Post-18 Study and Recommendations for the Disability Sector

Opportunities to enhance services and outcomes for persons with disabilities in Singapore

Study co-funded by

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SG Enable thanks the five social service agencies for taking the initiative to embark on this study, which develops recommendations to better serve persons with disabilities and caregivers in Singapore.

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Foreword from the Coalition & SG Enable

The Challenges of Post-18 Transitions

For many people with disabilities (PWDs) and their families, the transition into adulthood when they turn 18 brings with it profound challenges. At this stage, the Special Education (SPED) School system ends and often leaves young adults and their families having to navigate their own path forward. This is commonly referred to as the 'post-18 cliff.'

Even PWDs who manage to successfully transition into work or care arrangements post-18 may find themselves facing the unknown when other life transitions occur, such as declining physical health or the passing of a caregiver. Such situations can affect their opportunities for social participation, continued education, work or independent living. These transitions often pose complex choices for PWDs post-18 and their caregivers, and could impact caregiver stress and their ability to participate in the workforce.

This study has been commissioned by a 'Coalition' of Social Service Agencies (SSAs) that has long worked on the frontlines of Singapore's disability services, bearing witness to the challenges of post-18 transitions experienced by our clients and their families. As service providers, we understand the anxiety experienced by our clients and their families navigating these transitions. We believe that PWDs, like those of us with typical needs, deserve the opportunity for social participation, growth, and independence beyond school.

With co-funding from SG Enable, we commissioned Tri-Sector Charity Consultants Ltd. (TSCC) to conduct an analysis of Singapore's post-18 disability ecosystem and to suggest solutions and best practices from other countries that Singapore could learn from. The end goal was actionable recommendations for our people, public and private/ philanthropic sectors.

Study Approach

This study takes a deeper dive from where the Enabling Masterplan 2030 leaves off. It comprises three parts: a rapid scan of Singapore's post-18 disability ecosystem, a selection of the most relevant ideas and best practices from overseas (including their successes and challenges), and strategic opportunities for Singapore's disability sector. In line with demographic trends, this study focuses on post-18 transitions and the specific needs of individuals with moderate-to-severe intellectual disabilities (ID) and autism spectrum disorders (ASD). Guidance was provided by the Coalition and local disability experts.

This study examines approaches from countries with strong, person-centered support systems, which have tried to integrate health, social, and independent living resources into a continuum of care that supports PWDs at every stage in their life. By exploring international case studies, this study identifies relevant strategies and frameworks that can be adapted to the Singaporean context to improve post-18 disability support. The study recommendations provide Singapore's social sector and philanthropists with actionable ideas that can be piloted and refined for the local context. We hope it can inspire a wave of innovation in the disability sector here.

How to Read this Slide Deck

This presentation synthesizes the study's insights into a roadmap for potential innovation in Singapore's post-18 disability ecosystem:

- The first section provides a brief overview of the current state of Singapore's post-18 disability services, highlighting the key areas of need.
- The second section highlights examples of best practices from other countries, including South Korea, Ireland, and the United Kingdom, including models for seamless transition support, inter-disciplinary care teams, and independent living arrangements, as well as their challenges and benefits.
- The final section offers strategic opportunities and recommendations for Singapore's social sector – people, public and private/philanthropic - to consider pilots and experimental initiatives that could mitigate the effects of post-18 transitions, and provide comprehensive support for PWDs across life stages and changing circumstances.
- The appendices provide more information on the study's methods, opportunities identified, and evaluation frameworks to review disability pilots and policies.

The study's focus on learning from international best practices marks an important step towards a more inclusive and innovative disability ecosystem in Singapore. By suggesting ways to tailor ideas from other countries to our local context, the Coalition hopes to inspire a culture of experimentation and collaboration in Singapore's disability sector, paving the way for innovative solutions that support lifelong dignity, independence, and social participation for PWDs and their families.

Inspiring Change in the Sector

The Coalition notes that MSF and SG Enable have been engaging the social service agencies as well as PwDs and caregivers, culminating in new initiatives for PwDs in support of the Enabling Masterplan 2030:

- The pilot on Enabling Services Hub has started to bring community support for PwDs and their caregivers closer to their homes. The pilot on Enabling Business Hub has also started to bring employment support for persons with disabilities closer to home.
- The Enabling Masterplan 2030 Taskforce on Promoting Inclusive Employment Practices and Taskforce on Community Living for Persons with Disabilities announced their recommendations in September 2024.
- An Enabled Living Programme (ELP) will be piloted from 2025 to 2028 to serve up to 250 persons with disabilities so that they can continue living independently in the community.
- Disability sector professionals are working with MSF, SG Enable and other agencies to develop a sector-level person- and family-centred planning framework to support persons with disabilities and their caregivers in identifying, updating and implementing their goals and plans.
- MSF and SG Enable are reviewing current programmes for persons with disabilities with higher support needs, to provide more systematic and flexible support for skills training to live and work in the community. In line with the recommendations in this study, these enhancements could include allowing for greater porosity between services as needs change, and having a consistent and evidence-based learning framework to guide post-18 skill acquisition.

These are encouraging developments. During the course of the study, the Coalition engaged MSF and SG Enable to seek feedback and share ideas from the overseas scan. Upon the study’s completion in early 2024, the Coalition partnered SG Enable to share it with the community of disability sector professionals and policymakers. With this report and with our partners in this sector, we seek to continue working together to build a brighter future for PWDs and their families – a future where comprehensive, person-centered care continues seamlessly through all stages of life, minimising the cliff effect and the dislocation and disorientation caused by major life transitions, and creating a more inclusive society.

With best wishes from the Coalition and SG Enable

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Note from SG Enable

SG Enable is heartened to co-fund this meaningful initiative that was spearheaded by AWWA, and we thank Metta Welfare Association, MINDS, Thye Hua Kwan Moral Charities and Touch Community Services who have collaborated on this study.

With this report and its recommendations, we hope that the social service agencies (SSAs) could continue to look at innovative ways to pilot new ideas or service models to meet the needs of the post-18 group.

In terms of support, SSAs could leverage the Enabling Lives Initiative Grant (funded by Tote Board and managed by SG Enable) to drive innovative projects or programmes, as well as to tap on the Grant's vibrant ecosystem of innovators and researchers to form meaningful partnerships that could bring about greater impact for persons with disabilities and their caregivers.

Ku Geok Boon
CEO, SG Enable

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Executive Summary

The Coalition sought to build upon the EMP2030 to continue to identify specific areas where support for post-18 PWDs could be strengthened

0. Coalition Commences

- Kicking off the study with a group of five like-minded SSAs who want to collaborate and innovate for impact.

1. Singapore Rapid Scan

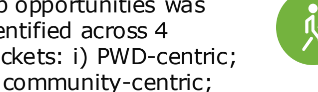
- Focusing on post-18 PWDs with moderate to severe ID/ASD, a view of all relevant programmes came into view through research, stakeholder interviews and site visits.

2. Continuum of Care

- Through understanding the current state, a 'day in the life' view was developed which helped align where current programmes support activities of daily living and where more support may be needed.

3. International Case Studies

- With a view of potential gaps, case studies from other geographies were identified and analysed as to how they could be tailored to the Singapore context.



4. Opportunities

- A non-exhaustive list of top opportunities was identified across 4 buckets: i) PWD-centric; ii) community-centric; iii) collaboration; and iv) enhancing existing services.

5. Recommendations & Next Steps

- Development of recommendations which range from quick wins to longer term change projects which can be piloted silo or in cooperation with other organisations / agencies.

Although employment is thoroughly addressed, there is opportunity to improve support for PWDs with higher support needs and their caregivers

The Clients

- Support services can be more tailored to the age or life stage of clients e.g. as they age or learning needs change.
- The areas with least support are: i) provision of upstream and primary healthcare support; ii) safety and security; and iii) digital environment.
- Caregivers' key concern is how PWDs will be supported once they are gone, both financially and from social & healthcare support perspectives.

The System

- Service models can provide more guidance on best practices for service delivery and interventions.
- Tiered funding is provided based on clients' level of support needs, rather than outcomes.
- Specialist training is currently limited for social and healthcare professionals.

The Community

- Most of the formal support structures for ID and ASD are residential or centre-based facilities; more alternative community-based options are needed.
- Caregiver respite requires additional support and intervention.
- Social service agencies typically provide services in specific areas, rather than across the full spectrum.

A programmatic approach to project- and systems-level change can help galvanise improvements to the post-18 PWD space

01 | Our focus centred on a continuum of care for clients with moderate-severe ID/ASD.

With clear steer from the Coalition working group, we focused our research and analysis on a few defined client segments:

- Moderate to severe intellectual disabilities and autism spectrum disorders; and
- Transitions including immediate post-18, the onset of a new health or mental health need, and end-of-life planning

02 | A combination of desktop research and site visits set the scene on the current state.

We conducted a review and analysis of current programmes and frameworks in SG, coupled with seven site visits/interviews to better understand what was happening on the ground. Further, by reflecting on international case studies which could be tailored to the Singapore context, a holistic current state view was developed.

03 | While Singapore's current approach to PWDs is extensive, more can be done.

Singapore provides support to PWDs and caregivers across at least 88 programmes, ensuring that a base level of service is provided. However, service gaps have been identified in multiple areas, as well as services which could be expanded or evolved to better meet the needs of PWDs and caregivers.

04 | Multiple upstream opportunities exist to provide enhanced client services.

While tactical opportunities exist to enhance programmes, fill gaps with new programmes, or approach an issue area in a different way, the synergies from combining multiple ones create a more strategic approach. By focusing on the client, their progression through the system, and their ability to be independent on the back end, we are being holistic in our approach to care.

05 | In taking a systems view, we are able to depict a future state with more holistic care.

With the goal of healthy and independent living for as long as possible in a PWD's life, three buckets of opportunities have been developed to support this goal and provide more person-centric care which is adapted to their specific needs. While some system-level changes would be needed, much can be done without government intervention in the first instance.

06 | By planning across organisations and agencies, we can broaden our outcomes.

By addressing both programme- and systems-level change initiatives, we provide opportunities for all stakeholders to meaningfully input into the future state of the industry, providing more benefits by being able to accomplish more than working in silos. Although the recommendations are not exhaustive, these actionable next steps provide a strong foundation for future gains.

We explored disability service models in other countries to identify opportunities for advancement in Singapore's disability sector

What Works Well in Singapore

- Interdisciplinary healthcare team (e.g, IDHealth, THK and AWWA)
  - Psychologists, behavioural therapists, nurses, doctors, social workers, programme specialists
- Person-centered and family-centered care
  - Development of individualised care plan to explore needs and interests
- A framework (Client Assessment Form (CAF)) to measure needs of PWDs; as well as resources and support required.

