Review of the CLBC Service Delivery Model

Prepared for
Ministry of Housing and Social Development

Queenswood
Consulting Group
539 Herald Street Victoria, B.C. V8W 1S5
www.queenswoodconsulting.com

TABLE OF CONTENTS

Executive Summary

Introduction

Since July 1, 2005, Community Living British Columbia (CLBC) has been the crown agency mandated to provide services to British Columbians with developmental disabilities. As CLBC moves into its fourth year of operations, government thought it an opportune time to examine and assess progress on some key areas of the new service delivery system. This report summarizes that review process.

This review had three key focuses: CLBC's service delivery model itself, the policy tools and processes that support the service delivery model, and the guardianship responsibilities and functions of CLBC. These three factors were examined with two key lenses in mind: the vision and mandate of CLBC, and longer-term cost certainty and sustainability. Consideration of children's services, governance, waitlist policies and procedures, and a comprehensive financial audit were specifically deemed out of scope.

From August through October 2008, over 150 participants provided input and feedback on CLBC's service delivery model. Input was obtained through individual and group meetings, written submissions, and a website-based feedback form. In addition, considerable research and analysis was undertaken with respect to the historical documentation, current data, and interjurisdictional comparators of systems with similar characteristics to those of CLBC.

Overall, the review was guided by four overarching questions:

- What were the key issues that CLBC was designed to address?
- What has worked well?
- What has not worked as well?
- What should be done to ensure that people are as well served as possible?

Background

After the closure of institutions in the 1980s and 1990s, services for people with developmental disabilities were delivered through the Ministry of Children and Family Development (MCFD). The service delivery system was often criticized as being unresponsive to the needs of individuals and families, overly focussed on a "protection" model, inconsistent in the way services were approved and funded, and financially unsustainable. After very extensive consultations with families and the community in 2002, the Community Living Transition Steering Committee (CLTSC) put forward 59 recommendations for transition to a community-governance based model.

The *Community Living Authority Act* that empowered CLBC is reflective of the same values that underlay the report of the CLTSC, mandating development of a service plan that offers a range of funding and planning options; promotes choice and innovation: encourages shared responsibility among families, service providers and community resources; and coordinates the provision of community living supports with services provided by the government and community resources. When the *Act* came into force on July 1, 2005, CLBC was provided with an ambitious legislative mandate, and had very high expectations from government, families, and the community in general.

The operating budget for CLBC as a whole was $688 million for 2007-08[1], of which adult services accounted for an expenditure of approximately $600 million. The table below summarizes the expenditure profile and the average cost of the services for adults that are funded through CLBC.[2]

Table i: CLBC Adult Expenditure Profile 2007/08

COMMUNITY LIVING BC
Adult Expenditure Profile 2007/08

$000s	**# Individuals**	**Annual Cost**	***Average Cost***
Contracted Services			
Residential			
Home Sharing	2,232	64,834	***29,047***
Semi-Independent Living	228	10,282	***45,096***
Staffed Residential	2,707	283,274	***104,645***
Individualised Funding (incl. Microboards)	235	15,256	***64,919***
Non-Residential Programs	11,121	185,846	***16,711***
		559,492	
Provincial Services		4,540	
Regional Operations		20,929	
Administration		15,440	
		600,401	

As of August 31, 2008, CLBC had open files for 11,663 adults with a developmental disability.[3] Of this number, approximately 9,225 were pre-existing clients who received services under MCFD; 2,438 are individuals who first registered as adults with CLBC. Approximately 5,150 clients receive residential services in group and home sharing arrangements or semi-independently. Most of these, plus an additional 5,250 individuals, receive family and/or community inclusion services or other CLBC services such as assistance to develop an individual support plan. Supports and services are delivered through over 4,178 contracts with 2,800 service providers.

Until recently, CLBC's service delivery model was built on the presumption that it would also have responsibility for children's services. On June 23, 2008, responsibility for CLBC shifted from the Ministry of Children and Family Development to the Ministry of Housing and Social Development. As part of this move, it was clarified that responsibility for children's services will be moved from CLBC and will be delivered instead by MCFD in 2009. CLBC will maintain a budget of approximately $640 million for the delivery of adult services as it moves forward.

Service Delivery Model: Key Characteristics and Challenges

Key factors regarding CLBC's service delivery model include:

---

[1] $715 million, 2008-09

[2] CLBC (2008d) - 2009/10 to 2011/12 Budget Plan

[3] Includes those on waitlist, per communications with CLBC. Individuals may receive services in more than one area, so there is overlap between categories which results in a cumulative total that is greater than 11,663.

Separation of planning and funding roles

A key component of CLBC's service delivery model is the division of "planning" and "funding" roles, which were previously undertaken by a single position, the social worker. Now, facilitators have responsibility for planning and community development (amongst other duties including confirming eligibility and addressing urgent requests for services), while quality service analysts have responsibility for funding decisions and contract management. This division is aimed at reducing the focus on funded supports and encouraging better objectivity and consistency in the allocation of resources. Although some regions have implemented a team approach, generally speaking there is a lack of shared reporting, teamwork and communication between the staff groups.

Focus on Planning

CLBC's model is based on individualized planning, focussing on identifying and addressing the specific needs and strengths of each of its clients. A result has been a planning process that is comprehensive and onerous, taking up to 25 hours per plan to complete. While families value being listened to and playing a clear role in the planning process, they have also reported strong disappointment when they go through the process, only to be put on a waitlist for lack of funding. CLBC has recognized these challenges and has taken some steps to address them, including undertaking planning only when funding is likely to be available. The planning process itself, however, remains highly time-consuming.

Movement away from case management

CLBC's model is based on the principle that people are not "cases" to be "managed" and do not necessarily require a social worker. Accordingly, people now access CLBC and can speak to any staff member about their file. However, by eliminating the social worker role, the service delivery model removes a fixed, mandated, and ongoing point of contact. This may work well for individuals and families who are well-supported and capable, but for other more vulnerable people, the loss of an ongoing contact who knows their situation well has been challenging and disappointing. In July 2007 CLBC implemented operational changes to address this issue, but this has not been well communicated and remains widely seen as a challenge with the service delivery system.

Facilitator role

Although the facilitator role as conceived includes emphasis on planning, determining eligibility, responding to urgent requests and accessing generic and informal community supports, the last function is widely seen as being neglected and under-skilled. There is a general sense of confusion about the role of the facilitator, how it fits in the system, and how families should interact with facilitators. There is also a shared sense that the workload of facilitators is generally lighter than that of analysts.

Analyst role

Although there is a clearer understanding of the role of analyst, concerns were expressed about communications between analysts and families, service providers and facilitators. A greater emphasis on teamwork with facilitators is required, as well as improved communications with other partners.

Individualized funding

Although individualized funding was a cornerstone of the service delivery model and its long-term sustainability, there has been very low uptake amongst existing or new CLBC clients. This has been mitigated to some degree by the easier provision and higher uptake of direct respite, but for the residential context it remains challenging.

Increased role of community

Increased engagement with and use of supports and services in the wider community is another cornerstone of the service delivery model, but this has been an area that has been highly challenging in terms of establishing new relationships and linkages. Facilitators do not appear to have a focus on, or have not yet had the opportunity to fully integrate, this part of their role. In addition, while Community Councils present a good opportunity to improve community linkages, they have been inconsistently implemented and applied across the province.

Systems/infrastructure

CLBC inherited information systems from MCFD that are universally agreed to have been insufficient and inadequate. The agency has made significant improvements in this area, with the development and implementation of improved client information and contract management databases and supporting systems. Much of this remains in process, and the ability of CLBC systems to interface with MHSD and other government systems is unclear.

Communications

CLBC has been committed to improving communications with families and the community in general, but this is widely seen to have had mixed results. While there is recognition of the efforts that have been made, there is a feeling that CLBC focuses too narrowly on existing partners and has had severe challenges with government relations. There is also a sense of fatigue with a continuous series of crises, which has led to a commonly-voiced disappointment with and mistrust of the agency.

Policy Tools to support the Service Delivery Model

This review focussed on those factors that provide the main support to the service delivery model as a whole: person centered planning; the Guide to Support Allocation; and the Catalogue of Services. These were designed to address a lack of consistency or objective bases for allocations; the previously existing *ad hoc* nature of funding; a lack of comparatives across province; lack of predictability; and the largely emotional nature of previous requests for service.

Person centered planning

In general, there is strong support for the movement away from placing people into available programs and instead undertaking person-focused planning which is “owned” by the individual and family. The planning process is well supported with planning guides and assistance from facilitators, but the long, and comprehensive process requiring 25 hours per plan is not always needed. This has been recognized by CLBC and addressed in some areas such as respite, but in general the process remains too time-consuming. Hand-offs between facilitators and analysts are also areas of concern, introducing a new person into the process and requiring families to tell their stories again.

Guide to Support Allocation

The Guide to Support Allocation (GSA) is a first attempt to provide an objective assessment of the disability-related need of the individual. It has promise, but also faces challenges in term of application: the information that is provided in plans is sometimes insufficient for analysts to make assessment, requiring them to contact families or facilitators for more information. There is also a misperception that going through the GSA process is akin to approval of the plan, but this is not the funding step.

Catalogue of Services

The Catalogue of Services is also a first step in attempting to rationalize and standardize costs per service, based on the individual's level of disability-related need, as established by the GSA. CLBC's cost structure was largely inherited from MCFD, which tended to fund large, global budgets for service providers without identifying individual-level costs. The Catalogue breaks down costs on a per-service basis, and will provide a standard, consistent funding level matrix for use throughout the province. It is very early in the implementation process, so assessment of the long-term viability of the model is uncertain. Development of the Catalogue included service provider participation, but as a policy tool it enjoys uneven support and a there is a sense of a lack of transparency around the process.

Guardianship considerations

When the provision of services for people with developmental disabilities was the responsibility of MCFD, the Ministry was designated under the *Adult Guardianship Act* as the agency of record responsible for addressing complaints of neglect and abuse. When devolution to CLBC took place in 2005, it inherited this legislative mandate, although the movement away from social workers brought with it some challenges in terms of operationalizing facilitators' responsibility for guardianship functions.

Initial growing pains regarding CLBC's guardianship functions included lack of clarity of roles and responsibilities and an over-emphasis and reliance on the role of the Office of the Public Guardian and Trustee (OPGT). These have largely been resolved through a concerted effort at CLBC to assume its proper role, train staff, implement appropriate policies, and improve communications with the OPGT and other partners such as Health Authorities.

Relatively minor issues remain, particularly with respect to improved staff training, and the development and implementation of guidelines to help guide the informal role that CLBC-funded service providers often play as intermediaries between clients and institutions such as banks and the medical system.

Sustainability considerations

One of the key motivations behind the devolution of service delivery from MCFD to CLBC was a belief that the proposed system would offer more predictability and overall sustainability than the historic model. This arose largely from the belief that a cost-effective model would be possible in part through a number of key factors including:

- Individualized funding, which would create system efficiencies and greater flexibility;
- Increased role of families, including the ability to pay families for extraordinary care costs (with the thought that costs would be lower if the family undertook this care, rather than paying for professional support when it was not necessary); and
- Increased use and reliance on generic community supports and services.

There is wide recognition that the key cost drivers for CLBC's adult community living services include demographic changes resulting in a larger client base. Concern has also been expressed that the planning process has raised expectations beyond those that may be affordable or sustainable. The financial pressures for CLBC are considerable, and the anticipated elasticity in the system has not been realized as quickly as anticipated, due to the continued effect of legacy global contracts and the lack of uptake for individualized funding.

CLBC's overall approach to addressing ongoing sustainability can be characterized as threefold:

- Gaining control of current spending through consistent analysis and allocations of funding;
- Encouraging greater interest in individualized funding while managing expectations; and
- Broadening the base of supports and services.

Specific initiatives include the following:

Regional Budgeting structure

One of the fundamental changes under CLBC has been the introduction of a fixed budget not only at the corporate level, but also at the regional operational level. A fixed, regional approach to budgeting is a new approach for this sector, and offers a number of clear advantages in terms of ongoing sustainability. It has also led to some criticism that regional offices are overly focused on managing their budgets, particularly when contrasted with an ongoing focus on rhetoric about increasing choice and flexibility.

Costing Guidelines

One of the major challenges of the previous system was applying consistency and objectivity to decision-making about the availability and level of services that would be funded for each individual case – the Guide to Support Allocation and Costing Guidelines, used together, are key in this effort. CLBC's costing tools are the first concerted effort to introduce regional and provincial standardization to funding allocations, and provide clear guidelines to analysts. These tools are meant to ensure that approved funding covers the reasonable costs of services, that contract negotiations are undertaken in a consistent manner, and that the time and effort required by analysts to focus on contract inputs are reduced.

Key issues for providers include a belief that the tool is overly complex and in a format that requires ongoing intensive maintenance (although CLBC has recently issued a more informal reporting option); concern that the costing tool has effectively unionized agencies that are non-union by using CSSEA job descriptions and associated rates; and concern with the way that the costing tools have been presented and communicated to the sector.

Contract Management
Over the next year, CLBC is introducing a new contract management system (CMS), which will change CLBC's approach to procurement and contracting, and which represents a significant improvement over the system that was inherited from MCFD. The CMS will allow CLBC to eliminate the focus on the paper-based processes and focus more on oversight and output/outcome monitoring. Most elements of the CMS are anticipated to by operational late in the next fiscal year. An unknown factor is the relationship of the CMS with the IT/MIS platform upon which it is based, and the ability to fully interact with the more integrated systems approach that is now being adopted by government. This may present an opportunity for CLBC and government to realize greater efficiencies and through a more seamless infrastructure.

Contract Monitoring / Performance Management
In the past, the lack of adequate or industry-standard performance measures, the global nature of contracts, and the lack of a monitoring framework hampered the ability of government to ensure that contracts were being performed with the highest degree of effectiveness and efficiency. CLBC has undertaken a project aimed specifically at reviewing and improving contract monitoring, in hope of implementing a comprehensive and consistent contract monitoring framework. The project is currently in its framework development phase. Business requirements are expected to be developed and approved by the end of this fiscal year and the system is anticipated to be operational in late 2009-10.

Unbundling / Individualized Funding
The use and uptake of individualized funding has been met with some challenges. Because of restrictions due in part to the legacy system and CLBC's assurances to the sector that it would not move families towards individualized funding involuntarily, there is insufficient overall system flexibility to allow for the degree of choice that CLBC planned for and built its communications upon.

A key step forward in promoting individualized funding has been to try to understand what services, at an individual level, have been supported through the large, global-style contracts that CLBC inherited from the MCFD contracting system. To address this situation, in 2007 CLBC embarked on an initiative to "unbundle" contracts and separate out services. This "unbundled" information is now available for all residential contracts, so that CLBC now knows the name of each individual served, their location, and the costs associated with providing their services.

Although individualized services are promoted as a fundamental component of the service delivery system, the only area that has shown demonstrable progress is that of home sharing. This initiative has been well supported in policy and procedures, which were developed with the active participation and support of service providers. Challenges remain however, in terms of monitoring, supervising, and managing the more personalized employment relationships between clients and caregivers.

Summary and Recommendations

Taken as a whole, the CLBC service delivery is caught in a dual paradigm as long as the legacy clients and global contracts remain a distinct and separately structured system. The required flexibility that the service delivery model seeks to implement is challenging to realize because such a large proportion of CLBC's contracts are structured under the legacy system, and CLBC has provided its assurances that clients will not be moved to the new system involuntarily.

Nevertheless, the model shows real promise, and is widely seen as an improvement over the system that was inherited from MCFD. To address identified challenges and improve the service delivery system for individuals, families, providers and other partners, this report makes 27 recommendations:

Service Delivery Model

1. Improve collaboration between facilitators and analysts

Once a plan is completed, a teamwork approach to the consideration of funding should be adopted. Rather than hand off the plan, the facilitator should be the conduit for setting up an appointment with the analyst, facilitator and family and, where appropriate, potential service providers. The facilitator should remain involved as a resource through the process, providing families with a constant touchstone, and working collaboratively to meet client's needs.

2. Introduce joint reporting responsibilities in the Community Planning and Development and Quality Service Streams

The current situation, where joint reporting occurs only at the CEO level, has exacerbated communications difficulties between the Community Planning and Development and Quality Service Streams. It is recommended that the streams report jointly at a lower level.

3. Introduce a constant point of contact

It is recommended that a consistent point of contact be reinstated for families that want it, and that the facilitator role should service this function. It is not recommended that mandated contact be re-introduced. Rather, this service should be provided only to clients who request it, using a differential process that makes assessments of the client's level of need and availability of other resources.

4. Expand role of facilitator to include application of GSA and discussion of waitlist

The facilitator role should be expanded to include application of the Guide to Support Allocation. In addition, before the planning process is complete, the facilitator should be aware of and formally discuss the likely availability of resources to support the plan. To support this, communication materials should be developed which could be provided to the family to reiterate the process and its limitations.

5. Expand role of facilitator: ability to approve limited services

Facilitators should be provided with a specific budget per year, which they can use at their discretion to meet minor or straightforward requests. Budget levels should be determined in collaboration by CLBC after conducting best practices review and consulting with regional managers and community councils. Analysts should continue to draft contracts and monitor performance.

6. Clarify role of facilitator: community development as well as planning
It is recommended that CLBC undertake a comprehensive training process to educate, assist and support facilitators in focussing on community development, with the goal of creating meaningful, systemic, and flexible ways to incorporate generic community services into the lives of the people that CLBC supports. This recommendation, along with the three preceding recommendations, will also help to address one of the common complaints about the respective roles of facilitator and analysts, which is a perception that analysts currently bear a disproportionate degree of the workload.

7. Clarify role of analysts to emphasize teamwork
It is recommended that a team approach to funding assessment be adopted, in which the analyst, facilitator and family work more collaboratively to discuss and apply funding.

8. Focus the role of Community Councils
The roles, responsibilities and functions of Community Councils should be reviewed and clarified, to move away from advocating for funding and focus more on supporting strategic initiatives. Training should be provided to CLBC managers to help them effectively engage Councils in a more meaningful way.

9. Improve communications about the service delivery model
It is recommended that changes arising out of this review, as well as future communications, be subject to a comprehensive communications/issues management plan.

Guardianship considerations

10. Maintain designated agency status and functions under the Adult Guardianship Act
While there are operational challenges associated with the loss of a mandated case management role for social workers, CBLC should continue as a designated agency, a designation that is also supported by the OGPT.

11. Enhance the proactivity of facilitators
The facilitator's role regarding adult guardianship should be enhanced to further encourage a more active approach to inquiry and investigation in situations where an individual may be vulnerable to abuse or neglect.

12. Involve Analysts in the process
CLBC should develop and consistently implement clear processes and procedures to encourage analysts to include monitoring for abuse and neglect as part of their regular contract and performance monitoring activities.

13. Enhanced orientation to guardianship responsibilities
CLBC has already embarked on comprehensive training for facilitators with respect to roles, responsibilities and duties as a designated agency for adult guardianship. It is

recommended that all staff, including analysts, be provided with an orientation to the guardianship responsibilities of CLBC.

14. Develop and implement clear guidelines for informal supports
CLBC should work to develop and communicate appropriate guidelines to assist CLBC-supported service providers who provide informal supports to clients in areas that involve potential conflict such as finances or health.

Policy Tools to support the Service Delivery Model

15. Rationalize planning processes
It is recommended that CLBC develop and implement consistent training for facilitators that focuses on the non-CLBC-funded aspect of planning, to encourage both staff and families to start thinking about options that go beyond the traditional government-funded support.

16. Query use of Guide to Support Allocation
Particularly in light of the recommendation that facilitators adopt the responsibility for applying the GSA, it is recommended that CLBC revisit the option of utilizing one of the established tools for assessing disability-related need.

