/street level entrance	25%	75%	100%	210,610
Other	43%	57%	100%	138,640
Elevator/lift service	29%	71%	100%	135,040
Automatic door	23%	77%	100%	122,930
Widened doorway/hallways	*21%	79%	100%	100,610
Visual alarm/audio warning device	*20%	80%	100%	67,680
Lowered counters in the kitchen	*45%	55%	100%	39,560
<b>Source: PALS, 2001</b>				
* Figure should be used with caution due to low sample size.				

### *Severity: Those with More Severe Disabilities Less Likely to Have Needs Met*

It is clear from the following Table that those with more severe disabilities are less likely to have those needs met.

<b>Table 1.16</b>					
<b>Met and Unmet Needs for Specialized Housing Features by Level of Severity</b>					
	<b>% Partially Met Need</b>	<b>% Fully Unmet Need</b>	<b>% Fully Met Need</b>	<b>% Total Who Require</b>	<b>Number Total Who Require</b>
Mild/Moderate	*	25%	69%	100%	153,020
Severe	11%	26%	63%	100%	173,280
Very Severe	15%	26%	58%	100%	172,530
<b>Source: PALS, 2001</b>					
* Percentage cannot be released due to low sample size.					



## Disability Type

Some disability types are associated with a higher *rate* of unmet need. The following Table illustrates those needs. It is important to note that among those with a developmental disability who require some type of specialized housing feature, 45% have an unmet need. However, these findings tend to suggest that there may be some type of barrier facing individuals with these disabilities types when they do require something.

Table 1.17					
Met and Unmet Needs for Specialized Housing Features by Disability Type					
	% Partially Met Need	% Fully Unmet Need	% Fully Met Need	% Total Who Require	Number Total Who Require
Agility	11%	25%	64%	100%	448,430
Hearing	9%	24%	67%	100%	172,900
Learning	*15%	25%	60%	100%	70,390
Mobility	11%	25%	64%	100%	464,570
Sight	13%	25%	62%	100%	138,870
Speech	*16%	23%	61%	100%	89,320
Memory	*9%	23%	68%	100%	92,460
Developmental	*20%	25%	*55%	100%	12,780
Pain	11%	28%	61%	100%	381,110
Psychological	*19%	31%	50%	100%	90,820
Source: PALS, 2001					
* Percentage cannot be released due to low sample size.					

While these preceding tables amply display the specific kinds of specialized needs, both met and unmet, by persons suffering from disabilities in Canada in 2001 those persons are not identified as to race or ethnicity. However we should not presume that the situation is better for those Aboriginals who face the same challenges.

In fact from the following data it is clear that as a whole Aboriginals suffer a greater rate of disabilities than other Canadians and given other factors and challenges they must face on a daily basis it is reasonable to assume that their unmet needs are even greater than the tables above would indicate .



## POLICY CONSIDERATIONS

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Many have written about the difficulties that Aboriginal persons with disabilities face in Canada. Dr. Douglas Durst and Mary Bluechardt, the authors of "*Urban Aboriginal Persons with Disabilities: Triple Jeopardy!*" 2001, Regina: Social Policy Research Unit, University of Regina have stated repeatedly:


- \* Aboriginal people with disabilities are caught in a public policy vacuum with little hope for amelioration,
- \* These people suffer triple jeopardy: they are Aboriginal, they have disabilities and they are urban (off-reserve). Women are even further disadvantaged.
- \* Aboriginal people are trapped in a public policy gap where accessing social and health related services are difficult and sometimes inaccessible.
- \* Jurisdictional issues create serious problems for many Aboriginal persons with disabilities, resulting in the ping-ponging of clients from one department/ government to another.

In order to properly understand and better address the issue of lack of suitable housing for Aboriginal persons with developmental disabilities it is important to comprehend the magnitude of difficulties those with any kind of disabilities currently face in Canada. The two year study conducted by Dr. Douglas Durst and Mary Bluechardt found that

" indigenous persons with disabilities usually left their communities in order to Access health and social services. In their communities there were few Services, buildings were inaccessible, transportation was impossible and independent housing was unattainable. Leaving behind their families, Aboriginal people found loneliness, isolation and social exclusion."