Our research typically focused on exploring challenges faced by PWDs globally, as there was limited research available that evaluated strategies and service models to support post-18 PWDs. We identified countries with nationwide strategies/service models to support post-18 PWDs:

Considerations

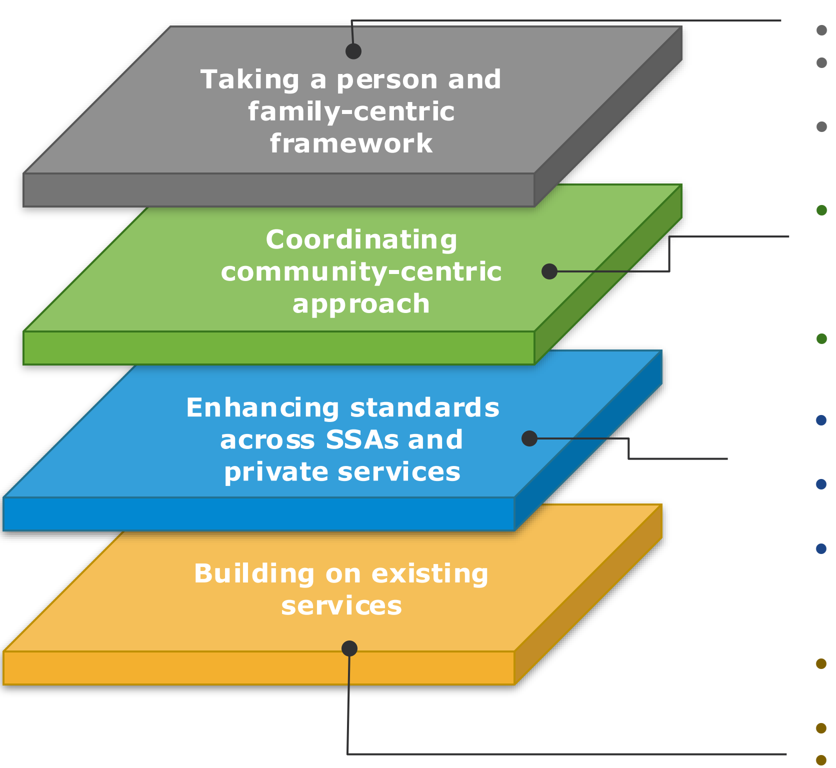
- Life Facets Addressed
- Applicability to Singapore context
- Programme Effectiveness
- Ease of Implementation
- Innovation and Uniqueness

Domains covered

- Person-centered and family-centered planning
- Healthcare support
- Residential support
- Learning support

Countries

By taking a full systems view of opportunities, we can align with the target groups and focus areas while still creating holistic impact



- Develop framework and approach to **support person-centric care**
- **Integrate health care** by supporting early diagnosis and identification of health needs through annual health checks
- Support **financial planning and literacy** of caregivers and PWDs

- **Enhance place-based care** through government-led community nodes (e.g., Enabling Services Hubs) or existing eldercare infrastructures such as Day Rehabilitation Centers to support progression across and within centers
- **Develop independent but connected community residences**

- **Data sharing** of aggregate PWD data and individual health and functional assessment records
- **Establish standardised framework** to support curriculum development
- **Capability build service providers** to support both health and social needs of PWDs

- Utilise existing eldercare infrastructure and service to **pilot health-social integration** for disability services
- Utilise existing residential facilities to **provide respite care options**
- **Trial independent living** at existing community living facilities

Though non-exhaustive, the list of recommendations is meant to create momentum by addressing some low hanging fruit via pilots

#	Recommendation	Opportunity Layer(s)	Key Results Sought	Ease of implementation
1	**MSF / SG Enable coordinates mini workgroups**	Enhancing standards across SSAs & private services	• Central government agency leading collaboration across SSAs • Additional SSAs brought into the mix • Central coordination of future pilots and insights generated	
2	**Support the health needs of PWDs by enhancing access to health screenings and infrastructure**	Taking a person and family-centric framework; enhancing standards across SSAs and private services; building on existing services	• Ensure annual health screenings provide the foundational basis for ongoing care needs • Capability build service providers to support both health and social needs of PWDs through interdisciplinary training • Utilise the infrastructure already in place for eldercare to extend to PWDs, thereby achieving cost effectiveness	
3	**Stabilise and grow support structures around family and caregiver support**	Taking a person and family-centric framework; building on existing services	• Launch new residential and community-based respite options for family and caregivers • Enhance training support for families and caregivers by piloting caregiver training curriculum to expand scope of courses provided under Caregiver Training Grant by AIC • Subsidise training for foreign workers in disability sector	
4	**Enhance place-based care with Community of Cares model**	Coordinating community-centric approach	• Development of standardised framework with defined progression milestones to support progression and transitions between and within services • Group services by geographic area and identify service gaps by geography	
5	**Pilot a new model of inclusive independent living**	Building on existing services	• Adapt existing assisted community living models for seniors or providing alternative community living model	

Potential pilot projects that can be led by service providers

While still kicking off efforts which are more complex and require additional planning and collaboration for longer term gains

#	Recommendation	Opportunity Layer(s)	Key Results Sought	Ease of implementation
6	**Support financial planning and literacy of caregivers and PWDs**	Taking a person and family-centric framework	• Partner with a financial institution to develop a literacy programme for PWDs and their caregivers • Use the partnership to identify financial products which can be tailored to the specific needs of caregivers and / or PWDs, e.g. insurance	
7	**Enhance transitions and transparency through data-led frameworks**	Enhancing standards across SSAs & private services	• Development of aggregate data collection and analyses shared with all SSAs • Development of a data sharing best practices framework linked to National Electronic Health Records	
8	**Introduce personal care plans and support for PWDs and caregivers to implement such plans**	Taking a person and family-centric framework	• Development of case management and service coordination framework	
			• Development of individualised plan and targeted support for PWD and caregivers to implement these plans	
9	**Refine funding models which incentivise improved outcomes for PWDs**	Coordinating community-centric approach	• Development and coordination of incentive-based funding for SSAs to reward progression outcomes through incentive payments while accounting for reduction in care needed when condition stabilises/improves.	

While some initiatives may pose greater challenges, piloting specific components within the recommendations can pave the way for long-term implementation. For example, starting with the development of a case management and service coordination framework could be a first step towards building targeted care through personal care plan and support to implement them.

Potential pilot projects that can be led by service providers

3

Motivation and Background

This study builds upon the EMP2030 to strengthen support for PWDs and their families in the post-18 space to address the cliff effect

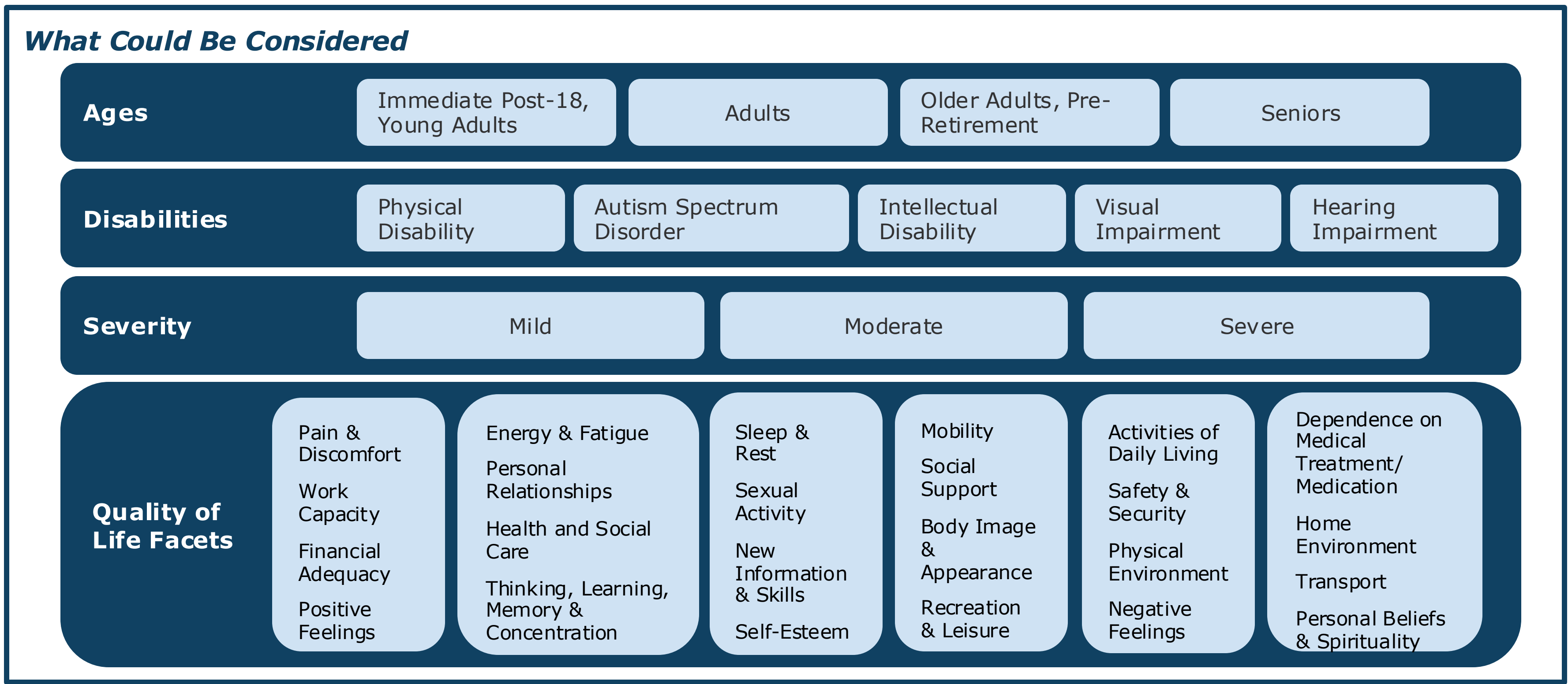
PROJECT BACKGROUND

The Enabling Masterplan 2030 (EMP2030) was released in 2022, covering various topics from education, transport, health to caregiving. Several organisations providing disability services (the “Coalition”) wish to dive deeper, understanding the needs and services available for the post-18 group.

Based on the needs and opportunities identified in the post-18 PWD space, we built upon the EMP2030 to articulate the value of strengthening support for post-18 PWDs, the social care systems which support them, and wider society. In particular, the Coalition explored a person-centric approach in the post-18 space, integrating health and social care.

PROJECT GOALS

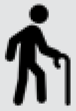
The post-18 space is very broad, encompassing many age groups, disabilities (including severity levels) and quality of life indicators



The Coalition Working Group helped TSCC define the areas with the most potential for impact where this work would focus

Target Groups:

Immediate post-18



Aging adults

Moderate to severe ID & ASD

Focus Areas:

Consider wellbeing needs at different life stages

Upstream facets of everyday life that have downstream cost savings to society

Note: where we reference PWDs in this report, we specifically mean the target groups identified above.

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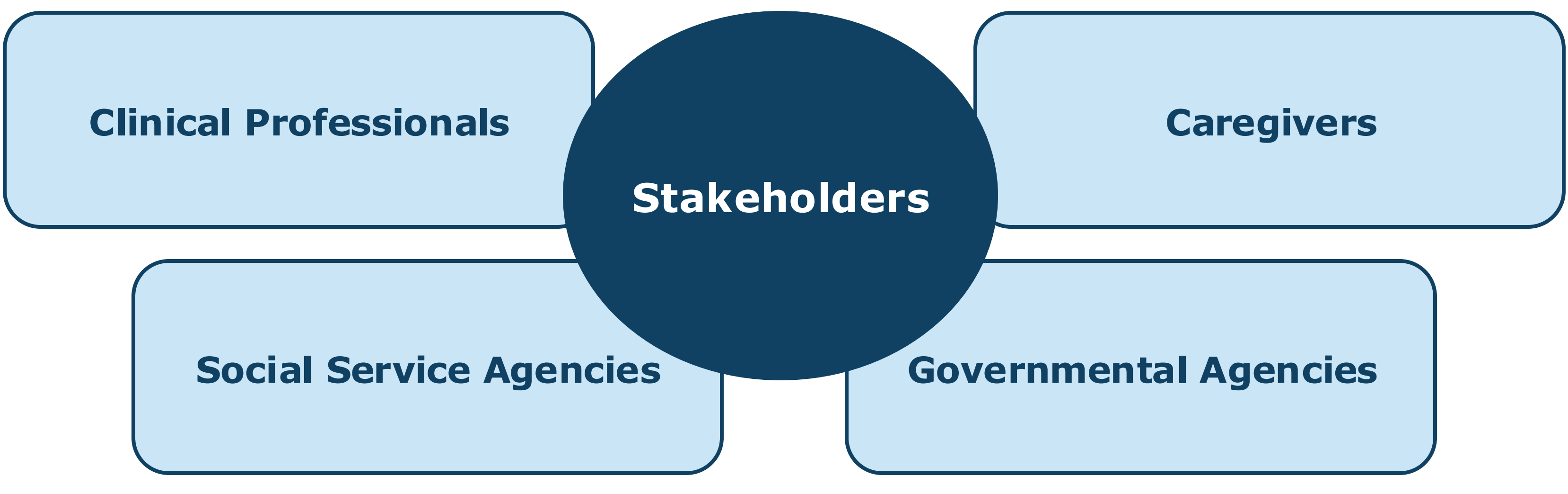
A Snapshot from Singapore