17. Provide consistent, comprehensive training for staff (upon confirmation of the ongoing use of GSA)
While the Guide to Support Allocation and the Catalogue of Services are based on sound premises, the lack of consistent application of these tools presents a vulnerability to the system. CLBC should implement a comprehensive round of training and education to all facilitators and analysts with respect to the proper application of the GSA and Catalogue of Services. Managers should also take part in this training.

18. Attention to performance management.
It is recommended that performance management be brought to the forefront of contracting procedures and processes, and that CLBC build on the opportunity to infuse performance management into its technological infrastructure as well as its staff training and job performance assessments.

19. Clarify potential integration with government systems
It is recommended that CLBC work closely with MHSD and other government partners to examine and clarify the potential benefits of greater systems integration.

20. Clarify government oversight of policy
It is recommended that CLBC and MHSD work together to implement a formal review and approval process for the development of appropriate policy.

21. Undertake Ongoing Assessment
CLBC should commit to ongoing assessment of the efficacy of its policy tools, including regular reporting to government, the Board of Directors, and to the public.

Sustainability Considerations

22. Foster partnerships
Greater outreach, becoming part of a wider web of services and creating a dynamic presence in the community is the general movement of leading systems such as those in the UK and Western Australia. Partnerships should play an equally key role in British Columbia.

23. Manage expectations and clarify mandate
CLBC should clarify, and clearly communicate, the boundaries of its role as a crown agency. It should be made clear to communities and to partners that the role of CLBC is to appropriately and competently allocate the resources that government provides for community living services, not to act as an advocate as would be proper for an agency such as the BC Association for Community Living.

24. Foster inclusive practice and the use of generic services
CLBC should play a leading role in improving community linkages, fostering situations that will encourage better use of generic community services, and bringing together federal, provincial, and municipal-level partners to make better use of the existing available resources.

25. Promote innovation
CLBC should examine the possibility of creating a specific innovation unit, with a dedicated budget and a wider mandate than being responsible for providing grants to individual proposals.

26. Engage service providers more effectively
Service providers require incentives to help foster a switch to individualized funding, and can play a much stronger role in this respect. Many spoke of their willingness to do so, if there is an honest discussion about the relative benefits as well as the drawbacks for moving to greater IF implementation.

27. Maintain focus on contract reform and contract management
The CLBC contract management initiative, while in its early days, shows great promise. It is also a logical "next step" in the evolution to a more robust system of contract design, delivery, management and performance. By initiating and implementing more rigorous contract design and monitoring practices and procedures, CLBC will not only address one of the major weaknesses of the system it inherited from MCFD, but it will also put in place a fundamental component to allow for better system design, tracking, and evaluation.

Review of the CLBC Service Delivery Model

1.0 Introduction

Community Living British Columbia (CLBC) has been the crown agency mandated to provide services to British Columbians with developmental disabilities for approximately three years, after passage of enabling legislation in 2004 and the transfer of service from the Ministry of Children and Family Development (MCFD) on July 1, 2005. One of the primary motivations for the devolution of service from MCFD to CLBC was the opportunity to provide supports and services to developmentally disabled citizens in a new and innovative way. As CLBC moves into its fourth year of operations, government thought it an opportune time to examine and assess progress on some key areas of the new service delivery system. This report summarizes that review process.

Queenswood Consulting Group (QCG) was retained to conduct this review, originally anticipated to commence in the spring of 2008. However, due to a number of reasons including a reorganization of ministerial responsibilities that directly affected CLBC, the review did not get underway until the end of July. QCG wishes to sincerely thank participants in the review process, particularly the staff of CLBC, families and service providers, who were very cooperative and responsive in providing a wide array of information and data within a very short timeframe. In addition, our thanks goes to the many people who rearranged their schedules to ensure that their voices were heard, and that their points of view were considered in this review.

2.0 Scope of the Review

This review was originally called for in early 2008, when CLBC was the responsibility of the Minister of Children and Family Development. MCFD sponsored the review as part of a larger government initiative to review and assess the CLBC's progress in a number of areas. The Terms of Reference for this review were as follows:

> To consider and assess CLBC's service delivery model and policy tools, with particular attention to:
> - Long-term sustainability and cost certainty within the fiscal parameters provided by government;
> - Continued development of innovative and flexible service delivery options that provide choice for families and individuals; and
> - Guardianship functions within the context of the service delivery model.

The Terms of Reference further specified:

> The main deliverable of this review will be a report that builds on information arising from the consultation sessions, interviews, and internal and jurisdictional reviews, to provide recommendations on potential directions with respect to:
> - Continuation of the development of innovative and flexible service delivery options that provide choice for families and individuals;
> - Guardianship functions within the context of the service delivery model; and
> - Long term sustainability and cost certainty within the fiscal parameters set by government.

Accordingly, our focus in this review has been on three key topic areas: the service delivery model itself, the policy tools and processes that support the service delivery model, and the guardianship responsibilities and functions of CLBC. These three factors were examined with two key lenses in mind: the vision and mandate of CLBC, and longer-term cost certainty and sustainability.

It is equally important to clarify what was not within scope of this review. As noted above, the service delivery model review is part of a larger re-evaluation of CLBC, which includes separate processes for the review and analysis of CLBC's waitlist system and its governance structure. Accordingly, these factors were not specifically considered as part of this process. Similarly, while sustainability is one of the factors against which the service delivery model, policy tools and guardianship functions of CLBC were considered, this review is not a financial audit and does not provide a comprehensive analysis of the organization's budget structure and processes.

The delivery of services to children was an additional area that was clarified as out of scope of this review from the outset. This was reiterated during the course of the review, when responsibility for children's services was transferred back to MCFD from CLBC. It is our understanding that the transfer of staff and infrastructure will take place through 2009.

3.0 Methodology

Information was gathered and analyzed through a variety of means and methods, which were discussed and agreed to by both MCFD and CLBC at the outset of the review process. As with the question of scope, once responsibility for CLBC transferred from MCFD to the Ministry of Housing and Social Development (MHSD) in June,[4] the issue of methodology was reviewed and the fundamental principles were approved.

This review process was guided by the concept of a targeted consultation process. Recognizing that this is a sector that has been characterized by a high degree of comprehensive consultation over the years, and with a view to focussing on the operational achievements and challenges of the service delivery model, a list of proposed participants was developed with the input of both the MCFD and CLBC. This list was reviewed and augmented once responsibility transferred to MHSD, and during the course of the review process, as judged appropriate by QCG. By the conclusion of the review process, over 170 people, representing CLBC governors, management and staff; service providers; clients; families; community councils; advocates; academics; and relevant branches of government had taken part in the targeted consultation process. A list of participants is included as Appendix 1.

It was also recognized that, while the community living sector has been widely consulted, there is always a high degree of interest in participating in review processes. For this reason, public feedback was invited through a web-based feedback form, accessed through the Queenswood Consulting Group website. The sector was made aware of this option through a letter of invitation, which was sent in August to a number of umbrella representative agencies (CLBC, British Columbia Association for Community

---

[4] On June 23, responsibility for CLBC transferred from the Hon. Tom Christensen, Minister of Children and Family Development, to the Hon. Rich Coleman, Minister of Social and Housing Development

Living [BCACL], Community Living Agencies Network Society [CLAN], and the Family Support Institute) for distribution via their mailing lists. Participants were ensured that their input would be confidential, and by the conclusion of the review process in late October, 72 individuals had provided input. These participants included 22 families/caregivers, 43 service providers, 11 Health Authority representatives, and six others (e.g. advocates). In addition, a number of family members directly called the QCG office to give their verbal feedback. Their input informed the findings and conclusions that are provided in this report.

A review of documentary materials, provided by both MCFD and CLBC, was another cornerstone of the review. This material ranged from comprehensive historical information about the genesis of CLBC to current financial data; from policies and procedures governing the delivery of CLBC services to examples of how the tools are used in practice; and service and contract data to academic treatises. The staff of CLBC, in particular, was very helpful in responding to requests for information and providing required data, and their cooperation was invaluable to the conduct of this review.

In addition, an examination of how other jurisdictions are addressing the delivery of services to people with developmental disabilities was one of the bases on which this review was placed. Recognizing the potentially vast range of possible research for this factor, and in an effort to ensure relevance of jurisdictional comparisons, it was jointly agreed at the outset to focus on jurisdictions that have the most relevance to British Columbia's model – in particular, Western Australia and the United Kingdom. Consideration was also made of jurisdictions with which BC shares closer relationships, particularly Alberta and Washington.

There is wide consensus amongst those that took part in this review that the concepts behind CLBC are largely new and have not yet been fully tested. Being an innovator in this field presents many opportunities and many challenges. With respect to this review, the clear challenge was to distil a vast amount of information into an analysis that provides meaningful conclusions and recommendations. This was our guiding principle, and the reason that we have focussed our review and report on four basic questions that we applied to each of the topics we considered:

- What were the key issues that CLBC was designed to address?
- What has worked well?
- What has not worked as well?
- What should be done to ensure that clients and families are as well served as possible?

The starting point for this discussion is a review and consideration of the reason that CLBC came into being in the first place. Understanding the background of the organization's development, including the key challenges that government was seeking to address by devolving service delivery to a crown agency, is a fundamental facet of the ability to assess how well CLBC has progressed and what remains to be accomplished.

4.0 Background: Genesis of CLBC

The community living sector in British Columbia has a history of being at the forefront of progress and change regarding how government and societies treat people who have developmental disabilities. Beginning in the 1980s, the province was among the first to recognize that institutionalization was not an acceptable policy, and began closing facilities. Part of the commitment towards progress in this area was ensuring that people had the supports and services to live as integrated members of the general community.

Throughout the 1980s and 1990s, government was directly responsible for providing services to people with developmental disabilities. At the outset this was done through a number of ministries, but in the early 1990s community living services became part of the Ministry of Children and Family Development, which was mandated to provide supports and services for children and adults with developmental disabilities.

While coalescing and organizing community living services under a single ministry offered a number of benefits, it also presented a number of significant challenges. Primary amongst these was the reality that the Ministry was perceived as having a focus on its child protection mandate, rather than its community living responsibilities. The sector was often vocal in its position that the needs of children in care were significantly different than those of people with developmental challenges, and that the social work model that was developed for the former often did not make sense for the latter.

The Core Review of all government services that took place in 2001 included a review of the mandate, programs, services and operations of MCFD, including its community living services. In October of 2001, MCFD released a document entitled *Discussion Paper on Community Living Services,* which included three messages:

- Acknowledgement that a system had to emerge that was based on peoples' contributions, not their deficiencies;
- Recognition that people were already at work in the community in pursuit of system reform; and
- Acknowledgement of an end to 'tinkering' with the Ministry and its operations.

The community living sector participated in the review process, and on November 30, 2001, members of the Community Living Coalition[5] presented the Minister of Children and Family Development, the Hon. Gordon Hogg, with its *Governance Proposal*[6]. This proposal outlined proposed changes to the way that community living services would be provided in the province, with the following key building blocks:

- Establishing a single provincial governance body for community living;
- Giving a meaningful and permanent voice for individuals and families at the policy table;
- Proposing to dramatically reform the system with efficiencies that would not impact services to individuals and families; and
- Providing individualized funding and direct funding to families as an option for those who wish it.[7]

---

[5] The coalition was comprised of representatives from the BC Association of Community Living, non profit service providers under the banner of Vision for Community Living, families and self-advocates.

[6] Community Living Coalition (2001a).

[7] Salisbury(2002: 1)

4.1 Community Living Transition Steering Committee

In early 2002, MCFD commissioned the Community Living Transition Steering Committee (CLTSC) to examine and make recommendations for transitioning the provincial ministry-driven model of service delivery. The CLTSC was made up of 25 community members, including individuals working with persons with developmental disabilities, service providers, self-advocates and family members caring for persons with developmental disabilities, and was co-chaired by a community representative (David Driscoll) and a government representative (Elaine Murray). Its mandate was to:

> make recommendations to the Minister defining the terms of the transition plan including determination of all financial, staff and other resources and all assets consistent with the Ministry's budget plan and incorporating all necessary elements and processes to successfully transfer the delivery of community living services to a new provincial authority.

The goals of the CLTSC were to provide the Minister of Children and Family Development with:

1. A framework for the creation of a community based governance structure for community living; and,
2. Proposed possibilities for alternative service delivery mechanisms to create more options for families and an opportunity for greater self-determination for people with a developmental disability.

Over its six-month mandate, the CLTSC worked to achieve this mandate through five separate planning committees and an advisory group. The focus areas of the groups were as follows:

- Governance;
- Accountability and Information Transfer;
- Individualized Funding;
- Human Resources and Finance;
- Services to Children with Special Needs; and
- Communications.

In its summary report, "A New Vision for Community Living…a vision of choice and change"[8], the CLTSC concluded that the best option was for services to be delivered through a community-based delivery structure that would be administered by a new semi-independent authority. The service delivery model was to be focused on inclusiveness and evidence-based decision-making, delivering services in a manner embracing the unique circumstances of the individual, and harnessing community-based supports. The report articulated a key overarching rationale for community-based governance: moving away from a system that focuses on delivering support services to a system that supports people to become contributing citizens.

The CLTSC's recommendations were based on a recognition that communities are integral in determining how to assist individuals in becoming integrated into society and how best to deliver and define their needed supports and services. There was also recognition that the historical model of response, based on the tenet that relying on

---

[8] Community Living Transition Steering Committee (2002a).

professional intervention is the initial and primary response in the area of community living services, was simply too expensive and did not necessarily offer the best solutions for people with developmental disabilities and their families.

The report provided 59 recommendations for the implementation of community governance and reforms to the service delivery system. Key recommendations included the following:

Community-Based Governance

- Establishment of a new community governance structure that moves from a system managed and delivered by government to one that gives the community the authority and responsibility for providing community living services to adults, children and their families with government maintaining the responsibility for provision of funding supports.
- The design and deliver of supports and services be enabled through a new corporation, Community Living British Columbia, established through legislation.
- Appointment of a Board of Directors for the new Authority by government, through a community-based nomination process with the majority of representatives consisting of self-advocates or family members of persons with developmental disabilities.
- The new Authority meet its regional and operational requirements through existing and new community service agencies who adhere to principles that ensure the safety and well being of individuals and making the best use of existing capacity where possible.
- Creation of an Independent Planning Commission through legislation to provide individuals and their families with independent planning and supports.
- Commission to be made up of five member; three of whom must be self-advocates or family members of a person with a disability appointed by Board of Directors from nominations from communities.
- Presence of Commission through 12-15 Community Planning Support Centres and a network of outreach and local staff to work with individuals who need support or services or require a change in existing services.

Citizenship and Choice

- Provide people with the support they need to live satisfying lives in their communities, enhancing their ability to contribute as citizens.
- The new Authority be empowered to establish individualized funding as an option for eligible individuals; in the case of children individualized funding to support both children and their family.
- Recipients of individualized funding can still have access to globally funded programs and to explore new service alternatives.

Accountability and Transparency

- The new Authority to operate within the financial parameters set by government and not be permitted to incur an operating deficit without approval by the Minister responsible.
- The new Authority distinguish between “personal outcomes” (reflecting personalized plans) with “service outcomes” (outcomes and elements of service delivery set by the Authority).

Safety and Wellbeing

- Establishment of quality assurance mechanisms to monitor safety, security, care and quality of life of individuals and families in both community living services and those being provided individualized funding.

4.2 Why there was a need for change

It is widely accepted both within government and in community that, historically, families were not generally given a choice in how services could be delivered to developmentally disabled persons under their care; this was one of the strongest messages arising from the comprehensive consultations of 2001. Families and individuals were placed into structured programs or services administered by government (or through its funded services providers) without consideration of the option of tailoring the service to the specific need(s) of the individual requiring the service. Service providers were often seen as being unresponsive to the needs of the individual or their family, and as a result, many families received only partial or inappropriate care until a defined health and/or safety criticality presented itself, allowing crisis services to be provided – often too late for the individual, or for the health and well-being of the family.

The former structure was often criticized for not providing options for individuals to direct supports and services in accordance with their specific needs, but instead focussing on "fixing" the individual instead of creating situations to enable their integration into broader society. This process not only inhibited an individual's ability to become independent, integrated into society and to choose the supports that best met their individual needs, but also did not always result in the best and most efficient use of public funds. The role of the social worker as both support/service planner and funding decision-maker was pivotal to this old system – two distinct roles which were often perceived as being in conflict of interest.

In addition, there was a growing concern over the sustainability of the existing service-based system which has resulted in growing waitlists for services. The associated cost pressures led to in-depth research resulting in a growing appreciation and awareness of the variety of alternative supports available by community and other organizations to assist individuals in meeting their needs and to foster integration into broader society. There was also the strong belief that community-based supports could serve a proactive purpose potentially acting as a buffer to prevent health and safety crises in certain instances.

So, in addition to strong community support for changing the historical model of delivering services to persons with developmental disabilities, the fiscal reality of budget restraint and reduction needed to be factored into a new service delivery model. Accordingly, given this and the other aforementioned factors, the community-based delivery model was born.

4.3 Devolution to CLBC: Interim Authority

Agreement to move towards the formation of CLBC was the direct result of the recommendations from the CLTSC report, and it can be fairly concluded that government devolved the delivery of community living services to CLBC largely at the urging of the community living sector itself, after a long consultative process that focussed on ways to transform the service delivery system in the province.

From November 2002, operational authority for service delivery for adults with developmental disabilities was shared between MCFD and the Interim Authority for Community Living BC, as established under the *Community Services Interim Authorities Act*. This shift allowed for the beginnings of a movement from service delivery by centralized government to a community governance authority focusing on innovation and choice as a driver guiding devolution of responsibility to a new authority.

Readiness criteria were prepared by KPMG Consulting in August 2002 in order to determine whether a change in governance would be a success. In August 2003, Sage Consulting Group was commissioned by the Deputy Minister of Children and Family Development, Chris Haynes, to identify a number of key components of devolution that needed to be addressed prior to complete transition taking place, including, but not limited to:

- a review of governance vision and principles;
- capacity issues;
- timeframes and deliverables;
- building on existing momentum;
- assessing the relative strengths of each sector; and
- consideration to the legislative framework.

In its report[9], the Sage Management Group noted that in addition to meeting operational readiness criteria, it would be paramount that four other criteria be met prior to being able to provide services in a comprehensive and functional manner:

- Service transformation must be successfully underway;
- Budget stability for services to children and families must be achieved;
- An actual service delivery plan must be developed and approved demonstrating that on day one of new governance, service delivery will be delivered well; and
- A high level of trust must be established among the parities involved in the new governance model.

The Sage Management Group recommended that the Interim Authority and the Ministry (with possible assistance from an expert panel of no more than three persons) should test for readiness as defined by the criteria above and, once accomplished in an acceptable manner, put the plans for the permanent Authority in place. Assuming all aspects of readiness were in place, it was thought that the new Permanent Authority for Community Living could be put in place in June 2004. If, however, all aspects of readiness were not demonstrated, the start up for the new Authority should be delayed until criteria could be met.

In particular, the Sage report made the following key recommendations:

- The Ministry must follow a service plan that is realistic; there is a limit on the amount of change that can be undertaken successfully in a short period of time

---

[9] Sage Group Management Consultants (2003).

and therefore must focus on service transformation and budget stability to start; moving to new governance later and done incrementally by region. This will allow for building on lessons learned as the process moves forward.

- To achieve the Ministry's strategic vision[10], the fundamentals of service delivery need to be transformed – individuals need choice and a greater say over funding and how it will be used.

In light of the Sage Report findings, a panel of experts was convened to conduct an independent external readiness assessment for the proposed devolution of community living services by June 2004. The panel of experts was made up of Vince Collins, Bert Boyd and Arlene Gladstone. In addition to performing a readiness assessment in accordance with the findings from the Sage Group Management report, the Panel was asked to assess the acceptability of work underway, identify any gaps, assess the achievability of the June 2004 deadline and, if that was not achievable, recommend appropriate timeframes for a successful devolution.