While service providers and professionals indicate that they welcome Aboriginal people to their programmes and services, and often boast of their attempts to reach diverse populations, the study revealed that few Aboriginal people are accessing these mainstream services.

Contributing factors to this situation are touched on in Deborah Stienstra's paper "*The Intersection of Disability and Race/Ethnicity/Official Language/Religion*" prepared for the Intersections of Diversity Seminar in 2002. In that paper she examines barriers to accessing appropriate supports including language difficulties, differences in health and illness belief, discrimination and lack of culturally appropriate services. Most interesting is her review of a study conducted by Cook et al that recognized the real contributions of the people with disabilities and their families to the research.




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“ By building links with the families in the context of their own communities it is likely the services that are provided will be seen more as ‘insider’ services (or community-based services), rather than those provided by ‘outsiders’ to the community. This reaffirms the importance of community-based services, including community-based rehabilitation. The community-based rehabilitation approach seeks to address ‘the divergent needs of people with disabilities in the context of a particular community. It is generally founded on rehabilitation measures taken at the community level that build on the resources of the community, the person with a disability and their family, In this situation, the local people take ‘ownership of their problems and their rehabilitation responsibilities.

Cook et al 1997, 207

In a January 2004 article in The Saskatchewan Institute of Public Policy, Durst and Bluechardt commented on the lack of connections of Aboriginal persons to the service sector raising questions as to how these clients are perceived. “Often the professionals understand ‘disability’ as a ‘health’ issue rather than an economic, social or recreational one. Furthermore it creates a situation where First Nations or Aboriginal identity is second in priority to the health or physical needs of the person, The cultural context is lost in the attention to the concreteness of the physical disability.” They go on further to state “ to a non-Aboriginal person this may not seem significant but it is a major concern for those clients who are struggling to maintain their cultural and ethnic identity in a hostile environment, which readily expresses overt and covert racism.” Durst’s study found that while mainstream providers stated they welcomed everyone, they had no Aboriginal staff, no Aboriginal board members and made no serious efforts to include the participation of Aboriginal peoples either as staff, volunteers or consumers of service. They found that while there was a general awareness about Aboriginal culture and issues of culturally sensitive practice, there was a resistance to making significant changes to service delivery and organizational practice.

Finally they address the issue of how a ‘disability’ is viewed. They point out that Aboriginal culture “ ...holds different views of the meaning of social inclusion, self-sufficiency, social and economic independence. Western Euro-Canadian culture values independence and self-sufficiency and, curiously, it values conformity. Mainstream society rejects interdependency and dependency on others. As a communitarian culture, Aboriginal society values interdependency, creating a belief that each individual can, in some way, contribute to the group as a whole. Each person has a role to play regardless of his or her physical, mental or intellectual capacities. There is no shame in asking for and receiving assistance; the shame is in refusing.”



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*"Urban Aboriginal Families of Children with Disabilities: Social Inclusion or Exclusion?"* , examined literature's overview of the situation and noted the following:

- \* In addition to being Aboriginal and having a disability, Aboriginal people often lack the skills or knowledge to cope in an urban environment, " and the result is awesome human misery and hopelessness that takes more than a welfare cheque can alleviate', (SK Network, 1996, p.4).
- \* The literature makes the link between health, socio-economic, political and cultural conditions, and disability. The issues are complex and interrelated, which precludes easy solutions.
- \* Native communities and Native people living in non-Native communities suffer on a daily basis from living conditions, which other Canadians experience only rarely. These adversities-economic, political, social and cultural in nature-greatly increase the probability of being disabled at some time in a person's life (cited in RCAP, Vol. III, p. 148).
- \* The First Nations Confederacy of Cultural Education Centres ( FNCCEC, 1995, p.30) acknowledges the 1990 finding of the National Aboriginal Network on Disabilities that poor health and poverty contribute to and exacerbate incidences of preventable disabilities.
- \* The Follow Up Report (Canada, 1987, p.5-6) acknowledges that "these adversities-political, economic, social and cultural and unemployment, poor nutrition, poverty, low education, and unhealthy lifestyles need to be addressed first, in any effort to deal with the problems of disability. Problems within government bureaucracies, poverty, un employment, social and geographical isolation, and substandard living conditions still contribute to the incidence of disability among Aboriginal people. It also makes the process of organizing and obtaining adequate services more difficult (Canada:, 1993, p.6).
- \* The Follow Up Report states that 'there is enough evidence to demonstrate the direct relationship between poor health conditions and the widespread incidence of disability among Native people' and calls for a holistic approach to health including social, economic, political and cultural conditions (Canada, 1987).

