Ministry of Social Development

Services to Adults with Developmental Disabilities (STADD)

Navigator Model

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Introduction

The need for improved delivery of services and supports for individuals with developmental disabilities and their families was clearly articulated both in the findings and recommendations of the *Deputy Ministers' Review*: *Improving Services to People with Developmental Disabilities* (December 2011). [1]

A number of the priorities for action point towards the need for more focus on coordinating activities between government agencies in order to better focus on individual and family needs:

- moving towards a 'one government' approach that focuses on transparency, consistency and ease of access to and movement across systems
- improving supports during transitions across the lifespan with particular attention to that between youth and adulthood
- initiating planning well before any life transition
- introducing a more streamlined approach to assessment processes and the use and storage of relevant assessment materials
- engaging families in the "conversation" about service delivery enhancements and innovation.

Using these priorities as a starting point, the project organized extensive engagement with individuals, families, advocates, professional groups, government staff, service providers and community representatives that, among other outcomes, confirmed support for a navigator-like function. Specifically, people spoke of a dedicated position who could navigate within and between service systems, act as a fixed point of contact for individuals and families, integrate essential elements of assessment materials, initiate and support planning, develop linkages across various government organizations, ensure accountability and work with communities and service providers to support a focus on individual needs as well as opportunities and innovation.

A high-level environmental scan of similar positions in other parts of the world demonstrated that navigators or their equivalents play both unique and similar roles depending on the jurisdiction, age cohorts, service system mandates and governance framework. Aspects of the navigator role as a support to individuals with developmental disabilities are incorporated into the service design of every jurisdiction reviewed. Facilitators, key workers, support brokers, and social workers all share many common attributes and responsibilities, although responsibilities and intensity of involvement vary.

It was also important to identify different approaches to and models of a navigator position and targeted research was carried out with respect to BC, other parts of Canada, the USA, the United Kingdom and Western Australia.

In addition to an overview of what information was gathered from research and community engagement, this paper will provide an outline of what a navigator's specific support of individuals in an improved service delivery system might entail, why a navigator position is a being considered, how the position could be implemented, and where and what specific accountabilities might improve chances for successful implementation. This paper

[1] http://www.sd.gov.bc.ca/pwd/docs/Improving_Services_to_People_with_Developmental_Disabilities_Report_FINAL.pdf

should be read in conjunction with the report *STADD: Integrated Service Delivery Model* which provides additional detail on the potential role of a navigator within the larger integrated service delivery model.

An Overview of Other Jurisdictions

Western Australia

The Local Area Coordination (LAC) concept was first developed by Eddie Bartnik in Western Australia in 1988 and has been supporting West Australians with disabilities and their families since that time. Support is provided to children and adults with physical, sensory, neurological, cognitive, and/or intellectual disability.

A Local Area Coordinator supports people with disabilities to live in welcoming and supportive communities, coordinates access to accurate and timely information from a variety of sources, provides a single, local, accessible point of contact, and helps to plan, select and receive needed supports and services. Local Area Coordinators are community-based and assist people with a disability to plan, organize, and access supports and services which enhance their participation in and contribution to their local community. They rely on community partnerships rather than professional interventions. The emphasis is on building networks and creating opportunities within community by "thinking local". Much of the expertise and skill identified as essential to the effectiveness of a LAC are similar to those of traditional community development workers.

To quote from Eddie Bartnik:

> *"A generalist or eclectic approach, insofar as it contains elements of case management, personal advocacy, family support, community development and direct consumer funding. The aim of LAC is to make disability services and supports more personal, local and accountable, and to support local people with disabilities and their families in their local communities."*

The LAC model advocates continuity from "cradle to grave" with more intensive, hands on involvement during life transitions. There is no separate transition role.

Individual to staff ratios are 1:50/60 but can increase or decrease as required as individuals achieve greater independence.

United Kingdom (UK)

The navigator-like role implemented in parts of the UK provides a single point of contact for a youth and their families and is responsible for coordination of services and information, design of care plans, assistance in developing supportive relationships, as well as emotional and practical support to keep young people and their families stable.

There are two primary models in place in the UK:

- The Local Area Coordinator (LAC) closely follows the key design, values and service approaches of Western Australia and is supported by an Inclusive Neighbourhoods initiative. The LAC provides a single, local, accessible point of contact, builds relationships with people, families, and local community, assists people to access, navigate and control supports and services, and promotes self - advocacy. Initial findings from a review completed in Scotland suggest that the LAC function supported better access to mainstream resources, enhanced family capacity, individual independence and self-sufficiency, improved the

development of informal support networks as well as access to alternative funding and reduced crisis support and out-of home placement.

- The Key Worker model is supported by the Care Co-ordination Network UK (CCNUK). Key working/care co-ordination is a service, involving two or more agencies that provide children or young people with disabilities and their families with a system where services from different agencies are co-ordinated by a key worker.

A Key Worker model has been implemented in parts of England, Wales, and Scotland to deliver supports that are family-focused and well- coordinated. Services are based on assessed needs which promote social inclusion and a key worker is the integrating link between the family and the various services. A key worker oversees and manages the delivery of services from all agencies involved in the care and support of the family.

Wales has also established a transition key worker position that supports youth through transition into adulthood. This worker concentrates on transition planning, needs assessment, and locating services and supports for youth aged 16 – 25 years. Their experience indicates that workload decreases after age 25 (except for significant life changes).

Individual to staff ratios in England vary depending on specific responsibilities 1: 12-35 cases while those in Wales average 1:45 reflecting intensity of involvement with families.

United States

Starting in the early 1990s, many American states began transitioning from case managers /social workers to a Support Brokers system. (Comparisons with the American system are challenging particularly given state vs. federal responsibilities related to medical waivers, states' rights, etc.)

Support Brokers support self-directed individuals by assisting with planning, ensuring they are informed of choices in self-directed services including funding options, promoting self-advocacy, communicating with individuals on a regular basis, sharing knowledge of community resources, assisting with employment requirements, supporting team building, and managing conflict resolution.

The emphasis of this model is on self-directed services and supports individuals and families in understanding their choices and translating them into individualized services and budgets whether personal, state or federally funded. Individuals and their families are able to choose their support broker and brokers can be state employees or independent, i.e., working with private agencies but are always independent of direct service providers.

Individuals who are not using self-directed services can be supported by case managers. Support brokers and case managers may assume similar functions; the primary difference is that a Support Broker has more hands-on involvement, meets with individuals more frequently, and facilitates community access and inclusion.

A support broker's workload is approximately 1: 25-30; a case manager's is 1:40-45

Dane County, Wisconsin has a transition coordinator role to assist with the transition from school system to employment. The transition period generally begins at age 20-21 years as the school system supports

individuals until age 22. Transition coordinator helps with planning, paper work, gather information for eligibility, public benefits, etc.

The workload average is 1:35.

Canada

In Canada, services and support systems for people with developmental disabilities follow different models based on the province of residence.

Nova Scotia

The Services for Persons with Disabilities (SPD) Program provides support to children, youth, and adults with disabilities through residential and at-home support programs. The program promotes an individual's independence, self-reliance, security, and social inclusion. A Care Coordinator role helps with assessment, finds appropriate housing, and coordinates the initial services until a person is placed in residential setting. Once a person is placed in residential setting, they are supported by a key worker.

Transition support in Nova Scotia is not integrated and usually begins close to age 19. There is no specific role to support transitions although a care coordinator will provide referral services to different educational or vocational / employment programs. Lack of timely, relevant information and direct family support are challenges and Nova Scotia is finding that involvement after age 24 is not reduced as individuals require ongoing support.

Quebec

The CRDITED de la Montérégie-Est is a public institution in the health and social service network. It offers specialized adjustment and rehabilitation services to persons with an intellectual impairment or pervasive developmental disorder, as well as support and services for an individual's family and friends. The services focus on the development of autonomy, integration and social participation, and reducing the impact of person's disability on their living situation.

An 'educator' works with members of a clinical team to support an individual's rehabilitation within the established programs. They participate in the clinical process: needs assessment, implementation of an intervention plan and outcomes measurement.

Ontario

Developmental Services Ontario (DSO) has been transforming its services for people with developmental disabilities since 2004. The transformation effort began with policy work as well as new legislation: the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act (2008)* that ensures quality services and supports are offered to people in their own communities based on consistent application processes and clear provincially established eligibility criteria.

A key distinction in Ontario is that much of the responsibility for planning, service identification and ongoing support is delegated to nine agencies that are funded by the Ontario Ministry of Community and Social Services. Nine large agencies receive transfer payments from government and are contracted to deliver various functions. They provide support and services and there is periodic re-assessment for people who are receiving services or are on a waiting list to receive services. Roles include assessor, service navigator, and intake role. These roles may be combined depending on the agency.

Saskatchewan

In Saskatchewan people with intellectual disabilities are supported by Community Living Service Delivery (CLSD). Programs and services are delivered through a system of community-based social, residential, vocational and early childhood agencies. The CLSD is one member of a three-way partnership agreement among the Saskatchewan Association of Rehabilitation Centres and the Saskatchewan Association for Community Living. CLSD employs Community Intervention Workers and Community Service Workers, both of which are provincial employees.

Saskatchewan has identified two key roles: a Community Intervention Worker and Community Service Worker. A Community Intervention Worker develops, implements, and coordinates specialized supports for individuals with complex needs and a Community Service Worker helps with assessment, individual program planning, counseling, referrals, crisis intervention, and consults with community-based organizations.

Community Intervention Worker

Develops, implements, and coordinates specialized supports for individuals with complex needs and service providers who support these individuals. The role of this position combines three critical functions: case coordination, direct therapeutic intervention and development of knowledge and capacity in community service providers.

A Community Intervention Worker's average workload is 1: 7-10.

Community Service Worker

Supports and empowers the community to assist individuals with intellectual disabilities to live more independently and participate more fully in communities. This includes assessment, individual program planning, counseling of individuals and/or families, referrals, crisis intervention as well as consulting with community-based organizations.

A Community Service Worker's average workload is 1:70-110.

There is no distinct transition worker role in Saskatchewan.

Alberta

Alberta Human Services, Persons with Developmental Disabilities Program (PDD) supports adults with developmental disabilities to participate fully in community life and to be as independent as possible. The PDD program is currently undergoing substantial change. One of the key initiatives is the implementation of a "one program/one organization approach" that includes the development of a consistent service delivery model with common processes across Alberta.

There are two primary models of support in Alberta, both of which assist individuals, families and guardians to identify and obtain needed services and supports:

Transition Service Coordinator

Transition Service Coordinator supports clients requiring transitional planning services defined as "a collaborative process of working with an individual / client who has complex or multiple needs and is transitioning through life stages and/or circumstances to develop and implement a plan to seamlessly

connect the client with appropriate services and supports during the period of transition." This role is currently under development.

A distinct Transition Coordinator role based in children's services and being tested in the Calgary region currently has a workload of 1:60.

Service Coordinator

The primary purpose of service coordinator is to assist individuals, families and guardians to identify and obtain needed services to enhance their well being and assist in maximizing their independence and inclusion in the community. The core work includes the functions of registration, eligibility determination, assessment, service design and planning and monitoring outcomes. The service coordinator also liaises with agencies, service providers, communities, other government departments and professional bodies. Service coordinators are responsible for participating in planning for the transition of children with developmental disabilities to adult services. This role is currently under development.