The Panel's report[11] outlined strengths and weaknesses in each of four readiness categories (accountability, financial management, service delivery and implementation planning) based on observations made while answering a series of high-level readiness questions, using the results to formulate recommendations for a path forward. The Panel concluded that for devolution to be successful within the original timeframe, three key issues needed to be resolved by the Ministry and the Interim Authority, by January 31, 2004:

1. Development of an Accountability Framework that is accepted by both parties, and the development of a draft performance agreement;
2. Resolution of the service delivery model to be used; and,
3. Resolution of the issues surrounding the transfer of services for children with special needs.

The report noted that there was a great degree of change and instability in the Ministry and Interim Authority, including the departure of key people who were instrumental in devolution work to date, and a preoccupation with budget pressures. The Panel was also of the opinion that the state of readiness should be reviewed through a further independent assessment by March 31, 2004.

In early February 2004, following a meeting between key representatives of MCFD and the Interim Authority, it was affirmed by all parties that organizational issues need to be resolved to make the transfer of services achievable, and the June 2004 target date to transfer services should be revised.

The Interim Authority agreed that Bert Boyd, a member of the initial readiness panel, would recommend a revised timeline for devolution of service delivery. His recommendations for a new transition plan were completed in May 2004. Key findings included a low likelihood of meeting devolution requirements if the Ministry and the Interim Authority continued to act independently and without coordination.

---

[10] A province of healthy children and responsible families living in safe caring and inclusive communities.

[11] Boyd, B., Collins, V., & Gladstone, A., (2003).

A new approach was recommended for a new transitional management structure whereby a joint process would be developed under the leadership of the Deputy Minister and the Board Chair of the Authority. This new approach would bring together the planning and operational components through the development of an organizational structure within the Ministry that would manage Community Living Services operations and initiate the organizational changes required for service delivery under the new Authority. This was to be led by an Assistant Deputy Minister, the CEO-Designate for the new Authority.

Between the May 2004 Assessment of Readiness and the Final Assessment of Readiness in June 2005, the Interim Authority worked with MCFD to address the identified deficiencies. This included a decision to separate the transition process into two distinct phases:

1) Devolution of authority and responsibilities from the Ministry to CLBC; and
2) Transformation of the services that would be available and how they would be provided. This was to take place in the twelve to eighteen month period post devolution.

Given this change in approach, the final assessment of readiness was based on assessing the new Authority's ability to assume responsibility for governance and management of community living services in British Columbia. The modified approach substantially minimized the potential areas for risk as the focus was now centered on transferring *existing* services to CLBC. In view of transformation of service delivery, it was determined that that it would only take place once the Board and the senior management team were confident that the corresponding risks had been properly addressed. This would allow for thorough planning, consultation and drawing on CLBC's leadership capacity and experience in managing the existing system, one to one and half years following devolution of services.

According to the Final Assessment of Readiness Report[12], CLBC was well prepared to assume responsibility for the provision of community living services on July 1, 2005. The report also noted supplemental challenges CLBC would be faced with, in addition to those identified in earlier reports, including:

- Developing the CLBC Service Plan;
- Obtaining better management information on services, those who receive them, and those who provide them;
- Developing and maintaining an effective working relationship with government (including Treasury Board);
- Working with other stakeholders;
- Addressing service and cost pressures from current clients aging, and new individuals entering the system; and,
- Implementing the business processes and an IT plan to support the desired service delivery model.

---

[12] Boyd, Bert (2005).

With proclamation of the *Community Living Authority Act*, CLBC came into being on July 1, 2005 and assumed responsibility for the delivery of community living services throughout the province.

4.4 Legislative Mandate

As Minister Hagen noted during second reading of Bill 45, which became the *Community Living Authority Act (CLAA),* a new approach to providing community living services was at the heart of the legislation that brought CLBC into being. Government sought the advice of the community in how to proceed, and a fundamental component of what it heard and acted on was the desire to move away from old service delivery models. Participation, choice, flexibility and improved services were amongst the basic rationales for the creation of CLBC:

> The passage of this act represents a momentous occasion for thousands of families and caregivers. This means more choice, greater flexibility and ultimately improved services. Our goal with the introduction of the act and the development of the authority is that services and supports will increasingly reflect the needs of the community. Most importantly, these resources will better address the individual needs of those participating in the programs and their families.

The mandate of CLBC is set out in section 11 of the *CLAA*, which empowers CLBC to "provide for the delivery in British Columbia of community living support identified by the minister [of Children and Family Development]…" and to "manage the delivery of community living support and administrative services…"

Some clarification of the scope and focus of this mandate is provided by s. 12(2) of the *CLAA*. This section sets out a number of guidelines that CLBC is mandated to use in the development of its service plan (and related budget plan), and gives some sense of the values, principles and objectives on which its service delivery system should be based.

> 12 (2) In developing a proposed plan…in relation to the provision of community living support, the authority must endeavour to:
>
> (a) offer a range of funding and planning options that promote choice, flexibility and self-determination, for example, individualized funding, independent planning support and the involvement of community resources,
>
> (b) promote choice and innovation in the manner in which services are delivered,
>
> (c) encourage shared responsibility among families, service providers and community resources,
>
> (d) utilize and further develop the capacity of individuals, families and community resources,
>
> (e) assist adults with developmental disabilities to achieve maximum independence and live full lives in their communities,
>
> (f) promote equitable access to community living support, and

(g) coordinate the provision of community living support with services provided by the government and community resources.

CLBC has used this more “person-centered” focus in the development of its service delivery model, which has provided a cornerstone for its redesign of the community living service delivery system.

4.5 Fundamentals of the new system

One of the primary reasons for the devolution of community living services from the Ministry of Children and Family Development to CLBC was the development of a new service delivery model. Without a clear antecedent upon which to directly base the model, leadership at CLBC decided to undertake a comprehensive review of the potential options, analysed what research indicated to be the most effective means of providing community living supports and service, and engaged the community itself in a comprehensive consultation process to develop the new service delivery model.

As noted above, the development of the new system was premised on transferring governance to a crown agency that would work collaboratively with other community support centres to facilitate the provision of supports and service delivery to persons with developmental disabilities. The vision of the new system was to be one that was flexible and based on individual need and choice.

The goals of the new system were centred on two main principles, that of individual choice (through the development of individualized support plans leading to individualized funding where desired and warranted) and fiscal responsibility and accountability.

In early 2005, a team of senior MCFD and CLBC staff worked to embed these principles in a precise service delivery model, which was set out in the *Service Delivery Project Report* (the *Gateway Report*).[13] The *Gateway Report* articulated the structure that would be put in place under CLBC, and provided a clear outline of the fundamentals of the service delivery system. Key commitments included:

- Facilitators to work as the planners and “public face” of CLBC;
- Analysts to work with service providers and CLBC Headquarters to implement/ fund plans;
- Separation of existing MCFD social worker positions: 58% to be facilitators and 42% to be analysts, based on a functional time study;
- Physical separation of Facilitators – located in Community Living Centres – and Operational analysts – located in Community living Operational Offices to ensure independence of the planning function;
- Establishment of 17 Community Living Centres; and
- Establishment of 9 Community Living Operational Offices [later re-named Quality Service Centres].

---

[13] Murray, Elaine (2005).

This is the model that was also articulated in CLBC's inaugural Business Plan, released in June 2005, and is fundamentally the same model that is in operation today. Although it was different from the ministry model in many respects – discussed throughout this report – the CLBC service delivery model's key change was the separation of social workers into facilitators, who work directly with individuals to develop personalized plans, and analysts, who assess the funding needs based on the personalized plan. Separation of planning and funding has been the prism through which many participants judge the fundamental success of CLBC.

In its development of the new service delivery model, CLBC was guided by a number of principles that were articulated not only in the literature on this subject, but also by the clients and families that participated in the consultation process. Key amongst these were the following:

- Encouraging independence: recognizing the need for ongoing support in some cases, but encouraging clients and families to be able to live as independently as possible;
- Flexibility of funding: moving away from funding programs and towards funding people to make their own choice about identifying and purchasing the supports and services they need;
- Family-driven decision making: ensuring that clients, families and/or caregivers make decisions about their paths to supports and service, rather than having such decisions made for them;
- Division of planning and funding roles: attempting to address a systemic issue, where the same person who made assessments about an individual's needs also made decisions about the funding levels that should be attached to meet those needs;
- Involving the community: recognizing that CLBC clients are citizens like any other, better utilizing generic community services when developing support plans for clients;
- Introducing better efficiencies: building on evidence that a more individualized approach to funding can result in an overall reduction in the per capita cost for services; and
- Moving away from case management: changing the systemic view that clients are "cases" to be "managed", and instead treating them as citizens who may or may not requiring changing levels of support over time.

5.0 Inter-jurisdictional comparison of models

5.1 Introduction

The Individualized Funding model in BC was developed pursuant to the experiences of other jurisdictions, particularly the United Kingdom, United States and Western Australia, all of whom directly or indirectly built on the individualized funding/service brokerage pilot projects that were undertaken in BC between 1991 and 1996. In these pilot projects, geared for adults with developmental disabilities, planners acted as independent service brokers, connecting individuals with service supports. Money went directly to the individuals and their families.

While the pilot projects did not develop into ongoing programs in BC at that time, they did set the stage for further study and implementation by other jurisdictions, which saw the results as promising and worthwhile to consider for further application.

The following inter-jurisdictional review provides a summary overview of four jurisdictions: two that are known to have influenced the service delivery model developed and applied in British Columbia; a US-based system used to allocate resources; and the two jurisdictions proximal to BC, so that their approaches can similarly be contrasted with that of CLBC.

The experts in the disability services field, with respect to service delivery and individualized funding, form a small specialized group. Approaches innovated in one area are often adapted and used in other jurisdictions. The four jurisdictions reviewed are Western Australia, in particular with regard to their Local Area Coordination approach to service delivery; the United Kingdom, for their approach to individualized funding, direct payments, resource allocation and individual planning; and the United States system for their often applied methodology for determining needed levels of funding support (Supports Intensity Scale); and Washington State and Alberta, due to their potential influence and impact given their geographical proximity to BC. A more detailed and extensive review of the models, programs and funding methodology applied in these jurisdictions is presented in Appendix 2.

5.2 Western Australia

Western Australia was the first jurisdiction to actually implement a component of the self-determination model through the creation of the Local Area Coordination (LAC) Program, which started in rural areas in 1988 and was expanded to urban centers starting in 1993. The premise of the LAC approach was 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*[14]*.*

The Local Area Coordinator[15] operates as a service coordinator rather than a service provider. While the role of the LAC as facilitator is separated from the funding arm of the Disability Services Commission's (DSCs) Service Purchasing and Development

---

[14] Disability Services Commission (2003: 12).

[15] Local Area Coordinators act in a similar capacity to facilitators in the CLBC model.

(SP&D) Directorate, the LACs are able to act as a *conduit* for the provision of funding directly to people with disabilities[16] and their families. The actual provision of accommodation services (hostel, community residential and supported community living) are provided by the Directorate with the same name. Emergency funding and individual funding support may be available where services cannot be met through existing local supports and services.

In Western Australia, funding for supports and programs are undertaken through different streams with program funding being undertaken by the SP&D arm; and flexible family support funding (up to $5,000 per person) and small grants (a few hundred dollars per person) provided directly through discretionary funding afforded to the LAC.

The Western Australian Local Area Coordination Program serves a dual role of supporting people with developmental disabilities and their families, and developing inclusive communities. Self-identified persons with disabilities[17] can acquire information and advocacy services from Local Area Coordinators, and persons with disabilities (as outlined by Commission policy[18]), can access the wider program which involves funding and placement assistance.

The program was based on the notion of using Local Area Coordinators to work as facilitators to help bridge the gap between individuals, service providers and the community.

The LAC Program contains elements of case management, personal advocacy, family support, community development and direct consumer funding. It is characterized by a fixed point of accountability to individuals with disabilities and their families caring for a family member with a disability, with each coordinator allocated a defined geographical area within which to work. The geographical area corresponds to the number of people with a disability who are known to reside in a given area. The number of people who can safely be supported by one LAC is between 45 and 60. The higher figure is allotted to metro areas given that the remoteness between clients is less than in country areas. As of 2006 there were 144 LACs providing support to over 7,600 people[19] – each coordinator works with the same group of individuals in perpetuity, unless they move to another geographical region.

Western Australia focuses on an approach that emphasizes the need (and requirement) for community support supports and other options to be exhausted before funding of any sort is afforded. The LAC program did not result in the elimination of the need for accommodation funding, however, its existence served to lower the overall average cost

---

[16] Not limited to persons with developmental disabilities

[17] These individuals are not captured in the system i.e., they do not factor into the registered number of persons with disabilities being serviced by LACs.

[18] Access to Funded and provided services (based on an assessment of need applied to people with a severe and profound disability): Local Area Coordination, Community-based support, Day options and Accommodation Services funded by the Commission for Disability Services; Access to Commission provided Services (based on assessment of need for people with an intellectual disability or autism): Access to Commission-provided services.

[19] Disability Services Commission (2007).

of service by assisting people in using generic community supports and more importantly, playing a pro-active and positive role to individuals through the provision of advice, information, advocacy and facilitating access to supports and services. Western Australia also moved to provide discretionary funding to the LACs which allows the LAC to make a direct determination of need for flexible family support funding, thus reducing the bureaucracy and wait time for money to provided to the individual or their family.

In view of program funding, however – funding for accommodation support; intensive family support assistance and alternatives to employment – adjudication is undertaken not only by the Commission but through an Independent Priority Assessment Panel which includes other non-DSC members including persons with a disability, their family members or carers so that a realistic and inclusive funding decision can be made.

It is important to recognize that the LAC program was not an overnight success; it was gradually implemented over a 20-year period – growing from a number of pilot projects to expansion across both rural and metropolitan areas. The program was not available throughout Western Australia until the 2000s. Overall program administration of the LAC program and the broader disability services provision has evolved over time and has grown from experience, building on lessons-learned.

5.3 United Kingdom[20]

Self-directed support in the United Kingdom grew out of the Independent Living Movement of people with physical disabilities, who campaigned in the 1980s and 1990s for the option of being provided with direct payments for supports and services to allow them to choose how best to manage their own care.

Self-directed support is a universal approach for the overall reform of social care. On December 10, 2007 the UK government put forth a policy position called "Putting People First", whose aim was to ensure that personal budgets are available for everyone who is eligible for publicly funded adult social care support, other than in circumstances where people require emergency access to provision of supports and services.[21] It is important to note that the UK groups all forms of disability together: physical, mental and developmental. People with developmental disabilities are not separated from the mix in terms of the service delivery. The transformative approach is applied to all aspects of the social service delivery model and to some degree, the health care system.

The UK's model for self-directed support is based on a form of individualized funding which focuses on individuals receiving a personal budget that they control to meet their own care needs instead of using a service-led approach.

In addition to self-directed support, a key aspect of the UK service delivery model is to create a healthy society that is better for everyone – community development being the key central theme.

---

[20] Hatton, Chris, J. Waters, S. Duffy, J. Senker, N, Crosby et al. (2008). NOTE: This is the reference unless otherwise noted.

[21] Department of Health UK (2007).

The self-directed support model involves setting individual budgets up front through a Resource Allocation System (RAS) which starts with self-assessment questionnaire undertaken by the individual followed by a determination of a general budget that will be afforded to them. Specific planning – funding for specific supports – is undertaken *after* a funding amount has been determined and communicated to the individual. This process is set up so that people can plan creatively within their specific budget. Furthermore, the use of an individual budget is not restricted such that as long as people are successfully meeting their assessed needs they can use the money for these purposes[22]. The shift is being made to move away from "how money is being spent" and towards, "the outcomes individuals achieve[23]."

A non-profit company called *In Control* that was set up in 2003 developed a governance model along with a range of tools and guidance documents to assist local authorities in the development of their own, region and case specific programs for direct funding. The suggested *In Control* RAS seven-step plan for self-directed support and directed funding, used to decide who gets what amount in their personal budget[24], is as follows:

1. Self-assessment – Completion of the self-assessment questionnaire (SAQ)[25] followed by analysis through a Resource Allocation System (RAS).
2. Plan support - Individual makes a plan of how he/she wants to get support.
3. Agree to the plan - The Council checks to see if the plan makes sense -- specific amounts of money get tied to each component of the plan (e.g., housing, shopping assistance etc.) the personal budget get re-evaluated and adjusted if necessary to ensure that all components of the plan can be funded to meet needs.
4. Manage individual budget.
5. Organize support.
6. Live life.
7. Review and learn.

The SAQ measures how disability impacts on a person's life in a number of key areas. Each area is scored and the total is adjusted to align with the amount of support that could reasonably be expected from the individual's friends and family. This allows people with similar levels of needs in similar circumstances to be allocated the same level of funding[26].

---

[22] ibid

[23] Duffy, Simon and J. Waters (2007).

[24] Where Direct Payments were not previously established. "If during the review process the person or the authority believes the package needs a proper re-assessment (perhaps because it seems insufficient or because the person is consistently under-using their allocation) then it will be appropriate to use the RAS to set the allocation. However it is important that local authorities consider carefully when and how any such review process is put in place" (Implementation Guide - Building upon Direct Payments as Key of the Wider System of Self-Directed Support Produced by the in Control's Yorkshire & Humber Forum Revised Version, June 2007 (p.8-9)).

[25] A comparison of the questions used to help with determining funding allotments under self-directed support plans in various jurisdictions can be found in Table X: Comparison between Resource Allocation Models

[26] Duffy S. and Waters, J (2008: 4).

While the UK government has the intention of rolling out self-directed support at a national level in the UK by 2012, currently, it is up to the discretion of the local authority as to what method of funding they employ for persons with disabilities, albeit most are opting to adopt the in Control model.

In 2008, more than three quarters of local authorities in England (122 of 150) were involved with *In Control* in trying to change their service delivery approach. More than twenty of those are already working towards using self-directed support as the approach for everyone needing social care support. In June 2008, 6,000 people were directing their own support, a considerable growth from 60 in 2005.

It is hoped that this model of providing budgets prior to plan development will lead to better use of funds, as funding caps are established at the outset and individuals must therefore be creative in how their budget is spent and use other forms of non-funded support so that they can use their limited funding more effectively. UK materials often cite studies which show the market to be more efficiently managed in a system where there are clear funding baselines set and incentives to work within capped funds. However, one downside of this model is that budget levels and allocations are not standardized, with every local authority responsible for setting its own rates and priorities.

Cost savings, while important, were not cited as the most important driving factor for the direct payment approach. Rather, the empowerment of individuals was the major focus. Self-directed support has yet to have a noticeable effect in the UK as significant restructuring is still required and it is only when more local authorities begin to operate under this structure will a better analysis and positive cost savings be realized.

5.4 Alberta

The Persons with Developmental Disabilities (PDD) program, which is part of the Ministry of Seniors and Community Supports, provides supports to adults who have a developmental disability. Six community boards deliver local programs and work with adults with developmental disabilities, their families and guardians to identify needs. The boards also work with local agencies to provide services. The PDD currently supports approximately 9,100 adult Albertans. The focus is on supporting individuals with developmental disabilities to live fulfilling and inclusive lives in Alberta communities.

In Alberta, individualized funding is provided by the Persons with Developmental Disabilities Community Boards. The amount of funding is determined by a plan that is ideally developed by parents, adults themselves and friends, often with the assistance of service providers or professionals, and submitted to the authorities for approval. The plan may attempt to address all of a person’s needs (e.g., employment, support staff at home, recreation, etc.) or only some needs. Usually negotiations will take place in relation to how much funding will actually be provided, and to the nature of the plan and will be adjusted accordingly. There is an appeal process for disagreements over funding and/or the plan[27] [28].

---

[27] Uditsky, Bruce.

[28] According to section 15(2) of the *Persons with Developmental Disabilities Community Governance Act,* (RSA 2000, cp-8 s19; 2006 c25 s18): *“an individual who is receiving services or has applied to receive*

Person Centered Planning (PCP) is the basis upon which many plans are created. Plan models and tools appear to be independently created by each Community Board such that slight regional differences in approach may be present.