## DIFFERENCES IN APPROACH

The Western concept of developmental disability has led to the devaluation and 'exclusion' of individuals with developmental disabilities (Simpson, 2001) and poor services (Bogdan & Taylor, 1982). Hanvey (2002) noted that while inclusion is the current goal of social policy, Canadian society continues to view children with disabilities as 'deficits'.

Carlson, Joyce Clouston, Travelling a Mirrored Pathway: Care of Children and Adults with Special Needs in Aboriginal Communities, Journal on Developmental Disabilities, Volume 12 Number 1, 2007


This is distinct from the Aboriginal inclusive model. In Joyce Carlson's article she notes the following:

*"In communities where 'everyone belongs' the strength is in the inter connections. Persons who were vulnerable were described as bringing a 'special' quality to communities; they were 'closer to the Creator', 'gifts' to their families. That individuals with disabilities help others learn spiritual insights was a recurring theme. ... Persons named as designated caregivers of individuals with disabilities considered their responsibilities 'an honour' and were supported by the community in their roles."*

In commenting upon her participants she observed that their "sensitivity to the cultural values within their own communities, while struggling with societal institutions upon which they relied for assistance, placed them at what Vaughan (1992) refers to as a 'critical nexus' within which complex and conflicting cultural values representing different world views intersect and impact upon children and families

In "Urban Aboriginal Families of Children with Disabilities: Social Inclusion or Exclusion?" issue was further examined. Joe and Miller (1987, p.1) point out the meanings of disability from the Euro-western definition are based on whether or not a person can support him/herself, the degree and type of work that the individual can complete and the degree of inability. Disability is the loss of a valued function and what is valued is different in different cultures. Differences between the Aboriginal culture and the dominant culture, and even within Aboriginal cultures, lead to differences in what constitutes a disability, causes of disabilities and appropriate interventions.





There is a difference between disability and handicap. Disable persons are not handicapped in all circumstances or in everything they do. Disability should, in no way, been seen as inability. Disability may be permanent. When someone loses a leg in an accident, this disabling condition will remain throughout a person's lifetime. It may be a handicap in, for example, walking, riding a bicycle, or working as a waitress, but may not while playing card games, cooking a meal, or working as a computer operator. Concentrating on ability-and not on what a person cannot do-should be the principal concern of every disabled person, and of those agencies and individuals interested in their welfare. (Boylan, 1991, p.viii).

Gething (1995, p. 78) notes a discrepancy in perception of disability due to culture: Aboriginal people may not see themselves as having a disability whereas the "trained professional" might. Gething (1985, p.81) attributes the lack of accurate statistics to variations in the personal definition of a disability between professionals and Aboriginal people. Only obvious and noticeable conditions such as an amputation or severe physical impairment are thought of as a disability. Subtle forms of fetal alcohol syndrome or mental health issues are not identified. "Disability is rarely seen as a separate issue, but is perceived as part of the problems which are widespread and accepted as part of the life cycle" (Gething, 1995, p.81).

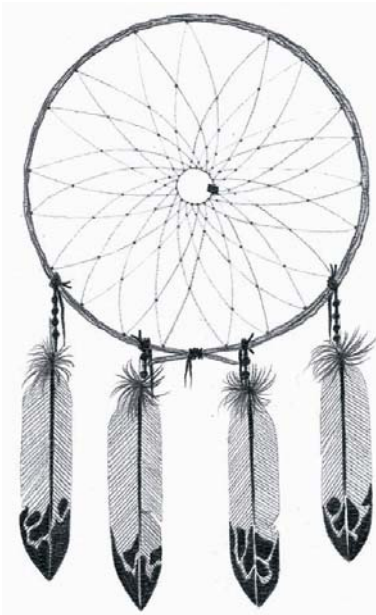
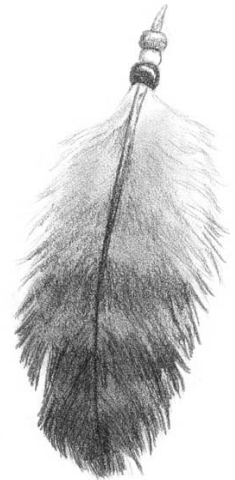
Depending on the cultural beliefs and values, conditions that are classified as disabilities by dominant ideology may not be considered in the same context in a particular First Nation. Robert Thomas stated, "the cultural conflict between Indians and non-Indians occurs because some traditional Indian cultural; views do not accept secular causes but only sacred foundations as explanations for all experiences" (Thomas, 1981:97).