We conducted a rapid scan and seven interviews/ site visits to understand the current state for PWDs in Singapore



Based on a scan of existing support services in Singapore, we saw areas that required additional research and understanding

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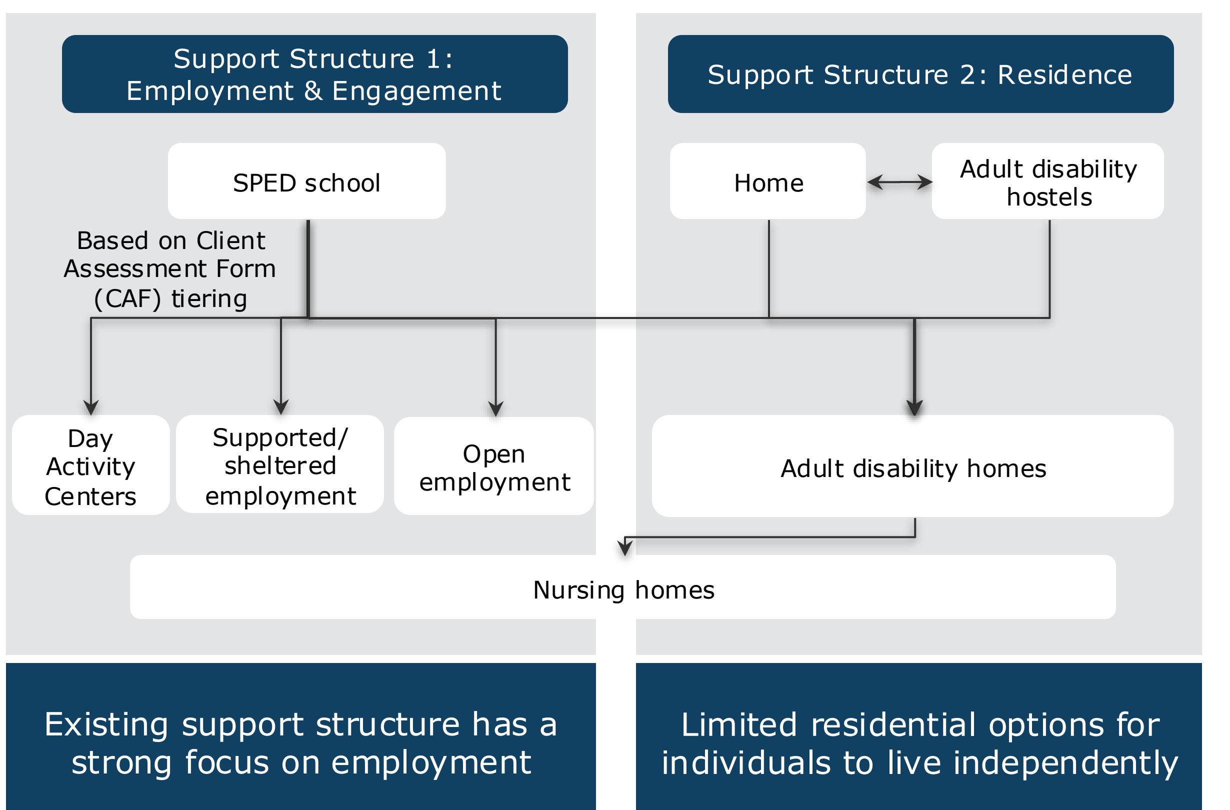


Support Structure 3: Physical & Mental Health

Community based care

- Therapeutic services in some centers
- Home-based nursing and personal care services

Primary care

- IDHealth clinic
- GP/Polyclinic

Secondary and tertiary care

- Hospitals
- Institute of Mental Health
- Nursing homes
- Hospital palliative care unit

Limited specialised training in disability for social and healthcare professionals

There can be better coordination between employment and engagement services to facilitate smoother progression and transitions for PWDs

Existing employment and engagement model:

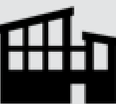
1. Determined by CAF tiering upon graduating from SPED school into two main tracks: employment (open, supported, sheltered); or engagement (in DACs~~, adult disability homes~~).
2. Each center develops their own curriculum, and some organisations standardised the curriculum across the centers they run.
3. Each center has differing ability to take on clients with varying levels of ADL-support, presence or management of behavioural issues or mental health conditions) based on the centre’s capabilities.
4. SPED schools work with adult disability service providers to provide transition care support when PWDs move from school to their first adult disability service; however, there is limited transition care support beyond that.
5. Stakeholders interviewed suggested a longer educational pathway to develop social skills, community living skills and vocational skills needed for work.

PWDs are typically cared for at home by caregivers, or in adult disability homes, with few alternative housing options in between

- Two primary options:

Homes with caregiver

To support caregiving burden of PWDs cared for at home, the Migrant Domestic Worker (MDW) Levy Concession for Persons with Disabilities provides a subsidy to the monthly levy concession. However, hiring MDW may not be a viable option for lower-income families financially and due to space constraints.



Adult disability hostel/home

Adult disability homes (ADH) are seen as a last resort for adults with disabilities who are neglected or whose caregivers are unable to provide care.

There are 10 ADHs in Singapore as of 18 June 2020.

- Those who are above the age limit of the adult disability hostel/home (55 years old) or may require high health support are admitted into nursing homes regardless of age. However, there are limited spaces and specialised care in nursing homes; as well as limited community-based options that can accommodate needs.

Healthcare[1] is typically provided in the same care providers as neurotypical adults, even though more specialised support is required

Young healthy adult

Preventative care: Health education (e.g. diet, hygiene) provided in centers

New health needs developing

Primary care: Visits to General Practitioners or Polyclinics
Secondary care: Admission into hospitals or Institute of Mental Health (IMH)
Tertiary care: Follow ups at specialist clinic
Community-based care: Home care programmes

End of life care

Palliative care: Nursing homes

Specialised support

Therapeutic services in some day activity centers/adult disability homes

ID Health clinic that specialises in supporting individuals with intellectual disability and their families

Specialised clinic in IMH: Adult Neurodevelopmental Service (ANDS)

Dental clinics that support PWDs: Mount Alvernia Outreach Medical & Dental Clinic, Tan Tock Seng Hospital Dental Clinic, Singapore General Hospital National Dental Centre

Challenges with existing physical and mental health support:

- Communication often poses a barrier for PWDs, requiring healthcare professionals to communicate differently. However, healthcare professionals may not be equipped to do so.
- ANDS in IMH specialises in supporting PwID/ASD who have mental health conditions. However, IMH ANDS does not support physical health needs.
- PWDs need to access support from healthcare providers and social care services which can be challenging to coordinate.
- Despite the complexity and interplay between social and health needs of PWDs, most centers and community-based support do not have an interdisciplinary care team.

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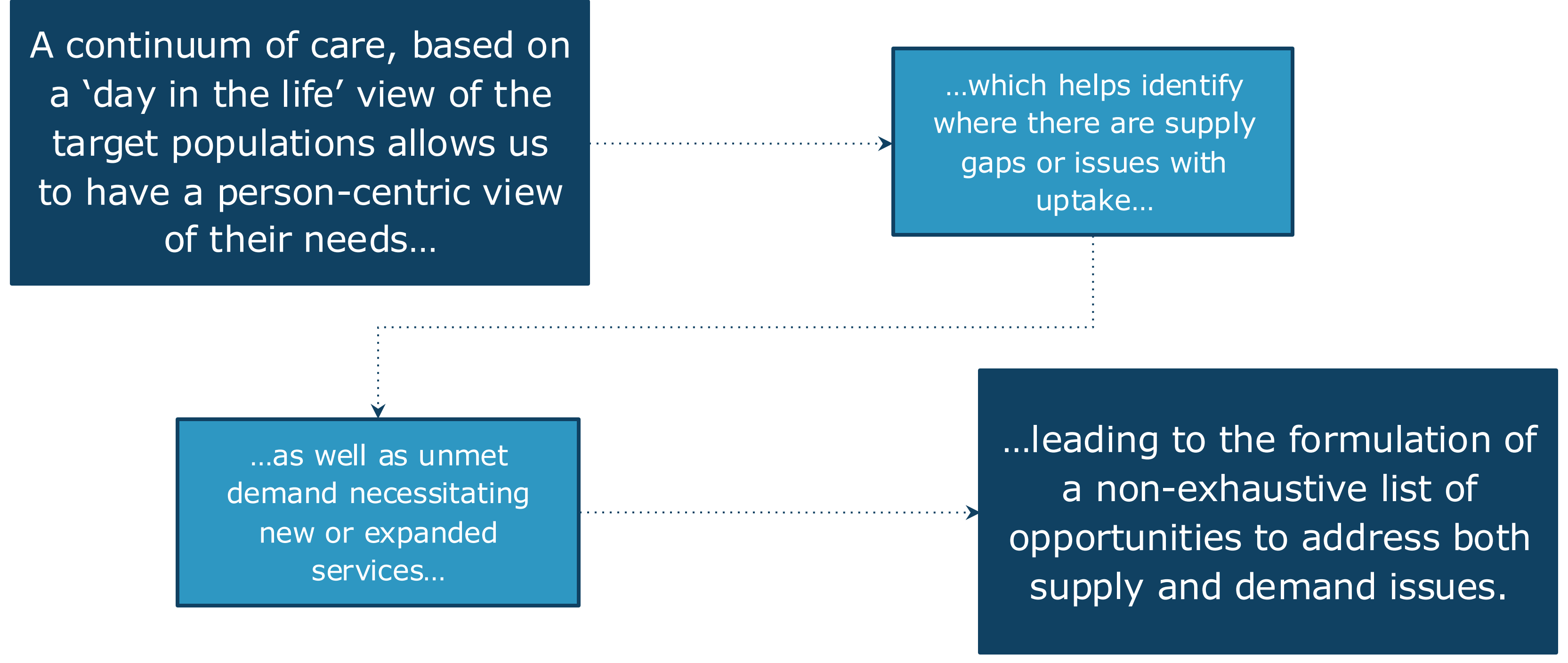
Insights from International Case Studies

Continuum of Care

On the back of desktop research and interviews with key stakeholders in Singapore, a continuum of care was developed to put client needs into focus

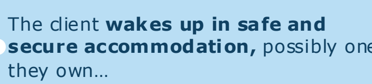


Post-18 Persons with Disabilities Continuum of Care

Optimising for:

- Independent living
- Addressing health and social issues further upstream
- Reducing the need for caregiving support and subsidies
- Enhancing quality of life
- Aging well

Young healthy adult with moderate to severe ID/ASD…



The client **wakes up in safe and secure accommodation,** possibly one they own…

…as part of their daily routine they **prepare for the day**…

…once ready, they **commute to their next set of activities,** if not already there…

…where they will **grow daily living skills**…

…where they are able to **engage in a fulfilling job or in meaningful activities** that are tailored to their needs…

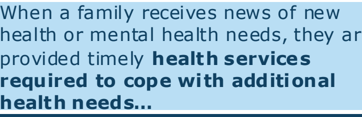
…while still being able to **receive support services** with a focus on social-health integrations…

…and still having time to enhance their social inclusion by **engaging in personal interests**…

…before they return to their accommodation and **prepare healthy and nutritious meals** (with or without the help of caregiver) which address their specific needs.

+ caregiving support
+ needs planning
+ residential care

…as they age, they develop new health needs…



When a family receives news of new health or mental health needs, they are provided timely **health services required to cope with additional health needs…**

…which supports clients to **wake up in safe and secure accommodation,** retaining as much normalcy while provided additional assistive support needed…

…as part of their daily routine, they **prepare for the day**…

…once ready, they **are transported to their next set of activities**…

…where they are provided support to maintain **their daily living skills** and sense of independence where possible…

…and have time to **continue to be engaged in meaningful activities (volunteering, caring for someone, education)…**

…before they return to their accommodation and are **provided support to maintain healthy and active aging lifestyle.**

+ caregiving support
+ needs planning
+ residential care

…leading to the eventual preparation for end-of-life.