An Individual Funding Application allows for a determination of eligibility and establishes responsibilities for all parties. In the application, the individual, family/guardian and private trustee:

- Identify the specific type and volume of services they want;
- Identify the staffing model and cost for services requested;
- Determine whether they want to fully manage the services or use a service provider to deliver the services; and
- Directs the PDD Program Community Board where to provide funds (i.e., to the administrator or the service provider).

The terms of the agreement for individual funding cannot exceed one year; an annual review of approved services is required[29].

Assistance in plan development and general access and information about community resources for persons with developmental disabilities are provided through the assistance of Community Supports Coordinators in each of the Community Board Regions. It is not clear whether the function of facilitator and funding assessor/contract provider play out as separate roles in all PDD regions, but in the Calgary Region, PDD serves as the funder, while service providers undertake planning with families and individuals.

5.6 Washington State

The Washington State Division of Developmental Disabilities (DDD) assists individuals with developmental disabilities and their families in obtaining services and supports based on individual preference, need, and which facilitate managing everyday routines and relationships that are part of all citizens' lives[30]. Approximately 33,000 people are served by the DDD[31].

The DDD falls under the jurisdiction of the Washington State Department of Social and Health Services and receives guidance from a State Advisory Committee (SAC) who provide input into DDD activities and programs with the aim of enhancing the quality of life for people with developmental disabilities.

Case Resource Managers (CRMs) are the Division's point of contact who assist clients and their families identify interests and support needs and aid them in accessing division services and navigating through the wide array of community resources to determine

---

services by means of funding or resources allocated by a community board and is affected by a decision of that community board respecting those services may appeal that decision if the decision is not exempt from appeal under the regulations."

[29] Province of Alberta PDD (2007a)

[30] Washington State (2008a).

[31] Washington State (2008b).

what they services they are eligible for and which services best meet their individual needs. Each individual is assigned a specific CRM.

Paid services are determined through a three step process:

1. Intake and eligibility determination[32]

   Part of the eligibility determination process involves determining whether the individual can be assessed as having a developmental disability. A component of the eligibility determination process involves documentation and/or diagnosis by an authorized person that the person falls under the category and often includes results from evaluative tests such as IQ or other standardized adaptive behaviour scale assessments.

2. Assessment of the person's support needs

   The assessment is undertaken via a specially designed tool called the "Supports Intensity Scale" (SIS). The Supports Intensity Scale (SIS) is a nationally recognized and normalized assessment tool, developed by experts in the field of developmental disabilities, used to assess employment needs, help build the Individual Support Plan (step 3), determine need for community support, and highlight additional needs for community or informal support for people with developmental disabilities age 16 and older. The tool was designed by experts in the field of developmental disabilities specifically to identify the needs of people with developmental disabilities. There are plans for a future SIS scale to be developed for children under the age of sixteen[33].

   This module also includes an assessment of caregiver needs, behavior issues, and protective supervision.

3. Determination whether person will have paid services or no paid services

   If it is determined that the person is not eligible for paid services by DDD, the person receives a report on the assessment findings, and the case resource manager then provides information, assistance, and referral to community resources.

   If it is determined that the person is eligible for paid services by DDD, the person will be asked questions by the CRM to determine need and the level of services that will be authorized resulting in a service level assessment, an Individual Support Plan on-going case management, and paid services through Medicaid or state-only resources. The case resource manager, using the information produced by the DDD Assessment, will determine the service level and authorize payment for client services[34].

5.2 Similarities in approach

It was not possible to undertake a direct comparative analysis of either the cost savings of different models/different jurisdictional approaches for applying the individualized funding methodology given that there were too many variables that could not be

---

[32] Washington State (2008d) and Washington State (2008a). For details, see Appendix 2.

[33] Washington State (2008e).

[34] Washington State (2008d).

standardized in any simple manner. For example, the models are based on different governance structures, with different legislative, regulatory and policy mandates. In the case of funding allocations in particular, adoption of the model is completely discretionary in the UK and the US – local authorities or states can choose to, or not to, adopt the program. Furthermore, local authorities (UK) and States (US) are at various stages of implementing the individualized funding and planning approach and on-boarding with this service delivery model (e.g., in the UK 9 of 150 local authorities have fully incorporated the individualized funding model developed by *In Control*; 122 are at various stages of adopting the approach).

However, it is possible to make some broad conclusions about the varying systems, and in particular to assess where they have adopted similar approaches in terms of planning, resource allocation and service delivery.

Principles of Service Delivery

All researched jurisdictions do subscribe to very similar visions and principles, focusing on individuals' self-determination, community integration and involvement, inclusiveness, trust, openness, equity and choice. All jurisdictions surveyed have transitioned or are in the process of transitioning their service delivery model from one that is service driven – fitting people into existing programs and systems; to one that is person-centric – focussed on establishing supports to fit the individual's needs. The "community-based" paradigm shift is also taking hold across all these jurisdictions.

Scope of Service Delivery

BC and Alberta have dedicated agencies to deliver and/or coordinate services specifically for adults with developmental disabilities: in BC, a Crown Agency; and in Alberta, a program within the Ministry, governed by a separate board. In the UK and Western Australia the focus of service delivery is more expansive, addressing the broader array of disabilities within the social care spectrum such as physical disabilities and early childhood development services in Western Australia, and seniors' disability needs in the case of the UK.

BC's model has drawn from components of the UK and Western Australian approaches to service delivery. The LAC model employed in Western Australia, whereby individuals' are integrated into the community, with their servicing needs being intrinsically linked to local community resources and supports delivered through regional centres, has been mirrored in the CLBC model through service provision out in the community afforded by the creation of Community Living Centres.

Facilitator/Quality Service Analyst Roles

BC's approach to providing human resource-based services to individuals with developmental disabilities seems to be rather unique. Only Alberta, and at that, perhaps only select Community Boards in Alberta such as in the South Alberta region, have distinct roles for facilitators and contract coordinators. In South Alberta, a "Community Connections Facilitator" serves as a community liaison, building awareness in the community and develops partnerships with Community organizations and also determines program eligibility while the "Contract Coordinator" ensures that funded supports reflects PDD's vision through monitoring and negotiates and evaluates contracts and works with service providers to improve efficiencies and develop new innovations.

Western Australia uses somewhat of a combined approach such that major funding initiatives and programs are determined and administered by the SP&D, a distinct directorate (albeit all directorates in Western Australia while separate, work in close association with each other), the LACs do have authority to assess, determine and provide funding allotments for smaller programs (less than $5000) and grants (in the range of a few hundred dollars). In BC, there is a clear differentiation between "Facilitator" and "Quality Analyst" in that the former provides assistance in the development of individualized plans, puts individuals in contact with resources and supports, and builds community relationships; and the latter focuses more on analyzing plans to make funding and service provision determinations and addresses accountability issues.

Finally, BC's original approach towards the client management changed in July 2007, when it implemented a policy allowing for ongoing contact between clients and a specific facilitator where requested (previous to that, the concept was that any facilitator could work on any client file). In Western Australia, Washington State, and in the UK, key functions of the "case management" approach apply more clearly such that in Western Australia, there is one LAC for each defined region (every person in that region has the one LAC); in Washington State "case resource managers" assist in defining an individual's resource needs and accessing services (each individual has their own CRM); and in the UK, a social worker plays a similar role by carrying out four distinct functions: completing assessments; writing care plans; developing or setting up services and monitoring and reviewing services and their provision[35].

Independent Board Oversight and input

Alberta, Western Australia and Washington all have, as a part of their reporting structure, an independent advisory board providing input into refining service delivery and programs based on local experiences. Most boards include people with developmental disabilities, their families and/or caregivers.

Resource Allocation Models

CLBC has also adopted components of the UK model of self-directed support, direct funding and personalized plan development in the formation of their Individualized Funding financial delivery model, in particular with regards to the development of the assessment tools used to determine individualized funding allotments. The Resource Allocation System model developed in the UK was used as a primary template for developing CLBC's Guide to Support Allocation tool (GSA) which was further refined to accommodate the needs and to align with the structure in BC[36].

The UK model differs from that in BC in that the individual completes a self-assessment questionnaire as the first step of the RAS model and through this evaluation process, is able to be informed at the outset, on the anticipated funding support that will be provided

---

[35] Duffy, Simon and J. Waters (2007). Guide to Self-Directed Support – Personal Budgets.
[36] Davies, John (2008). Personal Communication (e-mail). May 4, 2008 via Paul Grant CLBC.

for their personal set of circumstances. The BC model is not as transparent as the RSA model used in the UK given that the GSA tool is applied by the Quality Service Analyst in isolation of the individual or the facilitator who may be assisting in the development of the personalized plan for the individual. The individual is not aware of how their plan can affect the support allocation they will be afforded as a result.

The US model for resource allocation, which is based on a detailed evaluation of a "Supports Intensity Scale" (SIS) was not explicitly adopted in BC given the distinct separation between the facilitator and analyst (funder) in BC. The US model requires that the SIS analyst have a direct relationship to the individual in order to complete the complicated and intricate assessment process. This would impact the ability of the analyst to remain impartial to the determination of benefit allotments. The CLBC facilitator currently has the primary relationship with the person requesting service.

The original model for BC was based on a points system using relative weights of certain aspects of support, however, analysts testing the model found that it was difficult to use the calculations to determine the disability related need of the person. The tool desired by CLBC was one that could determine whether there were significant or extreme support requirements which should drive costs allocations but could not easily develop such a tool without an extensive validation process[37]. As a result, a generic tool was developed to be used as one component of the evaluation process, using "flags" in certain areas of the evaluation to identify specific, extreme situations that are considered paramount in determining an individual's support needs, so that professional judgment can be applied to determine the influence the flag has on the allocation of resources[38].

While the overall tool is somewhat subjective in nature, the use of the "flag" system can somewhat clarify this subjectivity potentially impacting funding allotments albeit in a less direct manner. Michael Kendrik, an expert consultant in the field, in his communications with CLBC recommended that funding level determination should not be based solely on psychometric assessment tools as this would limit the ability to employ innovative approached from being used[39].

What is common between the US, Western Australia, Alberta and BC service delivery models is that the process for determining individualized funding allotments begins with the identification of an individual's goals (personal living goal); moves to the development of a plan which identifies needed people, material and service system supports to meet the goal; followed by an evaluation process to determine the funding, availability and resource requirements to meet support needs. The UK's Resource Allocation System uses a simple scored self-assessment questionnaire as the starting point for self-directed funding or direct funding. In BC, the Quality Service Analyst takes a plan that is developed by the facilitator (and/or individual, caregiver, family, or service provider) and uses the contained information to complete the GSA.

A comparative overview of UK, US, Western Australia and BC funding determination models are presented below in Table 1.

---

[37] ibid

[38] CLBC Guide to Support Allocation (2008)

[39] Salisbury, Brian (2008).

Table 1: Comparison between key models[40]

	Supports Intensity Scale (SIS) US Individualized Plan Model	Resource Allocation System (RAS) & Self-Assessment Questionnaire (SAQ) U.K. (Adults under 65)	Guide to Support Allocation (GSA) BC Individualized Plan Model	Estimate of Requirement for Staff Support Instrument (ERSSI) DSC Western Australia
Rating Scale Consider-ations	1) Support Needs Scale a) Home living activities b) Community Living Activities c) Lifelong Learning Activities d) Employment Activities e) Health and Safety Activities f) Social Activities 2) Supplemental Protection and Advocacy Scale a) Protection and Advocacy Activities 3) Exceptional Medical and Behavioral Support Needs a) Medical Supports Needed i) Respiratory care ii) Feeding assistance iii) Skin care iv) Other exceptional medical care b) Behavioral Supports Needed i) Externally directed destructiveness ii) Self-directed destructiveness iii) Sexual iv) Other	1) Looking after myself – my personal needs 2) Relationships 3) Being part of the local community 4) Leisure and learning 5) Making decisions 6) Staying safe from harm 7) Complex needs and risks 8) a) Family carer and social support b) Family carer and social support	1) Nature and Impact of Disability a) Communication b) Meeting Personal Care Needs c) Creating and/or Maintaining Relationships d) Making Day to Day Decisions e) Making Important Life Decisions 2) Community Life a) Promoting Well Being – Staying Safe from Harm b) Work and Learning c) Being Part of the Local Community 3) Complex Health Needs (Including Mental Health Needs) 4) Complex Risks and Actions 5) Allocation Level	1) Adaptive Skills Domain a) Eating b) Toileting c) Toot Brushing d) Bathing and Showering e) Dressing f) Mobility g) Transfer h) Receptive Communication i) Expressive Communication j) Community Mobility k) Purchasing Skills 2) Behaviour Domain a) Endangering Behaviour b) Staying at Home Alone c) Aggressive Behaviour d) Destructive Behaviour e) Threatening Behaviour f) Disruptive Behaviour g) Stereotypic Behaviour h) Self Injurious Behaviour i) Illegal Behaviours i) Actual petty offences of minor nature and social nuisance value ii) Criminal behaviour of great seriousness or strong evidence of the likelihood of criminal behaviour of great seriousness

---

[40] Note: RAS and ERSSI models apply to a broader spectrum of individuals with disabilities (e.g., physical and mental); not limited to adults or to those with developmental disabilities.

	Supports Intensity Scale (SIS) US Individualized Plan Model	Resource Allocation System (RAS) & Self-Assessment Questionnaire (SAQ) U.K. (Adults under 65)	Guide to Support Allocation (GSA) BC Individualized Plan Model	Estimate of Requirement for Staff Support Instrument (ERSSI) DSC Western Australia
				3) Medical Domain[41]
Scale	1-4 in intensity (exception: Medical/behavioural supports rated from 0-2 (no support; some support; extensive support required))	Generally 0-3 but otherwise varied point system for each category. Point valuation may be substantially higher for options identified as "needing a high level support" as compared to option of "needing some level of support" for categorized associated with safety. E.g., "Staying safe from harm" – needing help all the time is awarded 15 points; needing help some of the time is awarded 4 points.	1-5 in level of disability along a continuum; Room for making supplemental/explanatory notes for consideration in overall decision (subjective?); Supplemental "flag" available for certain categories	Under the Adaptive Skills Domain, evaluation is based on a gradation of independence/need required. Scaled from 1 to 4 or 1 to 5. Under the Behaviour Domain, evaluation is based on frequency of behavioural tendencies. Most scales are 1 to 7; one is from 1 to 4.
Documentation of Scores	Each of the three main sections of Scale are analyzed using different methodologies 1) Support Needs Ratings Total raw score is calculated for each sub-category (e.g., Home living activities); a Standard score is determined using a developed formula and a sum of the standard scores are also figured; followed by a determination of a subscale percentile using same. An SIS Support Needs Index is then developed as a composite of the Standard Score following analysis from a separate Appendix and a percentile of Support Needs Index is determined as well. 2) Supports Needs Profile Standard score for each activity subscale in 1 is then plotted on a scale to develop a graph. 3) Support Considerations Based on Protection and Advocacy Scores The four highest ranked activities in this category are	Each level in the scale is scored and each area is weighted by a maximum and minimum possible score. Each area is scored and the total is adjusted according to the amount of support reasonably available from family and friends.	Total score added from each of the 10 sub-categories (1(a) – 4) then divided by the total number of sections completed to determine an average score. A "Flag" system is also used to identify areas where further subjective analysis is required. Flags identify specific, extreme situations are considered critical in determining the support needs of the individual. Careful consideration is needed to understand the underlying cause of the "flag". When flags do not relate to the individual's developmental disability per se but to other health (including mental) concerns, the analyst should ensure that other supports/funding agencies' involvement is noted in the plan. While flags are not scored, they can influence	Absence of information on how responses relate to overall funding – information is not published.

---

[41] Medical Domain was not discussed in further detail as it does not figure into a determination of needs specifically for developmental disabilities but reach into the health area.

	Supports Intensity Scale (SIS) US Individualized Plan Model	**Resource Allocation System (RAS) & Self-Assessment Questionnaire (SAQ) U.K. (Adults under 65)**	**Guide to Support Allocation (GSA) BC Individualized Plan Model**	**Estimate of Requirement for Staff Support Instrument (ERSSI) DSC Western Australia**
	outlined 4) Support Considerations Based on Exceptional Medical and Behavioral Support Needs. Summary of results presented		the disability-related needs.	
Overview: Different Assessment Scales	SIS scale sets the stage for analysis based on the level of support needed/independence capability for each category. Broken down further into sub-categories to analyze support needs: frequency, daily support time, type of support. Rating key provided to assist the analyst in providing a numerical rating (e.g., "frequency" is defined as "how frequently support is needed for [particular] activity" – scale: 1=at least once a month, but not once a week) Specificity of particular activities differentiated (e.g., category for being able to use the toilet, eating food, dressing etc.) and analyzed in terms of intensity/frequency of required assistance Extremely complex and intensive analysis required involving the use an approximately 100 pp detailed users manual and interpretation guide.	The SAQ is linked to a set of locally defined funding levels based on how much money is needed for people in similar circumstances. Cost information is drawn from existing care packages and the scale is refined over time – recalibrated in accordance with information from people who have experienced and used personal budgets. A weighting function is applied based on a 10 pt scatter – more points are given to domains having the most influence on the individual's decision to spend money. The assessment of the SAQ by the care worker helps to determine if the amount is justified – whether the price point should be elevated to ensure a reasonable level of support. Initial establishment of rate structure is complicated, time and cost intensive -- requires pilot study evaluation, sample verification and ongoing refinement. Once rate structure is completed for an area, the actual evaluation process is not overly complex.	Lack of specific metrics to help analyst determine appropriate rating choice (i.e., lack of rating key) Generalizes the needs support required into categories for assessment (i.e., does not differentiate between assistance needs for laundering clothes, preparing foods, using the toilet) No specific user manuals to assist in completing the assessment; assessment is based on 10 needs assessment questions.	Similar to the US SIS model. Scale sets the stage for analysis based on the level of support needed/independence capability for each category. Broken down further into sub-categories to analyze support needs: frequency, daily support time, type of support. Rating key provided to assist the analyst in providing a numerical rating (e.g., "frequency" is defined as "how frequently support is needed for [particular] activity" – scale: 1=at least once a month, but not once a week) Specificity of particular activities differentiated (e.g., category for being able to use the toilet, eating food, dressing etc.) and analyzed in terms of intensity/frequency of required assistance
Purpose	The SIS provides information that can help understand the support needs of people with intellectual disabilities.	To provide a fair and equitable process to help individuals in having an good estimate of the amount of money that will be	Tool to review an individualized plan; not an assessment tool to evaluate a service request.	Aims to identify the characteristics of individuals that will have an impact on the amount of support that they need in service

	Supports Intensity Scale (SIS) US Individualized Plan Model	Resource Allocation System (RAS) & Self-Assessment Questionnaire (SAQ) U.K. (Adults under 65)	Guide to Support Allocation (GSA) BC Individualized Plan Model	Estimate of Requirement for Staff Support Instrument (ERSSI) DSC Western Australia
	Focuses on the pattern and intensity of supports neede to enable a person to participated in valued settings and activities.	afforded to them to develop an Individual Support Plan.		settings. The ERSSI is designed to collect a number of key indicators to get a good idea of what the overall support needs of individuals are when linked to information about hours/cost of service. NOT designed to assess needs, design services or measure every support needed by individuals. Is not the only measure of resources needed; if needs are not captured, they are considered for funding through special consideration.
Process to develop Individual Support Plans	Four component process (Iterative) 1) Identification of individual's desired life experiences and goals a) Interview process with individual, advocates, family and supports with emphasis on "person-centered" planning. 2) Determination of the pattern and intensity of support needs (SIS scale) 3) Development of the individualized plan a) Prioritization of preferences b) Identification of needed supports c) Identification of support sources that are needed and those that are currently used d) Development of individualized plan	1. Self-assessment – Completion of the self-assessment questionnaire (SAQ) followed by analysis through a Resource Allocation System (RAS). 2. Plan support - Individual makes a plan of how he/she wants to get support. 3. Agree the plan - The Council checks to see if the plan makes sense -- specific amounts of money get tied to each component of the plan (e.g., housing, shopping assistance etc.) the personal budget get re-evaluated and adjusted if necessary to ensure that all components of the plan can be funded to meet needs. 4. Manage individual budget. 5. Organize support.	Development of the plan (CLBC facilitator) General review and analysis of the individualized plan focusing on developing an overview of the disability related needs. Assessment of needs using the Guide to Support Allocation	Used to allocate levels of funding once priority has been established

	Supports Intensity Scale (SIS) US Individualized Plan Model	Resource Allocation System (RAS) & Self-Assessment Questionnaire (SAQ) U.K. (Adults under 65)	Guide to Support Allocation (GSA) BC Individualized Plan Model	Estimate of Requirement for Staff Support Instrument (ERSSI) DSC Western Australia
	that specifies the pattern ad types of supports needed to participate in specific settings and activities 4) Monitoring progress a) Extent to which individual goals and experiences are being realized, extent to which they remain relevant, match to plan.			
Who completes the tool	Case Manager (same as one who does the plan)	SAQ is completed by the individual applying for individual or direct funding – a self-assessment Evaluation.	Quality Service Analyst	Staff member familiar with the individual's level of functioning and daily need for staff assistance or someone who knows the individual well.