The projected workload is approximately 60-100 cases.

British Columbia

Community Living British Columbia (CLBC)

CLBC delivers supports and services to individuals with developmental disabilities and their families. The Facilitator role is the closest parallel to that of a navigator.

Facilitator

Facilitators are the primary contacts for individuals with developmental disabilities and their families. Their role includes confirming eligibility for CLBC- funded services; determining disability-related needs and potential resources and services required, supporting and facilitating access to generic services, informal support and expediting the allocation of small targeted amounts of funding. A Facilitator may act as an ongoing point of contact for individuals and their families: responding to crisis situations, resolving problems, coordinating services, creating and implementing individual support plans and responding to adult guardianship concerns. Facilitators are located in each of CLBC's five regions.

Facilitator workloads average 1: 130.

Ministry of Children and Family Development (MCFD)

The Key Worker and Parent Support program provides support to families of children and youth under age 19 with Fetal Alcohol Spectrum Disorder (FASD) and similar neuro-developmental conditions.

Key Worker

A Key Worker assists families in understanding FASD, is familiar with community resources, assists families in accessing supports such as health and education services, and is involved in the development of local support services. A Key Worker supports parents, caregivers, family members and service providers in identifying ways to adapt a child's environment in response to his or her needs. The Key Worker also strives to empower the family to become their own best advocates for their child. Key

Workers supplement and enhance, but do not replace, existing community resources. Key workers can be provincial employees or work for private agencies and are located in six regions.

A key worker workload is approximately 20 – 40 cases.

There is no dedicated transition worker role in the MCFD model; it is incorporated in the current positions.

Note: MCFD also has a Child and Youth with Special Needs (CYSN) worker role that functions as a social worker. These workers assume a range of responsibilities but it is clear that given priorities, a large number of families may receive funded agency or community services but do not receive regular contact. Transition activities for Children-in Care are well supported but involvement with the larger group of transitioning youth is often more limited.

Caseload ranges from 1: 80 to 120

See *Appendix 1* for more detail

Engagement and Consultation

In addition to reviewing approaches in other areas, the project also considered the findings of the community engagement sessions that were held throughout British Columbia from October to November, 2012. This section highlights themes that emerged from these sessions with respect to a "Navigator" and corroborates many of the indicators of success identified by other jurisdictions.[2]

The following outlines some of the desired features of a navigator role that emerged during the community engagement sessions and reflects the current gaps as experienced by individuals and families:

- Single point of contact
- Continuity of knowledge and support
- Early planning for transitions
- Information and service coordination and management
- Integrated assessment processes
- Self- Determination
- Community connections
- Specialized Skills / Competencies
- Responsibility / Authority / Accountability/Organizational Autonomy
- Quality Assurance

Single Point of Contact

A navigator should be the primary person that an individual or their family can talk to and plan with, someone who develops knowledgeable, supportive relationships and is able to leverage external partnerships to translate plans into action. Relationships are based on trust and developed through meeting people, getting to know them, sharing experiences. Phone, email and other social media can support these activities but never replace

[2] (Initially, the term Key Worker was used but was changed to Navigator soon after the initiation of the community consultations based on advice from individuals, families and service providers. The position is referred to as a "Navigator" in this document but nomenclature is still open for discussion.)

them. For many, the most important aspect of a navigator's role is the rapport that he or she develops with an individual; if someone doesn't feel comfortable with a navigator it will be challenging to work together towards common objectives.

A navigator can operate like a hub in a wheel: a centre point of access to all systems and services that individuals might need or wish to explore. A navigator should have access to relevant information and the skills to integrate that information and associated documentation from a range of sources to support planning, decision-making and key community connections. A navigator is not just a contact person, but rather a specific individual who is there for a family as required and has the capacity to "make things happen".

Not all individuals or their families may require a navigator; many can and want to assume the related roles and responsibilities. Navigators should be available on an as needed basis.

Key Considerations:

- *How will referrals be made to a navigator- through school, MCFD, CLBC?*
- *What are the implications of families not involving a navigator?*
- *What will need to be in place to ensure the navigator does not duplicate work being done and/or inadvertently assume the statutory responsibility of others particularly MCFD and school system?*
- *How will transitions to other systems, e.g., post- 24, be managed when amount of hands-on support is being decreased?*
- *How to ensure the navigator is aware of and adapting to changes?*
- *Use of social media, access to websites and alternative resources and networks should support hands-on support*

Continuity

Continuity is critical to the successful implementation of a navigator role. This can be reflected in different ways: an intensive relationship with an individual and family over a prescribed period of time, e.g. 16- 24 or 55 and older, or an extended period of time- across the lifespan from 16 or earlier to end of life. Regardless of the administrative structure, the navigator must be able to work with and across ministries and agencies over the time required by individuals to develop, implement and adjust plans.

Depending on the circumstances but certainly during transition periods, navigators need to maintain regular contact and be proactive, anticipating needs rather than responding only when there is a crisis. Effective outcomes require ongoing discussions; regular meetings help ensure that progress is maintained and accountabilities and responsibilities remain clear.

Regardless of a Navigator's priorities or where they are located there must be a smooth, timely and thoughtful transition to new workers and new systems. All relevant information must be available, outstanding issues addressed and a plan for change-over in place. Lack of continuity creates or exacerbates stress.

Key Considerations:

- *Capacity for flexibility in re-involvement at later stages in adult's life?*
- *How to ensure ongoing accountability of systems across lifespan as role of navigator changes?*
- *Will accountabilities related to youth transition drift if navigator continues through lifespan? Always introducing 'new' workers to cohort of youth and young adults?*
- *What is the impact of staff turnover?*
- *What are the challenges inherent in moving from intense to 'light touch' involvement?*

- *Changes in role at age 24 could decrease currency and informal authority of navigator*
- *Support for self-determination could lead to unanticipated dependencies*

Early Planning for Transition

The need for effective planning particularly that associated with transitions cannot be overstated and was verified as key in every jurisdiction including BC. Planning supports can range from something as simple as an up-to-date and readily available information package given to youth who are soon to move into adulthood to detailed consultations with professional health care practitioners.

A navigator could potentially help families with many transitions:

- from child to adult services
- from adult to older adult / senior
- with cultural transitions (e.g. ethnicity, language barriers)
- from rural community to urban
- from family home to a new home
- addressing new health challenges
- moving from one agency to another agency

The planning for transition from youth to adulthood needs to start at age 16. Some youth may be ready to prepare for planning earlier than 16, and this should be encouraged and supported. It needs to be a team effort (e.g., school, CLBC, Health Authority staff, MSD, others) to help with the transition.

Key Considerations:

- *Access to diverse information lodged in an assessment platform will influence capacity to integrate information to support planning*
- *Matrix of who does what, at what time, and in partnership with whom must be explicit and available to team members as well as families*
- *Early planning should focus on support sector rather than service sector*
- *Families should be supported to identify individualized solutions and options for self-managed supports*
- *Early community connections initiated*
- *Written support plans with actual commitments, deliverables and timelines for all partners must be recorded and managed by the navigator*

Information and Service Coordination

The lack of coordination of information and services is one of the most significant challenges facing individuals and families. It contributes to stress and frustration and requires a disproportionate amount of time and expertise on the part of both families and those who support them. A navigator should:

- provide individuals and families information that is timely, comprehensive and easily understood. A navigator should also be able to access and consolidate relevant information to support planning and resource development
- coordinate information-sharing requirements in a way that promotes joint, standardized, consistent activities on behalf of individuals without compromising their privacy
- initiate and support opportunities for integrated processes to reduce the amount of time spent by individuals providing the same information to different professionals. An example would be the use of

a common assessment platform to identify specific strengths or requirements that influence planning and allocation of supports
- manage and update central information repositories as agreed to by the range of partners on the 'team'
- manage the completion and consolidation of common forms across different agencies, professionals, ministries and authorities
- be familiar with and connected to local resources, how they interact and how to access them
- facilitate coordination of services to meet the individual's needs including relationships with specialists
- build and strengthen networks
- encourage and support families with early financial planning and access to supports within federal benefits and tax systems

Integrated Assessment Process

Assessments are by their nature unique to the professional groups who conduct them and cannot be amalgamated to produce a "super assessment" or one tool. That said, relevant data from assessments should be centralized and a navigator needs to have access to the discrete but commonly understood elements in each assessment to develop a holistic picture of and plan for an individual.

A navigator can also help to coordinate assessments and provide guidance on eligibility criteria for services.

Key Considerations:

- *Consistent purpose should be the basis for the sharing of key information related to an individual*
- *How is an assessment platform managed when capacity to consent moves legally from individual and family to individual alone (or with legal representative at age 19)?*
- *The design of the assessment platform must address access and updates so that it continues to be a relevant and useful element of planning and monitoring*
- *Access to key community/support system information can reduce later service reliance*

Self-determination and Autonomy

A navigator's primary responsibility is to the person with a developmental disability and their family and responding to their goals and needs. A navigator is someone involved with the family, who takes time to build strong relationships. Each individual and family will have different expectations of a navigator and any system must be sufficiently flexible and adaptable to reflect that. Navigators support self-determination rather than assume decision-making powers and must be sensitive to the opportunities not only to support but to 'fade' supports when appropriate.

Key considerations:

- *Where families do not engage with navigator at age 16 and have minimal involvement with other systems such as education or MCF, how do you ensure an individual's voice is heard particularly post-19?*
- *Navigators must avoid becoming proxy for an individual while still acting as guide and support*
- *Individuals and families and the navigator need to be fully aware of the statutory as well as practical framework for autonomy as well as supported and substitute decision-making*
- *A navigator can be key in assisting individuals and their families to identify supports outside the service sector and opportunities to assume more control over the supports they require*

Community Connection

A navigator should be based in the community and know that community well. A navigator can educate community members as well as immediate team; develop community options and look for opportunities from social networks, to employment, to enabling communities to be more receptive to people with developmental disabilities.

Linkages to community supports are critical not only for the access to opportunities they present but also to ensure that the appropriate connections are made between these opportunities, e.g., involvement in an employment program that is supported by alternative community inclusion activities.

Key Considerations:

- *Building community connections is integral to the success of the model and may require initial, intensive activity by a navigator and then fade to a light touch over time*
- *A community connector could develop options not previously considered, e.g., a community college in the Lower Mainland recently modified one of its standard program's requirements (modified trade) through a situational assessment rather than through entry into an 'adult education' program*
- *Using the pilot to test out alternative or focused role of a navigator as 'community connector' should be considered. This reflects other initiatives in the sector to enhance practical support networks outside the service system and supports efforts to increase individualized, flexible responses*
- *Any approach must be streamlined and strategic as there are many competing interests particularly with respect to employment. The focus should not be on disability*
- *A key indicator of success could be reduced involvement of government staff over time although it is recognized that some individuals may require increased ongoing or sporadic support*

Organizational Structure and Accountabilities

Governance structures for improving services to persons with development disabilities are not directly within scope of this paper. However, there are certain key management imperatives that must be in place if the role of a navigator is to be successful in a multi-disciplinary environment. In the absence of a statutory framework, a clear management framework is essential, one that supports a change in culture rather than activity alone. Multi-disciplinary teams directed by a range of authorities will bring with them different priorities, attitudes, professional requirements, interests and commitments. These "cultural" connections need to be acknowledged but requirements associated with responsibilities and activities need to be underpinned by explicit, senior level Letters of Expectation and directives. Memoranda of Understanding and Protocols are not sufficient. Signed off requirements will be essentail.