When a family receives news about end-of-life and death, they are provided with **timely support services needed to cope with change**…

…which supports clients to **wake up in safe and secure accommodation,** retaining as much normalcy while provided additional assistive support needed…

…as part of their daily routine, they **prepare for the day**…

…once ready, they **are transported to care services**…

…to be **engaged in meaningful activities or personal interests to support comfort and dignity**…

…before the day ends, they are **provided with tasty and nutritious food they enjoy.**

+ caregiving support
+ needs planning
+ residential care

Case Studies

We explored disability service models in other countries to identify opportunities for advancement in Singapore's disability sector

What Works Well in Singapore

- Interdisciplinary healthcare team (e.g, IDHealth, THK and AWWA)
    - Psychologists, behavioural therapists, nurses, doctors, social workers, programme specialists
- Person-centered and family-centered care
    - Development of individualised care plan to explore needs and interests
- A framework (Client Assessment Form (CAF)) to measure needs of PWDs; as well as resources and support required.

Our research typically focused on exploring challenges faced by PWDs globally, as there was limited research available that evaluated strategies and service models to support post-18 PWDs. We identified countries with nationwide strategies/service models to support post-18 PWDs:

Considerations

- Life Facets Addressed
- Applicability to Singapore context
- Programme Effectiveness
- Ease of Implementation
- Innovation and Uniqueness

Domains covered

- Person-centered and family-centered planning
- Healthcare support
- Residential support
- Learning support

Countries

Case Study Assessment Framework – Part 1

Domain	Description	Score	Criteria
Life facets addressed	Number of key life facets addressed Key domains: - Health (Physical and mental health) - Family and social relationships - Daily living and independence - Environment - Caregiver or family support - Psychological support - Access to rights and legal protection	1 2 3	The case study addressed only one/none of the life facets. The case study addressed only two to three facets. The case study comprehensively covers more than three facets.
Innovation and uniqueness	Innovation: Program has innovative elements Uniqueness: Program is original and distinct in approach	1 2 3	The case study lacks innovation and is commonly implemented today. The case study has some innovative elements but lack uniqueness. The case study is highly innovative and stands out in uniqueness.
Ease of implementation	Resources: Financial, human resources required. Adaptability: Ability to be adapted to different context.	1 2 3	Case study is resource intensive and not adaptable to other contexts. Case study is moderately resource intensive and/or somewhat adaptable to other contexts. Case study is resource efficient and easily adaptable.

Case Study Assessment Framework – Part 2

Domain	Description	Score	Criteria
Availability of verified data	Source: Credibility of data source Data accuracy: Reliability and accuracy of data	1 2 3	Case study relies on unverified or limited data. Case study provides reasonably reliable and verifiable data. Case study is highly credible.
Programme effectiveness	Scale of program: Program scaled across geographical regions Program effectiveness: Availability of public data, number of studies that report effectiveness; statistical evidence of program effectiveness Long-term impact: Sustainability of impact beyond program	1 2 3	Limited public data available on effectiveness. Program is scaled across regions within the country; or there is strong research design with some evidence of program effectiveness. Program is scaled nationally. or there is evidence on program effectiveness.
Applicability to Singapore	Cultural relevance: Solution alignment with Singapore's economic and social context Ease of integration into Singapore's system	1 2 3	The case study is poorly suited to Singapore. The case study has some relevance and applicability. The case study is highly applicable to Singapore's context.

*For detailed scores on case studies, please refer to the appendix

Case Study Research

Case Study	Country	Description
NHS Service Model	UK	Service model to support individual's needs and interests, family and caregivers, residence, mainstream and specialised healthcare support.
Personal Budgets and Direct Payments	UK, S. Korea	Provision of direct payments to PWDs and caregivers based on support required, cost and affordability; to pay for any care services required.
Person-Centered Planning	Ireland	Guide for the development of a consistent person-centered plan across disability services in Ireland.
Adult Comprehensive Health Assessment Program (CHAP)	Australia	Yearly health check up based on a curated two-part questionnaire which creates a comprehensive health history, identifies commonly missed or poorly managed health conditions and supports development of a health action plan.
Community Living British Columbia (CLBC)	Canada	Canada's appointed agency to support PWDs through provision of an integrated service support team with staff from social welfare, health and education ministry; continuum of housing support and strategy for aging.
Adult Autism Housing Options	US	US Agency that outlines housing support options for individuals with ASD supported by private organisations, non-profits or family-owned.
New Directions: Adult Day Services	Ireland	Strategy to shift from provider-led programs to individualised supports where adults have access to flexible support to meet needs and aspirations.
Framework for Supporting Pupils with Severe and Profound Learning Needs	UK	Development of a framework to support students and young persons with severe and profound learning needs with development of a person-centered approach, individualised and measurable assessments and targets.
Supporting digital inclusion of PWDs	European Union	Digital roadmap highlighting 3 main levers (ensuring accessibility, promoting digital skills, and fostering digital employment) to support digital inclusion of PWDs.

Case Study Research

Component of support/care services	Programme Name	Country
Transition Planning	Family-Centered Transition Process	US
Transition Planning	Transitioning Together	US
Transition Planning	The Transition-To-Retirement Program	Australia
Social Skills	Program for the Education and Enrichment of Relational Skills (PEERS)	US
Healthcare Support	Diabetes management (DESMOND-ID)	UK
Healthcare Support	Get Healthy!	Australia
Healthcare Support	Equine-Assisted Psychotherapy	US
Behavioural Support	Active Music Therapy	Italy
Access to Stimuli	Smartphone-based Programme	Italy
Community Participation	Freshen Up Program	US
Digital Support	Online Safety Curriculum for Parents/Caregivers	US

6

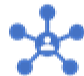
Recommendations for the Sector

By aligning what has worked well in Singapore with what has seen success in other countries, new opportunities can be considered

High-level Opportunity Areas to Explore

- **Progression Framework**: While there are existing individualised care plans to support PWDs' interests, we may further develop the framework to track progression made by PWDs yearly, with support for PWDs and caregivers to navigate and access the services and funding they need.
- **Funding Model:** Review existing funding model to reward effort made for PWD progression.
- **Interdisciplinary care team:** Provide holistic care to PWDs by scaling and mainstreaming the provision of interdisciplinary social and healthcare team and data sharing on National Electronic Health Records (NEHR).
- **Specialisation and coordination:** Given that PWDs require a continuum of care, centers can consider specialising to support a specific life stage and needs on the continuum.
- **Integration of services:** Given the early onset of frailty, integration between healthcare, elderly and disability services to exchange information and expertise, conduct physical and mental health screenings and check-ups, provide caregiving support and respite in the community.

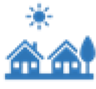
Many countries address similar issues with integrated strategies to empower PWDs towards independent living



In Ireland and the UK, **case worker/transition coordinator** supports each individual and their family to tap on various services needed at different life stages and transitions.

Person-centric care plans[4] with personalised budgets[5] are developed in South Korea, UK and Australia to empower clients with the freedom of choice to access required services, although evidence on cost effectiveness and fiscal sustainability is inconclusive.

Given that PWDs communicate differently, **annual health check ups with tailored questions[6]** are provided for PWDs in the UK to reduce missed or poorly managed health conditions.



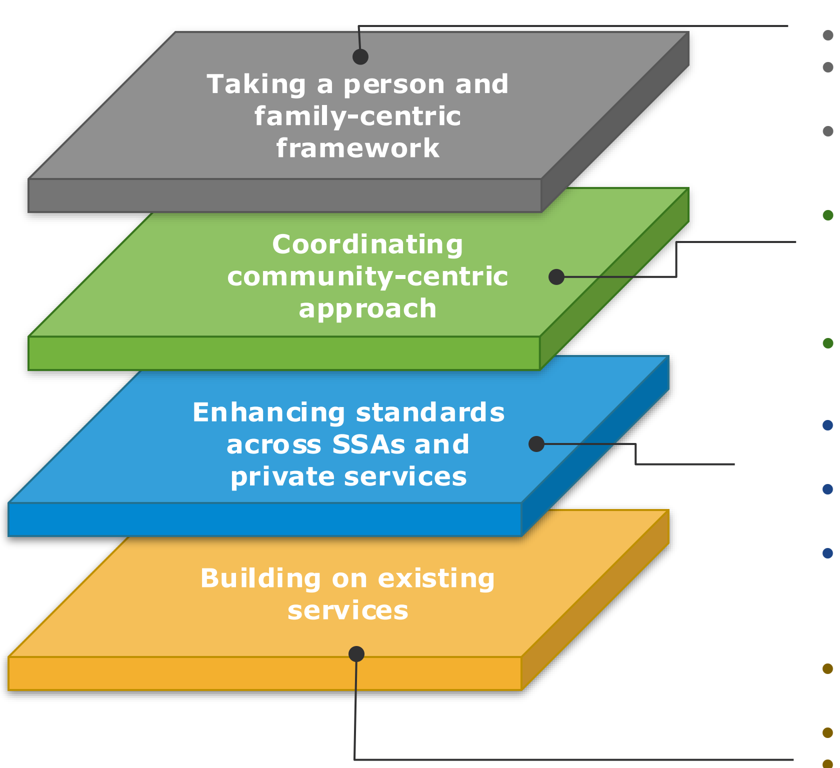
To reduce caregiver burden or loss of independence when caregivers pass away, a **continuum of housing support models** from staffed residential homes to intentional community models[7] is provided for in US and Canada.

In Ireland, a **standardised programme framework** is utilised across multiple service providers with individualised target setting so as to better support individual progress[8], staff capability building, collaboration and sharing of good practices[9].

[4] Source: NHS England. "NHS Service Model to support people with learning disability and/or autism". 2015.
[5] Source: NHS England. "Personal budgets and direct payments".
[6] Source: Australian Government Department of Health and Aged Care. "Adult Comprehensive Health Assessment Program (CHAP). 2023.
[7] Source: Integrated Autism Coordinating Committee, US Department of Health and Human Services "Adult Autism Housing Options".2019.
[8] Source: South Lanarkshire Council. "The South Lanarkshire Framework for Supporting Pupils with Severe and Profound Learning Needs." 2015.
[9] Source: Rees Kirsten. ""This is theirs": The implementation of the South Lanarkshire Framework for supporting pupils with severe and profound needs". 2017.