Unfortunately, non-Aboriginal communities, as well as many Aboriginal communities do not encourage participation of the disabled. Therefore, when examining issues pertaining to Aboriginal people ad disabilities it is necessary to consider the issues from their vantage point and not base them on non - Indian standards because, simply, they are not at all comparable. (*"Urban Aboriginal Families of Children with Disabilities:Social Inclusion or Exclusion?"* , p 13.)

## IMPORTANCE OF CULTURE

Aboriginal people have endured a cultural holocaust where their spiritual practices and cultural teachings were outlawed. Punishments and abuse (physical, mental, sexual, emotional and cultural) were often inflicted upon those in residential schools who practiced their culture or spoke their first language.

As a result the residential school and colonization experience has created mistrust by Aboriginal people in accessing mainstream programs and support. This mistrust goes beyond the original generation who attended the residential school and that legacy afflicts the current generation. The losses are felt intergenerational and extend into mental, emotional, spiritual and physical aspects of health of many Aboriginal people today. For example recent research has found that assessment tools for Aboriginal people need to be modified, or at least analysed with a different perspective, taking into account historical and social economic conditions of the Aboriginal patient. To begin the healing, individuals must have access to culture, customs and traditions.



Today there is a strong resurgence and practice to reinstate cultural supports for Aboriginal communities. Programs and services in a vast array of fields report that the cultural practices being reintroduced are having significant successes for Aboriginal families. There is ample evidence that by ensuring that Aboriginal children have a good sense of cultural identity and belonging to family and community, they will thrive in living and learning environments. Reinforcing the importance of the extended family and responsibility with the Aboriginal community can help an Aboriginal person with a developmental disability to feel more accepted and appreciated in their life.

Traditionally, Aboriginal culture celebrates and values their citizens with differences and this needs to be reinforced actively now. In Joyce Carlson's article all participants felt that recovery of culture was important. This included use of "holistic models of care of persons, as well as attention to spiritual, emotional, physical and mental needs". One participant suggested that "governments (*should*) facilitate a range of services such as temporary support or alternate housing, to help when the support was needed, rather than attempting to 'fit' the needs of families into 'existing programs' "

" Carlson, Joyce Clouston, Travelling a Mirrored Pathway: Care of Children and Adults with Special Needs in Aboriginal Communities, Journal on Developmental Disabilities, Volume 12 Number 1, 2007



## HOUSING SUPPORT

**“Housing is not just shelter. It must provide safety, security, a sense of one’s identity and place in the community and an expression of one’s personality”**

Heemercyk, Barrie & Biersdorff, Kathleen, Housing Issues for Albertans with Developmental Disabilities, A Discussion Paper, Produced by Persons with Developmental Disabilities Provincial Board, 2001

People with developmental disabilities are not a uniform group. Some exhibit intellectual disabilities, often exacerbated by sensory or motor limitations or health difficulties, while others have mental health, literacy and/or behavioural issues. Most have financial difficulties, while others possess an ability to secure and maintain employment, although usually at minimum wage. Some have significant family support systems while others are alone facing their challenges. Accordingly, the housing issues cannot be resolved with a single strategy.

### Bricks and Mortar

In the designation of housing units for Aboriginal people with developmental disabilities there are a number of key design concepts that should be considered. Access, quality, and environmental adaptations are some of the critical aspects for appropriate and effective housing.

Recent research indicated that social housing programs for people with disabilities should be built on the premise that units are integrated with other regular social housing units. This ensures that tenants have the opportunity to interact with one another and not be ghettoized into one building or house.