Authority and Autonomy

A navigator may report through one ministry but all partners are equally invested to operationalizing the shared model of planning and support. Success will depend on establishing key performance measures related to access and support, problem-solving, timeliness of task completion, response times and other deliverables negotiated both provincially and locally. The onus cannot be on the navigator to 'make it so'.

Unless the navigator is recognized as having the authority to engage and set expectations related to agreed upon processes and outcomes, the position will be limited in its effectiveness.

Job descriptions will need to be inclusive and detailed to avoid drift into alignments or confusion on scope of control and the need for autonomy must not compromise the need for timely and regular supervision.

Standards and Policies

Each participating ministry and its team members at the local and provincial level need to operate from a set of standards that are institutionalized in that they are consistent, continuously applicable and administered fairly. Navigators will need to hold authorities and ministries accountable for ensuring the standards remain applicable and policy is being followed.

Training

Training must be ongoing to move individual agencies towards a more holistic approach and to ensure optimal use of assets and resources. Training will also ensure that all partners maintain their awareness of roles and responsibilities over time.

Communication

Communication needs to be actively engaged in at a range of levels: between individuals and families and the navigator; among professionals; and up to senior management as necessary. Each organization will be responsible for ensuring information produced is clear, in plain language, accessible and reflective of joint objectives. Opportunities for joint websites, social networking, and use of social media should be explored.

Transitions

Individuals, families and those who support them must clearly understand who will support them and what to expect at each juncture of their journey. To enable this to occur, each agency will clarify when their particular involvement will end and another will begin; this could be a service such as mental health supports or a function such as moving for being supported by a MCFD worker to a navigator or from one navigator to another.

Complaint Resolution

Mechanisms must be established that facilitate dispute resolution locally both for individuals and where there is disagreement among authorities and ministries. A senior Steering Committee or secretariat function might be required to manage the escalation of unresolved issues at least during the initial set up and growth period. The existing Integrated Services and Supports Team functions would be subsumed into this structure.

Workload

Workloads must be manageable (appropriate load, proper staffing, shared responsibilities and support to sustain the role) and compensation should be commensurate with the level of responsibility and authority expected of the role.

Accountabilities

Wherever the navigator position is situated, it cannot be seen or operate as aligned with any particular service system. Although there are positive aspects to having a navigator accountable to a non-government management structure, research from the UK has indicated that operating "*outside the statutory system was limiting; they (key workers) had much less power in obtaining certain service resources in the statutory sector and were sometimes discounted and marginalized. The extra effort to develop and maintain close cooperative contact with health, education and social services was seen as very time-consuming....".*

Navigators also need to be independent of funding and resource allocation decisions but government must avoid establishing structures that reduce the two aspects of service to a model of 'good cop' vs.' bad cop'.

A navigator can function in a variety of roles that may change over the life of an individual or within a specific age cohort. Post-secondary training and qualifications are necessary given the scope of the job but they will also be expected to embark on a path of continuous learning.

Key Considerations:

- *A management framework that flows directly from the governance model will be required*
- *The STADD principles and provincial service standards will create a framework for operations and activities*
- *A navigator will have their assigned authority reinforced by operating agreements and protocols to: engage partners, to work towards clear understanding and consensus on responsibilities and deliverables and to escalate individual situations and systemic issues as required*
- *The process should subsume the role played by the ISST*
- *Each partner must provide clear standardized policies related to their specific role and involvement in the lives of individuals with developmental disabilities*
- *Funding mechanisms and the relationship between navigator/team recommendations and funding process/envelopes/allocations/wait time management will be clearly articulated. This will be a major vulnerability unless built into the foundation of the design of the new model.*

Essential Elements of a Navigator Model

Engagement results coupled with the scan of other jurisdictions and the overview above indicate the fundamental functions that a navigator could or should assume when working with individuals and families regardless of which model is chosen. They also provide a context for identifying 'Why?' a Navigator position is such a critical piece of an improved service delivery model.

In analyzing functions and responsibilities, the following builds on that information and complements the directions proposed in the *Integrated Service Delivery Model* as well its foundational principles: *user-friendly, transparency, predictability and consistency, continuity, administrative fairness and respect, efficiency and sustainability*. Variations of involvement are primarily in degree rather than scope as illustrated in the following table.

Function	Key Roles and Responsibilities
Intake	• Provides initial response to individuals and their families. • Confirms initial eligibility for services. • Reviews and manages requests for planning and support (transitional or ongoing). • Establishes key contact regardless of intensity of involvement going forward. • First step in orientation process. • Provides basic information on services/supports that are available and those that are not and why. • Arranges face-to-face meeting.
Assessment	• Provides support for families to participate in assessment and review processes. • Collates relevant assessment information through access to centralized data collection repository.

	• Assists with the interpretation of assessment results as basis of person-centred planning. • Ensure that there is a comprehensive and current picture of health and adaptive status of each individual. • Assists with and/or confirms eligibility for services.
Planning	• Provides individuals and families with support and practical assistance to clarify their goals, strengths, and needs. • Incorporates advanced planning and financial management support as required, e.g., RDSP initiation, Disability tax Credits, and the need for representation such as Representation Agreements • Assists individuals and families to identify outcomes that they wish to see in an individual's support plan. • Supports opportunities for self-determination and independence of each individual by ensuring their inclusion in all planning, orientation and activities that directly impact them. • Initiates earlier and more holistic planning for the individual, including integrated assessments, at every stage in lifespan segments, focus on strengths and abilities as well as risks. • Engages members of the transition planning team and secures commitment to process. • Navigator acts both as a "central hub" and an active liaison with all partners • Coordinates planning process: partners, location, agendas, required documentation or action, etc. • Mentors families to increase their capacity, knowledge, skills and confidence to become their own best advocates. • Focuses person-centered planning working from expected outcomes. • Provides family with tools, resources and support required to easily and effectively participate in the planning process. This includes plain language information packages, website links, connections with other members of the planning team • Ensures that key contributors to planning/support process are engaged and that accountabilities are clear. • Identifies key issues and/or gaps in services and supports for individuals and explore possible approaches to addressing them. • Assists with development and implementation of individual support plans including connections to community and service options. • Coordinates access to available supports as identified in cross- agency planning. • Monitor and review plans in context of quality of life outcomes.
Information and Service Coordination	• Acts as an 'information broker' for individuals and families, obtaining and ensuring currency of information • Provides families with clear, easy to understand information in a flexible manner, tailoring the format, timing and content of information to individual requirements but always in PLAIN LANGUAGE and as a package • Provides advice and guidance to eligible individuals and their families to assist them in decision- making.

	• Helps families to understand the system(s) involved in providing supports and, if required, helps them navigate through them • Coordinates cross-ministerial/agency networks to implement supports for adults with developmental disabilities and their families. • Facilitates coordinated and comprehensive responses by ensuring access to and coordination of appropriate services (as a service coordinator rather than a service provider). • Provides support with life transitions for individuals and their families including assisting with changes in existing supports. • Establishes and maintain an effective and collaborative relationships/liaison with a variety of individuals and groups, including families, diagnostic and assessment teams, schools, and other service providing or engaged agencies.
Community Connector	• Actively builds community linkages for individuals to provide informal as well as concrete supports through partnership and collaboration with individuals and families, service providers, local organizations and the broader community. • Actively builds awareness and understanding in community and service systems and increases involvement in successful transitions • Networks with, develops, and enhances links to business, industry, health, municipal and regional councils, school boards, recreation, colleges and community services. • Works with an individual and family to explore the possibilities and opportunities for incorporating employment into individual's life. • Facilitates referral services or coordinates access to optimal vocational / employment programs including Work BC during the last years of high school or when needed. • Uses schools as effective 'jumping off points' for future. • Supports efforts of individuals to develop social connections • Initiates or catalyzes efforts to develop social and support for individuals and families.
Crisis Intervention	• Responds proactively to situations in order to prevent crises. • Assists individuals and families who are in crisis. • Develops an effective crisis management approach. • Works collaboratively within larger quality assurance or statutory mandate of involved ministries and authorities such as licensing; monitoring schematics. • Acts as a focal point for safety net of information and response and assists with contingency plans for high-risk individuals in case of unexpected or extreme change in circumstances.
Guardianship	• Investigates and develops a support plan as a delegated agency under adult guardianship legislation. (Specialized, statutory function)
Basic Accountabilities	• Clarifies and ensures compliance with service standards • Articulates expected timelines and deliverables related to service/support provision • Key point of contact

	• Flagging issues or escalating concerns through a clear management structure

Navigator Competencies

Research and community input has highlighted the skills and competencies a navigator requires to effectively support people with developmental disabilities and their families. The following list of attributes is not exhaustive:

- dynamic, proactive, flexible - someone who can move things forward
- caring individual who develops supportive, respectful relationships
- good coordinator, facilitator and mediator
- able to leverage connections and supports on behalf of individuals in community and across government-funded systems
- knowledgeable of developmental disability and the potential impact on the individuals and family
- capacity to work independently in a variety of operational settings

Both research and the recent community engagement findings confirmed the range of competencies associated with a successful navigator role and these are summarized in *Appendix 2*. This list is not intended to be exhaustive or fully representative but it does recognize a set of core requirements. It also suggests a basic prerequisite for anyone who assumes this position; in addition to personal suitability, attitudes and skills, professional qualifications (probably in a social work related area) will be essential to enable the navigator to act with the authority and autonomy required.

A grasp of legislation, privacy constraints, operating mandates and access to assessment documentation and interpretation, etc., may not be primary considerations but without that professional experience and expertise, the role's capacity to act would be extremely diminished.

A well designed job description with delineated duties and responsibilities combined with a rigorous recruitment process will be essential to ensure the appropriate balance of knowledge, skills and abilities. It is in this forum that family and community participation should be considered.

Navigator Models

For purposes of this report, three potential models of navigator involvement were used as the basis for an initial description of what supports might be provided, when and how. No specific assignment of administrative mandate was ascribed. Also, each model assumes that a navigator role could continue through an individual's life span with various levels of involvement as need during different life stages.

The models further assume that there is no duplication of existing roles. The financial modeling presupposes that activities currently managed by facilitators would be incorporated into the 'To Be' models whether at status quo levels or realigned to provide additional or differential support. The relationship between CYSN workers and navigators will need to be reviewed in more depth given the specific duties and constraints imposed by the *CF&CS Act* as well as MCFD policies and standards. For purposes of modeling *only*, two further assumptions were made and would need to be confirmed through file reviews at MCFD:

- that the largest uptake of navigator support would probably be of families who currently have 'Low Involvement' with CYSN workers.
- that Children-in –Care may require a differential response and continued intensive involvement through transition from MCFD staff rather than a navigator

There appears to be no definitive evidence that a separate role for a navigator associated with specific life stages has advantages or disadvantages over a lifespan support role. There *is* consensus among most jurisdictions that the level of involvement during the transitions years needs to be more intense to accommodate the changes resulting from the move from youth to adulthood. There was strong indication that insufficient support during the transition creates stress and difficulties for individuals and their families, reduces their capacity for autonomy, and results in higher support requirements following transition. At the other end of the spectrum, as the cohort of baby boomers age, this transition period will undoubtedly require more focused attention.