6.0 Current State of CLBC

CLBC is responsible for directing operations, enforcing standards, establishing outcomes and managing funds and services for eligible adults. CLBC's service delivery model aims to support local decision-making through the creation of responsive and flexible supports and services for persons with developmental disabilities.

CLBC services are currently offered through nine Quality Services offices (which house the almost 195 staff that are primarily responsible for contract management and monitoring), 17 Community Living Centres (which house the 200 staff that are responsible for individualized planning and community development) and one headquarters office (housing the 71 members of the policy, corporate services and central management and support teams). When regional projects and Provincial Assessment Centre staff are considered, CLBC has a total of 509 operational staff.

The operating budget for CLBC as a whole now stands at $715 million for 2008-09, up from $688 million in the previous year, as set out below in Table 2:

Table 2: CLBC Operating Expenditures[42]

	Actual			Budget	Plan
$ millions	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**
Expenditures:	(9 mo.)				
Adult Services	378	532	564	588	622
Children's Services	-	55	74	74	74
Other (regional operations/admin)	33	46	50	53	53
Family Independence Fund	30	-	-	-	-
Total Expenditures	441	633	688	715	749
Funded By:					
Prov Govt Grant	425	610	647	677	712
Other (eg. recoveries fr. MCFD)	16	23	41	38	37
	441	633	688	715	749

Budget increases have been met through increases in the amount of grants from the provincial government, summarized below in Table 3:

Table 3: Provincial Grant Increases[43]

	Actual			Budget	Plan
$ millions	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**
Adult Service funding	19.0	23.2	19.5	22.3	23.2
Children's Service funding	1.5	-	-	4.4	-
Compensation lifts	-	8.1	15.8	12.7	11.4
Regional Staff/Programs	0.7	2.9	(1.4)	2.8	-
CLBC Transition/Creation	5.2	-	-	-	-
	26.3	34.2	33.8	42.2	34.6

---

[42] CLBC 2007/08 Annual Report and 2008/09 – 2010/11 Service Plan - CLBC (2008a) and CLBC(2008b)
[43] ibid

Supports and services are delivered through over 4,178 contracts with 2,800 contracted not-for-profit organizations, private agencies and individual caregivers that provide family support, residential and community inclusion services, life skills training and employment support. Professional and independent contractors also deliver services such as behavioural support.

CLBC contract management activities increasingly include monitoring supports and services provided to adults and their families, to ensure they are delivered appropriately and that CLBC obtains value for money. The vast majority of contracts are relatively large in nature, with about $650 million going towards contracts over $25,000 and about $30 million towards those under $25,000:

CLBC Schedule of payments made for the provision of goods and services – 12 months ending March 31, 2008[44]

Total paid to suppliers > 25K	650,547,721.50
Total paid to suppliers < 25K	29,989,533.84
	680,537,255.34

As of August 31, 2008, CLBC had open files for 11,663 adults with a developmental disability.[45] Of this number, approximately 9,225 were pre-existing clients who received services under MCFD; 2,438 are individuals who first registered as adults with CLBC.

With respect to the types of services provided through CLBC, approximately 5,150 clients receive residential services in group and home sharing arrangements or semi-independently. Most of these, plus an additional 5,250 individuals, receive family and/or community inclusion services or other CLBC services such as assistance to develop an individual support plan.

CLBC currently funds supports and services in the following categories:

- Residential Services
    - Home Sharing
    - Live-in Support
    - Supports to Home Sharing/Live-in Support
    - Support Living
    - Staffed Residential
- Community Inclusion Activities
    - Goal-specific Individual Services
    - Employment Services
    - Community-Based Services
    - Group-Home Based Services
- Family Support Services
    - Direct Family Support
    - Respite

---

[44] CLBC (2008c) – Schedule of Payments made for the Provision of Goods and Services ending March 31, 2008

[45] Includes those on waitlist, per communications with CLBC

  - Adult Direct Funded Respite
  - Homemaker Services
- Program Coordination
  - Respite Care Programs
  - Home Sharing Programs
  - Host Agency
  - Intentional Communities
- Professional Support
  - Psychological Consultation
  - Behavioural Consultation

Adult services accounted for an expenditure of approximately $600 million last year, with the highest costs being those for staffed residential services ($283 million, with an average of $104,000 per client served). The table below summarizes the expenditure profile and the average cost of the services that are funded through CLBC.[46]

Table 4: CLBC Adult Expenditure Profile 2007/08

COMMUNITY LIVING BC

Adult Expenditure Profile 2007/08

$000s	**# Individuals**	**Annual Cost**	***Average Cost***
Contracted Services			
Residential			
Home Sharing	2,232	64,834	***29,047***
Semi-Independent Living	228	10,282	***45,096***
Staffed Residential	2,707	283,274	***104,645***
Individualised Funding (incl. Microboards)	235	15,256	***64,919***
Non-Residential Programs	11,121	185,846	***16,711***
		559,492	
Provincial Services		4,540	
Regional Operations		20,929	
Administration		15,440	
		600,401	

Until recently, CLBC's service delivery model was built on the presumption that it would also have responsibility for children's services. On June 23, 2008, responsibility for CLBC recently shifted from the Ministry of Children and Family Development to the Ministry of Housing and Social Development. As part of this move, it was clarified that responsibility for children's services will be moved from CLBC and will be delivered instead by MCFD in 2009.

A very practical effect is that some CLBC staff will move to MCFD, while CLBC continues to have exclusive responsibility for adult services. Although the details of this

---

[46] CLBC (2008d) - 2009/10 to 2011/12 Budget Plan

move are now being determined, preliminary data suggests that once the move is complete, CLBC will have an estimated 232 staff remaining, of which approximately 170 will be field staff responsible for the front-line delivery of services[47]. Presuming a roughly 50/50 split between contracting and planning/community development staff, this will leave about 85 Analysts and 85 Facilitators to address the needs of almost 12,000 adult clients and their families.

This will be a considerable challenge for CLBC, particularly in rural or remote areas where a limited number of field staff have responsibility for both children's and adult services. CLBC is currently working actively with MCFD and MHSD to address the staffing implications of the ministerial reorganization, as well as the implications it may have with respect to CLBC's service delivery system.

Nevertheless, CLBC will have a budget of approximately $640 million for the delivery of adult services as it moves forward. This provides a strong base from which to build, and one that affords a real opportunity to facilitate the paradigm shift for service delivery which was envisioned by the Community Living Steering Committee, mandated by the *Community Living Authority Act*, and enshrined in CLBC's planning and strategic documents.

7.0 CLBC's Service Delivery Model

7.1 Introduction

As noted above, the fundamental concepts that underlie CLBC's service delivery model arose out of wide community consultations and research, and were articulated in the report of the Transition Steering Committee. That essential vision was based on the premise that individualized planning, family decision-making, and choice of services should be at the centre of a new system. Over the past three to four years, the guiding vision for CLBC has continued to reference the same fundamental characteristics. Its corporate vision, for example, states:

> CLBC has a vision of full citizenship in which people with developmental disabilities:
> - Lead good lives.
> - Enjoy rich relationships with family and friends.
> - Have financial security.
> - Are able to make choices in how they live their lives.
> - Have meaningful employment opportunities.
> - Are accepted and valued as citizens.
> - As a steward of this vision, CLBC is committed to supporting growth of inclusive, supportive communities.

Participants in this review also consistently identified a number of themes that they thought guided the development and implementation of the service delivery model, including:

- Encouraging independence;
- Providing individualized planning and funding;

---

[47] Discussions with CLBC executive, September 2008.

- Offering flexibility in funding arrangements;
- Ensuring a central role for the family in decision making;
- Moving away from case management;
- Dividing planning and funding roles within CLBC;
- Utilizing generic community services as means of both containing costs, and fostering full community integration; and
- Reducing the average per capita cost for services.

There is little disagreement about the value of the fundamental concepts or vision that gave rise to the service delivery model – participants who were the strongest critics of CLBC in the course of this review agreed that the fundamental principles are correct. While there is general agreement that the underlying philosophy is sound, there is not a similar widespread support for how these principles have been put into action through CLBC's service delivery model. The next sections describe the model as it currently exists and discusses some of the challenges that were identified during the course of this review.

7.2 Current Structure

Internally, CLBC's service delivery model is based on two main staff groups - facilitators and analysts - who work with individuals and families to develop, implement and monitor individual support plans, which are aimed at fostering and supporting clients to live their lives fully integrated with the larger community.

Facilitators are CLBC's "public face" and address most requests for information or help to access supports and services. Facilitators represent CLBC in performing the lead role in confirming eligibility of applicants for CLBC funded services; and supporting and enabling individuals and families to access unfunded services and informal supports, as well as paid formal supports. Where requested, Facilitators work with individuals and families to resolve problems, and create and implement individual support plans; they also support the building of networks of support and involvement in the community. Key duties of facilitators include confirming eligibility, providing information, advice and practical support to eligible individuals and families, and assisting in the development of individual support plans. Facilitators operate through 17 Community Living Centres and use person-centred planning to develop an individualized plan for clients. Facilitators do not request funds; rather they are responsible for helping people navigate the complex system and access or develop supports and services tailored to meet individual needs and maintain independence.

A key part of the facilitator's work is the development of individual support plans. Plans are developed through discussion with the individual/family and following a thorough examination of their situation which allows for detailed description of the individual and their goals. Funded support requests are documented, and plans are meant to include the use of generic services (those available to the general public) and informal community supports (those provided by family, friends, neighbours and community members) to enhance community inclusion.

Quality Service Analysts make decisions on requests for funding and/or services; monitor contracts; assess gaps in the service delivery system; develop increased provider capacity; ensure a crisis response capacity exists in local communities; and work to improve the effectiveness of contracted services. Analysts work out of nine Quality Service offices. Once an individual plan is completed (with or without the assistance of a facilitator), analysts review plans to assess disability-related needs, determine funding allocations and develop new contracts for services. Analysts also manage existing contracts with providers to ensure deliverables are met and value for money is achieved. They are responsible for: organizing effective community responses to crises experienced by individuals and families; freeing up funds from existing "global" contracts so people can choose more individualized supports; and increasing service provider capacity. Analysts also maintain ongoing relationships with service providers, monitoring, reviewing and revising contracts to ensure high quality of services.

7.3 Key characteristics of the Service Delivery Model

The following characteristics are those that were identified as the most significant factors to the evolution of CLBC's service delivery model. Each concept is explained, with a summary of the strengths and challenges that are associated with each characteristic.

7.3.1 Separation of planning and funding roles

The key concept behind the service delivery model is the separation of the planning and community development process (performed by facilitators) from the funding allocation decisions and contract administration (performed by analysts).

The original concept for the planning process for people with developmental disabilities was to create an independent commission with responsibility for planning and supports. The commission was to be a separately governed, separately funded agency, created through legislation of its own. It was recommended that the commission be staffed through 12-15 planning support centers across the province.[48] The aim here was to completely remove any possible conflict of interest and central concentration of power that was inherent when both planning and funding were the responsibility of one position, the social worker.

Due to concerns about funding and the potential complexity of the system as proposed, the planning function was not devolved to a separate organization, but became part of the duties of the CLBC Facilitator position (along with community planning and inclusion activities), reporting to Community Planning and Development Managers. Contract management and monitoring functions became the responsibility of Quality Service Analysts, reporting to Quality Service Managers.

CLBC's stated goals for this separation are the following:

- Less focus on funded supports as the solution to a disability-related need;
- Greater innovation in developing individualised solutions;
- Enhanced community development and more opportunity for community inclusion;
- Greater use of available generic services that all citizens enjoy;
- More objectivity in the allocation of resources to competing needs; and

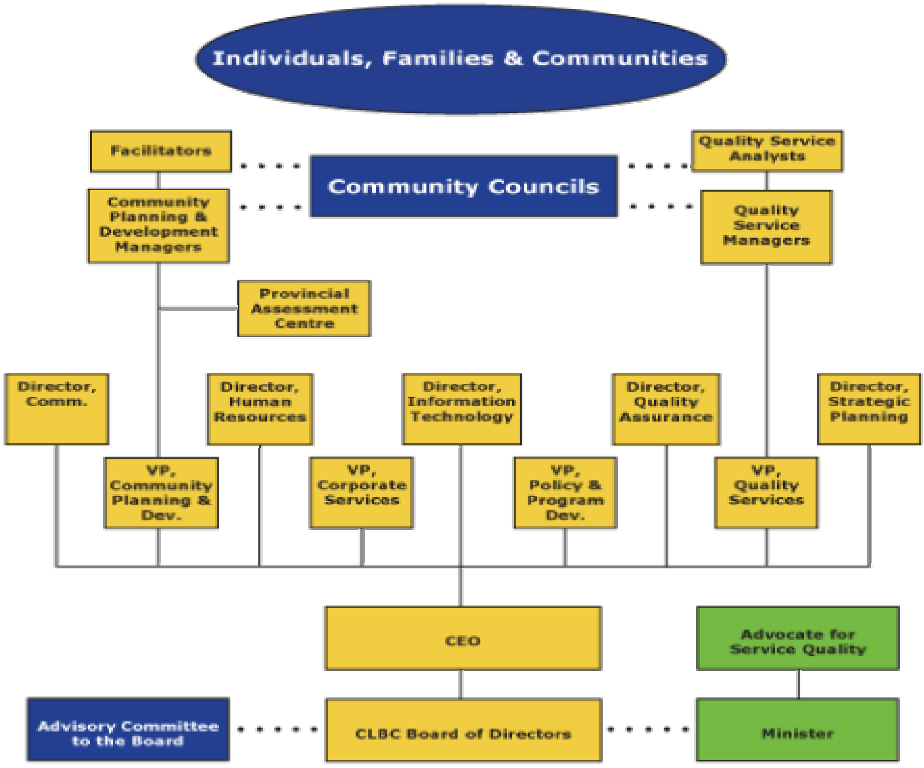
---

[48] Community Living Transition Steering Committee (2002a),

- Greater focus on the development of service provider resources and the oversight and accountability of the contracting process.[49]

The separation between facilitators and analysts is reflected not only in their roles, but also in their reporting structures, physical location, and communications procedures. As noted elsewhere, facilitators work out of one of 17 Community Living Centres, few of which are co-located with any of the 9 Regional Quality Service Offices where analysts reside. Completely separate reporting structures carry straight up the CLBC structure: Vice Presidents who are separately responsible for Community Planning and Development (facilitators) and Quality Service (analysts) report to the CEO, as set out in the organizational chart below.

Figure 1: Organizational Chart, Community Living BC



As illustrated above, the only place in the current organizational system that has oversight for both analyst and facilitators is at the CEO level. There is no co-management at a Vice-President, regional or local level, creating a situation where, many reported, there are almost two separate organizations in terms of reporting, goals, philosophies and responsibilities.

The comprehensive separation of roles has had significant implications. CLBC has emphasized the merits of “dynamic tension”, with the opportunity to encourage service

---

[49] CLBC (2008d) – 2009/10 to 2011/12 Budget Plan

excellence by allowing for two very different processes – planning and funding – to take place without being unduly influenced by the other stream. This has sound reasoning at its base, and is aimed at addressing the lack of robustness in the contracting system as it previously existed.

However, there was a widespread, almost universal recognition by participants of this review that the negative implications may outweigh the benefits of a complete separation of functions. As one participant noted, there is no place in the system to enable or promote interaction between the planning and funding arms of CLBC. This has resulted in poor communication with facilitators and analysts often working at cross purposes.

This tension has been also been recognized through an internal review of the planning process that CLBC commissioned from an independent consultant. Elizabeth Robinson's report[50] identifies the separation of roles as one of the key barriers to effective planning, summarizing her finding that:

> Separation of facilitators' and analysts' roles, limited communication, and restricted teamwork all contribute to building animosity, frustration and negative tension in the workplace and ultimately affects outcomes for families and/or individuals. Facilitators largely have little involvement beyond the planning process and are often in the dark as to what is happening after the plan has gone to the QS [Quality Service] office. The analysts focus on the funding decisions, contracts and implementation of supports. Their involvement with the family and/or individual is generally limited.

It was the sense of many participants in this review that the lack of communication between facilitators and analysts has gone far beyond dynamic tension, and is now characterized by confusion and, in some cases, animosity. Due to organizational and physical dislocation, the positions frequently operate independently of each other. When the two primary persons responsible for identifying and securing services for individuals cannot or do not work together, service delivery suffers.

Some areas – specific offices in the Fraser Valley, for example – have been successful at implementing a structured team approach, including regularly scheduled meetings that include both planning/community development and funding/contracting staff and managers. This is not a widespread practice, however, and there is a need for working in a harmonized fashion, focusing on fulfilling common, shared goals.

7.3.2 Focus on Planning

One of the most consistent criticisms of the service delivery model as currently structured is that the very nature of the planning process has the effect of raising individuals' and families' hopes and expectations, only to be disappointed by the lack of available funding to put the suggested supports and services in place. The planning process is comprehensive, time-consuming and based on exploring abilities, needs and goals. As noted in the Robinson report "it is a long, emotional, draining and foreign process" for some families, and for some of them it is seen as a hoop to be jumped through in order to secure funding. For many, though, the planning process has been

---

[50] Robinson, E. (2008)

identified as an area where CLBC is providing a highly meaningful service that places the individual's and family's own hopes and needs at the centre of the process.

Once the facilitator helps to create a plan, there is often a lack of an effective relationship with the analyst, whose role it is to "cost" the services that are available and put contracts in place to secure services. When the planning process results in feedback from the analyst that there is insufficient funding available, the disappointment and frustration for families is considerable. After putting in time and effort and being encouraged to "dream big dreams," only to be put on a waitlist for services, many families have experienced and articulated a strong sense of disappointment.

CLBC has recognized that this is an issue, and in July 2007 staff was advised that facilitators should prioritize their time to provide planning support only where it was clear that CLBC could implement the funding request in the plan. It was further clarified that funding priorities would be determined between managers and Community Councils at the local level. Since then, entering into the planning process has been restricted to situations where funding is known to be available.

In theory, this restriction should result in the diminishment of CLBC's waitlist over time, as funds become available and are applied based on the waitlist priority score of each individual. However, in reality, a large proportion of the new services that are approved are for urgent, crisis-driven cases. CLBC estimates that in 2007/08, approximately 55% of new services approved were for individuals who were not on the waitlist, but rather entered an unanticipated crisis and received supports ahead of waitlisted individuals. This has obvious implications on CLBC's ability to address the needs of those who have gone through planning and remain on the waitlist for services.