Other design factors include the following:

- ◇ Consider gender separate units,
- ◇ Fenced and private courtyard with garden atmosphere,
- ◇ Space for traditional ceremonial use, sweat/kumik lodge,
- ◇ Reduced noise levels, quiet areas, low stimulation with low lighting,
- ◇ Open sight lines in apartments and open space rooms,
- ◇ Use of plywood instead of dry-wall,
- ◇ Alarms placed on doors,
- ◇ Common rooms for activities and gatherings,
- ◇ Common kitchen dining room for meals,
- ◇ Wheel chair accessibility in all units and buildings,
- ◇ Unit or space for short term family stays,
- ◇ Nursing or community workers space, and
- ◇ Alarms within units to call for help



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## Housing Support Services

When considering housing support services for persons with developmental disabilities a range of models and services must be designed to fit the varying cognitive needs of the tenants.

However, there are some consistent components within each of the models that are essential to incorporate. These are:

- ◇ Aboriginal staff (Para-professional and professional)
- ◇ Advisory committee with representatives with DD
- ◇ Proper assessment and diagnosis (for Aboriginal people)
- ◇ Aboriginal cultural programming
- ◇ Including traditional healers/medicine and Elders
- ◇ Consistent structures and residential stability
- ◇ Crisis Teams mobility and response
- ◇ Incorporating support from extended and family members
- ◇ Daily activities and monitoring support, and
- ◇ Substance and Drug Abuse support

There is a necessity to create need-based tiered housing models. Each model will respond to the levels of severity of the disability and intervention of care required to support tenants living

conditions.

Each of the following models presented in this paper are adapted from mainstream models to support the unique needs of Aboriginal people with developmental disabilities.

Evaluation outcomes could not be found to determine success' indicators, therefore, pilot programming will need to include evaluation frameworks.

All models are based on the assumption that an organization (e.g. Friendship Centre) will take responsibility for the management and implementation of the housing model. Rentals would be based and geared to income rentals, with government support funding for additional services.

## Training Staff

Cultural awareness training through modular units would be required by all staff working with Aboriginal people assigned a housing unit. This would include government workers who were assigned case loads in the housing units.

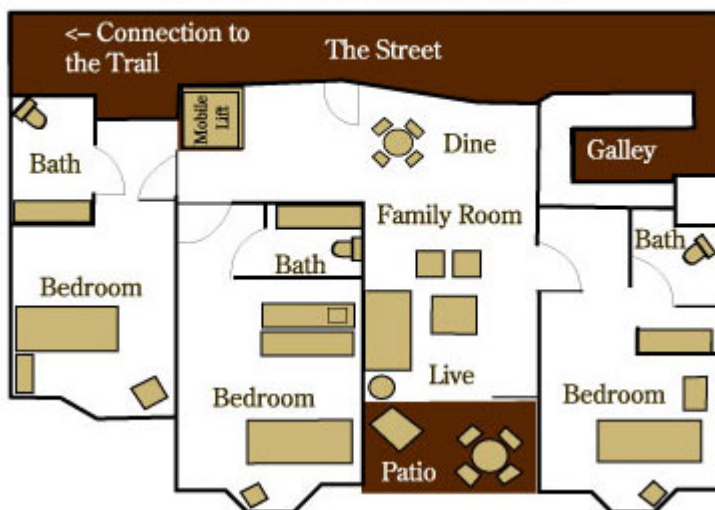
The cross-cultural training would revolve around assessment analysis, cultural interpretation, historical implications and traditional customs and teachings.

## MODELS

### Model #1: Care Living

- ◇ Care Living Model is compared to as “cognitive care model”.
- ◇ It is generally available to tenants who have severe symptoms resulting from developmental disabilities.
- ◇ It is a long term care strategy, balancing services with independent living.
- ◇ It provides independent units with congregate living supports, such as medical, dining, life and social skills programming, behavioural support, day programs, employment opportunities, recreational , leisure activities, training and laundry.
- ◇ There would be 24 hour, 7 days per week support and supervision and life lines in each unit.
- ◇ Ratio of staff to resident varies upon the needs of the residents.
- ◇ Access to cultural teachings and support would be made available on a regular basis.

*A Typical Care Suite (below is designed for 3 Residents)*  
**3 Bedroom Care Suites**



The Hamlets @ Westsyde  
3255 Overlander Drive  
Kamloops, BC V2B 0A5

# MODELS

## Model #2: Independent Living

The Independent Living Model is compared to an “assisted living model”, sometimes called Supportive Independent Living (SIL).