Options will need to be considered as part of the design and implementation plan.

Scenario 1:

- reflects a "case management" approach which uses a ratio of 1 staff to 60 individuals as across the lifespan

Scenario 2:

- proposes strong engagement during youth transition (16 -24) with lighter engagement thereafter

Scenario 3:

- proposes strong engagement during the period of youth transition (16- 24), lighter engagement until approximately age 55 with more intensive involvement at that stage to support transitions associated with aging.

Methodology:

Very little research on workload analysis has been done in any jurisdiction so we began with what could be validated locally. With the help of CLBC, key aspects of the current facilitator workload were identified through a review of 'Work Assignments' in the PARIS recording system which had been opened in that calendar year. These were then co-related to specific functional activities and weighted to reflect experience and assumptions with respect to intensity of activity in any area. Potential additional FTEs required for each of the future scenarios were estimated by applying the desired changes to current activities - *Status Quo* today – age 19 plus and *Base Scenario*- existing ratios applied for 16 – 19 year olds.

The full modeling of these scenarios follows. It is important to reiterate this was a modeling exercise only and was never intended to be interpreted as a validated work/time analysis. Nevertheless, it does provide an initial context for future decision-making.

Scenario 1 – Case Management Model

This model proposes enhanced support for all age groups based on the case management model. It assumes that a navigator would provide continuous, hands on support to all individuals and their families throughout their lifespan.

The anticipated workload for Case Management activities is 1:60.

Scenario 2 – Youth Transition Model

The Youth Transition model is based on the premise that during life transitions individuals and their families will require a strong level of support to deal with additional stresses of moving from one life stage to another. For youth 16 – 24 years, this transition is especially difficult as they leave school with its associated losses; the move into adulthood with its new challenges such as searching for employment, making new connections, accessing adult supports and services, applying for new benefits and perhaps even changing housing arrangements. It is anticipated that during this period of life many individuals will require a case management type of support to ease the transition. (Not all individuals will need the same level of assistance; some will require less support and/or be more self-sufficient).

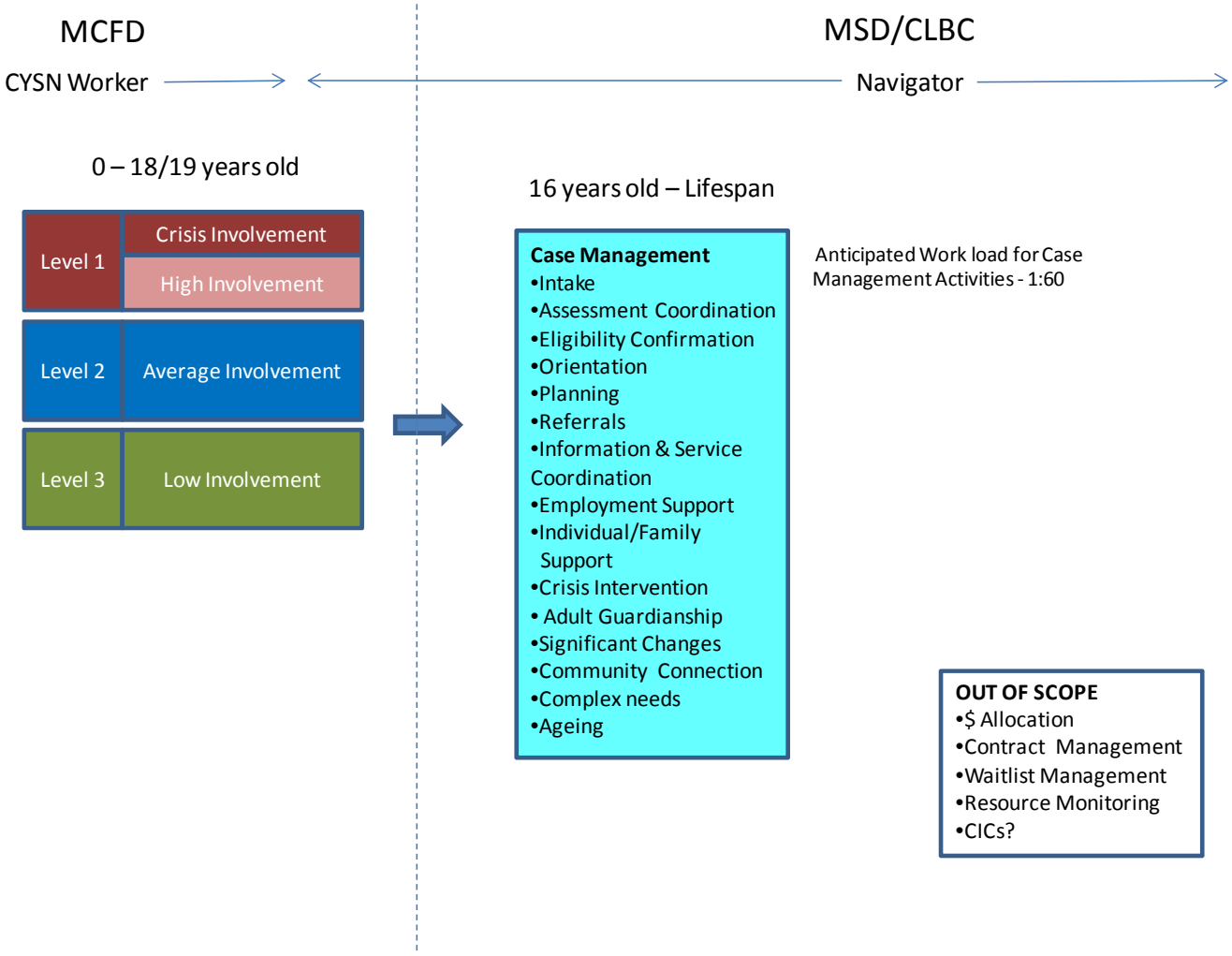
After age 24 it is anticipated that, in most situations and most of the time, the intensive involvement of a navigator should decrease - an assumption which is borne out by the experience in BC and other jurisdictions. There will still, however, be situations in a person's life that will require more dedicated involvement: crisis intervention, guardianship, or any significant changes or issues related to behavioural/health challenges.

The increased role of service providing agencies and 'generic' services in an individuals' life also influences navigator workload requirements.

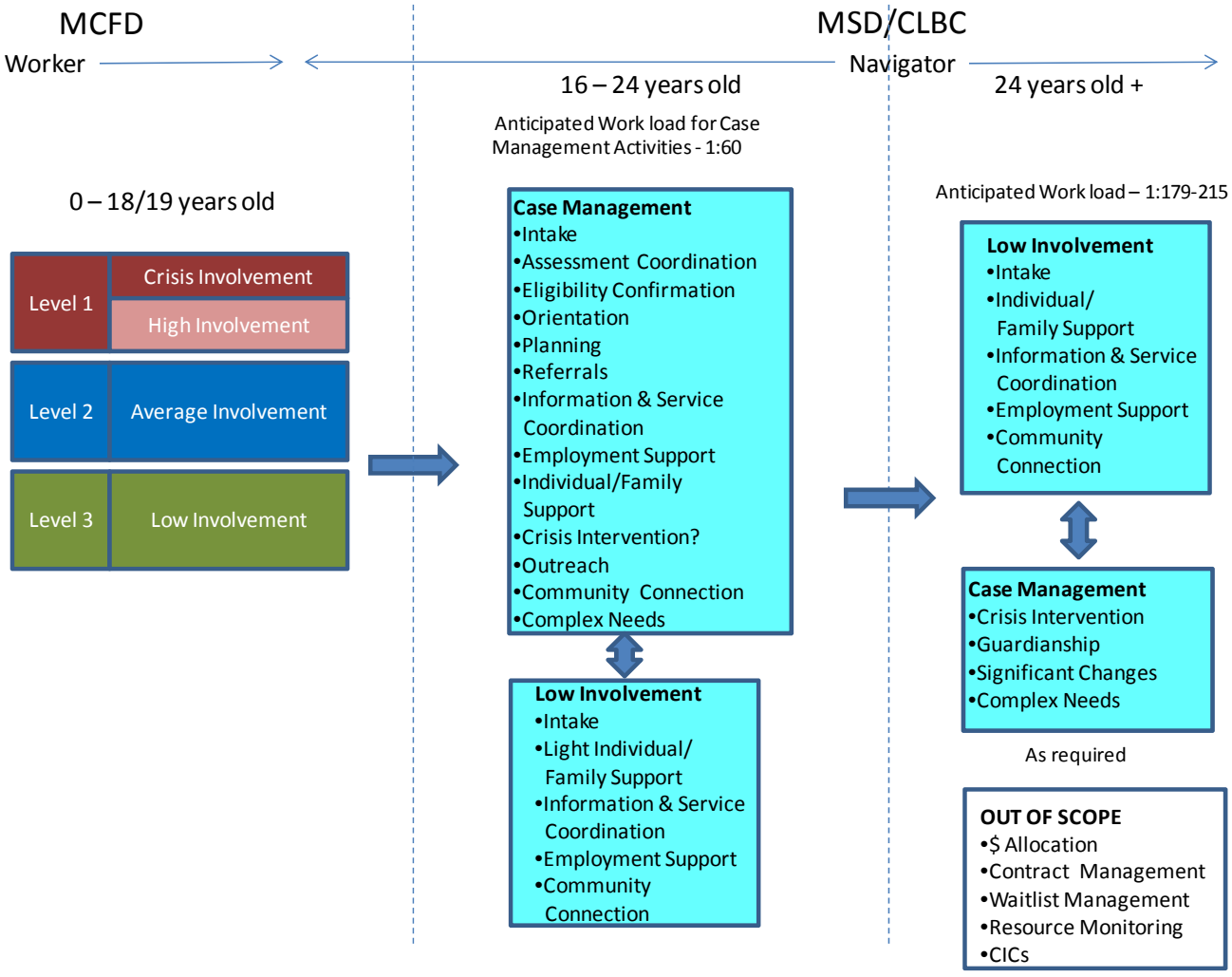
Scenario 3 – Mixed Level Model

This model proposes enhanced support to youth 16 – 24 years old as in Option 2 with less support required for individuals aged 24 – 55 and increasing involvement after age 55 reflecting the particular needs of the aging cohort.

