THE MANITOBA HUMAN RIGHTS COMMISSION
LA COMMISSION DES DROITS DE LA PERSONNE DU MANITOBA

Investigation Report

Complainant: Hampton, Amelia
Respondent: Government of Manitoba - Manitoba Health, Seniors and Active Living, Manitoba Families & Winnipeg Regional Health Authority
File No.: 16 EN 234
Prepared by: Tom Ponech
Complaint: July 22, 2016
Date: June 18, 2018
Reply: October 8, 19, and 21, 2016

The purpose of this report is to recommend to the Board of Commissioners to dismiss the complaint or refer it to the Human Rights Adjudication Panel. The recommendation is based on the evidence summarized in this report.

COMPLAINANT'S ALLEGATION:

The Complainant alleges that the Respondents have failed to provide adequate services for the Complainant as well as other adults with physical disabilities, contrary to section 13 of *The Human Rights Code ("The Code")*. The Complainant alleges that the Respondents are systemically discriminating against adults with disabilities by providing them with inadequate support services.

RESPONDENT GOVERNMENT OF MANITOBA'S POSITION:

Manitoba Health, Seniors and Active Living ("Manitoba Health")

The Home Care Services program is meant to supplement the role of family and other informal support networks in providing personal care to individuals in their homes which includes facilitating early hospital discharge and deferring entry into long term care facilities. All Manitobans are eligible for home care services based on their assessed need. Manitoba Health maintains policy guidelines to facilitate consistency across all regional health authorities and imposes a service limit of 55 hours of service per week but is flexible and allows for authorization that exceeds the limit in the case of unique or complex requirements. Individuals may appeal under *The Health Services Insurance Act* and the *Manitoba Health Appeal Board Regulation.*

Manitoba Health does not know of the Complainant's circumstances, the details of the homecare services she receives, or the nature of her interactions with the Respondents. The statutory responsibility for delivering homecare rests with regional health authorities. Manitoba Health's home care services constitute a special program as contemplated under *The Code.* In the alternative, the 55 hour service limit is a bona fide and reasonable means of safeguarding the sustainability of home care and the delivery of these services to as many Manitobans as possible.

Manitoba Families

Manitoba Families administers the Children's disability Services program (CDSP) and the Community Living disability Services (CLDS) program, the Employment and Income assistance (EIA) program and the Disability Health Supports Unit (DHSU).

CDSP provides policy direction and financial support for various initiatives including children's occupational therapy, physiotherapy, speech and language therapy and audiology services- and is a coordinated approach delivered through regional health authorities, school divisions and service agencies so that services for children are maximized.

CLDS services are voluntary, discretionary and prioritized based on individual need and available resources except as provided under the emergency protection provisions of the *Vulnerable Persons Act.* CLDS has recently implemented a standardized assessment tool to assist in the determination of the support needs for program participants and is working with an external organization to develop a funding allocation model linking the tool to the program. The standardized tool is critical to ensure Manitoba creates a transparent, equitable and sustainable program. Persons living with a disability are eligible to apply for EIA which include a disability benefit as well as supports through the disability and health supports unit that provides nutritional and health supplements, and medical or disability related items, and sometimes home modifications.

The Complainant's eligibility for the CDSP ended when she turned 18. Her family withdrew their application for CLDS in 2010 and has not re-applied. She has not availed herself of the supports available and has not been assessed for CLDS eligibility, and if she is "untestable", she could provide a letter from a qualified clinician confirming that she has significantly impaired intellectual functioning. She has received supports through EA and the disability health services unit.

Differential treatment cannot be found if the Complainant refuses to be treated. If systemic differential treatment exists, then that discrimination is "legislatively based" and beyond the jurisdiction of the Commission to consider. The CLDS is a special program under section 11 of *The Code* as its intention is to ameliorate the conditions of a distinct group of individuals, that being those with mental disabilities.

WINNIPEG REGIONAL HEALTH AUTHORITY'S POSITION:

Winnipeg Regional Health Authority (WRHA) denies that it has discriminated against the Complainant. In the alternative if it did provide differential treatment in the provision of services to the Complainant on the basis of age, physical or mental disability, such treatment was provided in order to provide reasonable accommodation for the special needs of an individual or group, or in the further alternative, such treatment was provided for bona fide or reasonable cause. WRHA administers the Manitoba Home Care Program (MHCP) to supplement the role of family and other informal support networks in providing personal care assistance to individuals in their homes, in the Winnipeg-Churchill Health Region in accordance with Manitoba Health policies. WRHA is not responsible for CDSP and CLDS program.

WRHA acknowledges the Complainant did not receive the same services when she transitioned from childhood to adulthood; the services available under the CDSP and/or CLDS are not the same as the services available under the MHCP but different services available under different programs does not constitute discrimination on the basis of disability, age or otherwise and any differences in services are bona fide.

The Complainant's parents are both approved under MHCP's Self and family Managed Care (SFMC) program and her father as the Self and Family Care Manager is responsible for coordinating, managing and directing the non-professional services needed by the Complainant to continue living at home and in the community. The Complainant would be eligible of the same type and level of service under the regular Home Care program as she receives through the SFMC Program. She is an appropriate candidate for the MHCP. The Complainant has never applied to exceed the 55 hour maximum provided in Manitoba Health's Service Level Policy.

ISSUES:

Issue #1: Do the Respondents discriminate against the Complainant and other adults with significant disabilities on the basis of age and/or disability by providing inadequate services?

Issue #2: If so, is the discrimination *bona fide* and reasonable?

Glossary:

CDSP- *Children with Disabilities Support Program*

CLDS- *Community Living Disability Support program*

DSHU- *Disability Support Health Unit*

SFMC- *Self and Family Managed Care program*

MHCP- *Manitoba Home Care Program*

EIA- *Employment and Income Assistance program*

SMD- *Society for Manitobans with Disabilities*

RHA- *Regional Health Authority*

ANALYSIS:

Section 13 of *The* Code prohibits discrimination in the provision of services. Section 9 defines discrimination as treating a person differently based on a characteristic listed in *The Code*, without reasonable justification for doing so. Discrimination is often based on prejudice and stereotypes that suggest a person is less capable or worthy of recognition or value than others in society.

The Complainant alleges that as a person with a disability, she is being discriminated against on the basis of her age and/or disability because when she became 18 she "aged out" of support services provided by the Respondents. Put another way, the Complainant alleges that the Respondents have together failed to provide adequate services for the Complainant as well as other adults with significant physical disabilities. The complaint indicates that the Complainant went from receiving a full suite of services to an "inadequate patchwork of supports" and that this constitutes systemic discrimination because it creates a hierarchy of disability and perpetuates the stereotype that people with disabilities are less worthy than others.

The Respondent Government of Manitoba takes the position that CLDS constitutes a special program under *The Code* because it is designed to ameliorate the condition of adults with intellectual or mental disabilities, and that the limits on the services they provide such as the service limit of 55 hours of home care services per week, is bona fide and reasonable. On the other hand, the Respondent WRHA acknowledges the Complainant did not receive the same services when she transitioned from childhood to adulthood; the services available under the CDSP and/or CLDS are not the same as the services available under the MHCP but states that this does not constitute discrimination on the basis of disability, age or otherwise and any differences in services are bona fide. The Respondents also state that the Complainant has never applied CLDS or to exceed the 55 hour maximum.

In cases in which it is alleged that a policy or program systemically discriminates against a group based on a characteristic protected in *The Code,* it is helpful to consider the guidance provided by the Supreme Court of Canada in *Withler v. Canada (Attorney General),* 2011 SCC 12. In this case the Court clearly stated that a contextual approach is necessary to identify prejudice or stereotypes that constitute substantive inequality. The Court explained at para 11:

> The first way that substantive inequality, or discrimination, may be established is by showing that the impugned law, in purpose or effect, perpetuates prejudice and disadvantage to members of a group on the basis of personal characteristics…Perpetuation of disadvantage typically occurs when the law treats a historically disadvantaged group in a way that exacerbates the situation of the group.

Section 52 of *The Code* sets out that a complainant has the onus of proving a *prima facie* case of discrimination. The *prima facie* test was confirmed by the Supreme Court of Canada in *Moore v. British Columbia (Education)*, 2012 SCC 61 at para 33, that:

> ... to demonstrate prima facie discrimination, complainants are required to show that they have a characteristic protected from discrimination under the *Code*; that they experienced an adverse impact with respect to the provision of services and that the protected characteristic was a factor in the adverse impact. Once a prima facie case has been established, the burden shifts to the respondent to justify the conduct or practice, within the framework of the exemptions available under human rights statutes. If it cannot be justified, discrimination will be found to occur.

Issue #1: Do the Respondents discriminate against the Complainant and other adults with significant disabilities on the basis of age and/or disability by providing inadequate services?

The issue of obstacles to full participation in society faced by people with disabilities was considered by the Supreme Court of Canada in *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624:

> It is an unfortunate truth that the history of disabled persons in Canada is largely one of exclusion and marginalization. Persons with disabilities have too often been excluded from the labour force, denied access to opportunities for social interaction and advancement, subjected to invidious stereotyping and relegated to institutions;...
>
> This historical disadvantage has to a great extent been shaped and perpetuated by the notion that disability is an abnormality or flaw. As a result, disabled persons have not generally been afforded the "equal concern, respect and consideration" that s. 15(1) of the *Charter* demands. Instead, they have been subjected to paternalistic attitudes of pity and charity, and their entrance into the social mainstream has been conditional upon their emulation of able-bodied norms;...
>
> One consequence of these attitudes is the persistent social and economic disadvantage faced by the disabled. Statistics indicate that persons with disabilities, in comparison to non-disabled persons, have less education, are more likely to be outside the labour force, face much higher unemployment rates, and are concentrated at the lower end of the pay scale when employed. (para 56).

The evidence establishes that the Complainant is an adult with a disability. She has cerebral palsy with spastic quadriplegia. The evidence establishes that she uses a wheelchair or walker, is non-verbal and requires assistance with all aspects of daily living including feeding, dressing, toileting, going to bed and transporting. As such, the Complainant is a person who is afforded protection under section 9(2)(l) of *The Code*.