The same July 2007 operational change also clarified that clients could receive assistance for accessing generic services and informal community supports without developing a support plan (similar to Tier 1 services in the Western Australia model) and access supported employment, respite and life-skills training with less detailed planning.

All of this is due in part to CLBC's inability to clearly articulate and implement its vision that obtaining CLBC-funded services should be only one facet or goal of planning. Instead, the current system has emphasized the link in families' minds between plan development and funding. CLBC has now begun to try to re-establish one of the key objectives of the planning process: the leveraging of generic services within the community to avoid the need for funded supports. This factor is discussed in greater detail later in this report.

7.3.3 Movement away from case management

A second key characteristic of the current service delivery model is the movement away from case management. Under MCFD, social workers were identified as the fixed point of responsibility for caseloads of 80 to 150 individuals and families. The workload was challenging, and in many cases social workers felt unable to adequately meet with the individuals for whom they were responsible. On the other hand, some social workers also formed highly supportive and long-term relationships with families and individuals. They were required to support individuals and families with their crises, manage the network of other professionals involved in their lives and negotiate for services based on their understanding of the needs of these individuals and families. Social workers also took forward the requests for funded supports for the individual/family and steered them through the resource allocation process.

The case management system had clear challenges. While having clear responsibility for a specific number of people created a duty to regularly communicate with clients, there is a wide consensus that, in practice, the large caseloads that social workers managed meant that many clients were dealt with in a pro forma basis, to ensure the social worker “checked off the right box”. Many families felt that their concerns were not adequately addressed, and that they did not have meaningful contact with their social worker.

Importantly, many families felt that the very term “case management” is both offensive and revealing of an underlying devaluation of individuals with developmental disabilities. To them, case management was appropriate for children in care – the model on which MCFD’s CLS services were based – but not for adults who are citizens in need of support. They are not “cases” to be “managed”, but individuals with particular abilities, needs, and requirements.

For these reasons, CLBC adopted a system that did not include providing a fixed point of accountability for each client. Rather, the system was modeled on the basis that any facilitator or analyst could access the file of any client and address their needs or concerns. Rather than having to track down their specific social worker, CLBC clients would be able to contact any CLBC office and discuss their issue with any staff who was available. The main benefit of this model was that contact would become demand driven, rather than simply being seen as an annual “hoop” for staff to jump through. It was also believed that this would allow staff to concentrate their efforts on clients who did not have adequate supports and older parent caregivers with increasingly complex needs.

While it was always conceived that facilitators would be available to address client concerns, the communication and monitoring of this message to front line staff and the community was not always strong or consistent. A number of factors have been suggested for this breakdown, including resistance among some managers to move to a new system; resentment amongst former social workers resulting in deliberate miscommunication to clients and communities; and workloads that did not adequately permit the formation of ongoing contact with clients. While the reasons vary, there is no doubt that the result was a wide acceptance of the belief that the facilitator’s role did not allow for ongoing relationships with specific clients.

As a result, the movement away from case management has been characterized as going hand-in-glove with the removal of a consistent point of contact. Having a single point of contact is a high priority for many parents and families, who often rank the necessity of telling their stories over and over again as one of their greatest frustrations with community living services. And it must be said that, for many families, there is no need for ongoing contact with a specific individual at CLBC - for individuals who have the benefit of strong support networks and skilled families to assist them, this systems works perfectly well. For those clients who are vulnerable, at risk, or without supports, however, the loss of a single point of contact has been a considerable challenge.

Even amongst many of those who are critical of case management, there is concern over the perceived loss of a focal point of responsibility. For them, there is no clear and consistent first responder who knows the individual's specific strengths and challenges, and many service providers report stepping in to serve as the *de facto* "case manager," ensuring that the interests of the client in question are met. However, this may not necessarily be inappropriate, as the agency is contractually responsible for ensuring the needs of the client are met, including negotiating with CLBC as the funder where there is an issue over funding.

As noted above, part of the issue here has been miscommunication, but it must also be said that CLBC has recently taken specific steps to address the articulated concerns regarding the need for a predictable and consistent point of contact. Recognizing that "individuals and families are increasingly requesting continuity with contacts at CLBC for family support, information and self advocacy…", in July 2007, the CEO announced operational changes that included moving toward a "more proactive person-centered system," in part by ensuring "individuals and families will have the name of a facilitator to call for information and advice."

In March 2008, this directive was formalized in the *Individual and Family Support Policy*, which clarified that facilitators are to be the point of contact. Section 4.2 of the policy states:

> Facilitators will provide their contact information to families or self-advocates at initial contact with CLBC so the self-advocate/family can contact them with questions, concerns or for advice. That specific facilitator remains the contact whether there is a work assignment or not until that responsibility is passed to another facilitator.

CLBC has recognized that for some individuals and families there is a desire for ongoing contact, and has implemented the means and process to ensure this takes place. This is unlike case management, it should be noted, in that facilitators are expected to respond on an as-needed basis, rather than the former system of mandated contact that was not necessarily realistic, meaningful, manageable or appropriate.

Putting this policy into practice faces some challenges, including the resistance amongst some CLBC staff noted above. It also faces a practical challenge in that families tend to turn to analysts, rather than facilitators, when they have concerns or questions. This is due in part to the fact that the last person they would have had contact with at CLBC is the analyst who approved or denied their plan; as well as the practical reality that people tend to turn to the position with control over access to services when they have issues, concerns or questions.

7.3.4 Roles and responsibilities: Facilitator

As originally conceived, the position of facilitator had two primary roles: working with individuals and families to help develop individual support plans, and helping to build community networks that would connect families with wider, generic community services in order to decrease the historical dependence on automatically turning to paid, professional staff to provide supports. This duality is reflected in the job description for facilitators, which states:

> Facilitators represent CLBC in performing the lead role in confirming eligibility of applications for CLBC funded service; support and enable individuals and families to access unfunded services and information supports, as well as paid informal supports. Where requested, Facilitators work with individuals and families to resolve problems, create and implement individuals support plans; as well as supporting the building of networks of support and involvement in the community.

Despite this clarity – which is expanded on in detail in the job description – this review identified a general sense of confusion and lack of clarity in the community about what exactly it is that facilitators do. For the majority of people who were already accessing community living supports and services before CLBC ("legacy" clients), there is little reason to contact facilitators and there is a generally lack of knowledge about the role and its responsibilities.

For new clients, and for many service providers and partners such as Health Authorities, there is a sense that facilitators have not been sufficiently active with respect to the community development and capacity building part of the job. Many factors were suggested for this complaint, including a general reluctance among pre-existing staff to make necessary changes, lack of sufficient support from CLBC to help shift staff from former to new roles, and an overall risk-aversion that was inherited from the social worker point of view, whereby staff often worked to meet strict deliverables and often found themselves in the position of bearing responsibility when criticisms were made. Some participants in this review spoke of an occupational disinclination to focus on community development, with the result that the "gate keeping" functions of the facilitator position (e.g. establishing eligibility, updating the waitlist, and undertaking planning) often takes precedence.

Focussing on requests for urgent assistance also makes up a considerable proportion of facilitator's work time allocation. CLBC estimates that 55% of new funds are allocated toward meeting urgent request from people who are not on the waitlist, and facilitators play a key role in gathering the information necessary to make decisions about these situations. CLBC estimates that approximately 30% of facilitator time is expended on addressing requests for urgent service needs.

All of this leaves relatively little time for the community linkages and development portions of facilitators' roles. While the community development part of facilitators' responsibilities is "soft" programmatically, there is a wide understanding that it is key to the success of the CLBC model, which emphasizes not only the receipt of appropriate funded supports and services, but also tapping into and maximizing the generic community services that are available to all citizens. A cornerstone of the CLBC approach and the community living philosophy is that these are the sorts of supports that create strong communities and meaningful supports for people, while also contributing to the sustainability of the service delivery system. Without a proper focus on developing the necessary contacts and networks, the basic philosophy and model for CLBC remains challenged, making expansion of community living beyond simply CLBC-funded services difficult to put into practice.

In addition, given the directive that planning should only take place when there are sufficient funds for supports and services, and given that there is a considerable waitlist of people who have plans in place and are simply awaiting funding, it seems amiss that there is a lack of clarity regarding the workloads of facilitators. This is an area that requires further study and analysis, and was not within scope of this review to fully address. It is a curiosity, however, that may be clarified as part of the resolution of human resources issues regarding the move of children's services to MCFD.

Despite the concerns outlined above, the role of facilitator has also presented some clear advantages to CLBC that are valued by clients, families, service providers, and the community in general. First, the increased flexibility of facilitators to work outside of their offices, with the mobility to actually go out to families rather than having families come into an office to see them, was highly valued by participants in this review. Many felt that this has been an important step forward, both in terms of enacting a more client-centred approach and of de-stigmatizing the previous sense that families were in the position of going cap in hand to government to ask for help.

In addition, many participants reported that they value the sense of connection with facilitator that comes about as part of the development of an Individual Support Plan. Although the vast majority of people have a short-term relationship with the facilitator, those who undergo planning highly value the time they take to develop the plan. Some participants felt that this results in the facilitator truly getting to know the individual and their family, understand their strengths and needs, and articulate their hopes accurately in the text of an Individual Support Plan.

While the concept of the facilitator as a position focussing on both planning and community development has merits, there are some practical challenges that must be addressed. In general, there is a sense that more senior and skilled staff tend towards the analysts' positions, both because of the power inherent in holding decision making about funding, and because of a sense that over time the facilitator role might slowly disappear as families and agencies step into the planning process in a stronger way. This has led to a lingering sense of resentment amongst some facilitators and may account for some of the corporate resistance to change that has been noted in this report and in other CLBC-related reviews.

The lack of communication between analysts and facilitators is an ongoing challenge to the optimal functioning of the facilitator's role. Particularly with respect to clarification of uncertain points in plans, there is a wide range in practice relating to how additional information is sought and provided. As noted in the Robinson report, and supported by feedback from this review process, "communication between facilitators and analysts was more problematic than the other lines of communication, revealing lack of understanding of roles, lack of teamwork, and 'turf wars'."

7.3.5 Roles and responsibilities: Quality Service Analysts

The role of Quality Service Analyst, in contrast to that of facilitator, is well understood – the position is essentially responsible for managing the contracts for services that are in place to support the clientele of CLBC. As stated in the job description:

> Quality Service Analysts are responsible for representing CLBC and performing the lead role in reviewing individual support plans where CLBC funding is requested, allocating funded supports and development of CLBC funded services.

In addition, analysts are responsible for:

- Negotiating contracts;
- Negotiating costing details;
- Monitoring contracts for complains;
- Monitoring contacts for quality and appropriateness;
- Identifying systemic issues and service gaps; and
- Supporting the allocation and management of local budgets.

Despite this clarity, and a greater sense of understanding about the role of the analyst in general, there are a number of practical challenges related to the position. First, although the CLBC service delivery model calls for facilitators to be the first point of contact and "public face" of CLBC, in practice analysts find themselves acting more and more as the *de facto* point of contact for individuals and families. This is in part due to the fact that they are often the last person that the family will have dealt with (to discuss the outcomes of a completed plan, for example, or to discuss the details of a funding arrangement). Families are often interested in discussing funding, so it makes sense to them to contact an analyst rather than a facilitator.

While CLBC has attempted to meet criticism about the loss of a predictable point of contact by allowing facilitators to step into this role, it will be challenging to implement because, in general, families often want to talk about funding and contract issues once they have secured services. It is natural that they will turn to the analyst rather than the facilitator in these situations. Many participants reported a sense that analysts bear an inequitable share of the workload regarding client services, and that becoming the effective point of ongoing contact only adds to this inequity. It also erodes the primary reason for the split in funding and planning responsibilities: to encourage independence, objective decision making in funding.

As noted elsewhere, communications between analysts and facilitators is another challenge to the effective implementation of the roles and responsibilities as outlined in CLBC's service delivery model. Participants reported many situations where plans with inadequate or insufficient information were simply returned to facilitators without any additional communication, both creating a delay in the processing of the request for services, and exacerbating tensions between facilitators and analysts. The Robinson report notes that practice in this respect varies widely, with some analysts simply returning inadequate plans while others contacting the facilitator directly to request more information.

In addition, facilitators, families and other participants expressed frustration at the lack of follow-up that occurs once a plan is submitted. Many felt that they spend a great deal of time and effort creating a quality plan, which then disappears without a sense of where the file is in the queue. Regular, predictable status updates would greatly assist in meeting this concern, and indications are that some offices have already implemented formal or informal status communications between facilitators and analysts.

A second widely-shared concern regarding analysts' communications related to the manner in which they communicate with families who are waiting for approval of requests for services, and with service providers who have questions about contracts. Although – as with all conclusions about roles and responsibilities – there is a wide range in how analysts practice their roles, feedback from a number of sources suggests that there are problems with communications. Some analysts are perceived as being overly curt and even harsh in their communications, especially in light of the considerable time and effort that clients spend with facilitators in the development of their plan.

Again, this concern is reflected in the recent internal review conducted by Elizabeth Robinson, who notes that in her sample, only 50% of communications from analysts to families were smooth and productive, involving combinations of meetings, calls, and ultimately a decision letter. In 25% of cases, the only contact was the decision letter, and in 25% there were serious communications issues from the point of view of families.[51]

Finally, some participants expressed concern that analysts are not fully taking into consideration or applying the larger capacity and resources that are available to individuals and families when they approve plans. This was not a universal sense, but some felt that analysts are too focussed on considering only CLBC-funded programs and services and are not as expansive as they should be in identifying and securing alternative supports and services. These participants were concerned that the new service delivery model is being compromised by effectively maintaining the previous point of view, and that individuals may continue to be slotted into programs based on the availability of space, not the appropriateness to the individual's needs.

In addition, the lack of constructive teamwork between analysts and facilitators means that analysts are not well positioned to take advantage of facilitators' putative links to community and generic services, further limiting their ability to consider a broader palette of services and supports. Antagonism and protectiveness means that alternative options are not identified, and the system restricts itself to considering only the programs and services that have long been in operation, negatively impacting the ability to identify and secure creative options to service requests.

7.3.6 Person Centered Planning

One of the fundamental concepts behind the split of traditional social worker functions into positions separately responsible planning and funding was to allow for the development of objective, disability-related needs plans that were not informed by a sense of immediate crisis, but rather by consideration of the longer term hopes and needs of the individual. The idea behind this separation was that value would be added to the process of planning when decisions could be made without reference to the funding that was available – all players in the process would be able to keep all possibilities open, and be able to consider a wider range of options than they might otherwise do.

The emphasis on person centred planning is a second fundamental element of the service delivery model. Previously, services were provided based on a highly subjective process, where social workers made a determination of the programs and services that were available to the individual who came to them for help, then attempted to secure

---

[51] It should be noted that the study was based on a small sample (37: 9 parents; 4 service providers;1 microboard representative; 8 facilitators; 8 analysts; and 7 CLBC managers).

placement for the individual in an open spot. As noted elsewhere, this was a crisis-driven process; one that was not able to fully consider the longer-term needs of the person.

Under the CLBC service delivery model, the individual's needs, abilities, wants and hopes are the starting point for a planning process that places the individual and their caregivers at the centre. As conceived, the individual – with or without the assistance of a CLBC facilitator, which is the choice of the individual – creates an Individual Support Plan (ISP), which identifies needs, strengths and goals. The ISP is used by CLBC to make decisions about funding and link the individual to both funded and unfunded services and supports. Strengths and challenges regarding the planning process are described later in this section, but it is clear that this individualized approach is central to the current service delivery model – both by design and in practice.

As CLBC notes in its service plan "achieving real service innovation over time requires people now served in residential or day programs to have a support plan (within policy guidelines) in place that clearly identifies their personal goals an objectives. A support plan enables CLBC to make appropriate, cost effective decisions on the allocation of both individualized funding and already funded supports and services…" Taken as a whole, person centered planning seeks to move clients away from simple service-led assistance (i.e. knowing of a program and saying "this is what I want" without fully considering alternative services that might suit one's needs and abilities), to a situation where supports and services are built around identifying goals and then finding creative ways to meet those goals.

CLBC's person centered planning approach has many strengths. Individualized planning, and the time taken by facilitators to know and understand the abilities, needs, and hopes of the individual and their family, is highly valued as an approach. It allows for services to be put in place that are based on real needs, and allows for an objective assessment of the appropriateness of those services through setting and monitoring appropriate outcomes. Individualized planning is valued for moving beyond an approach where the first step is to assessing what funds are available or what spaces have opened up and then placing an individual accordingly. Instead, funding can be assessed and placements made based on independently identified needs and requirements.

Importantly, as a concept, person centered planning offers the opportunity for decisions to be made rationally and based on objective assessment, rather then being crisis-driven and dependent on the ability of an individual or family to present their case emotionally. They are also responsive to changes in needs and abilities over time, and individuals and families can submit new or updated plans as their circumstances change.

While a detailed examination of the efficacy of the planning process is not within scope of this service delivery model review, participants in the review process indicated general support for the process as it is conceived. There was a sense that the process, while time consuming and comprehensive, is meaningful and valuable. Both families and CLBC staff report the value of building stronger relationships, the thoroughness of the process, and the usefulness of supporting materials.[52] As one participant summarized:

---

[52] See also Robinson, E (2008: 16-19).

"thinking about what's needed in a person's life, rather than always just reacting to crises, is really a new approach. That in itself is a victory."

How planning is implemented, however, gives rise to a number of concerns.

The planning process has already been reviewed and revised by CLBC, primarily through a July 2007 directive that recognized and responded to a number of concerns about the way the service delivery model was originally set up. This provided more flexibility in the system, allowing local managers to determine situations where less detailed planning might suffice – for example for day program, supported employment, respite and life-skills training services. Requirements were adjusted because staff simply could not produce plans fast enough, particularly in more urgent situations where there was a need to prevent crisis. This was a reasonable and responsive reaction to complaints from families (and staff) that too much time was required to complete a comprehensive plan, even in situations where minimal or straightforward supports were being requested.

It should also be noted that, where a crisis intervention service is provided, it is not provided interminably. Instead, CLBC policy requires completion of a plan and the assessment and appropriate alteration of funding levels. This way, high-cost intervention funding rates do not become entrenched in the system, as had occurred in the past.

In addition, there is a shared concern about how planning is linked to funding. Often, families grow to expect access to services through the planning process, only to be disappointed by the lack of funds to support the plan and being placed on a waitlist for services. Although this situation was addressed through the July 2007 operational communication which directed facilitators to "prioritize their time" to "provide family support and for plan development where CLBC can implement the funding request in the plan," outstanding challenges remain.

Consideration of the Waitlist and its related Priority Assessment Tool are specifically outside the scope of this review. However, it bears noting that in practical terms, CLBC estimates that approximately 55% of new funds are allocated to persons who are not on the waitlist, but instead have urgent needs. The 45% of remaining new funds are allocated towards the waitlist, according the priority of need of the individual, based on an assessment of their urgency. The practical outcome of this situation is a system that is still largely crisis and urgency-driven, in spite of considerable individualization, planning, and rhetoric about processes that increase choice.

This is related to a second concern, which is a continued focus on planning and identifying and securing services that are funded by CLBC. Despite a foundational belief in expanding a person's support network to include wider, more generic, community-based supports and services, it was a universal view that most facilitators' ultimate goal is to identify a funded program or service. Many felt that CLBC's vision of supporting a more inclusive, community-wide approach has not been translated to the practical planning process, which now simply creates even greater pressure on programs and services that are already over-subscribed. Making CLBC-funded services only one part of a much larger life plan has not yet been fully embraced and implemented by facilitators, and work remains to be done in this area.