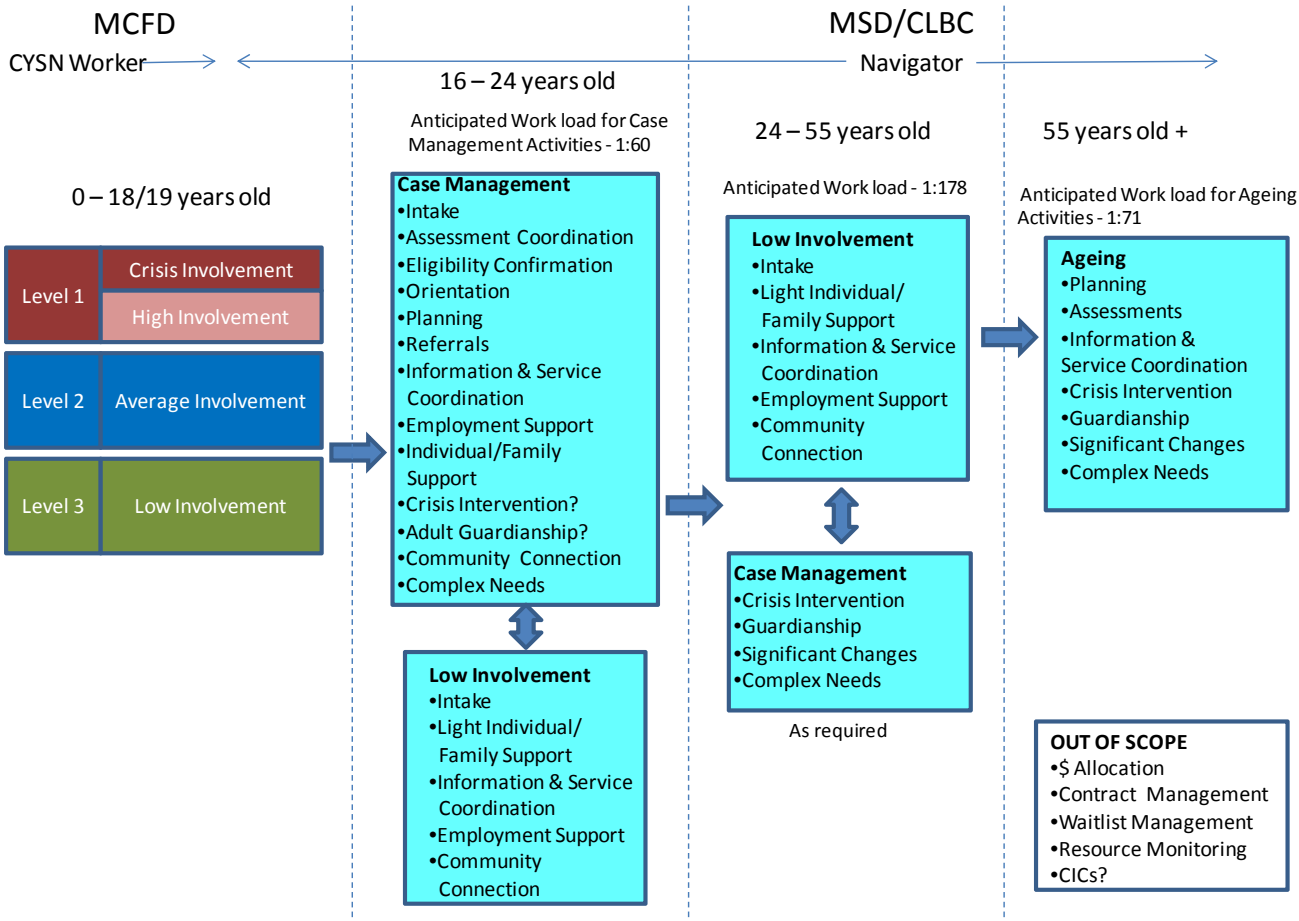
Scenario 1 Case Management Model Diagram



Scenario 2 – Youth Transition Model Diagram



Scenario 3 – Mixed Level Model Diagram



Summary Considerations

With the introduction of any new role but particularly as an element of a larger change process there are risks as well as opportunities.

Opportunities

- Earlier involvement in the life of a young person with a developmental disability through planning and exploration of possibilities can provide them with the opportunity to really identify what they would like to do as they 'grow up' and how to build the pieces of that desired experience on a step-by-step basis.
- Many practitioners would welcome the chance to operate in a more holistic environment and be able to follow a young person and family through transitions into adulthood or concentrate on specific periods of the lifespan. A change in focus that more closely aligns with the lived experience of people being supported could rejuvenate practice.
- A navigator could provide or support the impetus to build support networks that will transition with youth into adulthood. The supports that a young person builds or has help build around them need to start when he or she is young. As with anybody, early solid supports are often the ones that maintain and sustain people not only day-to- day but, especially, during periods of crisis and uncertainty.
- Introducing a navigator function increases the capacity to educate and involve partners earlier and more fully. The earlier government and community partners become engaged with youth with developmental disabilities, the greater the chances are that they will begin to plan and respond to an individual as someone who has something to contribute and/or might need a little extra support rather than someone whose "needs" are too challenging or complicated to be incorporated into their businesses, activities, work environments.
- Individuals and their families want one point of contact. Whether that contact is light or intense, it is still important to be able to put a face to a name and be able to connect when needed.
- Individuals and families may not always be aware of what assessments are required by what organizations for what purposes. Navigators could assist in providing this information, making referrals where appropriate, organizing the documentation and simplifying processes where they can. As the key user of an assessment platform, the navigator should be able to identify opportunities to reduce duplication of efforts so that families aren't constantly repeating their stories for the same purpose.
- Mandating a point person to organize a team of professionals and representatives from a range of ministries/authorities in a timely and focused manner will increase opportunities for collaborative practice.
- Reducing the amount of time spent trying to confirm commitment among government ministries/authorities/school districts, determining responsibilities and targeting resources effectively will lead to increased efficiencies at several levels.
- The role of the navigator supports a move towards earlier, simplified assessment processes and advanced planning activities in an individual's life, particularly during the transition from youth to adulthood. This proactive involvement should result in increased capacity and stronger community and social networks that, in turn, support transitions and reduce the likelihood of individuals requiring costly and not always the most effective crisis responses at a later point. Initial investments may actually prevent an increase in costs in the longer term.
- A navigator role is not the only element required for integrated service delivery but it is a strong part of the foundation.

Risks/Challenges

- Without clear delineation of roles and responsibilities and mechanisms to review human resource allocation, there could be unanticipated workload inequities, e.g., navigators assuming a higher proportion of children with challenging family situations, less involvement from other key players such as school district staff, etc.
- Families need one point of contact. An unanticipated duplication of roles could actually result in more confusion for them rather than less
- The support of a navigator has the potential to increase expectations of youth and their families when moving through transition into adulthood: that the resources and the navigators themselves will all be available when requested
- Even with Letters of Agreement and a strong management framework there remains a risk that authorities/ministries/school districts might not coordinate with or support joint activities , decreasing their efficacy
- The change in transition points, e.g., to 24 from 19 could become new 'flash points' unless the essential transfer plans are in place
- The transition from a service to network focus will require that network supports are actually in place and that the key connections have been made
- Communities may not always have the capacity to respond to changing requirements of individuals, e.g., from volunteer placements to actual employment or from specialized supports to ones that are available to any adult. It will be critical that a navigator as a community connector, in partnership with colleagues, develop approaches to catalyze untapped resources
- The navigator will be involved with and responsible not only to individuals and families but to the other 'system' representatives (the reverse is also true). This factor, the introduction of a new type of management framework with its dispersed accountabilities may present audit and management challenges
- Systems trend towards complexity. Conscious effort must be made to avoid this as the components are put in place and as they evolve over time.

The scenarios provide a structural approach to the realignment of current responsibilities and the addition of others into a navigator model. The key to success, however, will be testing these assumptions out in a 'real environment'.

Appendix 1

List of Jurisdictions and Models

The table below contains the list of jurisdictions that were contacted about a navigator role.

Organization
Disability Services and Operational Policy, Program and Service Design – Income Assistance and Disability Services, Community Living Service Delivery (CLSD), Saskatchewan
Ministry of Children and Family Development (MCFD) British Columbia, Interior Region, FASD/CCY and ECD/CYCN Community Development
MCFD BC, Nanaimo, British Columbia
Community Living British Columbia (CLBC)
Department of Community Services, Services for Persons with Disabilities, Nova Scotia
Human Services, Persons with Developmental Disabilities (PDD) Program, Alberta
Ministry of Community and Social Services Ontario, Developmental Services Ontario
Centre de réadaption en déficience intellectuelle (CRDI) Montérégie-Est
National Association of State Directors of Developmental Disabilities Services (NASDDDS), Virginia
Dane County, Wisconsin
Waiver Services, Connecticut Department of Developmental Services
Massachusetts Department of Developmental Services
Disability Services Commission Western Australia
Local Area Coordination, Inclusive Neighbourhoods
Care Co-ordination Cymru (CCN Cymru), Wales

The section below contains more detailed information on a navigator role or similar type of role that was obtained from other jurisdictions.

The information was collected mainly through meetings, conference calls and e-mails. The following data was collected:

- Name of jurisdiction / organization;
- Name of the position;
- Key responsibilities of the role;
- Accreditation / Education;
- Salary;
- Ages Supported;
- Average Duration of Support; and
- Work Load.

Western Australia

Name of Jurisdiction:	Disability Services Commission, Local Area Coordination, Western Australia
Name of Position:	Local Area Coordinator

Key Responsibilities:	• Support people with disabilities to live in welcoming and supportive communities. • Provide personalized, flexible, and responsive support to assist individuals, families, and communities to access accurate and timely information to clarify their goals, strengths and needs. • Operate as a service coordinator (rather than a service provider) and helps the person with the disability and their families and service providers to plan, select and receive needed supports and services. • Build inclusive communities through partnership and collaboration with individuals and families/carers, local organisations and the broader community. • Build relationships with individuals and their families. • Provides personalised, flexible and responsive support to help people to develop their goals and dreams for living a good life.
Salary:	Approximately ranging from $71,000 to 85,000.
Ages Supported:	Children and adults.
Work Load:	1:45-65

United Kingdom

Name of Jurisdiction:	Local Area Coordination, Inclusive Neighbourhoods, England and Wales
Name of Position:	Local Area Coordinator

Key Responsibilities:	• Single, local, accessible point of contact
	• Get to know people (children & adults), families & local community well – help people stay strong
	• Support access to accurate and timely information – from a variety of sources (including nurturing connections with other local people)
	• Provide support and assistance to identify their strengths, goals and needs – plan for the future
	• Promote self advocacy, advocate with people, access independent advocacy.
	• Build mutually supportive communities:
	  o Map, understand and connect existing community resources
	  o Assist in building inclusive, resourced local communities
	• Build partnerships – people, organisations, communities
	• Assist people to develop and use personal & local networks
	• Assists people to develop practical ways of meeting goals and needs – divert from services/reduce demand
	• Assist people to access, navigate and control support and services.