The Complainant alleges that the services available to her as an adult are inadequate and therefore the Respondents are treating her adversely. The evidence of the Complainant's mother and the Witness suggests that the inadequacy of services relates in particular to:

- a lack of coordination of supports between service providers and programs for adults with disabilities;
- the method of assessing or determining eligibility for supports so far as it relies on IQ testing;
- the extent of services themselves, such as home care, respite, physiotherapy, occupational therapy etc.; and
- the equipment or assistance that is covered or otherwise funded by the various service providers.

The evidence of the Complainant's Mother and the Witness is detailed as it relates to the specific supports the Complainant and the Witness had access to since birth and as they transitioned to adulthood. Their evidence describes the Respondent programs that provided support but also demonstrates challenges related the way in which requests for support from persons with disabilities are handled. For example, individual requests must be sent to EIA and will each be considered by a different therapist. The evidence also suggests that EIA is more restrictive in approving requests than CDSP is.

The evidence indicates that the Complainant previously had a CDSP worker and later had an EIA worker. In some cases the Complainant's mother was only made aware of funding options or programming when it was mentioned to her by another Respondent program officer. Although the Respondent witnesses referred to an integrated service model and the evidence suggests that a transitioning process exists to advise individuals and their families of the funding options available to them and that it starts before an individual turns 18, there was little evidence provided to establish a centralized space or mechanism for persons with disabilities and their families to access information about available supports or the availability of customized supports and equipment.

The evidence clearly establishes that eligibility for CLDS is based on IQ testing or assessment and will therefore exclude persons with disabilities who of higher mental functioning or moderate developmental delay. These persons will therefore seek supports through EIA which is intended to be a program that supplements when other funding has been exhausted.

The evidence suggests that once the Complainant was no longer eligible for CDSP, there was a strain put on the Complainant and her family to try and access customized equipment. For example, it appears that while CDSP provides for some of the family-oriented supports such as vehicle modifications or respite, the Respondent programs will not to the same degree.

The evidence also establishes that some equipment-related funding, including repairs, are not available to adults in the same way as they are available to children with disabilities and their families. The evidence is clear that EIA as a primary program to support adults with disabilities operates on the basis that it will supplement supports available through other means, which is a shift from the family-centred approach utilized by CDSP.

The various Respondent programs taken together establish a range of available supports that may be accessed from different entry points, without a holistic assessment of the individual's needs, including the impact of family supports. This is a clear departure from the approach taken through CDSP to support children with disabilities and their families.

As such, there is sufficient evidence to establish that the Complainant and other adults with significant disabilities experience changes in terms of how they can access funding, and that for adults, funding is more restrictive or less coordinated as individuals "age out" of CDSP funded supports, all of which constitutes adverse treatment.

The final step in the *prima facie* test is for the Complainant to establish a nexus between her protected characteristics and the adverse treatment. To do this, it is helpful to consider the overall context in which a person alleges they are being treated adversely. Given that the evidence is sufficient to establish that the Complainant as an adult with a disability who has experienced or is experiencing barriers to meaningful participation in daily activities, it is concluded that the Complainant has established a *prima facie* case of discrimination or that her disability was a factor in the adverse treatment she experienced. Accordingly, the Complainant has established a case of substantive inequality for adults with significant disabilities who have "aged out" of services.

Issue #2: If so, was the discrimination *bona fide* and reasonable?

The Commission has developed Policy G-5, *Services- Bona Fide and Reasonable Cause* based on the test set out by the Supreme Court of Canada in *British Columbia (Superintendent of Motor Vehicles) v. British Columbia (Council of Human Rights)* (1999) 36 C.H.R.R. D/129 ("*Grismer*"), to assess if the Respondents' discriminatory actions are reasonable.

Once a standard, policy or rule has been shown to be discriminatory based on any of the characteristics listed in *The Code*, a service provider must demonstrate that:

1. the standard, policy or rule adopted by the service provider was rationally connected to the provision of the service;

2. the service provider adopted the particular policy, standard or rule in an honest and good faith belief that it was necessary to the fulfillment of the legitimate service-related purpose;

3. the policy, standard or rule is reasonably necessary to accomplish the legitimate service-related purpose in the sense that the service provider cannot accommodate individuals with the Complainant's characteristics without incurring undue hardship.

To apply the test in *Grismer* to this complaint, the Respondents' service-related purpose must be identified. In *Moore* the Supreme Court found that provision of disability-related supports is not a service in and of itself but rather, "it is the means by which those students get meaningful access to the general education services available to all of [students].

> It is accepted that students with disabilities require accommodation of their differences in order to benefit from educational services. Jeffrey is seeking accommodation, in the form of special education through intensive remediation, to enable him equal access to the "mainstream" benefit of education available to all. . . . In Jeffrey's case, the specific accommodation sought is analogous to the interpreters in *Eldridge*: it is not an extra "ancillary" service, but rather the manner by which meaningful access to the provided benefit can be achieved. Without such special education, the disabled simply cannot receive equal benefit from the underlying service of public education. [Emphasis added; para. 103.]

The evidence gathered in the investigation suggests that the Respondents work together to provide supports for adults with disabilities to enable them to participate fully in society through various programs for adults such as CLDS, EIA, SFMCP, MHCP and others.

With respect to the purpose of each program, the evidence establishes that CDSP is intended to provide supports to children with disabilities and their families. To be eligible, an assessment based on the child's developmental milestones is done along with a comprehensive family assessment. The evidence indicates that CDSP services are coordinated through a CDSP worker who will provide information and assistance in navigating procurement of equipment, programming and other supports. When a child is of school age, some of that support is provided through the school system. Families are assumed to be caregiving and as a result they can access respite and other training and supports. Further, families may obtain funding for equipment and modifications required to ensure their child is supported and able to participate in society.

The evidence establishes that CLDS and EIA work together to provide support to adults with disabilities, largely through the DHSU:

- CLDS offers supports to adults with *intellectual* disabilities, including residential services, respite services and day programs to a person who has qualified as a vulnerable person under provincial legislation. An assessment is done based on the Supports Intensity Scale and approximately 40% of CLDS clients are assessed at the lowest level, meaning they are able to live on their own with minimal supports. An IQ test is administered and to be eligible, an individual must score below 70.

- EIA offers supports to individuals who are economically marginalised or unemployed and who have exhausted all other sources of income. EIA provides direct funding for basic assistance such as shelter and food and may include funding for basic dental, optical and medical services and is therefore accessed by persons with disabilities to pay for supports.

As such, it appears that the various programs administered by the Respondents are rationally connected to the Respondents' service-related purpose of enabling full participation for persons with disabilities in society.

It is accepted that the Respondents' services for adults with disabilities were developed r implemented based on a good faith belief that they are necessary to establish the Respondents' service-related purpose.

The final question in the *Grismer* test requires consideration as to whether or not the Respondents' services for adults with disabilities meet the standard of being reasonably necessary to accomplish the Respondents' service-related purpose. If so, it can be concluded that the Respondents' provision of services is bona fide and reasonable.

Here, it is necessary to examine whether or not the group impacted by the policy or program is being treated more harshly than others, whether or not alternative approaches have been considered, and also whether or not the Respondents accomplish their goal or purpose in less discriminatory ways.

There was no evidence obtained in this investigation to suggest that the adequacy of supports, including funding and equipment) for adults with significant disabilities who have "aged out" of the CDSP has been considered or that it has been specifically considered if services with a higher level of integration and coordination could be offered within the budgetary and other constraints of any publicly funded service. Similarly, there was no evidence to establish that the method of IQ testing is reasonable given that it may be challenging to utilize on adults with significant physical disabilities who may not have significant intellectual disabilities.

It is recognized that for many persons with disabilities, the Respondents' services may be adequate. The evidence establishes however that adults with significant disabilities who require a high degree of support go from a family-centred support model to one which is less coordinated and appears more restrictive, despite their disability-related needs remaining the same. As such, and in the absence of any evidence to establish that this shift or apparent gap is reasonable or justified, it appears that the Respondents' services or programs do not reasonably enable the full participation of adults with disabilities.

With respect to the argument that the Respondents' services constitute a special program under section 11 of *The Code* which essentially sets out an exception to discrimination, the reasoning in *Moore* instructs that we approach these issues with examining the overall service being provided by the Respondent which in this case appears to be the provision of services to enable meaningful participation by persons with disabilities in society. As a result, it does not seem appropriate or reasonable to conclude that the services are akin to an equity or affirmative action program that gives preference to a group protected by *The Code.* To view the provision of income supports (EIA) and funding for home care, respite and equipment as a program designed, based on benchmark data and otherwise, specifically to ameliorate the condition of persons with disabilities ignores the premise of the exception set out in section 11of *The Code* which is to acknowledge that to ameliorate the condition of historically disadvantaged groups we must consider "levelling the playing field" in hiring and housing in particular. Accordingly, there does not appear to be sufficient evidence that the Respondents' programs or services are a special program as contemplated under *The Code.*

CONCLUSION:

The evidence establishes on a balance of probabilities that the Complainant has been discriminated against as are other adults with significant disabilities, without reasonable cause, contrary to section 14 of *The Code.*

EVIDENCE CONSIDERED:

SUMMARY OF INTERVIEWS:

The Complainant's Mother

The Complainant's Mother provided evidence on behalf of the Complainant while in the presence of the Complainant and legal counsel at the offices of the Manitoba Human Rights commission.

The Complainant is 26 years old. She has cerebral palsy with spastic quadriplegia and scoliosis. She is non-verbal and communicates through gestures, sounds and facial expressions. She uses a feeding tube.

The Complainant requires assistance with a number of daily living tasks, including getting up in the morning, feeding, dressing, toileting, brushing her hair and teeth, washing her face and other personal hygiene, and taking medications three times daily. She needs assistance transporting to and from her walker or wheelchair and activities or programming. She requires daily stretching and has trouble sleeping so one of her parents usually stays up with her.

The Complainant uses a wheelchair with customized modifications to the seat and back and requires a headrest as well as a seat belt and side bolsters to keep her sitting upright.

The Complainant turned 18 in 2010 and graduated from high school at age 21.