CLBC's published documents[53] indicate that in 2006/07, approximately 6% of all adults currently receiving residential or day services had an individual support plan in place – a figure that was anticipated to rise to approximately 15% in 2007/08, and 20% in 2008/09. The most recent figures available indicate the following:

Table 5: Individual Service Plans for Adults (August 31, 2008) [54]

Plans initiated by facilitator, reviewed by analyst	494
Plans initiated by facilitator, not reviewed by analyst	991
Plans submitted directly to analyst[55]	412
Total	**1,897**
% Of Total Active Adults with ISP	16.3%

While 16.3% of adults currently 'have' an ISP, a high proportion of these have not gone completely through the process to secure supports. The 991 ISPs that have not been reviewed by an analyst are in this category – they may be at different stages of the process (e.g. still in the planning process with the facilitator, completed but simply waiting for review by analysts, or in the queue awaiting confirmation of available funding before proceeding to review by analyst), but they have not advanced to the stage of review and/or approval.

CLBC is not able to report how many clients have completely gone through the planning process, had plans approved, and received supports. Developing the necessary data attributes and incorporating them into the PARIS system is currently in development. A manual count in March 2008, however, suggested that approximately 950 clients were in this position, representing 8.4% of total clients, or 40% of the 2,438 clients that have registered with CLBC since its inception in 2005.

To summarize, while individualized planning is a fundamental component of the service delivery model and, in many respects, is highly valued and works well, it faces a number of practical challenges that are in large part linked to the ability to follow through with funding. This is in large part due to the fact that CLBC must balance managing to a budget (this is discussed below), responding to urgent health and safety-related requests for assistance, and responding to increased service demands. A key issue that underlies all of these factors is the large proportion of CLBC's budget that is tied up in legacy "global" contracts, which makes it challenging to respond to individual-level requests and plans. "Unbundling" funding and creating more flexibility is a fundamental requirement for CLBC to be able to properly fund individualized plans. This component of the service delivery model is the topic of the next section.

---

[53] CLBC (2008b) – 2008/09 – 2010/11 Service Plan

[54] Data based on the number of individuals with planning development and review work assignments. Includes plan development and review for the residential options project.

[55] Refers to ISPs completed and submitted by families or service providers, without the assistance of a facilitator

7.3.7 Individualized Funding

Closely tied to the concept of individualized planning is that of individualized funding. As noted in its 2007-2008 Annual Report, CLBC believes “increasing choices beyond current support and service models is necessary for individuals and families to achieve their goals and enhance quality of life. Individualized funding provides people opportunities to exercise greater control over the supports and services they choose or develop, and how they are provided.” Promoting and supporting individualized funding is a central concept of the service delivery model.

It is widely agreed that under the previous system, there were few objective rationales for the amount of funding that was provided to individuals. Whether a person was funded for services, and the level of the funding, was determined largely by the ability of the person to plead their case, the receptivity of the social worker to the case, and the willingness of both to protest decisions they disagreed with. The system was often summarized with the cliché “the squeaky wheel gets the grease”: it was highly dependent on families’ abilities to argue their case and was often characterized by bureaucratic and political intervention.

In addition, while funding was notionally provided to an individual client, in practice the funds most often went to an agency in the form of a large annual contract that would include funds that were meant to apply to more than one person – often, to many people. These “global” contracts did not specify the individuals to be served, were not specific about the nature of services to be provided or outcomes to be measures, and were rarely monitored.

In contrast to global funding, the CLBC service delivery model is based on individualized funding. This involves two key concepts: that the level of funding is related to the individual’s specific needs, abilities, and hopes; and that the funding itself “attaches” to the individual. If individuals choose, the attachment can be literal: direct funding allows for funds to be transferred to the individual, who then bears responsibility for identifying, hiring, monitoring and dismissing their own supports and services. It could be less literal, in that CLBC could contract with a service provider on behalf of the individual, but the contract would specify the individual’s expectations for services and be monitored. A middle option provides for the option of a “host agency,” which then takes on the responsibility of identifying, hiring, monitoring and dismissing supports and services on behalf of the individual, through CLBC-provided funds.

Individualized funding was a cornerstone of the CLBC service delivery model as originally conceived and presented to families and service providers. It was promoted not only for its ability to increase individual choice and flexibility in service provision, but also as a means of increasing the overall financial efficiency and accountability of the sector. In both respects, however, individualized funding as a concept has had to address some considerable challenges. These are discussed later in this section.

The overall goal of individualized planning and funding is to increase the choices that are available to individuals and families, and build greater flexibility into the service delivery system. As stated in CLBC’s Individualized Funding policy (January 2007):

> Individualized Funding (IF) provides individuals and families with a flexible and self directed option for arranging, managing and monitoring the network

> of supports and services they require to meet disability related needs. The objective of IF is to provide an alternative method of payment for supports and services typically provided through contracts between CLBC and service providers.

The notion of increased choice has been a consistent clarion call for the CLBC service delivery model, from the earliest days of Coalition planning and lobbying, to the current Strategic, Operational and Service Plans of the agency. Choice continues to be at the forefront of CLBC's philosophy, strategic vision, communications, and service delivery design. However, the degree to which choice has been reflected in practice has been challenged by two interconnected factors: low uptake amongst CLBC clients, and the high proportion of service delivery budgets that continue to be locked into pre-existing global contracts.

According to CLBC data, the proportion of adults who are in an individualized funding situation is minute. The 2008/09-2010/11 Service Plan suggests that a total of 25 individuals used individualized funding in 2006/07 and 28 in 2007/08. For the current year, the Service Plan indicates a target of 150 individuals for individualized funding – approximately 1.3% of the estimated total of 11,400 adults currently served. As of August 2008, data from CLBC suggests that this target will be exceeded, with approximately 220 individuals (1.9% of total clients) in either a direct funding or host agency situation.

As the table below shows, the proportion of clients in an *individualized service* situation increases if one considers those who now receive direct funding pursuant to CLBC's *Adult Direct Respite Funding Policy*, which was enacted by CLBC in September 2007. This change allowed for the approval of up to $5,000 in direct payments to a family to purchase respite services, without necessitating completion of an ISP. According to CLBC data, 214 people used this service in 2006/07; 404 in 2007/08 and 477 so far in the current year. These figures exceed the targets set out in CLBC's Service Plan (150 in 2006/07 and 365 in 2007/08, with 475 as a target for 2008/09).

Table 6: Community Living BC Performance Indicators[56]

	Current Year				
	YTD	**Service**	**O**	**March 31**	
Individualisation	**Actual**	**Plan**	**(U)**	**2008**	**2007**
Receiving Direct Funding	176	n/a	n/a	235	181
With Host Agency	44	n/a	n/a	0	0
Total IF	220	0	220	235	181
With Direct Funded Respite	477	365	112	404	214
Grand Total	697	365	332	639	395

Even if expanded to include those in receipt of direct funded adult respite, the total of 697 adults currently in receipt of individualized services represents only 6.1% of the total adults served by CLBC. This presents a number of challenges, particularly since individualized services and the choice, flexibility and efficiencies it would bring about

---

[56] Communications with CLBC August 2008

have been such a fundamental part of CLBC's model and communications. These challenges are discussed in part 10 of this report, "On Sustainability".

7.3.8 Increased Community Capacity

One of the fundamental tenets of CLBC, and a basis upon which its service delivery model has been built, has been the increased participation in and use of generic community supports. This is set out in a number of foundational documents, including CLBC's original Business Plan which states:

> The achievement of a sustainable community support system will depend on increased diversity in support options based on individual needs. These will include supporting families in their daily lives, involving community people in circles of support, and maximizing community energy and creativity to complement CLBC funded supports.

As conceived, a major function of facilitators and Community Planning & Development offices is the focus on the creation of linkages within the community between individuals with developmental disabilities and community based generic services. The underlying goal is that participating as regular citizens in community can reduce the need for funded supports, create a network of informal safeguards and enhance the quality of life and citizenship of the individual.

According to CLBC, access to generic resources is a significant component of an Individual Support Plan, and considerable emphasis should be placed on this by facilitators in the planning process. Plans are to be returned if generic resources have not been reviewed with the individual and family and implemented and documented where appropriate. The underlying operating principle is that an individual should not rely on specifically funded government services for all supports in their life; that, like any other citizen, a client of CLBC should be able to better avail themselves of services that are widely available through communities.

Relying less on professionals and more on resources from the community would not only build linkages and real community inclusion, but would also conceivably allow for cost savings and greater efficiencies. It would also support the fundamental principle of the community living movement, which is full community inclusion.

However, there was a common sense amongst most participants in this review that CLBC's emphasis on community supports and services has not yet been met in practice, in part because traditional community service agencies do not have the resources, expertise, or capacity to take on inclusion in a meaningful way. There is a consensus that CLBC has been challenged to identify and engage generic community supports, although this was and continues to be a key component of the service delivery model.

There is also a widely held view that, in light of CLBC's operational and financial challenges, the fostering of community inclusion and generic community supports has simply become a victim of prioritization. This is one explanation, but this review also indicates that moving towards better use of generic community supports has also been the subject of deliberate misinformation that suggests CLBC's goal is to shift responsibility for service provision from itself to families and the community in general.

As with many parts of CLBC, increasing the use and integration of generic community services is a new direction and requires a considerable shift in the approach and view of staff, many of whom are products of a system that maintained a narrower focus on identifying government or ministry-specific programs and services. Fully engaging the community requires appropriate training, education and skill development amongst CLBC facilitators, who have responsibility for this component of service delivery. Although a *Community Supports Policy* was put in place by CLBC in November 2007, it was the view of most participants in this review that facilitators as a whole do not have the skills that are required, or are not yet adequately employing them as part of their duties.

Community awareness and involvement with CLBC is highlighted as one of the organization's five key strategic goals in its 2008/09-2010/11 Service Plan. However, targets seem to be focused on performance measures that do not strongly encourage community development, or speak to specific goals around engaging generic supports. Instead "community development" performance indicators are limited to the number of people who visit CLBC's website and receive the CLBC newsletter. These are passive measures, and do not reflect the focus of community engagement, which is to increase the participation and inclusion of individuals in the community. CLBC has indicated an intention to implement more specific and appropriate measures, as set out in the table below, but these are still in the development phase and have not yet been fully implemented.

Table 7: CLBC Performance Indicators – Innovation, Community Integration & Development[57]

	Current Year			**March 31**	
	YTD Actual	**Service Plan**	**O (U)**	**2008**	**2007**
Community Development					
# Of Ppl Visiting Website (000s)	21.263	18.000	3.263	70.147	n/a
# Of New Ppl Visiting Website (000s)	n/a	n/a	n/a	n/a	n/a
# Of Ppl Receiving Newsletter (000s)	2.748	2.960	(0.212)	2.608	2.812
Generic & Informal Supports					
Average value (hrs) per plan completed	13.13			unavailable	
# Generic Support work assignments	396[58]				

With the lack of clear or adequate data on the subject, it is difficult to draw conclusions regarding the efficacy or make recommendations regarding the future direction of this component of the service delivery model. As a concept, the point is to foster connections to the wider community, reduce the reliance on paid services and engage the community in helping individuals to lead truly inclusive lives. This requires attention, training, and sustained support to achieve.

---

[57] From CLBC – statistics as of June 2008

[58] To September 20,2008

There is an increasing degree of understanding amongst community partners of the challenge of increasing and maximizing the use of generic community services. There is also a high degree of cynicism at CLBC's continued emphasis on communications pertaining to this component of the model, when there is a widely shared view that it has not been as successful as promoted. While the model is built on creating a "virtual" community and relying on the latent capacity of generic services, there are insufficient incentives or mechanisms in place to encourage sharing of resources, training, or other opportunities amongst agencies.

Finally, it should be noted that CLBC recognizes the difficulty of putting the required community linkages in place as well as the necessity of fully engaging staff in placing higher priority on this part of the service delivery model. It has completed a new staff training package that emphasises the need to blend CLBC-funded services with generic community services when developing and approving Individual Support Plans. Communications emphasize that the goal of using community services is not only to reduce costs, but to foster true community inclusion and, importantly, move away from an approach that essentially "cocoons" individuals in professional, funded supports and services.

7.3.9 Role of Community Councils

In its goal of fostering more community inclusion, one of the key components of the CLBC service delivery model is the creation and use of Community Councils. Community Councils now exist through each of CLBC's 17 Community Living Centre-defined "regions", and are aimed providing a place where self advocates, families, community members and service providers play a major role in achieving CLBC's Vision of fostering good lives in welcoming and inclusive communities. The intent of Community Councils is to ensure that communities have more meaningful involvement in how their services are delivered and outcomes achieved.

According to the CLBC Community Council Terms of Reference (2007), Community Councils are supposed to "work closely" with CLBC's Community Planning & Development and Quality Service managers in three key areas:

1. Building Welcoming Communities: make communities more inclusive and accessible by exploring new approaches to service delivery
2. Improving CLBC's Accountability to Community: participate in performance management by providing feedback about CLBC's services and practices
3. Financial Decision Making: have input into the allocation of financial resources, within budget limitations.

Terms of Reference also clarify that Community Councils should not deal with or try to influence specific situations; make provincial-level budget or policy decisions; hire or supervise CLBC staff; or legally/politically represent CLBC.

Community Councils are made up of 7–15 volunteer members, a majority of whom must be self-advocates or their families. At least 25% must be community representatives (e.g. business people) and up to 25% can be service providers. Community Councils are meant to reflect the geographic and demographic situation within each Community Living Centre.

As a general rule, Councils are focused on gathering better information to support individuals in identifying and obtaining supports, whether those are from CLBC or from elsewhere in the community. For example, the Surrey Community Council recently undertook a survey that was aimed at understanding the issues facing people with disabilities. Questions focussed on the life of the person in community, not about CLBC funded services specifically. This is also an example of where the focus can be on working with the community in a broader fashion: instead of an agency dealing with transportation challenges by buying a vehicle and needing more staff, the Community Council can foster communications with Handi-Dart and Trans-link about providing improved transit services.

In practice, how Community Councils function and what they focus on varies widely. Anecdotal information suggests that of the 17 Councils in the province, seven are considered to be established, seven are still maturing, and three are under-developed. A key component in the efficacy of Council is the effectiveness of the Chair, but as these are volunteer bodies it is challenging to ensure appropriate leadership is in place and maintained.

It is fair to say that CLBC staff, as a rule, have not fully integrated the potential Community Councils into their planning, and are still learning how to maximize the community relationship role. For example, Community Councils could be better used to advance the goals and priorities of CLBC, and to resolve local issues more effectively than by relying on managers alone. Better education, media relations, and community capacity building are also areas that Community Councils are anticipated to play a greater role as they, CLBC, and the community in general becomes more aware of and accustomed to their place in the system.

Currently, there is a sense of frustration amongst some that Community Councils cannot advocate on behalf of people with developmental disabilities, nor do they have any real role in decision-making process. They are seen as bodies that have a lot of positive ideas, but no clear forum or process to advance those ideas. According to Community Council participants in this review, there is also a sense that even in the short time that they have been operational, Community Councils have shifted from a body that had a role in providing input to CLBC, to one whose advice or opinion is not often sought or accepted.

Community Councils are thus widely seen as a part of the system that has considerable potential in terms of fostering real, meaningful integration – but this is an area that is still nascent and inconsistently applied. The ability to help inform CLBC decision-making and to bring the voice of the community to the local planning table is potentially very powerful in identifying and implementing creative solutions to service delivery needs. As a concept, it is widely supported and valued. It is too early, however, to assess the efficacy, relevance, or long-term value of Community Councils, and there is inadequate data to measure their success to date.

7.3.10 Stronger systems and infrastructure

One of the clearest challenges that the service delivery system had to address when it was the responsibility of the Ministry of Children and Family Development was the dearth of effective information technology systems and infrastructure. Lack of appropriate IT and Management Information (MIS) systems was noted by a number of commentators as a major challenge leading to devolution – for example, this is noted in both assessments of readiness for devolution conducted by Bert Boyd.[59]

All participants in this review acknowledge that CLBC inherited a system that did not allow for tracking the status or deliverables of contracts for service. The previous system had a number of important deficiencies, including:

- Persons served (SWS system): Inability to track the number of individuals served. No data on locations where service was provided or individuals in receipt of services; and
- Contracts management system (RAPS for residential contacts; Oracle for non-residential contracts): contracts where collapsed together, so one contract could cover multiple group homes, home sharing, respite and day programs. Contracts could be in excess of $500,000 per month, with no identification of the individuals serves by the program, no inputs or expected outcomes, and no data on the capacity of programs.

One of the key components of CLBC's service delivery model is the development and implementation of a supportive and enabling IT infrastructure. Towards this goal, CLBC has embarked on an information systems project that will provide for a fully electronic file management system, service delivery management, contract management and decision support. Mechanisms are being incorporated into the service delivery application that will allow CLBC to manage and triage the waitlist for services and monitor equity and consistency in the allocation of resources throughout the province.

Specific systems deficiencies that have been addressed or in the process of being addressed include the following:

- Client management: implemented the PARIS system, which provides individual-specific information regarding the client's demographics, services, and associated supports. Individuals in residence are now known, by person and location of services, verified by semi-annual reporting requirements.

- Enabling PARIS to analyze how well individual support plans include and incorporate generic community supports, which is in progress. Full integration of the Guide to Support Allocation is also being contemplated.

The PARIS system offers a number of clear improvements over the pre-existing infrastructure. It allows tracking of individuals, analysis of the specifics of service provision, and provides readier access and better ease of use for CLBC workers. As conceptualized, it will over time include both residential and non-residential services, although the focus has been on the former.

Significant challenges remain. PARIS was chosen as a model in large part because it was already in use by the Vancouver Coastal Health Authority, and so offered ease of adaptation as well as being a financially responsible choice. This has resulted in concerns about the system's ability to fully interact with government management information systems, particularly as systems at both ends are now undergoing significant

---

[59] Boyd (2004); Boyd (2005)

review. There are also concerns that, while the system may provide the information that is required, it is not being adequately updated by CLBC staff in the field.

With respect to contract management, although the dichotomized RAPS (residential) and Oracle (non-residential) systems are still in use, CLBC is reaching the implementation phase of a new integrated contract management system. Even within the existing changes, important changes have been made, including:

- Separate contracts are now identified for each different type of service;
- Costs of programs are now discretely identified;
- Service data is now available for all residential services, including resident occupancy, location and annual cost; and
- There is cross-linking between PARIS and RAPS for individuals in residence.

These changes have allowed for CLBC to make considerable progress in identifying specific information about individual contracts for the first time. CLBC now knows that, as of June 30, 2008, there were 5,063 individuals receiving residential services. Of these, 3,113 have had their contracts "unbundled" from large global contracts, so that their name, location, and individuals costs are now known. This is an important step forward not only in terms of an enhanced ability for contract costing, but also for performance management and the assessment of outcomes.

The contract management system upgrade has been guided by three key requirements: a single system of records for all contracts; a clear process for capturing and recording data; and a clear and consistent set of criteria for assessment and performance monitoring. CLBC has opted to use and adapt an off-the-shelf program ("Upside Contracts") and expects to have this fully implemented in the spring of 2009/10. The business rules for this system have been adopted, and user acceptance tests were recently completed.

Challenges remain, especially with respect to non-residential services which continue to be referenced on the legacy Oracle system. This system has limited functionality, is cumbersome, and does not provide individual-specific information. CLBC anticipates that non-residential services will also be included in the new contract management system, although residential services have been the focus up to this point, given the large proportion of the CLBC budget that they account for.

CLBC has placed IT systems infrastructure development at the centre of its strategic planning, having identified it as a priority action for the next three years[60]:

> ***Summary of the key issues and priority actions for the next three years***
> *Strengthen systems and infrastructure*
>
> - Continue enhancing data collection and management information systems to improve the overall information about programs, services, outcomes and costs and to reduce the burden of data collection on contracted agencies.
> - Identify and address ways to make the system more consistent, less complex and easier to access.

---

[60] Noble, Bobbi S. (2008: 5-6)

A significant “unknown”, however is the extent to which CLBC’s IT and MIS systems will be able to interface or integrate with government systems, both those of the Ministry of Housing and Social Development and the anticipated cross-ministry systems. Although this presents further opportunities for systems efficiencies and improvements, the degree to which this has been planned for or anticipated at either end is unclear.