Accreditation / Education:	LACs come from a range of backgrounds (e.g. communities, education, youth

	work, social work, health etc) - nurturing the sharing of a broad range of skills and experiences, within the clear strength based LAC values and approaches. In England, the developing sites have included "A relevant qualification at diploma level or above, in health, social care" etc. as either essential or desirable in the selection criteria.
Salary:	The role combines a range of existing, separate jobs and delivers them through one individual embedded in a local community. Most places have set the salary at the same range as a social worker position. This gives parity (and credibility) with existing service roles
Average Duration of Support:	The aim is for the support to be "cradle to grave" with a focus on people who may be vulnerable to disability, mental health needs, age or frailty in a local geographic area/community. This aims to break down the barriers that the system has imposed by putting people into service types/silos. So, rather than focusing on the service label or perceived "deficits", the focus is only gifts, contributions, mutual support and practical/non service solutions to problems wherever possible. Many people are part of families where there are multiple service labels - e.g. a mother with alcohol issues and mental health supports needs living with a son who has autism etc. This often results in very complicated service responses.
Work Load:	1:50-65

Name of Jurisdiction:	Care Co-ordination Network UK (CCNUK), England and Wales
Name of Position:	Key Worker
Key Responsibilities:	• Single point of contact for the child, young person and their families and responsible for co-ordinating services • Ensure that the voice of the child, young person is heard and central to any planning and review arrangements and that this is carried out using a person centred approach. To support children, young people and their families to prepare for and contribute to person centred annual statutory reviews • Co-ordinate and gather information that is timely, up to date, accurate, accessible and relevant • Help and support children and young people and families to identify their needs and aspirations for now and in the future • Co-ordinate and monitor action plans and ensure those tasked to undertake an action complete in a timely fashion • Ensure that plans support statutory planning in health, social care and education • Support children and young people to maintain & develop friends and

	relationships • Support children and young people and their families where there may be a difference of opinion and work with them to resolve • Be proactive and creative in developing new opportunities for children and young people • Provide emotional and practical support and be proactive and in regular contact to ensure that a 'steady state's is maintained or ensure that children and young people and their families remain in a 'steady state' and are prepared for the changes ahead
Ages Supported:	Children and Young Adults

United States

Name of Jurisdiction:	Dane County Department of Human Services, Wisconsin
Name of Position:	Support Broker
Key Responsibilities:	• Planning: Initiate the planning process with the person and her/his team. The Support Broker will coordinate the planning meeting, help ensure all key people have input, and document the planning session. • Fiscal Responsibility: Informing the person and/or guardian with the choices available in Self-Directed Services including State and Federal funding programs, both for personal funds and support funds. In addition, a Broker should understand how an individual may blend their personal funds, family resources and public funding to help an individual achieve their goals. • Communication: Have a minimum of monthly contact with one person on each support team. A face-to-face visit with each individual is required a minimum of once every three months in a variety of settings. • Mandatory Reporting: Proficient in the Abuse and Neglect Policies provided by Dane County Human Services and the State of Wisconsin, and must follow this format for any suspected abuse and neglect situation. • Paperwork/Documentation: Including annual plans, fiscal paperwork, case notes, requests for adaptation modifications and DD System Change Form. • Knowledge of Community Resources: Having an extensive knowledge of community and neighborhood resources including paid and natural supports, housing, low income programs, community connections, transportation options, assessment and referrals. • Team Building and Conflict Resolution: Assist individuals in building and maintaining strong teams that help a person live the life they desire and assist in conflict mediation and resolution.
Accreditation / Education:	All Support Brokers are hired and trained by one of the seven Support Broker agencies. Support Broker agency develops its own job descriptions and all agree to the universal elements. Additionally, Broker job descriptions get individualized by the people with disabilities who select them.

Ages Supported:	Adults, 18 years and up.
Work Load:	1:24-26 County employs 10 support brokers and 70 support brokers work for private agencies.

Name of Jurisdiction:	Waiver Services, Connecticut Department of Developmental Services
Name of Position:	Support Broker, Case Manager There are 30 support brokers supporting self-directed individuals and about 350 case managers supporting remaining individuals with developmental disabilities.
Key Responsibilities for Support Broker:	• Assist individuals and families to understand their choices about self determination and self direction and translate their choices into individualized services and budgets. • Assist individuals and families to develop and maintain relationships and natural supports in the community. • Assist individuals and families to explore and develop new social roles in the community. • Assist individuals and families with employer responsibilities. • Perform tasks associated with development of relationships and natural supports in the community, self advocacy, and creativity and innovation in person centered planning. • Promote hiring and managing personal supports through training and information sharing. • Develop opportunities for individuals to exercise self advocacy and informed decision making skills. • Advise agency policy makers of barriers to and possible solutions for the advancement of self determination, self direction and self advocacy.
Salary:	State support broker's salary is approximately $55,000 to 70,000. Independent support brokers are also paid by the state at $48 per hour. Support brokers are generally state employees but individuals can hire independent support brokers if they wish.
Ages Supported:	Children and adults.
Work Load:	Support broker's workload ratio is 1:30. Case manager's workload is 1:40-45.

Name of Jurisdiction:	Massachusetts Department of Developmental Services
Name of Position:	Support Broker, Case Manager, Transition Workers

	Support brokers perform similar functions as case manager for self-directed individuals with more hands-on involvement. Transition workers support youth 18-22 years old. It is a more intensive role as they are assisting youth to prepare and plan for the future.
Key Responsibilities for Support Broker:	• Facilitate the Development of the Individual Support Plan. • Monitoring and assisting the individual with the Support Plan including helping to identify potential providers for access to identified services. • Assist the Individual to Recruit, Train and Hire Staff. • Monitor the Provision of Services. • Assist the Individual in working with the ISO to Recruit, Train and Hire Staff. • Facilitate Community Access and Inclusion Opportunities. • Meet with families receiving intensive supports on a monthly face-to-face basis.
Key Responsibilities for Case Manager:	• Assist with Eligibility and Establish the Individual Budget. • Oversee and Approve the Individual Support Plan. • Monitor and Evaluate the effectiveness of the Support Plan. • Contracting with Providers and Monitoring Provider Performance. • When necessary review requests for funding of environmental modifications. • Review the Individual Budget and spending quarterly. • Review Reports related to vulnerability of the misuse of public funds. • Participate in the yearly LOC redetermination.
Accreditation / Education:	One of the following qualifications is required: • A current and valid Massachusetts license or registration as a physical therapist, speech-language pathologist, occupational therapist, audiologist, registered nurse, dietitian, or social worker; or • A Bachelor's or higher degree in social work, psychology, sociology, counseling, counseling education, education of the physically or emotionally handicapped, education of the multiple handicapped, education of the learning disabled, human services, rehabilitation, rehabilitation counseling, nursing, recreation therapy, art therapy, dance therapy, music therapy, or physical education.
Salary:	Average salary is from $40,000 to 70,000. State salaries tend to be higher than salaries in private agencies. Case managers work for state and support brokers work for private agencies.
Ages Supported:	Children and adults.
Average Duration of Support:	Not known.

Work Load:	Case Manager workload is 1:55. The current 55 workload is felt to be too high, ideally it should be under 50. Transition Worker workload is 1:45-55. Support Broker workload is 1: 30-40.

Canada

Name of Jurisdiction:	CRDI Montérégie-Est, Quebec
Name of Position:	Educator / Éducateur
Key Responsibilities for Educator:	*Evaluation / assessment:* • Assessing the client's needs, in conjunction with the school psychologist or Psychosocial Rehabilitation Specialist, and in accordance with the institution's mandate. • Knowledge and documentation of the client's file and associated records. • In collaboration with the school psychologist or Psychosocial Rehabilitation Specialist, preparing and proceeding with the first meeting with the client and/or their representative. May be called on to obtain authorization to conduct an evaluation. • Administering various assessment tools to support the school psychologist or psychosocial rehabilitation specialist provision of a clinical hypothesis, leading to a plan of action. • Observing the client, the client's environment and the client's interactions within their environment, in order to create a clear and full profile of the person's circumstances. • Participating, if necessary, in communicating assessment results to the client, or to the client's representative. *Development of the intervention plan:* • With the school psychologist or the Psychosocial Rehabilitation Specialist, meeting in order to prepare an intervention plan that that identifies the primary objectives that will meet the client's needs. • If necessary, working with the client to help them understand the results of assessments/analysis in order to help prepare the client for their PI/PSI meeting [don't know the acronym] • In the presence of the user or his representative, and working with the school psychologist or the Psychosocial Rehabilitation Specialist, determining what is necessary for the plan to be successful. • After the plan is developed, the educator may be called on to obtain the client's (or their representative's) consent [for its use], and to provide the client with the plan. *Plan implementation:*

	• Writing action plans appropriate for the objectives defined in the intervention plan, and preparing observation and intervention materials. • Applying practical intervention strategies and updating its activities, taking into account the objectives set out in the action plan • Ensuring that internal and external participants/collaborators understand the action plan by providing necessary coaching and support. The goal is to ensure consistency of approaches, and that participants are kept informed of changes to the plan. • Writes progress notes in the appropriate information system, in accordance with standards established by the institution. *Outcome measurement:* • In collaboration with the school psychologist or Psychosocial Rehabilitation Specialist, measuring outcomes according to the timelines set out in the plan, as well as on an *ad hoc* basis. • Making suggestions for improvements if necessary. • Participating in collecting the data that is necessary to measure the achievement of objectives, and making adjustments if necessary.
Accreditation / Education:	Diploma of collegiate studies in specialized education or in criminal intervention or a baccalaureate in psycho-education or in school adaptation or in psychology.
Salary:	$39,195 – $57,837
Ages Supported:	Not known.
Average Duration of Support:	Not known.
Work Load:	Not known.

Name of Jurisdiction:	Income Assistance and Disability Services Division, Community Living Service Delivery (CLSD), Saskatchewan
Name of Position:	CLSD has two positions that support people with intellectual disabilities and their families: • Community Intervention Worker • Community Service Worker
Key Responsibilities for Community Intervention	1. Coordinating a limited and specialized complex needs caseload: Implements integrated case planning and coordination processes with individuals with intellectual disability and representatives from various

Worker:	agencies and sectors to develop a comprehensive community support plan. This responsibility includes application of specialized case-management approaches that address: • Community-based support and service requirements of individuals with intellectual disabilities who display challenging, dangerous or harmful behaviours; and • Coordination and accessibility of community-based services to meet the support needs of individuals with complex needs. 2. Creating community capacity to support individuals with complex needs: Includes educating, consulting, collaborating and mediating with community-based organizations (CBO) personnel, Community Living Division personnel and other service providers regarding individuals with complex needs. The typical activities of this responsibility will include: • Delivery of formal behaviour support training to service providers; • Provision of guidance and consultation to service providers regarding disability-related services and behavioural supports; • Demonstration of support strategies; and • Creating or facilitating connections between community-based service providers for individuals with intellectual disabilities to generic services (such as corrections, mental health services and therapeutic practitioners). 3. Developing, delivering and evaluating behavioural support services and interventions for individuals with complex needs (e.g., aggression, destruction, self-injury, criminal behaviours): This responsibility will be achieved primarily through the following activities: • Behavioural assessment and analysis of behavioural and historical data; • Development of intervention hypotheses; • Delivering direct therapy with clients; • Facilitating the delivery of behavioural supports through 3rd parties, such as Community-based organization staff, family members, Approved Private Service Home proprietors, and others; • Offering technical behavioural/clinical guidance to government and non-government service providers; and • Training service providers in the use of complex and technical therapeutic/behavioural techniques. Outcomes of these activities include the prevention of crisis, continued community living and participation of individuals with complex needs (e.g., preservation or enhancement of residential or day program services), and reduction of discharges of individuals from community-

	based programs due to challenging behaviours. 4. Evaluating the effectiveness of services and behavioural supports for assigned individuals with complex needs and ensuring a matching of supports with individual needs. 5. Engaging, and interacting and collaborating with generic services such as Mental Health, Corrections and therapeutic practitioners in the provision of complex needs supports for persons with intellectual disabilities.
Key Responsibilities for Community Service Worker:	• Individual client support, counselling and crisis intervention. • Assessment of client and family needs. • Planning with individuals, families and other stakeholders. • Family support services such as counselling, respite planning and funding, information and referrals. • Development and support of approved private-service homes which are licensed to provide a supportive family living environment for individuals with intellectual disabilities. • Working together with residential and vocational service providers in the community to ensure client needs are being met.
Accreditation / Education:	Community Intervention Worker: this position requires the successful completion of a (4-year) Bachelor's Degree in Social Work, Psychology, Educational Psychology, Nursing or a related human services field.
Salary:	Not known.
Ages Supported:	18 years old to death.
Average Duration of Support:	Community Intervention Worker: Average duration of support is approximately 18 – 24 months.
Work Load:	Community Intervention Worker handles about 7 – 10 cases on average. Community Service Worker handles about 80 – 110 cases on average.