Eligibility & Coordination of Services

The Complainant received services through CDSP. This gave them lots of one-on-one support and coordinated access to a number of different supports, including respite, physiotherapy, occupational therapy, behaviour modification, feeding clinics, speech therapy, medical supplies and equipment. They were able to borrow equipment that helped improve the Complainant's quality of life, such as wheelchairs specially designed for the beach or pools. The Complainant attended summer camps, communications assessments and feeding clinics. Health care professionals would come to the house. Through CDSP, their family van was modified in 1994 with a lift and wheel restraints. With the money left over from the van modification the Complainant had a ceiling track system put in the home. In 2004, a new van was also modified with a Bruno Turney seat. Through CDSP the Complainant had a custom bathroom built that includes a lift to get into the tub as well as a special sink that can move up and down. Her eligibility for CDSP services ended when she graduated from high school.

The Complainant did not apply for CLDS. Back when the Worker was providing information about the transition to adulthood it was mentioned to take the IQ test and it was discussed that when she was 16 the option for CLDS was not closed and the test could be taken later on. The Complainant's Mother got a call that she needed to meet the school psychologist for the IQ test. She asked the psychologist how he would know how the Complainant was answering as she was non-verbal. The psychologist did not know how he would administer the test. She herd from other families that she knew that the psychologist would just put down that the Complainant's IQ as below 70. She spoke to the Worker about the test. The test should rather be based on life skills.

Her main concern is what will happen to the Complainant when she and her husband are no longer alive. She knows some of the Complainant's friends who qualify for the CLDS. They are living in a home with 24/7 care and they get to attend programs that interest them. Her understanding is that when she and her husband have passed on the Complainant will have to live in a personal care home.

The Complainant is 25 and does not want to live in a care home. The Complainant needs to have funding so she can have a roof over her head. While she and her husband have put money aside for the Complainant they do not have a large enough sum of money for her to hire full time care. Anyone who would care for the Complainant would have day jobs to attend leaving the Complainant alone so there needs to be money for someone to look after her when her supports are at work.

When the Complainant was 14 she met with the Complainant's CDSP worker who introduced them to an adult stream worker who could explain the different levels of funding the Complainant had access to. The first was minimal funding for home care services including preparing meals and administering medications. The second was for respite care provided through WRHA. The third level was if the Complainant took an IQ test and scored below 70 which would qualify the Complainant for CLDS, which can provide up to 24/7 care and access to day programs.

The Complainant requires the third level of care as she cannot live on her own. The Complainant's parents believe that the IQ test is demeaning and it is not possible for her to take which leaves her without the supports that she needs. The day programs and other supports provided through CLDS would not be available through the other two levels of funding.

Once the Complainant turned 18, she applied for and was approved for EIA funding, however the funds are limited. If she were living on her own, she would be living in the slums.

Since turning 21 years old, the Complainant no longer has access to coordinated service delivery through CDSP. She has to go to a number of different agencies to access the supports that she requires and these supports do not meet her needs or come close to the kind of services she could previously access through CDSP.

Home Care, Respite & Other Supports

The Complainant is eligible for 55 hours of home care services per week through the Manitoba Home Care Program (MHCP). She qualifies for the Self and Family Managed Care Program ("SFMCP") and the Complainant's Mother receives funding to provide 45 hours of care per week. She only found out about these programs when the Complainant was 20.

They hire a respite worker with the remaining 10 hours of funding. When the Complainant was receiving services through CDSP, she received 15 hours of respite services per week. By hiring a respite worker through the SFMCP, they ensure the Complainant receives respite at home and in the community (for example, the Complainant's respite worker takes her to movies). If the Complainant was receiving respite through MHCP, they would not take her into the community – she would be limited to staying at home.

The Complainant needs something to do during the day, such as attend university. The Complainant's Mother would like her to go to university with a care provider (other than her parents) but this is not possible. A care home would not be appropriate for the Complainant as there are only seniors there and there would be nothing for the Complainant to do. The complainant volunteered at a care home while in high school assisting with bingo and handing out prizes. If she lived there however she would just be watching television all day. She is fearful that the care home staff would sedate the Complainant to keep her quiet.

Equipment

When the Complainant was young, CDSP connected her with the Children's Rehabilitation Centre for equipment. Now she has to go to at least five different agencies for her equipment needs. EIA provides funding for some equipment-related needs, but to access funding from EIA for things like wheelchair components, the Complainant needs to be assessed by Community Therapy Services. Each request is a new file with a new therapist. She heard about Community Therapy Services through the home care worker. If something is not provided, they try EIA but there are limits and restrictions on what EIA will cover.

The Complainant's therapist put in a request for a full length armrest for her wheelchair so she could rest her food tray and food pods on her chair, but EIA would only cover a partial armrest. The adult rehab staff wanted to put a side bolster on both sides of her chair but EIA would only fund a single swing-away-side bolster. The Complainant needed to have a seat belt repaired in the van that had been previously modified through CDSP. EIA would not cover the cost of the repair as the belt had been purchased through CDSP or fund the $150.00 for replacement of the seat belt, but EIA would cover the cost of the Complainant's taxi trips using a handi-cab service.

The Complainant needs a new chair but her family is worried that they will not be able to get one that is modified with seat belts or that otherwise meets her needs because EIA is denying many requests.

Their van had been modified for the Complainant's transport through Children's Special Services and they had covered all ongoing maintenance costs until she turned 18. As an adult, they cannot access funding for any additional van modifications. They purchased a new van and paid $25,000 to make it wheelchair accessible.

Recently the Complainant was assessed for a stander so she could be in an upright position. She went through Community Therapy Services and was told by their therapist that EIA would probably not cover the cost of the stander so the parents purchased it.

When the Complainant needed [redacted] she had to go through the process of [redacted], which are not the same as provided by CDSP and did not work for the Complainant. After seeing that the [redacted] did not work, EIA provided funding [redacted]

She has received funding from EIA for three chest and body point belts which the Complainant needs for her bath seat.

The Witness

The Witness was interviewed in person while in the presence of his mother and legal counsel.

He has Cerebral Palsy. He has vision loss and requires a screen reader, JAWS, to use the computer. He requires assistance to do tasks associated with daily living such as cooking, cleaning, and using the washroom. He cannot go out on his own and requires someone to be with him at all times. If he were to attend university, he would require someone to prepare notes and would also need an attendant to set up his computer to ensure he does not crash into anything. He turned 18 on November 20, 2014.

An occupational therapist from WRHA determined that his standing is a risk. This was determined after a [redacted] dropped him during a transfer in May 2016. He used to be able to safely transfer himself in and out of his wheelchair. He however now cannot do so and needs to be transferred using the ceiling lift. He has lost a lot of his general mobility. This is because he has not had physiotherapy or occupational therapy since he turned 18. Since he has not been able to go to physiotherapy or occupational therapy his muscles have locked up. This causes him to not be able to move his joints.

When he turned 18 he lost all funding through CDSP. He no longer receives respite or technology. He does not receive occupational or physiotherapy. He only receives $500 per month from EIA When he turned 18 he was not provided with any information about services he required. Rather he was left on his own to find them. The only physiotherapy he gets is from the [redacted] staff and only includes range of motion. The stretches are aimed at keeping his current mobility however it is not working as the [redacted] do it infrequently. He no longer can stand and is losing the mobility in his hands. When he was a youth he had physiotherapy every day to assist his range of motion and relax his muscles.

He worked with an SMD Worker during his transition to the adult system. The SMD Worker indicated during the transition that the Complainant did not qualify for a social worker or an SMD worker.

When he and his mother attended the EIA office he applied for their marketAbilities program. This program would assist in his finding work. EIA denied this request. He was also not eligible for CLDS.

If he needs to use the washroom he has to call for a worker to assist him. Whether or not there is a worker available is the determining factor if he can use the washroom. He has had to wait up to half an hour if no workers are available to assist him with using the washroom. At the residents share the workers. Homecare grants him 40 hours of care from the workers. He does not receive the maximum of 55 hours.

Home Care, Respite and Other Services

He received supports through CDSP as a youth and had access to respite, physiotherapy and occupational therapy. The respite workers through CDSP provided him independence. This also meant his mother had time to herself. When he does not leave the house he feels segregated from the community. He always had a respite worker to go out into the community and could participate in recreational activities or spend time with friends. The respite worker would take him to the mall or to other forms of entertainment. When he began receiving home care as an adult he received respite but it was limited to remaining in the home. The home care workers would call the office to see if they could take him to places like the mall but they were told they could not. *[The Witness' Mother: the Complainant had 10 hours a week of respite care as well as before and after school respite as a youth. She was able to hire his respite worker as she managed the funds.]*

When he was with CDSP he received respite. He started receiving home care when he turned 18. Through homecare he receives a worker but they are not the same. He constantly has to explain his routine and needs to the home care workers which has resulted in a lot of confusion.

He receives a homecare worker for 30 minutes in the morning. In that time the worker needs to get him out of bed, assist him to use the toilet, get his breakfast, administer his medications and anything else he needs. He then has to wait 2 to 3 hours until the next visit from a worker. The amount of time he qualifies for is not enough. He often runs out of time with his worker and he either has to rush through his routine or will not eat breakfast. This is because once the workers time is up they will leave even if the routine is not complete. Some workers will do the bare minim for him which might only be administering his medications. Others may only give him five minutes to use the washroom and then leave him. If he cannot use the washroom in that five minutes he misses his chance to do so. Missing the washroom has caused him to develop pressure sores and resulted in his clothing being soiled after the worker leaves. This means he has to spend extra money to do his laundry more often. He does not drink a lot of water during the day to avoid using the washroom when no worker is there, this means he is not getting enough water during the day. His home care workers will ask where his medications are but he cannot see where the last worker left them. Some workers do not know he is blind and he has to explain that to them.

Many of the homecare workers are not trained to use the equipment he requires. For instance many workers are not trained to use the hygiene sling. He has to constantly explain to the home care workers how to use the equipment. With his visual impairment this is difficult. For instance he needs to know the colours of the straps to attach to the ceiling lift. A lot of the times the workers cannot read or do not pay attention to what he is trying to describe. For instance the workers will ask him questions about the buttons in order to work the microwave.

The workers would come in and do their job and leave. He did not have the same workers and he did not feel a connection to them. With homecare he cannot leave the yard. When he received respite before he was 18 he could go out on walks with the respite worker. When he had homecare after he was 18 all he could do was use the computer. He was bored and did not get to communicate with his worker.