Opportunities

By taking a full systems view of opportunities, we can align with the target groups and focus areas while still creating holistic impact



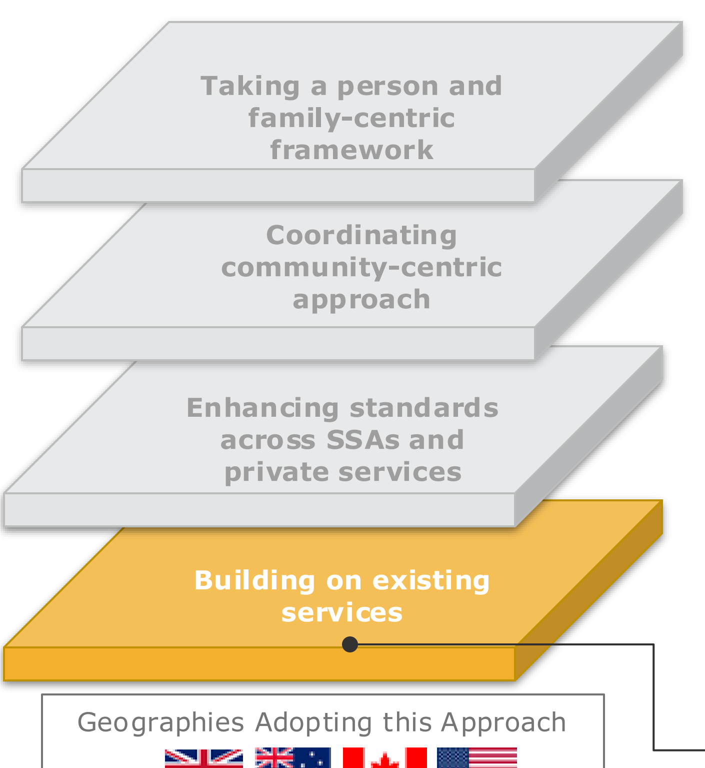
- Develop framework and approach to **support person-centric care**
- **Integrate health care** by supporting early diagnosis and identification of health needs through annual health checks
- Support **financial planning and literacy** of caregivers and PWDs

- **Enhance place-based care** through government-led community nodes (e.g., Enabling Services Hubs) or existing eldercare infrastructures such as Day Rehabilitation Centers to support progression across and within centers
- **Develop independent but connected community residences**

- **Data sharing** of aggregate PWD data and individual health and functional assessment records
- **Establish standardised framework** to support curriculum development
- **Capability build service providers** to support both health and social needs of PWDs

- Utilise existing eldercare infrastructure and service to **pilot health-social integration** for disability services
- Utilise existing residential facilities to **provide respite care options**
- **Trial independent living** at existing community living facilities

Moreover, existing services can be supported to pilot initiatives that build towards providing client-centric and community-based care



Utilise existing eldercare infrastructure and service to pilot health-social integration for disability services

- Multi-service organisations with existing integrated eldercare and disability care through modification of spaces and inclusion of disability professional into interdisciplinary case teams

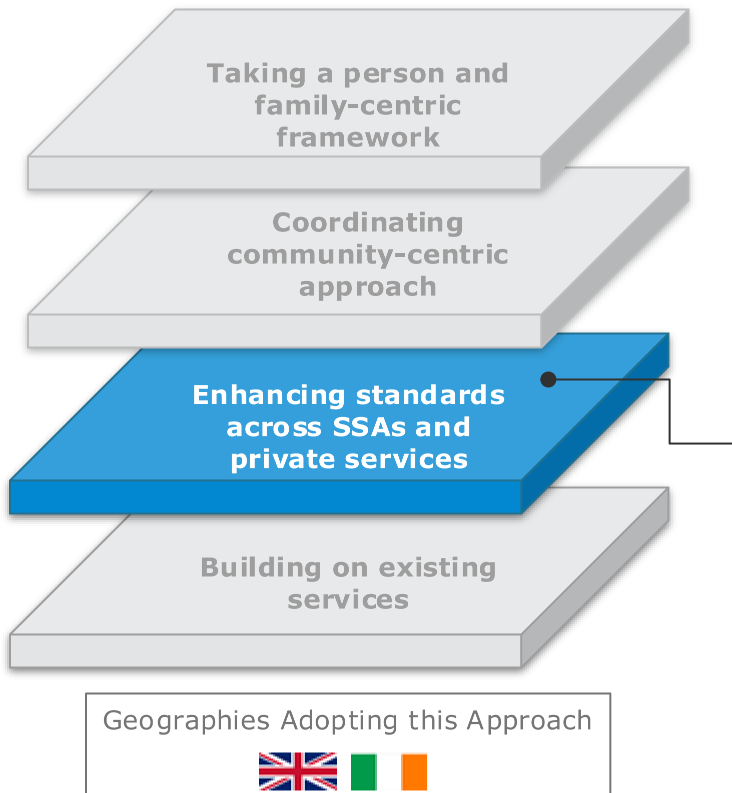
Enhance existing family and caregiver support to prevent caregiver burnout

- Utilise existing residential facilities to provide out-of-home respite care option; and utilise existing home-based care expertise to provide in-home respite for family and caregivers
- Enhance training support for families and caregivers by expanding scope of courses provided under Caregiver Training Grant by AIC

Trial independent living at existing community living facilities

- Adaptation of existing community living facilities with provision of specialised services needed for independent and assisted living in existing community living facilities

To support the future development of client-centered Communities of Care, we can enhance and standardise quality of services provided



Data sharing of aggregate PWD data and individual health and functional assessment records

- Aggregate PWD data analysis and sharing by relevant government agencies to support SSA's advance planning based on demand and resource allocation
- Access to PWD National Electronic Health Records (NEHR) and functional assessment records to reduce time needed to assess individual's social and health needs

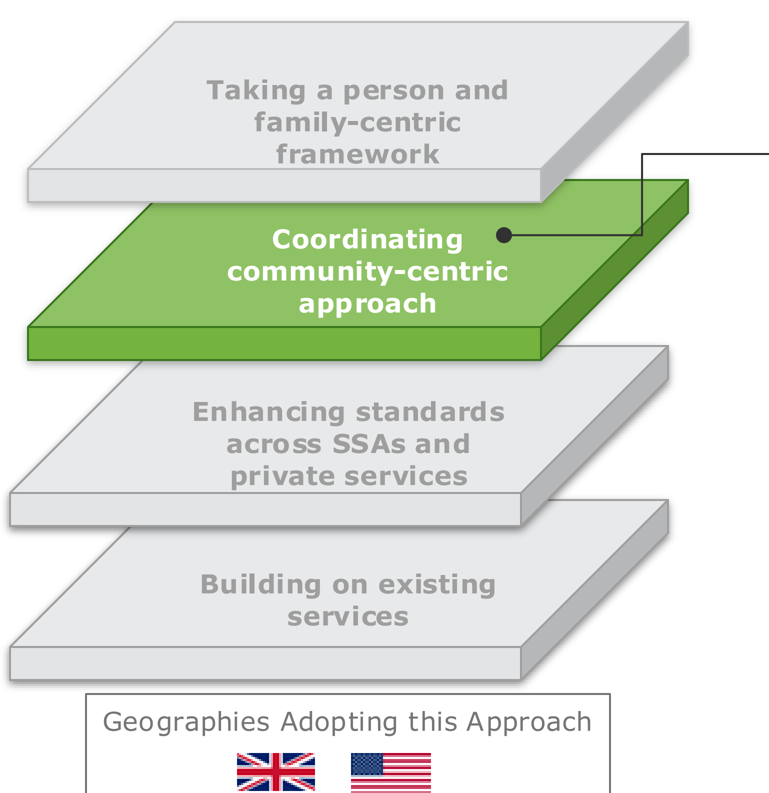
Establish standardised framework to support curriculum development

- Establish a standardised framework using best practices would streamline the process, saving time and resources for each center to develop their own while ensuring optimal care for every PWD

Capability build service providers to support both health and social needs of PWDs

- Provide interdisciplinary training for specialised workers. This could be done through NCSS Social Service Institute (SSI)

We envision a person-centered approach with an inclusive community to support the complex needs of PWDs



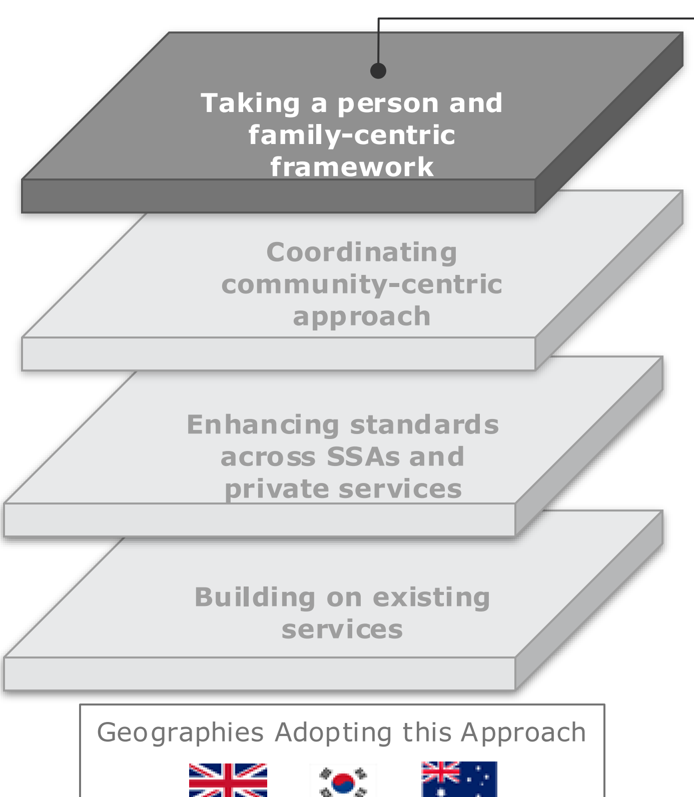
Enhancing place-based care through government-led community nodes (e.g., Enabling Services Hubs) or existing eldercare infrastructures such as Day Rehabilitation Centers to support progression across and within centers

- Support progression and transitions between and within services through the development of standardised framework with progression milestones
- Develop and coordinate incentive-based funding for SSAs to reward progression outcomes through incentive payments while accounting for reduction in care needed when condition stabilises/improves.

Develop independent but connected community residences

- Adapt existing assisted community living models for seniors or providing alternative community living model such as the Intentional Community Model and Dispersed Community and Service Delivery Model to reduce burden of care on individual caregivers and dependence on homes/institutions with high cost
- Financial planning and literacy of PWD and caregivers to support long-term care and needs

We envision a person-centric approach with an inclusive community to support the complex needs of PWDs



Develop framework and approach to support person and family-centric care

- Case management and coordination of services by conducting needs assessment
- Develop a individualised plan for PWD and caregivers and support them to implement the plan

Integrate health care by supporting early diagnosis and identification of health needs through annual health checks

- Develop annual health checkup questionnaire tailored for PWDs
- Build interdisciplinary care teams (psychologist, doctor, nurse, social worker, occupational therapist, trained SPED teacher) to provide holistic care that support social and health needs of PWDs

Support financial planning and literacy of caregivers and PWDs

- Partner with a financial institution to develop a literacy programme for PWDs and their caregivers
- Use the partnership to identify financial products which can be tailored to the specific needs of caregivers and / or PWDs, e.g. insurance

Recommendations

Focusing on high impact opportunities with differentiated focus and a mix of time horizons can help build the foundation for future success

#	Recommendation	Opportunity Layer(s)	Key Results Sought	Ease of implementation
1	**MSF / SG Enable coordinates mini workgroups**	Enhancing standards across SSAs & private services	• Central government agency leading collaboration across SSAs • Additional SSAs brought into the mix • Central coordination of future pilots and insights generated	
2	**Support the health needs of PWDs by enhancing access to health screenings and infrastructure**	Taking a person and family-centric framework; enhancing standards across SSAs and private services; building on existing services	• Ensure annual health screenings provide the foundational basis for ongoing care needs • Capability build service providers to support both health and social needs of PWDs through interdisciplinary training • Utilise the infrastructure already in place for eldercare to extend to PWDs, thereby achieving cost effectiveness	
3	**Stabilise and grow support structures around family and caregiver support**	Taking a person and family-centric framework; building on existing services	• Launch new residential and community-based respite options for family and caregivers • Enhance training support for families and caregivers by piloting caregiver training curriculum to expand scope of courses provided under Caregiver Training Grant by AIC • Subsidise training for foreign workers in disability sector	
4	**Enhance place-based care with Community of Cares model**	Coordinating community-centric approach	• Development of standardised framework with defined progression milestones to support progression and transitions between and within services • Group services by geographic area and identify service gaps by geography	
5	**Pilot a new model of inclusive independent living**	Building on existing services	• Adapt existing assisted community living models for seniors or providing alternative community living model	

Potential pilot projects that can be led by service providers

Some recommendations are more complex than others and will require strong collaboration across SSAs and government agencies

#	Recommendation	Opportunity Layer(s)	Key Results Sought	Ease of implementation
6	**Support financial planning and literacy of caregivers and PWDs**	Taking a person and family-centric framework	• Partner with a financial institution to develop a literacy programme for PWDs and their caregivers • Use the partnership to identify financial products which can be tailored to the specific needs of caregivers and / or PWDs, e.g. insurance	
7	**Enhance transitions and transparency through data-led frameworks**	Enhancing standards across SSAs & private services	• Development of aggregate data collection and analyses shared with all SSAs • Development of a data sharing best practices framework linked to National Electronic Health Records	
8	**Introduce personal care plans and support for PWDs and caregivers to implement such plans**	Taking a person and family-centric framework	• Development of case management and service coordination framework	
			• Development of individualised plan and targeted support for PWD and caregivers to implement these plans	
9	**Refine funding models which incentivise improved outcomes for PWDs**	Coordinating community-centric approach	• Development and coordination of incentive-based funding for SSAs to reward progression outcomes through incentive payments while accounting for reduction in care needed when condition stabilises/improves.	