Units are designated in one building and spaces are shared, albeit with fewer individuals (usually 2-3).

Support services are provided on a need basis with tenant.

Support often consists of daily living, budgeting and problem-solving.

Auxiliary programming and supports may be available onsite through congregate space.

The tenants have access to professional and non-professional home care services.

Access to cultural teachings and support would be made available on a regular basis.

Amenities in typical assisted living complex



## BC LIVING INDEPENDENT SERVICES

BC Living Independent Services (BCLIS) provides housing and associated home care and attendant care services to physically disabled individuals and seniors who wish to live independently in apartments in Vancouver and Victoria. BCLIS has been providing its housing and care services since 1998.

### HOW DO WE PROVIDE SERVICE?

As disabled individuals we seldom have assigned to us enough attendant care hours to make the contracting of attendants easy or reliable, thereby rendering independent living unrealistic. Seniors who face a loss of independence experience similar problems, those associated with maintaining an independent lifestyle in a non institutional setting yet having access to home and attendant care, and to do so economically. BCLIS solves these problems through purchase or lease of multiple apartments into which individuals who are willing to share staffed care, move. Attendant care is available 24/7 in all our models. This is made possible by the pooling of 'care' hours provided to clients by external agencies such as the Health Authority, ICBC, WCB and/or care purchased directly from BCLIS. Staff are trained and are expected to help clients with the personal care, cooking, and home care needs necessary to support the independent living model. This model of housing and associated care is generally referred to as 'clustered care' or 'clustered living'.

### WHERE ARE BCLIS' CARE PROGRAMS LOCATED?

We currently have two programs up and running in Vancouver and two in Victoria. Each program provides housing and care to between 6-10 clients, each in their own apartment. BCLIS also provides human resources and administrative services to many individual clients who live in their own house or apartment. BCLIS will be opening a third program

in March, 2004. This program will start gradually. Additional apartments will be added as they become available. Please contact BCLIS if you are interested in details. *Note: Employment Application forms for Caregivers are available from our web site <http://www.independent-living.ca>*

### WHAT ARE THE CLIENTS' OBLIGATIONS?

- Clients must have, or be eligible for, attendant care hours provided through the Health Authority, ICBC, WCB or other source and must be willing to pool a significant number of those hours.
- Clients must also be capable of directing their own care and daily living.
- Client contribution to the cost of the apartment rent is based upon income and is negotiated with BC Living Independent Services.

### SO, WHAT DOES BCLIS PROVIDE TO HELP YOU LIVE INDEPENDENTLY?

1. your own apartment
2. attendant care 24/7
3. housekeeping & cooking
4. affordability
5. proximity to shopping and Recreation

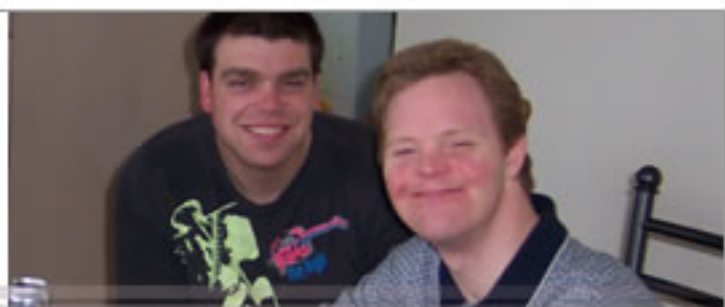


Brochure Content for Assisted Living site in BC

## MODELS

### Model #3: Partnership In Care Living

- ◇ The Partnership In Care Living Model is compared to the Familyhome Program, which began in 1984.
- ◇ It requires volunteers to sign up and be available to provide day to day support, meals and care to an individual living within their own rental unit.
- ◇ Volunteers would provide advice, meals and assistance in arranging home care or other professional or non-professional care.
- ◇ The volunteers may be extended family members and are paid a small tax-free stipend for their support.
- ◇ MCSS provides screening of potential families, supervision and support for the families.
- ◇ Access to cultural teachings and support would be made available on a regular basis.