When he first moved into he received meal prep as part of his workers duties. However this time has been completely cut. He does not know if it has been the 1010 staff or home care that has cut his meal prep hours. Now his grandmother has to come in and prepare a weeks worth of food for him. The staff do not know how to cook his food rather they just microwave it. His mother or grandmother have to bring him food all of the time. He does not receive enough money to get enough food so it is costly on his family to provide what he cannot afford. He was recently diagnosed with esophagitis so he cannot swallow. He can only eat Ensure and this is costing his grandmother a lot of money. He is still waiting to see if EIA will approve his therapeutic diet. If they do not his family will have to continue providing his supplemental foods.

The homecare staff do not take him to appointments. Rather he is reliant on his mother and grandmother to take him. This takes time out of their day. He is not as self reliant as he wants to be. He does not like when someone has to constantly shadow him. He is no longer being taught independent living skills. He does not have a power chair and he can no longer wheel himself around. His sight got so bad that he had to stop the power chair training. Sight is required for a power chair.

He would like to attend university. He would have to go with someone but he does not have funding for it. This has delayed his education. He has approached the University of Manitoba independently to see if he can start attending classes. He starts class in 2019.

He did not qualify for CLDS. He did not qualify as his IQ was borderline however not below average. To qualify for CLDS he would have to have scored below average on the IQ test. Having to take the IQ test was very demeaning. He felt mistreated by having to take the test to get supports. He felt the process was stressful and became depressed as a result. The IQ test was only testing his mental capabilities and did not take into consideration his physical status. For instance he could use a computer but cannot use a stove. The IQ test relied too much on what his mental ability was and not what he could or could not do as a person. It was an extreme slap in the face to have a good mental capacity.

He did not want to take the test and pretend to have mental problems in order to qualify. If he did so he would not reach his full potential as a person.

If he were to qualify for CLDS he would be able to access group homes to live with other people. He would have access to technology and training on how to use it. CLDS provides workers to go out into the community and do things. Right now he is limited to activities put on by the SMD. This is the extent of his activities outside his residence.

A lot of the time he is alone in his apartment. He is not happy in general as a result. Not having the ability to go out is very lonesome. He is very alone.

Under CDSP he was absolutely more active in the community than he is today. He was able to receive counseling while in school. He was able to go out into the community. He was provided transportation to and from events and he had more events open to him. The supports provided through CDSP are similar to what he could access through CLDS if he qualified.

If he were to live in a personal care home he would be living with seniors. He has nothing in common with seniors. He would have his funding radically cut to providing food if moved to a personal care home. He would also be monitored constantly and not be able to live a full life. For him to go anywhere he needs to arrange to have someone meet him at the location and to have someone go with him in the taxi. This is extremely hard as he does not receive funding for an attendant. Before he turned 18 his respite workers would do this for him. He does not receive respite at

Equipment

CDSP also provided assistance with technology and provided him a JAWS screen reader. CDSP provided him with brail displays and a brail note taker. He received adaptive materials for his classes as well as a note taker. With the working copy of his screen reader he could use the computer and do research. He also had Openbook which is an optical character recognition software. The brail note empower he had gave him the ability to take notes on the go.

EIA provides him with general items for his disabilities but not what is specifically required. For instance when trying to apply for a new chair as an adult, EIA gets to determine what gets to be funded or not. Everything he needs has to be categorised as a medical requirement and a lot of the time EIA says no. He had a single part approved for his new chair. This is a strap to keep him in is chair when getting in and out of cabs.

EIA provided a bath seat and a large button telephone. The request for a talking telephone was denied. EIA has approved a Hoyer ceiling lift. He requires a worker to strap him into the lift. He has not received anything else from EIA. He was denied a printer and optical character recognition software by EIA. His doctor also made two requests for Ensure as he is having difficulty swallowing. EIA has denied the request both times.

EIA denied his JAWS software so he obtained it from the Transcona Legion. As he is losing mobility in his hands he also uses J-Say which allows him to use the computer by voice input using Dragon Naturally Speaking. He had to purchase J-Say as it was denied by EIA.

He has had to pay for system access to Go, an optical character recognition software, out of pocket which cost $1000. He could not use System Access to Go when he did not have JAWS. This meant that others had to read his mail to him. He is not comfortable with others reading his mail as this is his personal life and he should be entitled to privacy. He has had to save his little EIA money to buy System Access to Go. When he needed items he has sometimes had to go into debt. His family then has to get him out of debt.

When he needed a van modified he had to pay $5000 for the modifications to lift the roof.

Prior to turning 18 he had access to mobility training inside and outside the house. He also received training to use his adaptive technology. Now he sees a worker once a month and they will look into his requests. They say they cannot be sure if the requests will be granted.

He no longer gets access to taxis all of the time and instead gets a maximum of 45 taxi chits a year through EIA.

He received his current wheelchair through CDSP before he left the program. He needed a power assist, the chair tilt modified and a custom seat. He no longer has the ability to get a new chair as there is no funding for the modifications. His current chair is five years old and he is grown out of it.

He is trying to get a new chair through SMD. He needs customised parts however and has to locate service providers to repair them. Previously under the CDSP any repairs would be through Children's Rehab. Now, when EIA does not fund a part he has to pay for it out of pocket. CDSP approved any wheelchair component without question. Now he has to go on Facebook and ask for help. He does not know where to go for the supports he needs. Without someone who has knowledge he feels lost in the system and does not know what services are out there.

[The Witness' Mother: the SMD has not had anything to do with the Witness' current chair as an adult as he received it from CDSP.]

Two weeks before he left CDSP the Complainant had a new chair customised. SMD provides just the basic wheelchair; all of the custom parts the Complainant needs has to be applied for through the Manitoba Wheelchair Program. Currently the Complainant only has access to the chairs provided by SMD.

The Assistant Deputy Minister for Community Service Delivery

The Assistant Deputy Minister was interviewed in person.

She is the Assistant Deputy Minister for Community Service Delivery which is responsible for the delivery of social programs like CDSP, CLDS, EIA and the DHSU in the province. Members of the public access the programs either through public buildings or through social work staff depending on the specific program.

Eligibility & Coordination of Services

There is coordination among the different departments and service providers. In Winnipeg there is an integrated service delivery model. There is a committee that meets every two months for the integrated service delivery. It is co-chaired by Manitoba Families and WRHA.

Each program lead works with WRHA. A client's CDSP, CLDS or EIA worker will often coordinate services received and assist in navigating the different services. Services are integrated all the way up to the leadership level but each program is bound by their specific program mandate.

The departments get their budgets through the treasury board. Last year's EIA budget was approximately $400 million. She believes CLDS is approaching the $400 million budget point as well. The budget for CDSP is small. Some services offered through CDSP are provided by CDSP grants to other agencies.

Assessment for services under CLDS is done based on the Supports Intensity Scale. This tool identifies support needs across a variety of domains. Approximately 40% of CLDS clients have a support level of one which means the individual can live in the community with minimal supports.

Her understanding is that it is the school divisions that provide screen readers, note takers and educational assistants. As an adult if these services are needed for employment preparation, vocational rehabilitation or MarketAbilities will provide it. For general use EIA will provide items for basic communication needs. CDSP may provide community grants for communication devices however EIA would have to provide more detail on what is covered.

MarketAbilities and vocational rehabilitation are programs for adults. They can receive individuals on EIA and those that are not as long as they have disabilities and are under-employed. To qualify for the vocational rehabilitation or MarketAbilities programs an individual must have the potential to be employed. She does not know what the threshold is for this assessment. This is a separate department under Manitoba Families and is currently being transferred to the department of education.

She does not know if the Complainant has accessed vocational rehabilitation or MarketAbilities.

The DHSU is the purchaser for CDSP, CLDS, and EIA. She does not know how homecare provides its supplies.

CDSP aims to keep families strong to avoid children coming into care. Her staff provide social work, case management services and also facilitate equipment, supplies, and respite services. The staff will help the families and their children navigate the system, including coordinating access to different therapies and service providers. Her staff do not make funding decisions. Respite is provided largely to give parents a break and can involve taking children into the community or providing respite in the home. Respite staff is provided or families are given funding to obtain their own respite staff. A comprehensive assessment is done for respite support that includes both the support needs of the child and the needs of the family.

When considering supports for child development it is the development milestones which will be looked at. This will identify any delays and strategies will be implemented for intervention. The specific tools used to assess development milestones depend on the child's disability. She does not know the specific tools used. She is not provided the specifics of the assessment process at her level. Provision of behavioural supports is done by referral to Behavioural Services if the family is struggling to manage behaviours in the home that are disability related such as aggression in non verbal autistic youth.

The Complainant's family had a support worker assigned when she received CDSP services. She does not know if the Complainant qualifies for CLDS. It is possible that she is eligible for CLDS but her family stepped away from it.

Since leaving CDSP the Complainant has an EIA worker assigned to her. She does not know about the services the Complainant receives through WRHA.

Home Care, Respite & Other Supports

CDSP provides children with disabilities and their families supports designed to assist and foster participation in the community. CDSP will generally provide families with respite, equipment and supplies required for a child's disability and services for a child's development. CDSP recognizes the more developmental milestones a child can reach, the more functional they will be in the long term. The educational system provides supports that CDSP does not. CDSP has a wait list as there is a limited budget. CDSP will prioritise the essential requests first. Specialised needs cannot always be covered during a fiscal year.

CLDS is a program for adults with intellectual disabilities that offers residential services, respite services and day programs. To qualify for CLDS an individual must be considered a vulnerable person under provincial legislation which is based on diagnosis. CLDS has the goal and ambition to support individuals in the community and to keep them safe and provides residential support services, including independent living and group homes. The day programming is used to give individuals work experience or providing supports for the individual to gain employment. CLDS offers some funding for clinical and psychological services as well as specialised case management. CLDS does not provide medical supports, rather this is provided through MHCP. CLDS will provide supports for banking, budget preparation, and food preparation.

For individuals who live at home with family there are respite services available that can include both in-home respite or trips into the community for activities such as swimming.