Name of Jurisdiction:	Alberta Human Services, Persons with Developmental Disabilities Program (PDD), Alberta
Name of Position:	PDD Program has two positions that will support people with developmental disabilities and their families: • Transition Service Coordinator • Service Coordinator Both of these roles are under development and have not been implemented.
Key Responsibilities for	The Transition Service Coordinator Role manages the provision of client-

Transition Service Coordinator:	centred transitional processes for individuals requiring: • support from specialized services • a coordinated approach to determine a preferred course(s) of action • connection to a number and/or an array of programs and services over a period of time • support to obtain the required supports and services As a single point of contact for clients transitioning from one "life-stage" and/or "life-state" to another, this position supports clients to identify and access information, resources and services and make informed choices to achieve their goals and outcomes. In addition to coordinating the provision of eligibility determination, assessment, and outcome planning functions, the Service Coordinator Role provides case management services for clients. This position advocates on behalf of clients, coordinates access to programs and services, ensures services and benefits are provided to achieve established goals and outcomes, and monitors progress through transitions. With the appropriate consent, employees in the Service Coordinator Role can act on behalf of clients to request and apply for services. This position analyzes information and client requirements and interprets and applies policies and legislation to refer and facilitate access of clients, their families, and other relevant parties to appropriate Alberta Government and community-based programs and services. The Service Coordinator applies a full working knowledge of in-scope programs and existing partnerships and initiatives to support clients through the phases of the transition planning model. This position also leads the collaborative engagement of participating partners in assisting clients to identify service needs and action items to be included in transition plans. The Service Coordinator is accountable for monitoring transition plans and supporting clients, caregivers, and other relevant partners to achieve outcomes identified in transition plans. This role functions within relevant legislation and regulations and applicable Ministry and government policies, procedures, and guidelines. *Responsibilities and Activities:* 1. Consistent with guiding principles of the Ministry, presenting circumstances and current information are reviewed and goal setting meetings are conducted to identify and support transitional requirements of clients. *Activities:* • Discusses cases with referral sources and completes thorough review of existing documentation related to clients. • Opens transition planning files and prepares transition planning checklists and summaries of information in preparation for goal setting meetings.

- Conducts goal setting meetings with clients, family members, caregiver(s), and/or other support representatives to review and validate information and documentation, facilitate development of client goals, and complete transition planning questionnaires.
- Identifies natural supports currently being accessed and that may be accessed following transitions and identifies gaps in natural support networks.
- Identifies potential benefits / services that may be required by clients to achieve identified goals and identifies potential gaps in benefits / services.
- Determines need for transition planning case conferences based on identified requirements for supports and the desire of clients, family members, and other support persons to continue with transition planning services.

2. Individualized transition plans encompassing Alberta Government and community-based programs and services are developed in consultation with clients, family members, and other support representatives as appropriate.

Activities:

Works collaboratively to develop approaches for client-centred transition planning with goal of developing individualized transition plans to move clients toward desired goals and outcomes; client-centred transition planning case conferences typically involve clients, relevant family members, support persons, and other service providers / program representatives (participating partners) who may participate in the transition plan.

Prior to transition planning case conferences, the Service Coordinator:

- analyzes and assesses case files in entirety to develop a thorough, longitudinal understanding of client circumstances and potential issues associated with transition between programs.
- schedules and organizes case conferences, including identifying relevant service providers / program representatives and inviting clients, family members, support persons, and participating partners.

The Service Coordinator chairs and facilitates transition planning case conferences, ensuring clients, family members, support persons, and participating partners engage in collaborative dialogue to:

- review and confirm goals for clients as determined during goal setting meetings, including reviewing and verifying transition questionnaire information.
- discuss supports that can be provided in relation to information identified in transition planning questionnaires.
- determine, confirm, clarify, refine, and prioritize short and long term

client service needs using needs identification questionnaires.

- determine potential eligibility for financial benefits and related supports required to bridge gaps until short and long term services required following transitions are arranged and implemented.
- provide relevant information and referrals.
- formulate agreed upon, specific, and incremental tasks and action items to move clients toward individual transition plan goals.

Following planning conferences, the Service Coordinator:

- develops and records individual transition plans that:
  - include clearly stated activities and action items that must be performed to achieve client goals and outcomes.
  - state who will be involved or responsible for each task over a specified period of time.
  - indicate which tasks are the responsibilities of Alberta Government representatives and service providers.
  - include time frames for beginning and ending each activity.
  - sequence tasks so that they do not all begin and end at the same time.
  - break down tasks requiring multiple steps.
- ensures transition plan is signed off where relevant by all participating parties.
- determines readiness to move from immediate to short term to long term transition planning stages.

3. Eligibility for relevant services is determined, assessments to determine service(s) and related service level(s) are completed, and associated access to programs and services is coordinated to support achievement of client goals and outcomes identified in transition plans (case management).

Activities:

- Determines and/or coordinates determination of client eligibility for Alberta Government programs and services following transition to new "life-stage" and/or "life-state."
- In consultation with participating partners as appropriate, assesses and determines (or coordinates assessment and determination of) applicable range of service(s) and related service level(s) for clients, and authorizes (or coordinates the authorization of) provision of service(s) and service levels(s) to clients following transition to new "life-stage" and/or "life-state" (e.g., Alberta Works, Housing, Alberta Seniors Benefit, Child Care Subsidy, Assured Income for the Severely Handicapped, Persons with Developmental Disabilities).
- Arranges, coordinates, and connects clients to services, including assisting clients and families in completing the applications for appropriate programs and community resources and preparing clients for participation in services following the transition period.

	• Schedules meetings and assessments with program and service providers, coordinates services to enable clients to attend meetings and assessments where necessary (e.g., transportation), and/or accompanies clients as required to facilitate access to and participation in programs and services detailed in transition plans. • Provides information and refers clients to various internal and external programs and services as required (e.g., AADAC, Addictions and Mental Health, etc.), assuring focus on goals and outcomes is maintained. • Provides information regarding court procedures, laws, legislation, etc. impacting clients as applicable and/or required. 4. Transition plans are monitored to facilitate and support progress of clients toward identified goals and outcomes, including appropriate responses to changing circumstances and client goals as they emerge. *Activities:* • Manages implementation of transition plan action items to hold assigned parties accountable for completion of assigned tasks and ensure tasks are completed by dates indicated in transition plans. • Intervenes on behalf of clients and/or participating partners to resolve issues and facilitate completion of transition plan action items not completed according to established time lines. • Assesses progress toward identified client goals and outcomes, collaborating with clients and participating partners to: - ensure continued alignment of current needs of clients with future goals and outcomes. - determine if circumstances or outcome goals have changed. - identify need to modify goals or add new goals to transition plans. - determine requirements for additional goal setting meetings and/or transition planning case conferences to identify specific supports required to assist clients to achieve revised list of goals and whether those supports can be accessed by and/or for clients. - revise and/or update transition plans based on results of action items completed and/or changes in client circumstances or outcome goals and obtain sign-off by appropriate parties for plan updates and revisions. - share revised and/or updated transition plans with all impacted parties - Closes transition plan files upon completion of transition plan implementation. 5. Collaborative relationships are developed and maintained within a multi-disciplinary team to ensure clients have access to appropriate resources to support transition from one "life-stage" and/or one "life-state" to another.

	Activities: • Consults with colleagues and community partners to assist, support, and, when appropriate, refer clients, families, and/or caregivers throughout all phases of the transition planning model. • Provides input to re-assessments and documents significant case events and relevant information gathered during transition plan case conferences, discussions and processes. • Ensures the timely completion and accuracy of hard copy and electronic file documentation as required for managing transition plans and information sharing with colleagues and service providers. • Provides feedback and recommendations relating to the value of the Service Coordinator role and its application for other individuals / clients.
Key Responsibilities for Service Coordinator:	This position focuses on the determination of the individual's service needs, the identification and coordination of services, and the ongoing monitoring of those services to ensure the achievement of outcomes. This includes individuals with complex service needs requiring integrated case management. Needs Identification • Work with Albertans who do not know what GoA services they require, to determine the appropriate services for which the individual may be potentially eligible • Provide information on other GoA programs and services as needed Registration • Receive registration information from applicants to the PDD program and other GoA programs and services • Contact individuals who have registered for services and confirm their desire to apply for PDD services and/or forward registration information to other GoA program and services • Meet with individuals to confirm their identity, provide information on PDD services, and collect information required to determine eligibility Eligibility • Determine if the applicant meets the general eligibility criteria for the PDD program • Review assessment information to determine IQ, age of onset and complete the adaptive skills inventory to determine if the applicant has a developmental disability • Collect general information on current and requested supports and services that will be used to inform assessment and planning Assessment

	• Refer individuals that have been deemed eligible for the PDD program for the completion of a SIS assessment • Ensure individuals are referred for other assessments as deemed necessary • Complete risk assessments or participate in the completion of risk assessments for individuals who have complex service needs Service Design and Planning • Review assessment information (My Supports Profile) • Discuss/review individuals support needs with individual, their guardian and/or primary contact • Identify any natural supports, generic services, or community resources that are available to meet the individuals support needs, including those provided by other GoA departments i.e. Alberta Health Services • Identify the individuals outstanding PDD service needs including the type (code) and amount (units) of service • Facilitate the Individuals and/or their guardian's exploration of available service providers, including the identification of service provider capacity • Work with other PDD staff and the service provider sector to build capacity as required • Obtain approvals for service funding & communicate funding approvals to Individual and/or their guardian, and the service provider • Develop and communicate the funded service plan including the desired client goals, outcomes, assigned responsibilities and accountabilities of all parties involved in delivery of services over a specified period of time • Participate in supports planning, including documenting/obtaining evidence of the individual's support plan • Provide information on family managed services Service Delivery & Monitoring • Monitor to ensure the delivery of the agreed upon service(s) and related service level(s) as detailed in the service and support plans including attendance at conferences to review the individuals support plan • Arrange for a reassessment of the individuals support needs as required based on changes in functioning/progression through life stages • Adjust the type and amount of PDD funded services based on any changes to the individuals support needs • Update the individuals service profile as required • Participate in integrated case management for individuals with complex service needs • Negotiate/refer to Family Managed Services

Accreditation / Education:	Transition Service Coordinator Bachelor of Social Work is preferred and considerable (e.g., at least five years) directly related experience working with clients with complex or multiple needs and transitioning through life events requiring support from a multi-disciplinary team. Knowledge of in-scope social-based programs and community resources is essential. Knowledge of, and experience working with, Aboriginal and immigrant cultures may be required. Service Coordinator Post-secondary degree in social sciences or related field. Post-secondary training provides research, writing, critical thinking and analytical skills, as well as familiarity with social science issues, or equivalent experience gathered through work experience. Experience in working with adults with developmental disabilities and/or other disabilities.
Salary:	Not known.
Ages Supported:	Youth and adults.
Average Duration of Support:	Not known.
Work Load:	The case load information for the service coordinator position has not completed and will be based on the numbers of current caseloads. The problem with the current numbers is that regions differ and functions performed by workers differ as well based on a region. The current caseload is approximately 1:60-100 cases. They are in the process of making a decision whether caseloads should be mixed and potentially complex needs may be handled by more specialized workers.