While some initiatives may pose greater challenges, piloting specific components within the recommendations can pave the way for long-term implementation. For example, starting with the development of a case management and service coordination framework could be a first step towards building targeted care through personal care plan and support to implement them.

Potential pilot projects that can be led by service providers

Recommendation #1: MSF / SG Enable takes on coordination of Workgroups (WG)

Goal: The WG exemplifies inter-agency collaboration to support PWDs by continuously working with one another and sharing data, where permitted, to build upon one another's strengths and support the launching of new or improved initiatives. Service providers can join the thematic WFs depending on their interests and priorities.

Example

Engagement and coordination by MSF/SG Enable

- MSF/SG Enable can coordinate various thematic WGs and bring organisations together to share learning and insights informally.

Thematic WG

- Based on an agreed strategy, WG members can either (a) test similar pilot interventions on distinct target groups; or (b) implement diverse pilot interventions.
- The group convenes every two months to share best practices and explore new opportunities for inter-agency collaborations.

Potential Next Steps

- Relevant organisations, such as MSF, MOH, and/or SG Enable, to lead the coordination of various WGs to share insights on a half-yearly basis.
- Existing thematic workgroups (e.g. task force on Community Living) can coordinate key strategies and pilot interventions for implementation.
- The WGs will be the central coordinator of future pilots and insights generated related to the theme.
- Agree on frequency of WG meetings.

Recommendation #2: Support health needs of PWDs by enhancing access to health screenings and infrastructure

Goal: Beyond the inclusion of PWDs in primary health settings, provide specialised holistic care and support for PWDs.

Strategy

- **Conduct annual health screening:** As PWDs may communicate their needs differently, regular health screening will ensure early detection of illness and disease.
- **Allow referral of PWDs to existing eldercare services by trained professionals:** Research has shown that PWDs age and become frail earlier and faster than the general population. Thus, allowing trained professionals to flexibly refer PWDs can ensure PWD's quick and early access to support required.
- **Capacity build disability providers with healthcare knowledge:** Given the complex interplay between health and social factor, disability providers may be equipped to provide basic healthcare services. This can be hosted on NCSS SSI platform as part of its existing suite of "Disability & Special Needs" courses.
- **Utilise existing infrastructure in place for eldercare for PWDs:** Achieve cost effectiveness by utilising space, expertise and resources for both eldercare and disability services.

Potential Next Steps

- Identify an annual health screening tool that can be adapted to local context, for implementation through ESH.
  - Considerations can include location where check ups can be done; referral processes arising from screening; and capability building needed to support screening process.
- Engage relevant government stakeholders to discuss flexibility in eligibility criteria for PWDs to access health-related services and subsidies.
- Identify disability health professionals and work with them to develop a curriculum outline as well as lesson plan.
- Work with NCSS SSI to develop modules to build its existing suite of "Disability & Special Needs" courses.
- Identify common support and specialised support needed for eldercare and disability care; and pilot an initiative to use existing infrastructure for both eldercare and disability services.

Recommendation #3: Stabilise and grow support structures around family and caregiver support

Goal: Given that caregiving is lifelong, caregivers need care and support as they support their loved ones.

Strategy

- **Launch new residential and community-based respite options for family and caregivers:**
  - **In-home[24]:** Foster caregivers provide overnight respite at family's home
  - **Out-of-home:** Existing residential facilities can build a programme to support short-term respite for family. The programme will include a transition phase where both caregivers and residential staff will support the transition of PWD into the new space over a few weeks. Thereafter, caregivers can book slots to check in PWD into the facility for short-term respite in advance.
- **Subsidise training for foreign workers in disability sector**
  - In the eldercare sector, Basic Eldercare Course by AIC is provided for caregivers including foreign domestic workers to support seniors at home.
  - A similar model can be adopted for the disability sector.
- **Enhance training support for families and caregivers by expanding scope of courses provided under Caregiver Training Grant by AIC:** Provide courses specialising in adult care and geriatric support for caregivers. This may include:
  - Communicating with PWDs;
  - Nutrition and exercise for aging PWDs;
  - Prevention of secondary illness; and
  - Resources and support available.

Potential Next Steps

- A lead agency can develop a respite care model to pilot in the community
- The lead agency can also play a role in working with AIC and a disability healthcare professional to develop the curriculum outline and lesson plan for a course to support adult and aging PWD caregivers.
- Monitor and evaluate pilot programmes

24 Source: Abrahams "Respite care models and practices for persons with intellectual disability: A scoping review" 2023.

Recommendation #4: Enhance place-based care with Communities of Care model (1/2)

Goal: (a) Ensure that all necessary care is within geographic reach and provides a sense of community amongst practitioners, clients and caregivers. In this regard, a community node may be built within existing infrastructures through inter-agency coordination.

	Existing role	Potential role
Centers (DACs/ Sheltered Employment/ ADHs)	Centers support individual's employment capabilities, daily living, community living and social skills.	Play a role in building capability of nursing home staff to support individuals' and caregivers' needs; coordinate with nursing home to identify where individual may be best placed; coordinate data-sharing of health records and functional assessment
Nursing Homes	Nursing homes support individual's end-of-life healthcare support needed.	Play a role in building capability of centers' staff to support palliative healthcare needs of individual; coordinate with centers to identify where individual may be best placed; coordinate data-sharing of health
Polyclinics	As with the general public, PWDs may book an appointment and enjoy government subsidies at polyclinics.	While some GPs conduct regular visits to centers/nursing homes, they cannot dispense medication subsidised by government. Support qualified GPs with delivery of medication prescribed by GPs

Potential Next Steps

- WG can appoint a lead agency and align on interest to coordinate services and track milestones within a geographical region. This could also be led by a government agency or SG Enable.
- Map out existing services, group services by geographic area and identify service gaps (PWD demographic and type of services) by geography.
- Reach out to disability and healthcare services within geographical region.
- Form communities of care through (a) sharing of knowledge and expertise to support inter-agency capability building; and (b) coordinated referral systems.

Recommendation #4: Enhance place-based care with Communities of Care model (2/2)

Goal: (b) Support progression and transitions between and within services

Standardised Learning Framework with Progression Milestones

Example: Development of relevant work skills for young healthy adult

A job plan is developed based on skills for specific jobs based on functional assessment records, motivation and job-search capacities. Individuals have the opportunity to progress from one center to another as he/she gain skills.

Assigned to learn specific work task within DACs	Assigned for a training programme within sheltered employment	Secure supported employment in production units
Training on a specific work task **Milestones**: Learn basic work skills, perform work task well, ability to exhibit positive work habits	Technical work training with provision of employment wages; with increment as PWDs learn and execute more complex tasks **Milestones:** Set schedule for work, learn specific subtasks, ability to analyse work tasks, and develop appropriate methods[13]	Supported employment with increment in wages based on productivity **Milestones:** Achieve some independence in conducting work activities, increase in efficiency and/or effectiveness

Adapted for SG based on case studies of New Life Psychiatric Rehabilitation Association from Hong Kong and Eden House from Korea

Beyond employment skills, progression milestones can also be developed to prepare PWDs for voluntary activities; pre-work or independent living within the community.

Potential Next Steps

- Based on analysis of data in Component A, identify varied employment opportunities across each centre (e.g. centre which focuses on F&B, another on logistics etc).
- Develop progression pathways for each of the employment opportunities in consultation with industry professionals.
- WG may coordinate to provide training and services along different components of the progression pathway or offering different employment opportunities.

[13] Source: Perry, Debra A. International Labour Organisation. "Moving Forward Toward Decent Work for People with Disabilities: Examples of Good Practices in Vocational Training and Employment from Asia and the Pacific." 2003.

Recommendation #5: Pilot A New Model of Inclusive Independent Living

Goal: Provide tailored independent living options to PWDs while still allowing them to live in communities and receive personalised care. For example, existing Community Care Apartments for seniors can be modified to support independent living in the community.

Current State:
For older adults with new health needs, current residential options are limited to (a) living with family, (b) in an adult disability home, or (c) in a nursing home. However, with longer life expectancies, the number of aging PWDs with multimorbidities[18] will increase, and there is a need to ensure sufficient residential, health and social care support for them.

- Subsidies and grants available for those living with their family/caregivers to encourage living and aging in place.
- Adult disability homes are built to cope with specific needs of PWDs, and to support long-term care.

Key principles/components from case studies:

- Development of an inclusive town with residences (e.g. Center for Discovery Healthy Community Model[19])
- Group/single residential apartments with both private and communal space (e.g. First Place AZ[20], Arc Jacksonville Village[21])
- Provision of skills support (community living, independent living) by specialised staff, catered for individuals with work, with volunteering activities, and without work (e.g. First Place AZ).
- Community manager to provide access to community support and recreational services (e.g. Arc Jacksonville Village).

Potential next steps

- Engage local community to identify existing support services available and additional wraparound support needed for independent living.
- WG may propose modifications of existing Community Care Apartments (CCAs) to HDB.
- Based on existing services CCAs provide[22], identify (a) profile of PWD population that may adapt to CCAs (for example, older adults with ID and/or ASD); and (b) additional services that target group may require
- Propose ways in which government agencies may potentially modify CCAs. For example:
    - Support frailty management and multimorbidities through the development of an interdisciplinary support team[22], provision of therapeutic and nursing care services
    - Provide continuous light-touch skills training needed to maintain independent living in a nearby DAC
    - Engage with neighbourhood to provide community support

[18] Source: Hermans et al. "Multimorbidity in older adults with intellectual disabilities". 2014. In Sweden, prevalence of multimorbidities for those aged 50 and older is 72-80%.
[19] Source: Center for Discovery Healthy Community Model. "Small Town, Big Ideas". [20] Source: First Place AZ. "First Place Apartments". [21] Source: The Arc Jacksonville. "The Arc Jacksonville Village".
[22] Source: MOH. "About Atlas Care". Existing CCAs provide preventative healthcare services (emergency response, active aging, vital signs monitoring), custodial care (support with ADLs), social participation and housekeeping support

Recommendation #6: Support Financial Planning and Literacy for PWDs

Goal: Provide banking, financial and insurance products which are specifically adapted to the needs of PWDs towards obtaining additional financial independence and inclusion[15].

Potential strategy:

- **Long-term financial planning service based on needs and goals of families:** Support caregivers in uptake of existing services such as Special Needs Trust and tailored insurance schemes for ASD and Down Syndrome by NTUC; and support the development of more tailored products.
- **Basic money management skills to support PWDs' daily independent living where possible:** Build skills and give PWDs autonomy in spending through applications such as SpendABLE. The application allows PWD to have some autonomy in spending while allowing for customised spending controls and sending transaction receipts instantaneously to caregivers.

Example of young healthy adult accessing financial products:

- PWD works with a coordinator to develop a **financial plan** along with caregiver to ensure that PWDs long-term needs will be met.
- Based on financial plan and PWD's needs, coordinator may refer PWD to **relevant financial products**.
- As part of money management curriculum, PWD is exposed to **assistive technologies** to support digital payment services.

Potential Next Steps:

- Identify number of PWDs and families in Singapore who require financial assistance and better understand needs and financial literacy levels.
- Engage with a financial institution to brainstorm and create a proof-of-concept financial product tailored to PWD needs; with WG providing professional expertise on PWD support needs.
- If successful, build out a suite of financial planning products that can be used by PwID/ASD with higher support needs.

Recommendation #7: Enhance transitions and transparency through data-led frameworks

Goal: A WG can focus on building additional person-centric approaches into care systems which are based on data and best practices. The WG could undertake two key tasks:

Develop Data Frameworks…

For service planning

Example: Data Request

Without an exhaustive data request which collects categories of data to be analysed, it is hard to coordinate and optimise the provision of services.