Pictures from  
<http://www.familyhomeontario.org/index.htm>

## History

The FamilyHome Program was introduced as a new support program in 1984. It operates under the Developmental Services Act, which is an act concerning the provision of services to persons with developmental disabilities. It was designed to expand the range of residential options available to the community and to allow individual needs to be addressed in a more flexible or personal manner. Family Homes are not formally licensed, however, they must meet the FamilyHome Guidelines (January, 2004) adopted by the Ministry for consistency, accountability, and for the ultimate goal of ensuring that the needs of individuals are being met.

## Mission & Vision

The mission of the FamilyHome program is to support people with developmental disabilities by partnering them with families in the community. In doing so, individuals with disabilities are provided the opportunity to live and grow in a nurturing family environment. We believe in a community that respects the dignity and inherent value of each of its members and supports its members to participate, contribute, and lead enriched and meaningful lives.

## The People We Support

The FamilyHome Program provides services and support to individuals with developmental disabilities. Each individual is as unique as the family they are partnered with. Some individuals may be independent and require minimal support, while others may have more significant challenges and require continuous support and supervision. In addition to a developmental disability, some individuals may have a physical handicap or mental health need. All adult individuals are in receipt of Ontario Disability Support Program (ODSP) benefits.

## Description

The FamilyHome Program is about people in the community sharing their lives and homes with an individual who has a developmental disability. One, or possibly two individuals with developmental disabilities, lives with families who provide a supportive and caring environment. Families providing support are granted the privilege of making a positive difference in the life of another person and of developing a long-term relationship with someone they might not otherwise have met. The feelings of shared accomplishment and joy that come from supporting another person to meet their life goals far outweigh the challenges.

## Families Providing Support

Families providing support come in all different shapes and sizes. They can be single people, couples, or families with a variety of lifestyles. Becoming involved in the FamilyHome program requires the commitment of building a long-term relationship and providing a stable home environment that can accommodate an additional person. Families providing support need to have ample time to provide the necessary support and have the ability to recognize and nurture individual strengths. Educational qualifications in a relevant discipline and/or previous experience working with people with disabilities are assets but not always necessities.



## Responsibilities of Families Providing Support

Being a family who provides support to somebody with a developmental disability is a lifestyle commitment. It means sharing a home and being a part of an individual's life. It also means helping an individual to achieve their personal goals and to be a valued member in their home and community. Families providing support encourage individuals to be active in their community, help develop their skills, interests, and competencies, and develop and promote relationships. Individuals participate in the life and activities of the family with the individual receiving attention in a family atmosphere. The types of responsibilities families may assume are: providing meals and laundry, assisting with finances, attending health care and other appointments, as well as involvement in work, recreation and social activities.



## Training & Support

Families providing support receive ongoing training, support, remuneration (in the form of a per diem payment and transportation allowance), as well as respite care for the individual receiving support. This respite care allows families to have some time off throughout the year.

Families providing support are required to attend training events as specified by the agency they are working for.

Agencies work closely with families to address individual needs, solve problems, and support the relationship between the family and individual. A worker is assigned to each individual and family. This worker is responsible for the supervision and co-ordination of the arrangement and will keep in regular contact. The worker will also visit regularly with the individual receiving support outside of the home.

## Natural Families

Some supported individuals visit with or contact their families on a regular or occasional basis. Others may not have any involvement with their natural families.

## Day Programming

Most individuals in the FamilyHome Program attend a sheltered workshop or day program during the week. Some individuals may also work or attend volunteer placements. Others may have an individualized day program in the community with a one-to-one worker. Day-time activities vary, but individuals are usually busy for up to 7-8 hours per day, Monday to Friday.

The following overview of the FamilyHome program (a form of Partnership in Care Living) comes from their website  
<http://www.familyhomeontario.org/index.htm>



# MODELS

## Model # 4: Co-Operative Housing

- ◇ The Co-Operative Housing Model is used when housing or services are simply too costly for in-home care.
- ◇ Individuals can still maintain a high-level of independence and quality of life in small cooperative living situations.
- ◇ Shared housing and services in groups of three to fifteen allow individuals to provide for their needs at a reasonable expense, maintain independence and live in a less regimented environment.
- ◇ Access to cultural teachings and support would be made available on a regular basis.
- ◇ Co-operative housing fosters cross-disability coordination as well. For example, a cognitively impaired resident may provide assistance to one who has mobility impairment, while that person may help another resident who has difficulty reading as a result of a brain injury.
- ◇ Community care professionals are available on a need basis to tenants within the house.