Name of Jurisdiction:	Ministry of Child and Family Development (MCFD), British Columbia
Name of Position:	Key Worker
Key Responsibilities for Key Worker:	*Family-Centered Approach* • Invite families to determine the frequency of contact, select meeting times/places that are convenient for them, and which individuals are to be present at meetings • Provide information in a clear, easy to understand and flexible manner by tailoring the format, timing, and content to the family's requirements • Mentor families to facilitate an increase in their knowledge, skills and

	confidence to become their own best advocates • Assist the family to select and access appropriate services by providing information on the range of available programs and services • Attend multidisciplinary interagency care planning meetings when requested by the family • Meet with Aboriginal elders and key community members to discuss the best approach to services for Aboriginal children and youth and their families • Assist parents to identify outcomes that they wish to see in their child's program plan • Assist parents to understand and implement the recommendations from the diagnostic team, other professionals, and service providers • Identify and address the needs of all family members to foster a supportive environment for the child *Cultural Safety Framework for Aboriginal Families and Communities* • Reflect on personal cultural perspective and biases, and how these impact the assumptions, values, and beliefs that inform one's approach to service • Seek out opportunities to network and build relationships of trust and respect with key community members • As determined by the family, seek input from and collaborate with parents, as well as elders and respected community members, community governing bodies, and trusted service providers when designing and implementing services • Identify the strengths of indigenous worldviews and traditional healing practices, and seek out opportunities to incorporate indigenous perspectives in the delivery of services *Building on Child's/Youth's Strengths* • Support families to identify their strengths and develop strategies to build upon them • Assist families to recognize and reinforce their child's strengths • Provide child/youth with information in an age- and developmentally-appropriate manner when requested • Assist the child/youth to identify awareness of his or her strengths, abilities, needs and priorities • Facilitate child/youth/ family decision making both individually and collaboratively • Incorporate child/youth/family preferences when referring to other supports and services *Community Resource on FASD* • Help families and communities understand the process and the importance of assessment and diagnosis

	• Work with parents, family members, caregivers and service providers in identifying ways to adapt the child's environment in response to the individual child's emotional maturity, and his or her executive and adaptive functioning. • Follow up on referrals to other services to ensure they are appropriate and meet identified needs • Establish and maintain effective collaborative and constructive liaisons/relationships with a variety of individuals and groups, including families, diagnostic and assessment teams, schools, and other agencies • Support local parent-to-parent organizations by referring parents to the service and acting as an information resource as requested *Develop and Strengthen Community Networks* • Seek out opportunities to work with community partners to raise awareness of FASD and the risks of consuming alcohol during pregnancy • Incorporate information about FASD into all contacts with professional team members • Liaise with the multidisciplinary diagnostic team on behalf of families who are pursuing diagnosis/assessment • Participate in interagency meetings, forums and committees as requested • Assist families to address their questions and concerns to the appropriate professionals • Assist in the development of parent support approaches
Accreditation / Education:	• Undergraduate degree in health or human services (social work, nursing, psychology, child and youth care) or equivalent education and experience. • Extensive understanding of FASD as a brain-based physical disability • Education and training in child development
Salary:	Not known
Ages Supported:	Under 19 years old.
Average Duration of Support:	Average duration of support is usually under two years. There can be a short term support of (e.g. 3 – 4 weeks) and one family has been supported for 4 years.
Work Load:	The key worker workload for MCFD operated Nanaimo office is approximately 1:33 cases. Non-MCFD (Penticton) has a range of 20-40 cases per key worker.

Name of Jurisdiction:	Community Living British Columbia (CLBC), Community Planning and Development, British Columbia
Name of Position:	Facilitator
Key Responsibilities for Facilitator:	Facilitators are responsible for representing CLBC as the primary contact for individuals with developmental disabilities and their families. • Reviewing reports from psychologists to confirm eligibility and notifying individual/family accordingly; • Providing full and complete information about informal community supports, generic services, CLBC services, peer and family support services available; • Making referrals as required on an individual basis and/or coordinating supports with other agencies outside CLBC (e.g. MCFD, Health Authorities, educational/vocational and municipal services); • Providing information about available supports and services and expected levels of support to address the individuals' disability related needs; • Providing advice and guidance to eligible individuals and their families to assist them in decision making; • Assisting individuals and their families to develop goals or an individual support plan (specifically: determine both community and CLBC funded options, identify alternative supports and services, identify formal and informal safeguards and assist with implementing approved funded supports); • Providing timely notification to individuals and families of CLBC decisions about provision of CLBC funded services, funding limitations or delays so that individuals and their families may adjust their plans accordingly; • Identifying key issues for their manager, including gaps in services and supports for individuals and trends, developing new approaches to addressing individual requests; • Responding proactively to situations in order to prevent a crisis with individuals and their families; • Providing support with life transitions for individuals and their families including assisting with changes in existing supports; • Investigating, planning and developing a support plan when CLBC acts as a delegated agency under the Adult Guardianship Legislation; and • Allocating small amounts of available resources.
Accreditation / Education:	Bachelor of Social Work or equivalent. Experience working in Community Living field with children, youth or adults with developmental disabilities and their families.
Salary:	Not known.
Ages Supported:	19 years and older

Average Duration of Support:	Not known.
Work Load:	Facilitator workload is on average 1:47.

Appendix 2 - Key Worker Competencies

The role of a key worker requires people with the right qualities, skills, and attitudes.

The table below presents some of the competencies that were perceived to be beneficial for a key worker to be successful.

	Competencies	LAC[1]	MCFD[2]	DSC[3]	CCNUK[4]	NASDDDDS[5]	CLBC[6]
Family-Centered	Understanding of family development and family dynamics, as well as familiarity with issues commonly experienced by families of youth and adults with disabilities.		✓		✓	✓	
	Understanding of the grief, loss, and guilt that can be associated with developmental disabilities.		✓			✓	
	Ability to work with individuals and families to identify required supports without imposing personal or professional bias.						✓
	Ability to demonstrate a high degree of ethical practice in their relationships.						✓
	Ability to support and interact with families in a way that acknowledges their capacity, and incorporates their needs, perspectives, preferences, and expertise.	✓	✓	✓	✓		✓
	Ability to facilitate communication and shared decision-making between the family and service providers.		✓		✓		
	Ability to adapt approach to the ethno-cultural, spiritual and socio-economic context of the family and community.		✓	✓			
	Minimizing intrusion into each individual's life by checking to ensure they are not doing unnecessary things or doing necessary things in intrusive ways.					✓	
	Holding high expectations for quality of each individual's life, and assist her/him in participating as a full citizen and community member.	✓		✓		✓	
Strengths-Based	Ability to recognize and incorporate into services the strengths, interests, skills and abilities of the individuals and families served.	✓	✓	✓		✓	✓
	Ability to interact with the individual and family to promote and preserve existing strengths, capacities and resources.	✓	✓	✓			✓
	Ability to use an intervention approach that builds on strengths rather than one that focuses on deficits.	✓	✓	✓			✓
	Ability to build rapport and develop relationships of trust with parents, family members, caregivers and affected children and	✓	✓	✓			

	Competencies	LAC[1]	MCFD[2]	DSC[3]	CCCNUK[4]	NASDDDDS[5]	CLBC[6]
	youth.						
Community-Based	Understanding of service system delivery dynamics at the community, regional and provincial level, and effectively working toward removing barriers.		✓		✓		✓
	Ability to maintain current, comprehensive knowledge of local and other resources for individuals with range of developmental disabilities or challenges.	✓	✓	✓	✓		
	Ability to develop effective, collaborative relationships with community partners to build on and enhance existing services.	✓	✓	✓			✓
	Demonstrated skill in advocacy, diplomacy and facilitation with multiple stakeholders.		✓	✓			
	Demonstrated local knowledge and a real commitment to local people and communities.	✓		✓			
	Embedded in the community.	✓		✓			
	Knowledge of the scope and limitations of services available in the community.		✓				✓
Skills-Based	A “can do” approach – displaying creativity and ability to take the initiative.	✓					
	Excellent interpersonal and communication skills. Ability to listen/actively listen.			✓	✓		✓
	Committed to long-term relationships.			✓			
	Ability to respect confidentiality.			✓			
	Someone who is not an “authority” does not always have an answer.			✓			
	Displays spirit, passion, and energy to make a real difference to lives of people with disabilities.			✓			
	Understanding of, and ability to apply, promising practices and current research regarding FASD and other disabilities.		✓		✓		
	Ability to maintain and enhance one’s own levels of expertise regarding FASD and/or other similar developmental disabilities.		✓		✓		
	Ability to promote a common understanding among families, professionals, and service providers of developmental disabilities (or FASD).	✓	✓	✓	✓		
	Recognition of how modifications to the environment can enhance		✓				

	Competencies	LAC[1]	MCFD[2]	DSC[3]	CCCNUK[4]	NASDDDDS[5]	CLBC[6]
	or stabilize functioning.						
	Understanding of the distinct differences in the social and emotional dynamics experienced by birth, adoptive and foster families.		✓				
	Recognition of where his or her expertise ends and when to refer on to other supports and services, access clinical consultation, or consult with professionals.		✓				
	Well informed on a variety of person-centered planning tools.					✓	
	Ability to mediate conflicts in order to find a resolution within a situation with a wide range of stakeholders. Good negotiation and mediation skills.				✓	✓	✓

Note: The wording of competency descriptions may have been slightly modified to reflect the collective essence of various models and research.

Legend:

[1]The Centre for Welfare Reform, Local Area Coordination – From Service Users to Citizens
[2]Ministry of Children and Family Development - Key Worker and Parent Support, Program Standards
[3]Government of Australia, Disability Services Commission - Local Area Coordination
[4]Care Co-ordination Network UK – Key Worker Standards
[5]National Association of State Directors of Developmental Disabilities Services (includes NASDDDS report, Oregon - Key Functions of a Support Service Brokerage, Massachusetts – Support Brokers, and Wisconsin
[6]Community Living British Columbia – Facilitator, Community Planning & Development