EIA is a program for those who are economically marginalised. EIA is meant for those with no employment and who have exhausted all other sources of income. EIA provides funding for basic assistance such as shelter and food and will provide basic dental, optical and medical services. Medications covered by EIA are only those that are covered under the provincial pharmacare plan. EIA provides funds directly to the clients. For medical needs clients are provided service through the DHSU which covers the costs. CLDS clients are generally on EIA as well and CLDS will cover the cost of their shelter. CLDS provides for shelter if the client qualifies for group home living. Respite through CLDS can be provided through either government hired respite workers, funding provided for community agency respite workers, or funding to hire a respite worker.

CLDS and CDSP provide behavioural therapy. She does not know about behaviour therapy outside of CLDS for adults. There are no programs for providing support to family members. Generally support groups start outside of the service providers. Support groups are community based. She cannot think of any support groups for families on either the children's or adult side of the programming. CDSP provides family counseling through St. Amant. The program is an intensive social work program for families who are struggling with the care of their child. CDSP provides the referral and St. Amant provides the service.

EIA will provide for emergency medical transport such as by ambulance and will cover trips to medical appointments if an individual is not ambulatory. When on EIA, individuals are expected to use public transport such as the bus or handi transit if they are able to. Taxi trips to medical appointments are covered. For individuals in wheelchairs, EIA will provide an additional five taxi chips for social purposes each year. EIA or the DHSU would know for sure how the taxi trips work.

Manitoba Health provides feeding clinics and feeding assistance. Manitoba Families does not provide these services. EIA does not provide support for daily living tasks like bathing, use of restrooms or dressing. If the supports intensity scale indicates a need for individuals in CLDS these supports are funded. She does not know if CDSP provides these supports.

Manitoba Health provides physiotherapy and occupational therapy. There are occasions for CDSP to refer individuals to St. Amant for these services. CDSP will use the publically funded system. Generally these services will come through the regional health authorities. Manitoba Families provides funding to St. Amant for supportive group homes and community living for CLDS. To access these programs you just need to apply, there is no referral needed.

Manitoba Families does not fund speech therapy through its programs.

Equipment

Items such as commodes, bath seats and orthotics are a support provided by MHCP. MHCP will provide items like ceiling lifts, ramps or wheelchair accessible fixtures. She does not know about provision of these types of items for children. CDSP will provide for vehicle modifications but CLDS does not.

EIA will provide basic medical equipment and supplies if they are not covered by either a RHA or Manitoba Health. EIA will provide basic disability supports through the DHSU. If there is other funding available for the equipment or an individual gets money through an inheritance or other means the money must be used first before EIA will provide supports.

Manitoba Health provides wheelchairs, including customised wheelchair parts such as seats, backs and straps, through the Manitoba Wheelchair Program, but scooters are not covered. EIA provides wheelchairs for both adults and children and she believes it provides all of the maintenance for the chairs and parts. Wheelchairs are delivered through Society for Manitobans with Disabilities and through the regional health authorities. If the Wheelchair Program does not cover something, EIA may pick up the part or cost of the repair through DHSU.

She does not know the specific supports that the different programs provide. She is not sure if WRHA would provide walkers, standers and their components. If EIA were to approve any equipment the item would need to be supported with medical documents. CLDS would not provide walkers. If no other program provided a walker and it was supported by medical it would be picked up by EIA.

The Program Policy Analyst (CDSP)

The Program Policy Analyst was interviewed in person while in the presence of the Respondent's legal counsel.

He is the program policy analyst for CDSP.

Eligibility & Coordination of Services

To assess a child's developmental quotient, a test is performed. The test is not given to young children, he is not sure of the age but believes it is not administered before 5 years. He believes that the developmental quotient looks at developmental milestones such as whether or not the child can follow movement with their eyes, is able to socialize or communicate, which is different than an IQ test.

CDSP provides supports for families so they can raise their children at home and in the community. CDSP tries to meet the needs of the family that they have in order to raise their child. Services through CDSP are done in a family centric way in order to incorporate the family into the care of the child. There are some services through CDSP which are interventions for the child but the over arching service is to provide supports for the family to raise the child at home.

To qualify for CDSP an individual must be under the age of 18 and be a resident of Manitoba. The child must have a developmental delay with a developmental quotient of 70 or less, complex medical needs or a life long disability with significant limitations to their mobility. A child can qualify at birth if there is a high probability of a developmental delay and they will be reassessed as they get older to see if they still qualify. The specific services will depend on the child's specific disability. Assessments are done in some cases through a multi-disciplinary team. For those with physical disabilities there is work with the parents and physicians can make the referral for a specific service offered by CDSP.

There is a comprehensive family assessment that looks at the family's ability to support the child and the child's informal supports. For equipment, home modifications or vehicle modifications there is a priority based on how the family will be impacted if it is not provided. The DHSU receives a budget from CDSP for consumable items, equipment and vehicle modifications. The DHSU is the program that will assess the priority for receiving the items as they administer these supports. Community service workers will administer the remainder of CDSP supports.

CDSP is given a budget from Manitoba Families. Half of the budget goes towards supporting the families through provision of respite, after school care, skills development and home modifications. The other half of the CDSP budget is given to other agencies in the form of grants to provide services for those in CDSP. This can include Autism services and intervention therapy for pre-school, and Speechology. CDSP provides grants to the CNIB for youth with vision loss even if they do not qualify for the CDSP program. The budget is fixed so the CDSP prioritises based on need.

CDSP is the primary contact for individuals and their families when they are in the program. Depending on the disability there may also be other service providers involved as well. In instances where the child has significant care needs there are a lot of services that are provided through WRHA. There can be instances where children receive home care prior to turning 18 and they may also require life sustaining equipment. In these cases WRHA will have more contact with the child and their family. For Autistic children St. Amant is a point of contact with the family. The CDSP worker is the main coordinator for all of the supports. The CDSP caseworker will provide families information on services and where to get them. The school divisions provide alternate format learning materials through the department of education.

Once an individual turns 18 they no longer receive CDSP services. At about the age of 16 transition planning starts. The family will meet with a Community Service Worker in conjunction with a team from the school division. There is a discussion about the transition and about other programs from different agencies and schools and a timeline is set for the family to work towards as the child approaches 18. Part of the transition involves the family meeting with the school team, the community service worker and any other agencies involved in the care. If the child has a physical disability, the family will already be connected with SMD. Most youth with a physical disability transition over to SMD in adulthood. There would be transition case notes for the Complainant that record the main services the Complainant applied for. The notes are there so the caseworker supervisors know the right services were referred to.

Orthopedic surgery is provided through Manitoba Health. Educational assistants would be provided by the school divisions. If a student needs a screen reader or brail display for school this is also provided by the school division. CDSP does provide some communication devices for the home but not the screen reader. Training for the brail displays or screen readers is done through the school division. There is a specific unit from the school board that takes care of these types of devices.

The closest thing to a MarketAbilities program that is provided by CDSP is the summer skills program. When children are getting close to employment he would guess that the

MarketAbilities program can be tied in for pre vocational purposes. The MarketAbilties program can be accessed by those 16 years of age or older.

CDSP provides an Autism day program for preschool entry through St. Amant. The program is 30 hours a week. This is a one on one intervention for Autistic children before they enter preschool. Starting at age 4 children with Autism can enter the pre kindergarten program at St. Amant. This helps the children get used to the classroom setting.

For children with other types of developmental delays there is a consultant service called Child Development Service offered through CDSP. A child development counselor teaches the family and caregivers different strategies to meet the child's developmental goals.

Home Care, Respite and Other Supports

CDSP will provide funding for respite services to give the family a break from care giving, this however does not cover housekeeping. CDSP does cover some special dietary items. For instance if a child has PKU where the child will need a high protein diet in place of carbs. Within Manitoba Health there is the nutrition branch that will also provide for these types of supplements. Feeding clinics are provided by Manitoba Health. CDSP provides some behavioural feeding clinics at St. Amant. This does not cover mechanical feeding but rather is to expand a child's food repertoire.

CDSP supports the family and it is there responsibility to raise them which includes performing these types of hygiene tasks. The exception is when a respite worker is providing the family with a break. In these circumstances the respite worker will provide this type of service if it is needed in the course of providing respite care. CDSP does not fund hygiene tasks such as bathing, dressing or use of the restroom.

For children in preschool CDSP provides funding for speech pathology, occupational therapy and physiotherapy. Once they are in school the school division provides these services. CDSP provides some supplemental support to the school divisions but it is their responsibility once the child enters the school system.

Parents are trained to help their children reach their developmental goals. Typically 24/7 supportive living is not provided by CDSP. In some cases, there may be overnight respite that is provided. The intent of respite is not to fund taking the child to a medical appointment. Respite cares for the child in the home or on trips into the community.

Equipment

In most cases wheelchairs are provided to children through SMD's Wheelchair Program and WRHA. Any specialised seating is provided through CDSP. Anything above the chair from SMD for specialised mobility needs would be through CDSP. CDSP provides funding for the maintenance for the chair components that are provided through the program. The chair itself is maintained through SMD. Standers and walkers along with any customised parts are provided through CDSP. Requests for equipment are made through a therapist. The DHSU receives the request and it is assessed to see if the request is appropriate. Maintenance for any walkers or standers provided through CDSP is also covered.

Equipment such as bath seats and orthotics are provided through CDSP. He is not sure on the provision of commodes. Manitoba Health covers medical equipment and related supplies. CDSP covers mobility at the home and self care needs.

CDSP provides home modifications such as ceiling lifts, ramps and accessible fixtures through the DHSU as well as vehicle modifications. Priority for vehicle modifications is done based on the DHSU's priority guidelines. CDSP provides a policy to the decision of the DHSU on CDSP funding. CDSP might not be able to meet all requests related to a disability but it will meet the basic needs. Once the CDSP has made the decision to fund, the DHSU applies its priority policy.

The Acting Director of Provincial Services

The Acting Director of Provincial Services was interviewed in person while in the Presence of the Respondent's legal counsel.

She is the Acting Director of the provincial services department which includes the DHSU. The DHSU provides all of the supports assessed or approved through CDSP, CLDS and EIA. The DHSU was created in August 2014 to streamline decision making for services throughout the province.

Eligibility & Coordination of Services

Requests for service come to the DHSU from a regulated health professional such as doctors, registered nurses or dieticians. For some items, a family may request an extension of the service as long as the original request was made by a medical professional. Food and dietary service requests can only be made through a regulated health professional. Most of the contact the DHSU makes for client side requests is through the health professionals. Conversations with the clients or their families are only done on certain items such as incontinence products.