# MENU OF SERVICES FOR THE HOUSING MODELS

Programming	Model 1	Model 2	Model 3	Model 4
Services & Supports	Cognitive Care Living	Independent Living	Shared Care Living	Partnership Care Living
24/7 Professional/Paraprofessional support onsite	☀			
Visiting Community Support (as required)		☀	☀	☀
Visiting Elder Support	☀	☀	☀	☀
Satellite Family Support			☀	☀
Cleaning Services	☀	☀	☀	
Personal care support	☀	☀	☀	☀
Kitchens in units	☀	☀	☀	☀
Common dining room	☀			
Meals on wheels	☀	☀	☀	☀
Meals provided off site (as required)			☀	☀
Community kitchen - meal preparations	☀	☀	☀	☀
Food selection & delivery assistance	☀	☀	☀	☀
Life skills training	☀	☀	☀	☀
Regular recreational activities	☀	☀	☀	☀
Financial management support	☀	☀	☀	☀
Substance Abuse programming	☀	☀	☀	☀
Cultural teachings	☀	☀	☀	☀
Ceremonial practices	☀	☀	☀	☀
Traditional Healer	☀	☀	☀	☀
Anger Management	☀	☀	☀	☀
Mediated learning	☀	☀	☀	☀
Individual treatments	☀	☀	☀	☀
Regular monitoring	☀	☀	☀	☀
Life line in units	☀	☀	☀	☀
Fenced garden courtyard	☀	☀		
Alarms placed on doors	☀			
Drug monitoring	☀	☀	☀	☀



## KEY FINDINGS

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An examination of the housing issue for developmental disabled Aboriginal persons discloses the following key findings.

1. There is a critical need for housing support services for Aboriginal people with disabilities living in the urban setting,
2. Current funding levels do not meet the need for housing spaces for mainstream applicants, let alone urban Aboriginals,
3. Aboriginal people with developmental disabilities require unique programming to support their independent living goals,
4. Aboriginal para-professional and professionals must be directly involved in the delivery and implementation of housing support models,
5. Enhancement of services must include culturally appropriate programming and design,
6. Programming must be holistic in approach and implementation to make a systemic difference for Aboriginal people with developmental disabilities,
7. Aboriginal extended families and Elders must be integrated into program supports,
8. Pilot programming for housing models should be tested in for a minimum two year time period, and
9. An evaluation framework must be part of any pilot project

## CONCLUSION

The housing model recommendations for Aboriginal people with developmental disabilities is the first step to acknowledging the worth and ability that these individuals make contributing to society. It will construct safe environments while creating cost efficiencies for the future.

It is a future that recognizes the needs of these individuals, the healing that needs to take place and finally provides the same basic human rights to them, as for the rest of the population.

Most important it stops the stigmatization they have had to face throughout their lives and validates their place within Aboriginal communities.





## RESOURCES

Aboriginal Children the Healing Power of Identity

<http://www.canadian-health-network.ca>

Aboriginal Healing and Wellness Strategy

<http://www.ahwsontario.ca/publications/longitudinalstudy.html>

Addressing Community Inclusion for Aboriginal Albertan with Developmental Disabilities – A Policy Framework of the Persons with Developmental Disabilities

Alberta Provincial Board : <http://www.pdd.org/docs/prov/AboriginalFramework2006.pdf>

AFN Comparative Resource Analysis of Support Services for First Nations People with Disabilities Dr. Rose-Alma J. McDonald : <http://www.afn.ca>

*“A Shared Responsibility Ontario’s Policy Framework for Child and Youth Mental Health”* Ministry of Children and Youth Services

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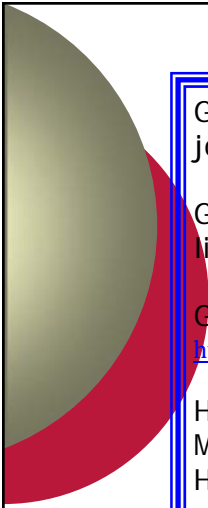
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