Number of PWDs in Singapore based on:

- Disability type;
- Age;
- Household income;
- Educational background (school, year of graduation);
- Health needs;
- Support utilised (e.g., enrollment in centers, job support, subsidies); and
- Employment history.

To understand health and social needs

Example: Sharing of NEHR, SPED school data and CAF on a shared platform

Taking reference from the SSNet system for low-income families, NEHR, SPED school data, and CAF scores can be shared on a common platform, to be assessed by approved primary service provider supporting individual.

Potential Next Steps

- Develop a standardised data collection framework with which the WG aligns.
- Each individual WG member utilises data collection framework to collect data within centers.
- Relevant government agency will analyse and share aggregated data with WG members.
- Where possible, work with government agencies to have access to specific client data.
- With an independent evaluator, analyse data within WG to identify potential demographic trends.
- Engage government agencies to share data, ground experience and knowledge.

Recommendation #8: Introduce personal care plans and support for PWDs and caregivers to implement such plans (1/2)

Goal: Centralised government agency can expand person-centric care by developing case management and service coordination framework to be implemented through ESH with a dedicated care planner; creating more tailored plans which make the most use of funding available, aligned to the already-developed data and progression frameworks.

	Experiences in other countries	Learning points for Singapore's context
Benefits[14]	Empowers PWDs to take charge of care decisions; fewer unmet needs for help; increased satisfaction of services; improvement in self-esteem and psychological well-being.	A personalised care plan can be developed to empower PWDs and caregivers to take charge of care decisions.
Limitations[15]	If the onus is on caregivers to manage funding to implement personal care plans, there may be increased barriers to access services needed; higher monthly costs and annual expenditures.	It is crucial to align and train facilitators and service providers to support the development of individualised plans.

Illustrative process of an adult who develops new health needs:

Conduct annual health screening → Development/ review of personalised care plan → Service provider support PWD & caregiver to navigate and access the services & funding they need → Service provider supports case management and access to healthcare and social services needed → Service provider supports outcomes measurement → (back to Conduct annual health screening)

[14] Source: Robinson et al. "The Effects and Costs of Personalised Budgets for People with Disabilities: A Systematic Review. 2022.
[15] Source: Robertson et al. "Reported Barriers to the Implementation of Person-Centred Plannign for People with Intellectual Disabilities in the UK". 2007.

Recommendation #8: Introduce personal care plans and support for PWDs and caregivers to implement such plans (2/2)

Service providers can consider piloting a personalised care plan and support for PWDs and caregivers to implement the plan and presenting the outcomes to relevant government agencies.

Potential Next Steps

- Designate a lead agency to test approach with trial group
- Develop case management and service coordination framework, for example:
    - Have a dedicated care planner that can work with PWD and their family to maximise use of existing services, subsidies and grants. Beyond supporting PWD's activities for daily living, it can also include recreation (e.g., sports), social activities, volunteering opportunities within the community.
    - Identify outcomes and develop evaluation plan.
    - PWDs and their caregivers can tap on the list of services administered by SG Enable.
- Implement framework in a particular locale and monitor outcomes.
- Evaluate framework according to evaluation plan.
- Document the process and outcomes to present to MSF and other government agencies.

Recommendation #9: Develop funding models which incentivise improved outcomes for PWDs (1/2)

Goal: Better allocating funding to incentivise the achievement of outcomes that drive well-being and independent living for PWDs

Example: Young healthy adult

Existing funding structure:

1. MSF developed Client Assessment Form (CAF) to assess support required in adult disability services.
2. CAF has 3 tiers with a different funding amount allocated based on level of support required.
3. Funding is provided to each center based on number of clients within a center that falls under each CAF tier.
4. Where a client shifts in CAF tiering, the funding allocated will change accordingly.

Potential funding structure:

1. Develop a highly granular functional assessment form that enables tracking across different domains.
2. Aligned with existing funding structure, funding is provided based on tiering and number of clients in each tier.
3. When a client progresses in functional capabilities, a bonus incentive will be provided to the service provider.
4. Thereafter, funding allocated will change according to shifts in tiering.

Outcomes-based incentive payments may also be trialled on a specific issue area (e.g. progression within a care-based facility (DAC)).

Recommendation #9: Develop funding models which incentivise improved outcomes for PWDs (2/2)

WG may identify a lead agency to trial outcomes-based incentive payments on a specific issue area through a small pilot.

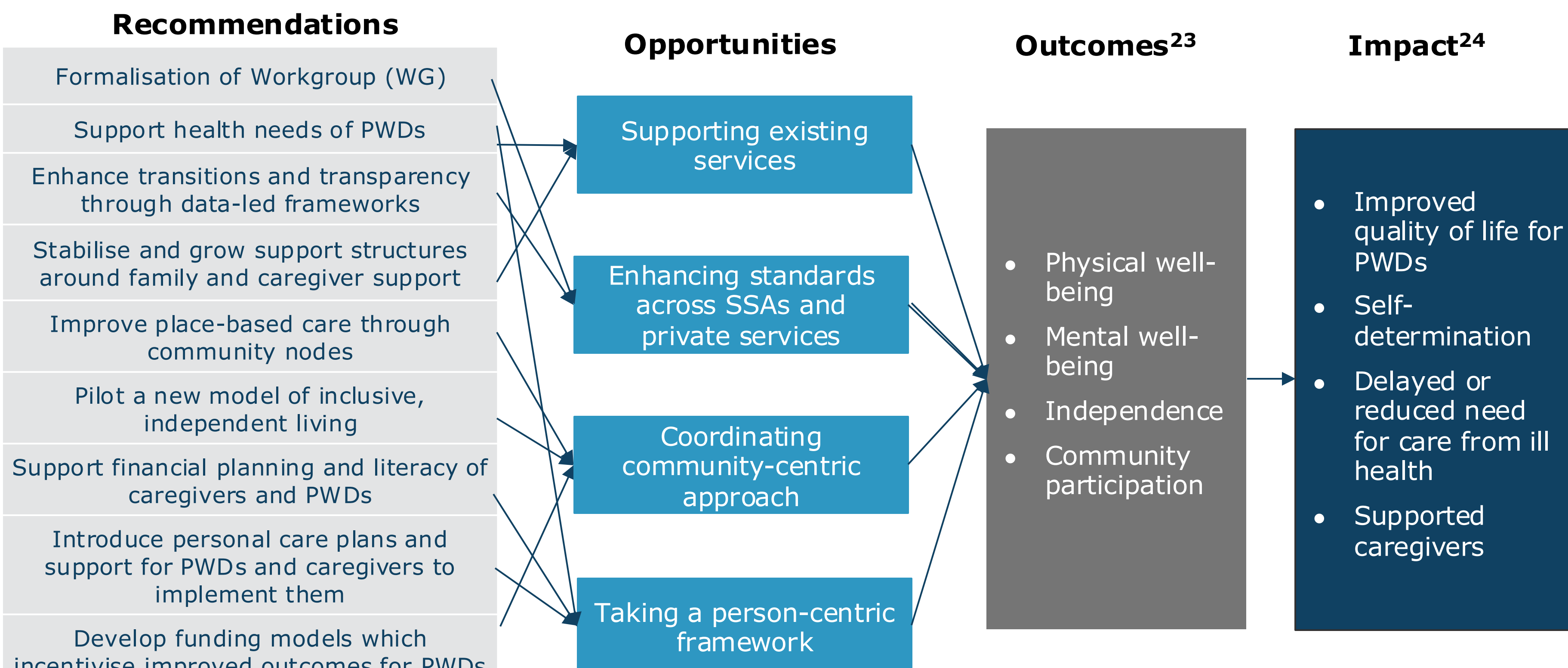
Potential Next Steps	Identify emerging issue area and needs	Design programme according to PWD profile	Structure funding mechanism	Implement, monitor and evaluate
Example (Care-based services within DAC)	- Identify potential needs using a validated scale (such as Supports Intensity Scale - Adult Version[23]) that assesses support required for individuals to live independently in the community. - Establish baseline data	- Using validated scales as a foundation, develop progression framework for PWDs of a specific profile - Develop programme to support the development of independent living and community living skills	- Based on progression framework developed, outcomes incentives are given when PWDs achieve progression milestones. - Identify funders who may be interested to fund for such outcomes.	- Implement programme with outcomes incentives. - Monitor and evaluate effectiveness of programme. - Monitor and evaluate effectiveness of funding mechanism (pricing of incentive payments) and outcomes achieved.

23 Note: Supports Intensity Scale - Adult Version assess needs across three main domains:

1. Exceptional medical and behavioural support: Support needed due to medical condition and challenging behaviour
2. Support needs across independent living, community living, learning, health and safety, as well as social domains
3. Supplemental protection and advocacy

However, this is a paid assessment and TSCC has no access to the full scale.

We hope that these recommendations may contribute towards building an ecosystem of support, enhancing quality of life of PWDs in Singapore



[23] Source: Burke et al. "Quality of Life Outcomes in a Community Cohort of Adults With an Intellectual Disability Using the Personal Outcome Scale". 2022.
[24] Source: The Royal College of Psychiatrists. "An Intellectual Disability Outcomes Framework for improving the quality of services for people with intellectual disability". 2015.

As next steps, the Coalition can consider working with relevant government agencies to pilot initiatives

#	Potential Pilots
1	Pilot residential or community-based respite options
2	Trial independent living in existing community living facilities
3	Utilise existing eldercare services to support PWDs in the area
4	Pilot outcomes-based incentive model with progression milestones
5	Pilot caregiver training curriculum

Appendix A
Additional Information Relating to Case Studies

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International Case Study Scores: NHS Service Model, UK

Description:

Person-centered and family centered service model with 9 key principles:
1. A good and meaningful life through inclusion in activities, education, skills training and employment, relationships and support
2. Support to family and professional caregivers through training, respite care, alternative short-term accommodation
3. Choice of where to live and who to live with through choice of housing, tenure security and strategic housing planning
4. Provision of mainstream health services such as annual health checks, health actions plans, liaison workers to facilitate access, and making adjustments for PWDs where needed
5. Provision of specialised multi-disciplinary health and social care support in the community through interagency collaboration and coordination with mainstream services, and provision of specialised care.
6.Support integration of healthcare and community services; discharge planning; review of care and treatment plan; clear admission criteria suitable for PWD
7. Person-centric and family-centric support

Overall Score: 16/18

Life Facets Addressed: 3/3

Innovation & Uniqueness: 2/3

Ease of Implementation: 2/3

Availability of Verified Data: 3/3

Programme Effectiveness: 3/3

Applicability to Singapore: 3/3

International Case Study Scores: New Directions: Adult Day Services, Ireland

Description:

New Directions aim to shift adult day services from provider-led programmes to individualised, user-led supports. Adults would have access to flexible and outcome-driven supports that meet their needs and aspirations. Supports in 12 different domains should be available to adult with disability:

1. Support for making choices and plans
2. Support for making transitions and progression
3. Support for inclusion in one's local community
4. Support for accessing education and formal learning
5. Support for maximising independence
6. Support for personal and social development
7. Support for health and wellbeing
8. Support for accessing bridging programmes to vocational training
9. Support for accessing vocational training and work opportunities
10. Support for personal expression and creativity
11. Support for having meaningful social roles
12. Support for influencing service policy and practice

Overall Score: 16/18

Life Facets Addressed: 3/3

Innovation & Uniqueness: 2/3

Ease of Implementation: 2/3

Availability of Verified Data: 3/3

Programme Effectiveness: 3/3

Applicability to Singapore: 3/3

International Case Study Scores: Adult Comprehensive Health Assessment Programme (CHAP), Australia

Description:

This is a two part questionnaire designed to be taken yearly. The first part of the questionnaire creates a comprehensive health history to be completed by family/caregiver and/or PWD. The GP completes the second part of the questionnaire by filling up commonly missed or poorly managed health conditions to create an agreed health action plan. This is currently used by Australia's health services, NGOs, disability service providers.