When assessing needs there is no involvement from the client's program worker. Rather the DHSU has four assessment officers that review each request. There are also four service advisors that assess basic supply requests and dietary needs. Non standard items or diets are reviewed by an assessment officer and herself.

When a request is made the DHSU has a medical request and justification form. The DHSU will look for information on this form to justify the request being made. For instance either an Occupational or Physiotherapist must provide information on the assessment and other supports in place. For instance if a request is made for installation of a ramp there must be additional information provided to justify the request. For walkers there is a specific guideline for providing them. Other items that do not have specific guidelines are assessed in a meeting with the assessors each week.

Each program through the DHSU has its own funding. CDSP provides the DHSU a budget with a cap each year. The DHSU assesses the requests for each individual based on both the nature of the request and the amount of funds at the time. EIA provides funding for products provided through its program. There is no cap on the EIA budget so each request is assessed based on the need. Most CLDS clients receive items through EIA funding. There are few services that DHSU provides that are funded directly from CLDS. Items funded directly from CLDS can include new build costs if an individual receiving CLDS services moves out of an institution such as St. Amant. CLDS will also cover the installation of lifesaving devices such as sprinklers.

EIA is billed directly by the DHSU. CLDS and CDSP provide the DHSU with a lump sum for the fiscal year.

Home Care, Respite and Other Services

MHCP will provide commodes. The DHSU provides toilet frames and bath seats. Clients who have home care qualify for a basic Hoyer lift and tracking. If a client cannot get a lift through MHCP or if the Hoyer lift is not appropriate, the DHSU can provide the lift tracking through the appropriate program.

Feeding clinics are provided through Manitoba Health. The DHSU will get requests for special diets from Children's Rehabilitation or from the Manitoba Home Nutrition Program. These requests come from a registered dietician. SMD has a feeding clinic which is used if a person has swallowing needs. The Manitoba Home Nutrition program is for tube feeding. SMD will conduct the swallowing assessment. For clients on EIA the DHSU can provide tube feeding supplies and equipment. Clients can also receive other miscellaneous items through EIA such as compression stockings or gloves. EIA. does not fund modifications to sinks or counter tops. EIA will fund door widening to allow wheelchair access. For installation of ramps, clients are first asked to go through the Manitoba Residential Adaptations Program which is through Manitoba Housing. This program is income tested and if a person meets the income qualification Manitoba Housing will do the modifications.

CDSP does not cover all adaptations. For instance, CDSP will meet a bathing need through the installation of lift tracking instead of a shower stall. Modification for vehicles is only available through CDSP and only if there are funds available. CDSP will look for co-funding from community organisations to assist with vehicle modifications. When applications come in for accessible van modifications the DHSU usually recommends to look at charitable organisations. Funds for these type of modifications are usually considered in December. For those receiving EIA they will be covered for 24 round trips per year. EIA will consider handi-transit or other companies if there are ongoing transportation needs.

The DHSU will provide transfer poles or grab bars to assist with transfers to bathtubs or toilets through its programs.

The DHSU does not provide physiotherapy or occupational therapy. Community Therapy Services will be brought in to do assessments on specialised item requests such as a four wheeled walker, wheelchair seating or ramps.

For communication therapy the DHSU has an agreement with Deer Lodge. There is a hearing and communication devices agreement. Requests come in and are added to the budget. The CNIB also sends in requests to the DHSU for large button phones, canes and other products. EIA will cover hearing aids that are prescribed by an audiologist. CDSP will also provide hearing aids to youth through their audiologist.

She does not know about respite services and who would provide them if they are available. Items such as screen readers are not covered as they are not for basic and essential information. Basic magnification aids such as magnifying glasses are funded through EIA.

Equipment

Some items such as home wraps or bath seats are considered critical needs. Ceiling tracking is also considered a critical need if it is not provided through MHCP. Other items range from high to low priority. A medium priority may be an additional stroller if an individual has already received a wheelchair through SMD. Modifications to vans are considered a low priority and are subject to the availability of CDSP funds.

For wheelchair seating there is a specific form and criteria. The form can only be completed by an occupational therapist or physiotherapist. The DHSU provides wheelchairs for individuals in institutions or group homes. Those receiving EIA will receive funding for wheelchair seating. If a family has insurance for a CDSP client the DHSU will co-fund an item. Wheelchair straps are all funded through EIA and CDSP. The seating straps are all covered in the wheelchair seating request form. This can include leg supports or lifts and postural straps. The DHSU covers the maintenance for any components funded through EIA. If not funded through EIA, the DHSU will to see if maintenance can be funded. The DHSU will cover the costs for repairing items previously obtained through CDSP even when an individual is an adult.

She believes the Complainant has had new wheelchair components funded through EIA specifically she has had new wheelchair seats provided. She believes EIA has also funded head rests for the Complainant. There is a file at the DHSU with the items requested for both approved and denied requests. If a request is denied the Complainant would receive a letter indicating why the item was denied and how to appeal. Appeals are done through the Social Services Appeal Board.

The Complainant has received a custom ride cushion through EIA. She has been provided repairs to her wheelchair and has received a bath seat and catheters. The

Complainant was denied feeding supplies and van repairs in 2014. The Complainant's family was advised that she has taxi chits and medical transport coverage to rely on.

The DHSU is aware of the items provided through home care. One of the assessment officers is a manager with the MHCP. There is a good working relationship to see what each program provides. If it is not on the home care list the DHSU will look at funding through EIA. This can include items such as walkers, wheelchair seating, grab bars or urinals.

The Acting Director of EIA

The Acting Director of EIA was interviewed in person while in the presence of the Respondent's legal counsel.

Eligibility & Coordination of Services

EIA provides general assistance and there are other categories such as single parenting and disability. There is wording in the legislation that states other sources of income need to be accessed first and EIA will provide a basic need if they cannot acquire another form of funding.

If someone has a medical need they just need to let their EIA caseworker know and the caseworker will let them know the process to apply for the disability benefit. Health professionals can also indicate that an EIA recipient has a medical need to apply for the disability category. When looking at funding disability needs a medical professional needs to make the request.

There are a number of forms used by EIA for the medical professionals to fill out when applying for disability supports. For coverage of medical transports it is a verbal conversation from the medical practitioners office or a note from the physician. For dietary needs, medical supplies and other equipment there are the specific forms that need to be filled out.

The DHSU provides most of the supports for EIA disability clients. The DHSU staff assess the request to see if the individual is eligible for the request through EIA If an individual is approved for extra diet funding EIA will provide additional funds for dietary needs. EIA staff are responsible for the regular case management. They are involved less with the disability supports now that the DHSU is available. The EIA caseworker will identify the needs and provide information about the programs that an individual can receive. There are some exemptions for those with disabilities to help them qualify for EIA that are not available for individuals without disabilities. For example there is a higher level of family trust or gifts that can be held by a person with a disability to qualify for EIA which is not available for those in the general stream.

The majority of assessment for disability supports is done by the DHSU. There may be some instances where the DHSU is missing some information and they may look at the case workers notes during the assessment to get the information. The DHSU primarily relies on medical professionals and will reach out to them to get information. In most situations it is a medical professional who will initiate a request for disability supports.

Within the context of case management, EIA tries to coordinate with other service providers to provide individuals with the most independence. While EIA does not coordinate the services offered by other agencies directly they will look for gaps during assessments and direct individuals to the services. EIA caseworkers are expected to have a knowledge of other services that are available such as home care, the CNIB, or SMD. In Winnipeg EIA works in an integrated delivery model with primary health care and community mental health. This provides individuals the ability to receive referrals to the other systems and get the services at the same location.

EIA is a program of last resort that provides what is basic and essential to meet a need. There are policies from EIA on specific equipment and the detailed assessment guidelines exist at the level of the DHSU. It is left for the expertise of the DHSU and the medical professionals to determine what is basic and essential.

She does not have a lot of detailed knowledge of the CDSP. There is a protocol for youth transitioning to adulthood with significant disabilities. This includes a referral to EIA if appropriate.

Home Care, Respite and Other Services

EIA has a policy to cover transport. Providing for personal vehicles and any associated costs is not within the transportation policy. EIA does not assist with the modification of vehicles for disability needs.

If feeding equipment is not covered by another program EIA will cover the cost. There are programs offered by WRHA however she does not know the details. Feeding clinics are the responsibility of the regional health authorities.

EIA does not fund grooming, bathing, toileting or other hygiene tasks. EIA does not provide funding for occupational or physiotherapists. Certain types of these services are provided by the healthcare system. Others are through private benefits.

EIA has a rate structure for individuals living in community care such as that offered by CLDS. EIA is involved in locating shelter for individuals along with WRHA. For those with significant disabilities, EIA will partner with Manitoba Housing and the health care system to find appropriate housing. EI.A. provides a shelter benefit and will cover the cost of beds, bedding, moving costs and new identification.

She does not know the detail about what the Complainant may have been approved for or denied. There would be notes on their case files.

Equipment

For equipment that is approved the DHSU will get the item from MDA. If MDA does not stock the item another vendor may be used. The DHSU staff process the payment through the EIA system.

Basic and essential is a general guideline for EIA and it extends beyond medical equipment. It is the responsibility of the director to look at the situation and the regulations to determine what is the lowest cost alternative. As an example the transport policy, which states EIA will provide for the most economic mode of transport. So if a person can take the bus EIA may cover the cost, if not there is handi-transit, followed by cabs or other forms of transport based on need. EIA does not provide benefits that someone with a low employment income could not obtain. EIA brings a person to the point where they are at the same point as someone who is receiving low income while working.

EIA is very involved in the delivery of wheelchair benefits. The provision of wheelchairs and their components is managed by the DHSU and SMD. For those receiving EIA the cost is covered through EIA. It is the medical professional that will start the process by completing the appropriate wheelchair form. EIA will cover the maintenance of wheelchair parts provided through the program.

EIA covers items such as walkers and transfer aids. The program also covers maintenance for these items. EIA provides orthotics, hearing aids, dental and optical. If a person receives home care they may get a commode through that program. If not EIA will provide the commode if needed.

For home modifications EIA will first look to other programs such as that offered through Manitoba Housing. If there is funding available outside of EIA for these modifications individuals will be assisted to apply for the funding. Modifications can be difficult if there is a rental situation as it needs to be considered if the property can be adapted and if the landlord will take part in the funding. If modifications are not covered elsewhere, it is needed and basic EIA will fund it. Modifications would be the most basic and essential to meet the person's needs.

The Acting Director of Adult Disability Programs

The Acting Director of Adult Disability Programs was interviewed in person while in the presence of the Respondent's legal counsel.

She is the acting director of adult disability programs. This is the part of Manitoba Health's branch responsible for the policy and interaction part of CLDS.

Eligibility & Coordination of Services

CLDS tries to work in partnership with other agencies such as EIA and MHCP. This typically includes a meeting with the CLDS case worker and the home care worker to develop and adapt the care plans. For supports in schools it is the school divisions that provide them.

To be eligible for CLDS an individual must have a mental disability as defined in the *Vulnerable Persons Living with a Disability Act.* The policy has three components to qualify for CLDS. First thee individual has to have an intellectual disability. There must be a significant impairment to intellectual functioning, impaired adaptive behaviour and the condition must have manifested before 18 years of age. The policy spells out how the respondent knows if the individual has an intellectual disability.

The current assessment form must be completed by a qualified clinician such as a school psychologist. Once there is a clear clinical conclusion then an individual is eligible for CLDS. If there is not a clean clinical conclusion there is a discussion with the departmental Psychologist.

There are also questions about what the person's intellectual functioning was before turning 18 if they are referred to CLDS when they are 40. There needs to be information to speak to the individual always having their level of intellectual functioning. In these cases information is gathered from the individual's support network and a discussion is done with the departmental psychologist to determine if there is a mental disability. The director has the final say for eligibility.

One of the elements of the legislation is that there needs to be significantly impaired intellectual functioning to qualify for CLDS. This means there needs to be a clinical finding of intellectual functioning two or more standard deviation points below the general population. This works out to an IQ of 70 or less. It is accepted that there are measurement errors so this can be an IQ of 70 plus or minus 5 points as the consideration level. The policy used by CLDS is to go by the findings of the clinician. If the clinician states that the individual has an IQ of 71 but still has significantly impaired intellectual functioning, they will meet this criteria for CLDS services.

CLDS does not stipulate a specific test to assess intellectual functioning. The test commonly seen is the Wechsler adult intelligence scale or the Wechsler test for children. This is not the only test used. CLDS recognises that some individuals cannot take the IQ test due to impairments related to their disability. If an IQ test or other psychometric assessment cannot be performed then CLDS will rely on the opinion of the clinician if they say the individual is untestable.

The second part of the legislation is that the individual must have impaired adaptive behaviour. This refers to how the individual functions in society. This includes barriers that would prevent someone from getting out in the community, their ability to perform household skills, their personal skills, and their ability to hold employment. Adaptive behaviour is the individuals ability to function in life.

When an individual is transitioning out of CLDS there is typically a conversation with the parents, adolescent and the CDSP case worker. During this conversation options such as CLDS and MarketAbilities would be discussed and how to apply for them. There is a consent form for parents to sign for children under 18 to have them referred to CLDS. If a clinical assessment is available it is provided to CLDS otherwise an assessment is arranged. The consent form allows CLDS to gather the relevant clinical info to assess their application for CLDS.

CLDS is funded through Manitoba Families but receives its own funding separate from EIA and other programs. To assess the specific services an individual receives through CLDS the supports intensity scale is used. This measures the strengths of the individual and their community network. The assessment looks at the individual's ability to do tasks such as banking, working, navigating in the community and using the washroom. The results are used to determine the level of funding for the individual from level 1 to 7. Level 1 funding is low level support where level 7 is for individuals with high needs. When someone is new to the program the Respondent needs to look at their level of need to determine the individual's support budget.

Home Care, Respite and Other Services

For individuals who live with their families CLDS can provide respite care. The number of hours provided all depends on the needs of the family. CLDS can also provide overnight respite if the need is there. Respite can be provided both in the home and in the community, it all depends on the specific needs and preferences. This can include movies or other recreational activities the individual enjoys.

If a person is between the ages of 18 and 21 CLDS can provide after school supports and day programs for those older than 21. Day programs start at 21 as it is assumed that those under 21 are still in school. Day programs are provided by different agencies during normal business hours. Typically the programs run from 9:00 AM to 3:00 PM or 4:00 PM. Day programs can range from employment support and work searching to recreational activities. CLDS will provide the transport to the day activities. All CLDS clients are offered appropriate day programs once their support level is known.

CLDS offers a few different residential services. For those individuals who can live independently in an apartment CLDS may only need to provide basic supports such as grocery shopping or menu planning. Other individuals may receive banking and budget assistance or assistance with household tasks. These types of services can range from a few hours a week to 20 or more hours. CLDS also provides individuals support to live in adult home shares or adult foster homes. The home shares are referred to as host family homes and are licenced under the *Social Services Administration Act*. In these instances CLDS contracts with a provider home to provide the lodging and the care provider lives with the clients. CLDS also contracts agency or group homes where staff come in and do the work. For residential services there is a prioritisation criteria used. If a person can live safely with family they will not be prioritised for residential services.

Equipment

Wheelchairs and walkers are not provided by CLDS rather this is done through EIA. EIA also provides items such as orthotics, bath seats and commodes. CLDS does not fund modifications to housing or installation of ceiling lifts. She believes this may be provided through EIA or MHCP. CLDS does not provide for vehicle modifications.

She believes for those living at home there is the home nutrition program for tube feeding. This is a Manitoba Health program. Grooming and other hygiene tasks are provided through home care or by the family. CLDS clients also are able to receive home care if they qualify. Sometimes during the provision of respite through CLDS the worker may need to provide personal care tasks such as assistance with the washroom. For individuals receiving home share or living in a home operated by an agency these tasks are the responsibility of the care provider or agency staff. Respite is not available to CLDS clients in a residential setting as this is the responsibility of the staff. In a home share there may be respite depending on the specific provider.

CLDS does not offer therapy services for family members. There is one on one clinical counseling services for the CLDS participant. This is done on a case by case basis and is generally short term such as counseling for the loss of a family member.

Services for individuals with severe mobility restrictions are provided through the MHCP. For those with low income they also can receive supports through EIA.

The Complainant has not applied for CLDS services.

The Executive Director of Continuing Care

The Executive Director of Continuing Care was interviewed in person while in the presence of the Respondent's legal counsel.

She is the Executive Director of the Continuing Care Branch.

Manitoba Health has oversight for the delivery of home care services in Manitoba. It is in the purview of the regional health authorities to deliver the services directly. Manitoba Health sets the home care policies that oversee the delivery of the program. The policies related to home care have been in place for 10 years and have evolved during this time. Each RHA has its own funding envelope and they have to both manage and deliver the services with this funding.

She does not have a lot of working knowledge of CLDS. This program is from another government department. At the level of the RHA there are varying levels of integrated service for children in the community. The specific model may vary among the different regional health authorities. Either the regional health authorities or Manitoba Families would have the details around their integration.

The Assessment and Placement Process policy is used for supportive living and personal care homes. The policy is that once a person's needs are to high to remain in the community they will be assessed for supportive living or a personal care home. This is triggered when it becomes more costly to care for the person in the community than in the supportive housing or personal care home. A care panel from the RHA will review the assessment to see if they are eligible for the supportive living or personal care home.

Home Care, Respite and Other Services

The purpose of home care is to keep people in the community for as long as possible to avoid the higher cost of care. The intention is to support individuals and their caregivers in the home for as long as possible. The website contains an electronic booklet which is a guide to home care services in Manitoba. There is an assessment when applying for home care and there is case management through a home care case coordinator if an individual is eligible for home care. The case manager sets the individual's care plan and the parameters of the care that is required. It is the regional health authorities that do the direct provision of both the professional and non-professional care. For care that is non-professional there is also the option to receive funding for SFMCP. In these instances an arrangement is made to provide funds to a manager who hires the non professional care givers.

There is a philosophy in home care that they are there to work with the family and other informal care networks. This assists the individual stay in the community. Homecare is not meant to replace the care provided by families. If individuals have family or other support networks they are expected to assist the individual out in the community. As part of assessing the care plan the individual's support network is assessed.

Both home care and the SFMCP are assessed for services by the regional health authorities in the same way. There is an assessment done on the manager's ability to manage the money which would be provided through SFMCP and their ability to do payroll for the hired staff. Some individuals manage their own staff through the SFMCP program while others use a manager. To qualify for SFMCP there needs to be a stable care plan in place. So if the person's needs are changing or if the medical condition is changing this may not be a good fit for SFMCP because SFMCP funds are provided for months at a time and could not change with the person's circumstances. For example they may need more or less care needs in a short period of time, they may be hospitalised or transferred to a personal care home.

Both home care and SFMCP provide non-professional services to individuals. This includes daily living tasks such as laundry, house keeping and meal preparation. These tasks may be provided by either a support worker or health care aid depending on the other supports the individual needs. Laundry and housekeeping is an assessed need offered to clients in Winnipeg. The RHA would assess and look at who else lives with the individual and their ability to assist in cleaning. Home care provides professional services such as nurses to both home care and SFMCP clients.

Respite is provided to give the caregivers breaks from the care tasks. The hours are based on the family assessment. Respite can range from overnight, a few hours a day to a couple of times a month depending on the need. There is also respite for longer terms such as for a few weeks so family members providing care can go on vacations. This involves the individual receiving care to be placed in a respite facility for this time and is booked in advance.

There are supervised day program activities as part of home care. This can be a form of respite. She does not know the specifics of each specific day program that is available. Each RHA would have types of day programs available. Other agencies may also provide them and are sponsored by the RHA. These programs are for socialisation and recreation and are based on the local area and the clients there. The day program includes the transport to and from the program. Personal Care Homes also have day programs available.

WRHA runs the home nutrition program. The qualifications for this program come from the home nutrition policy. There needs to be an assessment done to see if the person's care needs are stable and qualify for home care. They will also be assessed for the home nutrition program to see what supplies and equipment they may need. These are items such as formulas and pumps to bring the formula directly to the stomach.