Overall Score: 15/18

Life Facets Addressed: 1/3

Innovation & Uniqueness: 2/3

Ease of Implementation: 3/3

Availability of Verified Data: 3/3

Programme Effectiveness: 3/3

Applicability to Singapore: 3/3

International Case Study Scores: Community Living British Columbia, Canada

Description:

CLBC is a crown agency appointed by the government to support PWDs in British Columbia. The organisation supports individuals through

1. Integrated Services Support Team with staff from social welfare ministry, health ministry and education ministry to review the services an individual is receiving to ensure that they receive appropriate level of services
2. Inclusive Housing Initiative to provide continuum of housing support models from staffed residential homes to shared living arrangements, to support in homes directly owned or rented by individuals and/or their families.
3. Strategy for Aging which involves intentional check in with PWDs age 55 to 63 to ensure preparation is incorporated into person-centered plans, development of guide to support caregivers in developing transition plan for PWDs.

Overall Score: 15/18

Life Facets Addressed: 3/3

Innovation & Uniqueness: 3/3

Ease of Implementation: 2/3

Availability of Verified Data: 3/3

Programme Effectiveness: 2/3

Applicability to Singapore: 2/3

International Case Study Scores: The South Lanarkshire Framework for Supporting Pupils with Severe and Profound Learning Needs, UK (Scotland)

Description:

South Lanarkshire Council developed a curriculum of excellence to support students and young persons with severe and profound learning needs. The curriculum framework includes:
1. Person-centered approach in supporting learning by considering the interaction between disabilities and health issues; identifying the needs, interests and motivators of each individual; and developing individualised and measurable assessments and targets.
2. Developing communication, cognition, self-help and independence, as well as physical skills of individuals

Overall Score: 14/18

Life Facets Addressed: 2/3

Innovation & Uniqueness: 2/3

Ease of Implementation: 2/3

Availability of Verified Data: 3/3

Programme Effectiveness: 2/3

Applicability to Singapore: 3/3

International Case Study Scores: Person-Centered Planning, Ireland

Description:

There is a guide produced for the development of a consistent person-centered plan across disability services in Ireland. Service providers are to self-evaluate their service if it is in line with the framework. It is recommended that the person-centered plan comprises of 4 key stages:

1. Preparing for the person-centred plan
2. Designing the person-centred plan
3. Implementing the person-centred plan
4. Evaluating the person-centred plan

The key principles that underpin the person-centred plans are:

1. Person-centered
2. Based on what PWDs want to change in their own lives and what they want moving into the future
3. Should include actionable strategies and activities to support PWDs in attaining their goals
4. Continually reviewed throughout the process
5. Address everyday life choices, independence, milestones

Overall Score: 14/18

Life Facets Addressed: 2/3

Innovation & Uniqueness: 1/3

Ease of Implementation: 2/3

Availability of Verified Data: 3/3

Programme Effectiveness: 3/3

Applicability to Singapore: 3/3

International Case Study Scores: Adult Autism Housing Options, USA

Description:

The Interagency Autism Coordinating Committee (part of the US Department of Health and Human Services) outlined examples of potential housing support for individuals with ASD. These examples are supported by private organisations, non-profits, or family-owned.
1. Intentional Community Models: First Place AZ is a specialised apartment complex to foster community and independence through a curriculum with practical skills and practical experience.
2. Apartment/Dispersed Community and Service Delivery Models: The Arc Jacksonville Village supports individuals with IDD through non-structured, independence-focused living program. Residents live in their own homes, and may freely access a wider community with community center, game and fitness room, activity and meeting rooms to enhance independent living skills and social relationships.
3. Personalised Adult Services and Housing Navigation: Shared Support Maryland helps individuals gain control and responsibility over housing by providing people with IDD tools and resources needed to manage their own housing and community settings.

Other models include group homes (located in residential areas) where several people with disabilities live alongside rotating support staff. At least 67 'consumer-controlled settings' exist across 23 states which are of a similar model.

Overall Score: 14/18

Life Facets Addressed: 2/3

Innovation & Uniqueness: 3/3

Ease of Implementation: 2/3

Availability of Verified Data: 3/3

Programme Effectiveness: 2/3

Applicability to Singapore: 2/3

International Case Study Scores: Personal Budgets and Direct Payments, UK, South Korea, Australia

Description:

Personal budgets and direct payments for PWD and carer
1. Development of a needs assessment to work out care and support needed, cost and affordability
2. Based on needs assessment, a personal budget would be developed to pay for any social care and support
3. PWD or carer has a choice for local council to manage personal budget, pay money directly to care organisations, or pay money directly to PWD or carer

Overall Score: 13/18

Life Facets Addressed: 2/3

Innovation & Uniqueness: 3/3

Ease of Implementation: 1/3

Availability of Verified Data: 3/3

Programme Effectiveness: 2/3

Applicability to Singapore: 2/3

*Further info: Korea; Australia

Appendix B

Additional Information Relating to Opportunities

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Example of standardised programme framework with progressive milestones

With reference to The South Lanarkshire Framework for Supporting Pupils with Severe and Profound Learning Needs[25], the development of a framework may include the following components:

1. Domains: communication, cognition, self-help and independence, physical skills.
2. Consider the complex interaction between health needs and disability on learning.
3. Development of individualised assessment, target setting (task-based or process-based targets).
4. Development of learning approach based on needs, interests and motivators of each individual.

To adapt it to local context, it is important to:

1. Ensure that the framework builds upon existing SPED curriculum offered in school.
2. Train and develop staff competency to carry out programmes.

[25] Source: South Lanarkshire Council. "The South Lanarkshire Framework for Supporting Pupils with Severe and Profound Learning Needs". 2015.

Curriculum for Excellence Experiences and outcomes	Learning outcomes
Daily living skills	
I have experimented with imaginative ways such as modelling and drawing, to represent the world around me, the journeys I make and the different ways I can travel. SOC 0-09a Within my everyday experiences and play, I make choices about where I work, how I work and who I work with. SOC 0-18a I am developing problem-solving strategies, navigation and co-ordination skills, as I play and learn with electronic games, remote control or programmable toys. TCH 0-09a / TCH 1-09a When I am out in community, I know and can demonstrate how to travel safely. HWB 0-18a / HWB 1-18a / HWB 2-18a / HWB 3-18a / HWB 4-18a In real-life settings and imaginary play, I explore how local shops and services provide us with what we need in our daily lives. SOC 0-20a I understand positive things about friendships and relationships but when something worries or upsets me I know who I should talk to. HWB 0-44b / HWB 1-44b	• Am aware of and demonstrate appropriate behaviour when riding in a car or bus (e.g. attempt to put seat belt on; keep it on; remain seated) • Demonstrate understanding of function of money • Can choose appropriate item in shop for activity (e.g. choose bread for lunch) • Can buy item in shop with adult support • Can ask for help in a shop or out in the community • Can buy item in shop unaided when given correct money • Can attempt to count out coins for item in shop • Start games on computer iPad when it has been switched on • Demonstrate understanding of how to play games activities on computer/ iPad (e.g. can swipe screen/ click at the end of a game; can click on a new game; can click or press incorrect responses) • Can switch iPad or computer on and off • Can find correct game or activity on machine • Can name days of the week • Say current day of the week when asked • Demonstrate understanding of the correct time of the day (e.g. morning/ after lunch/ break) • Stay on pavement when out in the community

Figure 2: Example of learning outcomes of a component of daily living skills based on The South Lanarkshire Framework.

Other alternative frameworks for consideration

Name of scale	Description
Scales of Independent Behaviour Revised	Developed in 1996, this scale measures functional independence and adaptive functioning across various settings, for individuals aged 3 to 80 years old.
Supports Intensity Scale - Adult Version (SIS-A)	Developed by the American Association on Intellectual and Developmental Disabilities, it is a standardised assessment tool that assess support required for individuals with intellectual and developmental disabilities for them to be independent in community settings.

Appendix C

Outcomes and Indicators to Review Disability Policies

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While there are limited published evaluation studies conducted on disability services, existing studies provide a view on potential outcomes and measurement tools

Countries are mixed when it comes to qualitative and quantitative indicators, providing opportunities for a more tailored solution in SG.

Countries that conducted a review of their disability policies tend to do so qualitatively

We outline a high-level view of some disability policy reviews on programmes to support education, health and aging in PWDs.

Country	Description
Australia	Evaluation of a disability support program to increase access of higher education for students with disability
Scotland	Service provision in Scotland for people with an intellectual disability who have, or are at risk of developing, dementia
New Zealand	Review of health and disability services, with a focus on costs, accessibility and utilisation of services
UK	Evaluation of a series of programmes proposed as part of a policy reform
Ireland	Value for Money and Policy Review of the Disability Services Program funded under a particular health act in Ireland

When quantitative tools are used, different countries focused on different outcomes, and employed different tools to measure outcomes

We provided a view of some quantitative tools used on a policy level.

Outcomes	Description	Ireland	UK
Individual outcomes	Evaluate individual progress	Quality of Life • National Core Indicators (NCI) instrument (21% higher Life Decisions Scale score; 27% higher Satisfaction with Community Inclusion Scale; 1.5x odds that self-reported health is excellent or very good; and 3.6x odds that services help person have a good life compared to those who did not access services) • Other indicators used: Generic patient-reported outcome measures (PROMS) (including WHOQOL-BREF; EQ-5D; and SF-36); ASCOT Social Care Related Quality of Life Toolkit (UK)	Quality of Life • Measured qualitatively Employment • Using difference-in-difference estimates to compare Control vs Treatment Group; Treatment Group is 2.7 percentage points more likely to flow out of incapacity benefit at 6 months
Quality of Service Provision	Evaluate quality of support provided by services	Quality of Life (on service level) • Quality of Life Impact of Services (QOLIS) tool Service Quality • Buntinx Quality 'Qube'	Control over services: • Comparing comparison and treatment group, there is a difference of 23 percentage points of caregivers that reported an improvement in being kept informed of decisions affecting children/young person; a difference of 20 percentage points in families that experience improvement in personalisation.

We have also identified some case studies with high-level results that could be used as benchmarks

Outcome	Description	Result
Quality of Life	Developing a measure for quality of life - multiple disabilities in Netherlands and Belgium Outcomes measured • Quality of life - profound multiple disabilities (QOL-PMD)	Mean QOL-PMD total score for the total group was 69.33. However, no standardisation has been carried out to identify benchmarks.
Physical health	Evaluation of a health promotion program for PWDs in USA Outcomes measured • Health care costs measured using frequency of physician visits, emergency room visits, outpatient surgeries and hospital days • Unhealthy days measured using two items of the Behavior Risk Factor Surveillance System, and • Secondary conditions measured using a brief version of secondary condition surveillance instrument	Used Odds Ratio to compare Control vs Treatment Group • Healthcare costs: 1.53 • Unhealthy days: 1.72 • Secondary conditions: 2.07
	Perceived health of adults with intellectual disability in Norway Outcomes measured: • Perceived physical health measured using the question,'How is your health in general?'	• 70% perceived health to be good; compared to 88% in Ireland, 78% in Australia and 48% in Scotland
Mental health	Evaluation of a positive behaviour support programme for individuals with developmental disabilities in Ireland Outcomes measured • Mental health using Mini PAS-ADD • Quality of life using Quality of Life - Questionnaire (QOL-Q) • Costs of service	• 4 of 5 individuals had reduction in mental health problems • 3 of 5 individuals had significant improvement in quality of life • Total reduction in costs of service for 5 individuals from £418,000 to £300,000

Moreover, the Coalition can consider these tools to measure individual client's outcomes according to the Theory of Change

Many of these tools have not been used in evaluation setting, but are developed as potential scales to measure relevant outcomes.

Outcomes	Potential measurement tools
Quality of Life	Life Satisfaction Matrix
Physical well-being	POMONA-15 (P15) health indicators Perceived health status
Mental well-being	Clinical Outcomes in Routine Evaluation - Learning Disabilities
Independence	Scales of Independent Behaviour Revised
	Supports Intensity Scale - Adult Version (SIS-A)
Community participation	Guernsey community participation and leisure assessment (GCPLA)
Caregiver stress	Zarit Burden Interview

Thank you!

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