Hygiene tasks such as grooming, bathing, dressing and brushing teeth are all services covered by home care. It is the RHA that will assess the level of needs required when preparing the care plan. Part of the assessment is to see what the individual can do for themselves. This assists in keeping the person strong by doing the tasks themselves if they are able.

She believes there are some speech and language services available through the regional health authorities. They would be the ones who could speak to these programs.

There is supportive housing which provides more supports and supervision but no nursing care. Personal care homes provide nursing services 24 hours a day. This is a higher level of care than supportive living. Supportive housing and personal care homes are for frail or cognitively impaired seniors. Frail seniors refers to those getting weaker due to aging, this does not include medical conditions such as Cerebral Palsy. She does not know what type of supportive housing is available for younger individuals with disabilities. This is not a service provided through Manitoba Health or the regional health authorities. Manitoba Health's Community Living program is focused on aging individuals. Manitoba Health does not have focused care for younger individuals. There may be group homes for younger individuals offered through Manitoba Families.

Manitoba Health has an offsite services policy that is designed to provide home care supports if they are participating in either employment or education. The care plan would assess if the individual requires care such as toileting when working or taking classes.

There is no age requirement to qualify for home care. Anyone can be assessed for services from the program. Coordination can vary in the province around how closely the different agencies share case management or individually manage each program.

Equipment

Manitoba Health sets a policy for the provision of both manual and power wheelchairs as well as components such as seats and straps. WRHA administers the wheelchair delivery province wide through a purchase agreement with SMD. She does not know the details of the agreement. SMD orders the wheelchairs and establishes the maintenance program. This program is changing and more of the delivery of the wheelchair program will be housed through WRHA.

Manitoba Health has an equipment policy that references a particular wheelchair cushion. Individuals are assessed for the cushion parameters. The assessment for the wheelchair program is done by a WRHA occupational therapist. There is a list of other wheelchair supplies which are covered. She does not know what items may also be covered through EIA as she does not know what their wheelchair supply list contains.

Manitoba Health does not provide a list of specific equipment like walkers. Items such as commodes and bathseats would be items that may be on a RHA's list of approved items. Orthotics are not provided through the home care program.

She is not aware of Manitoba Health covering home modifications including ramps, lifts or wheelchair accessible fixtures. She does not believe that modifications to personal vehicles to transport wheelchairs is covered. She believes this is possibly done through Manitoba Families.

The Team Manager of Self and Family Managed Care

The Team Manager of SFMC was interviewed by telephone while in the presence of the Respondent's legal counsel.

He is the team manager for SFMCP. SFMCP is part of WRHA's centralised home care program. Home care is a program to supplement the resources of an individual in their care such as family. Home care supports the family or other natural care providers. SFMCP supports and supplements the Complainant's mother who is the Complainant's care provider.

He does not know if the Complainant received care through WRHA's programs when she was a youth.

Home Care Services, Respite and Other Services

The scheduling coordinator looks at the needs of individuals and the staff and visit times are set accordingly.

To qualify for SFMCP an individual must qualify for home care. WRHA will then work with the managers or the individual if they are self managing to ensure the home care needs are met. The SFMCP replaces the home care workers and health care aids with funding dollars. The manager then purchases the care with their funding resources. The manager is then responsible for hiring the care staff and training them around the person's needs.

An agreement is made about how the funds will be used. A manager is responsible for setting up a bank account to be used for the funding. Every six months a financial report is sent in.

The qualifications for home care are the same as for SFMCP. The home care case coordinator and the SFMCP worker use the same scripts for assessing. The same assessment tools are used for home care and SFMCP. SFMCP funds at two different rates for health care aids and home support workers which would be provided through home care. SFMCP does not fund for nursing services rather the home nursing program will provide the service. Individuals can also fund a nurse themselves if they wish.

Essentially the SFMCP program seeks to achieve the same as a worker would when attending through the home care program. The difference is that the manager picks the worker and hires them directly.

Services funded through SFMCP are the same as home care services. They are the core activities of daily living including personal care, dressing, toileting, bathing, brushing teeth, getting up or going to bed. SFMCP and home care will also provide tasks for instrumental activities such as home cleaning, meal preparation and home maintenance. Health care aids or funding for health care aids is provided for hands on care such as dressing and toileting. The other tasks such as meal preparation and laundry will be done by a support worker or be funded at the home support worker rate of funding.

Each individual is assessed and their specific tasks are tailored to their needs. Time allotted for each task is also tailored to the individual's needs. Some individuals may be assessed for 30 minutes for a task while another may receive an hour for the same task. Each file is assigned a case coordinator and has a needs assessment done at the onset. An updated assessment is done each year or if the person receiving care becomes hospitalised.

Modifications to vehicles falls outside of what home care provides. If a person is tube fed they will receive support through the home nutrition program. The home nutrition program will provide the supplies for tube feeding. Otherwise home care does not provide food. The inserting of the tube is a surgical procedure and is covered by

Manitoba Health. Tube feeding is done when an individual has significant swallowing difficulties. WRHA does not provide funding for a pureed diet.

Within the home care program there can be tasks done to assist with range of motion. These are done by health care aids. This is done if the family cannot manage and there is a need for this support. Home care does not provide any physiotherapy programs. If a doctor or therapist indicates that certain exercises can reduce spasms this can be added to the health care aid's tasks. Through SFMCP these tasks would be funded through the health care aid dollars.

Speech and behaviour therapy is not part of the home care program. Orthopedic surgery is covered by Respondent A. The recommendation would need to come from either a general practitioner or a surgeon.

Respite is available through the SFMCP program for the Complainant as she lives with her family, she receives 10 hours of respite. Respite is designed to give the family members a break. The Complainant's mother is paid as a care giver through an exception in the SFMCP policy. As a result When the Complainant needs to go to medical appointments or community outings it is her mother who does this. Some is paid and some is unpaid. The 10 hours of respite can be used as the SFMCP manager sees fit. It can be used for appointments or outings. Within the SFMCP program the manager will train the hired workers around the specifics of the individual's condition and care needs.

Manitoba Health funds the home care and SFMCP program. The Respondent does a 3 year plan to Manitoba Health and Manitoba Finance about funding and deliverables. He does not know the specifics.

WRHA works with the other service providers to ensure no duplication of service. The Respondent will also look at the individual's eligibility for other services not provided through the home care program or if they receive the same benefits through either WCB or Veteran's Affairs.

Equipment

Wheelchairs are provided to individuals through SMD. WRHA does not fund the chairs rather if someone needs chairs or parts WRHA engages with SMD. If repairs are needed it is done through SMD.

SMD does the wheelchair assessments and provides the chairs and parts. Things like lap belts and other wheelchair supplies are provided through SMD. The respondent does not provide these items. He believes that SMD may receive some funding from the government for these items and does not know if WRHA provides any funding. He does not know enough to speak to whether WRHA funds any part of SMD's wheelchair program. Rather there is a manager who looks after the relationship between SMD and WRHA.

If there are questions related to seating, positioning, or transfers WRHA contracts out to Community Therapy Services who make recommendations on proper seating or mattresses and other positioning. The Respondent will provide items such as dressings for wound maintenance or incontinence products. Raised toilet seats and commodes are provided through home care.

When an assessment is done a person may be eligible for a Hoyer lift, ceiling tracking, or any other equipment required to assist in the delivery of care. The Hoyer lift allows the person to be transferred for instance from their bed to the bath tub using the track on the ceiling. The lift assists the health care aid in transferring individuals. The person will have slings typically used and the aid uses a button to lift them. The aid then will turn the individual and move to the destination. Sometimes the use of the lift will need two people depending on the specific individual circumstances. WRHA will provide bath seats, grab bars or shower seats based on the assessment.

For items such as ramps and showers or other renovations they fall outside of what home care provides. If a person is assessed to have difficulty getting in or out of a tub home care will provide staff and equipment to get in and out. Home care does not replace the tub.

LIST OF DOCUMENTS:

All documents obtained during the investigation of the complaint were reviewed. Documents determined to be relevant to the investigation of the complaint are listed below.

Undated: Home Care Administrative Manual providing that level of services is aimed at avoiding inappropriate acute or long term care facility admission. Home care is not meant to replace family members and informal supports and will not exceed the equivalent of 55 hours of care from a home care attendant. The cost of home care shall not exceed the average cost of a bed in a personal care home. Family members and informal networks are expected to provide as much support as is reasonable in their circumstances, home care my include respite for the family or informal care givers, including:

- Personal Care Services policy, revised March 2017
- Meal preparation service policy, revised March 2017
- Home nutrition program policy, revised March 2017
- Therapy services policy, revised March 2017
- Adult day programs policy, revised March 2017
- Access to alternate care environments, Manitoba assessment and placement process policy, revised March 2017
- Manitoba Wheelchair Program policy for power and manual wheelchairs, revised March 2017
- Notification of appeal policy, revised march 2017

Undated – CLDS Eligibility Criteria

Undated – Medical Equipment Request and Justification form (not completed)

February 2003 – Services for Person's With Disabilities, Children's Special Services Policy

October 9, 2009 to March 12, 2010 – CDSP Transition Case Notes for the Complainant

November 24, 2014 – letter from EIA to the Complainant

January 8, 2016 to September 27, 2016- Movement center Invoices

April 2017 – Wheelchair Seating Component Request and Justification Form (uncompleted)

Undated - DHSU Wheelchair Seating Component Manual

Undated – EIA Assessment and Provision of Medical Supplies and Equipment policy and backgrounder

Undated – Self and Family Managed Care agreement for the Complainant

October 4, 2017 Home Care Plan for the Complainant

September 19, 2014 to February 2, 2018 – spreadsheet of items requested through EIA by the Complainant

RECOMMENDATION:

There is sufficient evidence in support of the complaint and this complaint should not be dismissed. It is therefore recommended that the Commission attempt to resolve this complaint pursuant to subsection 24.1(1) of *The Code*. If this complaint is not settled, additional proceedings would further the objectives of *The Code*, and it is recommended that the Commission request that a member of the Human Rights Adjudication Panel conduct a hearing of this complaint pursuant to subsection 29(3)(a) of *The Code*.

ATTACHMENTS:

1. Complaint of Discrimination registered on July 22, 2016.
2. Reply dated October 8, 19 and 21, 2016.
3. Any submission received in response to this report.

Tom Ponech
Investigator

Karen Sharma
Director of Investigations & Policy