7.3.11 Children / Transitioning to Adulthood

At the outset of this review, a determination was made that the focus would be on adult service delivery only, and would not consider the role of children’s services as part of the service delivery model review. This was re-enforced in June, when a government reorganization resulted in the transfer of CLBC to the Ministry of Housing and Social Development (MHSD), and the clarification that the Ministry of Children and Family Development (MCFD) would re-assume responsibility for children’s services.

While an assessment of children’s services is outside scope of this review, the effect of these recent developments on the adult service delivery system bears some comment in two respects: system design and human resources; and services for those transitioning to adulthood.

With respect to human resources and system design, CLBC has gone forward on the presumption that it would have responsibility for both children’s and adult’s services – this is reflected even in its foundational strategic statements such as its mission which states “CLBC responds to the life long needs and goals of individuals and families…” At a practical level, while some offices have implemented a differential system between staff who focus on children and those who focus on adults, in many offices a single facilitator or analyst is responsible for both groups of clients. In smaller or more remote areas, particularly, it will be challenging to continue to provide services as it is anticipated that a significant proportion staff will go back to MCFD. As noted earlier, this re-allocation is currently being analyzed and addressed by CLBC, MCFD and MHSD.

The transfer of children’s services to MCFD may also create greater challenges for youth transitioning to adulthood. This was already seen as an area of concern, with many participants suggesting the system did not engage youth and their families early enough. Many participants identified a missed opportunity for considered and thorough planning, which in general did not take place until youth were on the verge of turning 19 and losing the wider array of children’s services that are available to youth. Others strongly supported the return of children’s services to MCFD, which was seen as having a more child-centric focus to their service delivery system.

Some also noted that CLBC had not yet capitalized on the advantage that children are more likely and easier to connect to generic services. The increased likelihood of engagement offered an opportunity to infuse the use of community services into individual’s and families’ thinking and planning at an earlier age, setting the stage for a lifetime of enhanced inclusion. This is an under-developed part of CLBC’s service delivery model, as noted elsewhere.

While the return of children’s services to MCFD may present challenges for seamless transitioning to adulthood, it also presents an opportunity for MCFD and CLBC to work together in a constructive and open way. The lack of clarity regarding where children’s services would reside has created tension and misapprehension in both organizations.

With the recent reorganization, CBLC and MCFD can both provide leadership, in part by focusing on youth beginning at age 15 or 16 and making it a priority to ensure that the transition out of childhood is planned for and supported.

In addition, CLBC's re-location under MHSD provides an opportunity for MCFD to link not only those children who will be eligible for CLBC services, but also those who do not meet current eligibility requirements. For CLBC, this is an opportunity to work more closely with other government agencies, to take advantage of the benefits that are available through being one part of a complex system of supports and services for people with developmental disabilities, as well as those who are more broadly vulnerable.

7.3.12 Focus on innovation

A cornerstone concept in CLBC's service delivery model is that of innovation. Trying to find new and creative ways to provide supports and services was one of the fundamental reasons for devolution, and this has remained a consistent and constant driver of CLBC's actions and communications.

CLBC started with an intense focus on this area, creating an overall Innovation Framework that was aimed at guiding the thinking and planning not only of CLBC, but of community partners, service providers, and families. The framework is based on extensive research and best practices, and focused on the following components[61]:

1. Strategic Innovation Fund: setting aside a portion of CLBC's yearly budget (about $300,000 last year) to enable CLBC to fund projects that provide more choice and flexibility for individuals and their families.
2. Supporting the Establishment of Service User and Family Governed Projects: Consumer/family governed projects are developed by small groups of service users or families to arrange and oversee supports tailored to their needs.
3. Establishing innovative personalized support arrangements as a priority with new funding: the primary means for this was through the introduction of individualized funding in the fall of 2006.
4. More effectively using funds that are already in the system: converting existing services to other models through program re-design or re-modeling.
5. Supporting community workshops and training events to raise awareness about what is possible
6. Recognizing BC innovators and innovations: establishing a recognition program to encourage people to become more innovation-minded and to take reasonable risks.
7. Extending formal invitations to the field to proceed with needed innovations: working with service users and families to determine what is presently lacking in the system, and what would be preferable.
8. Leadership development: for example through Community Councils and the Advisory Committee to the CLBC Board.
9. Ongoing evaluation.
10. Issuing an annual innovation status report

---

[61] CLBC (2008f) – Innovation Framework

CLBC's framework is intended to promote innovative thinking and practice within CLBC, community living and the broader community. The goal of this framework is the creation of sustainable, person-focused approaches to developing, funding and implementing needed supports and services. It has been one of the guiding factors for a number of key initiatives discussed elsewhere in this report – for example, the introduction of individualized funding, the residential options program, and the contract "unbundling" initiative.

The main initiative that is specifically innovation-driven is the $300,000 Innovation Fund, grants from which are available on a one-time only basis for innovative projects that are meant to help create sustainable, person-focused approaches to developing, funding and implementing needed supports and services. In 2008–2009 – its third year of operations – CLBC's Innovation Grants Program targeted family governed projects, and seven specific projects were funded including the following examples:

> Family Based Economic Inclusion Project
>
> This project will conduct research and establish partnerships with families and economic leaders to identify and advance three to five economic inclusion strategies for adults with developmental disabilities. A final report and speakers' series will share findings and lessons learned.
>
> Exploring the Options for People with Disabilities
>
> A day-long workshop will be organized for people living in the Quesnel area on home ownership, wills and estate planning and the registered disability savings plan by the project governance group.

While there is not consensus about the efficacy of the Innovation Fund or the overall Innovation Framework, there was a widespread acknowledgement amongst participants in this review that CLBC deserves credit for its efforts at focussing on innovation and best practices as a driving principle. Many noted that, whether driven by costs or not, CLBC is a good broker of education and information, and is consistent in trying to infuse these concepts into its service delivery system.

Participants also spoke encouragingly of CLBC's approach to working quickly and decisively when considering initiatives or other decisions. They also valued the high degree of input that CLBC invites from families and individuals with respect to program and service delivery and design, as reflected in the following:

- The 2006 and 2008 Service Satisfaction Surveys, the former focusing on establishing a baseline on how individuals felt the CLBC model was working after its first year of operation and the latter, to identify areas of concern where CLBC can improve supports and services moving forward[62];
- The "Community Living British Columbia Field Test of Planning Policy Project" undertaken by Elizabeth Robinson to evaluate whether the processes that CLBC has in place for plan development, review, making funding decisions result in consistent decisions that accurately reflect the needs of the individuals and families involved; and

---

[62] CLBC (2008g) – Service Satisfaction Survey: Provincial Overview

- Through focus groups, families, individuals and communities participated in providing recommendations to CLBC on its Draft Three-year Strategic Plan, just after becoming a semi-independent entity in 2005.[63]

The Innovation Support Network (ISN) – a group of CLBC managers and 20 service providers – has been up and running since early 2006, charged with leading innovation initiatives. This year two sub-groups are focusing on 1) employment and 2) delivery of person centred thinking workshops around the province. The ISN also hosted the Innovation Fair last year in Richmond which featured a trade show format on BC innovations.

This group does present some challenges, particularly in maintaining service provider interest in participating. Reasons cited for this challenge included workload issues as well as a sense of fatigue with the agenda of ongoing change. It is also unclear how ISN links to local-level operations, both internally to CLBC (through facilitators' planning training/agendas, for example) and externally (through community partners, community councils or the private sector).

Although CLBC has put processes into place to help people to rethink their approaches, this is an area where CLBC risks having its rhetoric create expectations that are simply too high to meet. While the Innovation Fund provides concrete examples of innovation initiatives, it must be noted that these are very small scale, and have not translated to larger system innovations.

As with many parts of the service delivery model transformation that CLBC is endeavouring to implement, the area of innovation is one that will require time for design, implementation, and assessment. While the shift from bureaucracy to a full consumer-driven system may have had limited success to now, there remains a great opportunity for innovation and for introducing new approaches.

7.3.13 Communications

Although it not a discrete or separately articulated part of the service delivery system, enhanced and increased communications between CLBC and its clientele, service providers, strategic partners and the community at large is a fundamental component in the way the organization has designed its model. When participants were asked to describe what made CLBC's service delivery model different than what came before it, improved communications was commonly cited as one of the "softer" characteristics. This was true even of those who were most critical of CLBC, who often agreed that CLBC has made considerable efforts to improve the flow of information both in and out of the agency.

While for some participants, improved communications has been a quality of the service delivery model from the outset, for others this is a clear example of an area where there have been some growing pains, but where CLBC has listened to criticism and responded by making positive adjustments. Health Authority respondents, in particular, made note of working relationships that were initially difficult, often limited to CLBC staff declining to get involved with situations and showing reluctance to work together to solve specific issues. In general, this has improved over time as individuals in both

---

[63] CLBC (2005) – Consultation Document for Communities – Draft Three-Year Strategic Plan

organizations have forged better working relationships. This is an area however, where leadership at the management and executive levels (e.g. the establishment of a joint Ministry of Health/CLBC provincial working group) has not been translated to increased communication between and amongst front-line staff.

In terms of communications out to the community at large, this was also an area where participants generally felt that CLBC has risen to the challenge and shown significant improvement after an initially rocky beginning. Part of this has been the development of appropriate and meaningful forums for individual, family and community participation – for example, Community Councils have the potential to be forums where people can express their views and have real affect on decisions that are important to them. In this area, too, adjustments have been made after an initial criticism that CLBC's communications around fostering choice were being interpreted as a call for minimizing support and assistance. As one participant noted, "it went from 'you're on your own' to 'how can we help you find what you need'." In general, for those who have fully participated in the planning process and have interacted with CLBC in obtaining or changing supports, participants spoke of a new sense being listened to, and of a general sense of improved empowerment.

Significant challenges remain, however. Many participants suggested that enhanced communications have almost overshot their intended purpose, watering down their inherent benefit. For example, when there is a new issue or initiative, it is frequently highlighted and emphasized at the early stages, quickly fading away as a new priority arises. Participants sensed a lack of coordination in communications, and felt that this resulted in a sense that CLBC lacks a long-term plan, or the ability to focus on a limited number of initiatives and ensure they are accomplished well.

There was also a sense that CLBC is not well understood within the community at large; that it is not clear to the public what CLBC is and what it does. Many also felt that CLBC has mistakenly chosen a communications strategy that focuses on emphasizing "negative news" and funding issues, rather than on highlighting areas of success and making the case for the of the short and long terms benefits of fostering community development. Understandably, CLBC has paid significant attention to managing its budget, but there is a sense that there is no energy left to articulate and work towards the bigger goals and vision of the organization.

And while many felt that CLBC has been admirably responsive to concerns, there are also concerns about the efficacy of communications. Many felt that CLBC has been slow to understand and respond to what is perceived as not working well – a specific example is the lack of a predictable point of contact at CLBC for families who desire that level of ongoing contact. While CLBC has in fact altered its practices to allow for ongoing contact between families and a specific facilitator, this has not been well communicated or fully integrated into day-to-day operations, based on a general lack of awareness of the change that this review revealed.

Finally, a number of participants were highly critical of the communications and relationships between CLBC and government. Many felt that there is a lack of clarity about the overall role of the organization, and that this has had significant implications on how it has communicated with government partners. Specifically, a lack of clarity about whether CLBC is an advocacy organization or a more traditional Crown Agency was often cited, the difference having clear relevance with respect to how CLBC should engage with government. This lack of clarity was identified in all areas of CLBC, from its leadership team to its staff in community offices. Put benignly, this sends mixed messages to individuals and the community. Another conclusion is that this has been inflammatory and has distracted both CLBC and its clientèle from its more constructive work.

7.4 Recommendations, Service Delivery Model

Our review of CLBC's service delivery model revealed a number of areas where there are significant challenges, particularly with respect to the planning vs. funding processes, the roles and responsibilities of facilitators and analysts, communications issues and a lack of clarity with respect to the roles of community councils.

That being said, it should be reiterated that the fundamental principles of the service delivery model were derived from research, consideration, and most importantly significant engagement and consultation with the community. Most participants in this review agreed that the underlying vision is still relevant and worth working towards, and that the model presents a rare opportunity to support people to have better, more inclusive lives. In particular, it is recommended that the fundamental change to a division in planning functions versus funding functions be retained, with the modifications that are recommended below. Evidence from other leading jurisdictions indicates that this model shows the best promise for infusing objectivity into the decision-making process, and allows for the fostering of highly qualified skills sets in staff. This also meets one of the larger criticisms of the previous system, which was its lack of expertise in contract development, implementation and monitoring.

The model, with just over three years in operations, is new and as conceived it presents a dramatic paradigm shift. It is our view that it is worthwhile to provide the required time for CLBC to make this shift, and to focus on building stability in a sector that has been subject to a large degree of change and reorganization. With that as a guide, and taking into consideration all of the foregoing information about the service delivery model, the following recommendations are made:

Improve collaboration between facilitators and analysts

While dynamic tension can have a benefit in terms of encouraging efficiencies and promoting creative thinking, the current situation is compromising CLBC's ability to work effectively with families. One of the key points of tension is that, once a plan is completed it is handed off to an analyst who then works independently, contacts the family for further information, and comes to a decision often without informing the facilitator.

It is recommended that once a plan is completed, a teamwork approach to the consideration of funding be adopted. Rather than hand off the plan, the facilitator should be the conduit for setting up an appointment with the analyst, facilitator and family and, where appropriate, potential service providers. The facilitator should remain involved as a resource through the process, providing families with a constant touchstone, and working collaboratively to meet client's needs.

Introduce joint reporting responsibilities in the CPD and QS streams

The current situation, where joint reporting occurs only at the CEO level, has exacerbated communications difficulties between the Community Planning and Development and Quality Service Streams. It is recommended that the streams report jointly at a lower level. This could be at the Vice-President level, but for less urbanized areas it would be advantageous to have the streams report to regional managers. This will help improve communications and collaboration between the two groups, ensure that all staff is working towards the same goal, and decrease the chances of clients being caught in the middle of internal power struggles.

Reinforce a constant point of contact

While few people advocate a return to a case management system, there was a consistent and considerable call for the availability of a fixed or predictable point of contact at CLBC for families to turn to if needed. The current system is aimed at maximizing efficiencies by ensuring any staff can work on any file. What can be lost is a factor that individuals and families value highly: the sense that someone actually knows them, is aware of their challenges, and will not have to be brought up to speed on their “story.” It is recommended that this fixed point of contact be reinforced for families that want it, and that the facilitator be assigned this duty.

It is not recommended that *mandated* contact be introduced. Rather, this service should be provided only to clients who request it, using a different process that makes assessments of the client’s level of need and availability of other resources to mitigate against situations where the support is not necessary.

Expand role of facilitator: planning to include application of GSA and discussion of waitlist

Currently, it is too often the situation that planning takes place without sufficient reference to the reality of available funding. Although facilitators have been instructed to verbally tell people about the limited amount of funding, this message is not always strongly or consistently expressed. Families and individuals tend to focus on the more positive aspects of planning, and the reality of the amount of availability funds is often lost as a focus of discussion.

To address this, it is recommended that the facilitator role be expanded to include application of the Guide to Support Allocation (or whatever tool to assess disability-related need that CLBC uses in the future). While this may be construed as compromising the objective determination of disability-related need, the reality is that currently analysts often turn to facilitators for clarification or assistance, and that, through the teamwork approach outlined above, this objective measure will continue to be a key part of the system.

In addition, before the planning process is complete, the facilitator should be aware of and discuss the likely availability of resources to support the plan. This should be a consistent, focussed, and central part of all facilitators’ planning processes. This does not mean simply a strict application of the waitlist/priority ranking position of the client. Rather, it means consideration of all available means of support, options for community support, and availability of shorter term funding options.

Expand role of facilitator: ability to approve limited services

Current CLBC policy allows for the provision of service up to $5,000 without completion of a full Individual Service Plan, a change that was introduced to respond to the concern that inordinate amounts of families' and facilitators'' time and resources was being spent on situations that did not require comprehensive planning. This should be moved one step further, and allow for facilitators themselves to approve such services without requiring approval by an analyst. It is recommended that facilitators be provided with a specific budget per year, which they can use at their discretion to meet minor or straightforward requests.

Budget levels should be determined in collaboration by CLBC after conducting best practices review and consulting with regional managers and community councils. Analysts should continue to draft contracts and monitor performance.

Clarify role of facilitator: community development as well as planning

Facilitators have tended to focus on their role as planners to the detriment of their responsibilities as the community development and liaison arm of CLBC. Participants spoke with frustration of the over-emphasis on planning, and the under-emphasis on developing the community linkages and contacts that are crucial to CLBC's vision of fostering a truly inclusive community. It is recommended that CLBC undertake a comprehensive training process to educate, assist and support facilitators in focussing on community development, with the goal of creating meaningful, systemic, and flexible ways to incorporate generic community services into the lives of the people that CLBC supports.

This recommendation, along with the three preceding recommendations, will also help to address one of the common complaints about the respective roles of facilitator and analysts, which is that analysts currently bear a disproportionate degree of the workload.

Clarify role of analysts to emphasize teamwork

As noted, there is much greater clarity and understanding of the role of analysts as compared to facilitators. One of the difficulties with the position is that it is asked to make financial decisions in isolation, which has led to problematic messaging when analysts approach facilitators or families with questions about completed plans. It is recommended that this be addressed through a team approach to funding assessment, in which the analyst, facilitator and family work more collaboratively to discuss and apply funding.

Focus the role of Community Councils

While there is wide recognition that advocating on behalf of individuals clients is inappropriate for Community Councils, there is also a need for education and consistency with respect to what constitutes "advocacy". For example, it is not clear to Community Councils what might be their potential role in determining wider regional issues and priorities, a potential role that is currently underutilized.

The roles, responsibilities and functions of Community Councils should be reviewed and clarified, to move away from advocating for funding and focus more on supporting strategic initiatives. There is great appetite amongst Community Councils to play a meaningful role, which should be defined by what is in scope for these bodies to do, not only what is out of scope. One clear role here should be enhancing communications and linkages between CLBC and families/the wider community.

To support this, training should also be provided to CLBC managers to help them effectively engage Councils in a more meaningful way.

Finally, it should be noted that there was a shared sense that the most successful Community Councils focus on one or two themes such as transportation, then undertake specific work to try to meet the objectives they set for those themes. This is an operational model that should be promoted for Community Councils across the province.

Improve communications about the service delivery model

Although CLBC has made a number of operational changes in response to feedback from the community and others, these changes have not always been well communicated, leaving people with a sense that problems are not dealt with. For example, the July 2007 operational changes which linked planning to the availability of funding and allowed facilitators to provide for continuity of contact in some situations, is not sufficiently known by facilitators and others alike.

It is recommended that changes arising out of this review, as well as future communications, be subject to a comprehensive communications plan. Assurance should be made that families, community partners, funders, advocates, service providers, and other partners are all aware of the changes are that made, and the reasons for those changes.

8.0 CLBC's Adult Guardianship Role

The terms of reference for this review process specifically included consideration of CLBC's adult guardianship roles and responsibilities, within the context of the service delivery model. This role is something of a historical anomaly, and bears some explanation in order to understand the context for concerns or questions that have arisen since the devolution of services to CLBC.

8.1 Statutory Framework

When the provision of services for people with developmental disabilities was the responsibility of MCFD, the Ministry was designated under the *Adult Guardianship Act* as the agency of record responsible for addressing complaints of neglect and abuse. This was in large part due to the fact that one of MCFD's primary areas of responsibility was addressing the needs of children taken into care. This work was primarily undertaken by social workers, who brought a health and safety focus to other aspects of their work, including in the community living services area of the Ministry, through which services for adults and children with developmental disabilities was delivered.

When devolution to CLBC took place in 2005, the legislative mandate to investigate allegations of abuse or neglect that is set out in Part 3 of the *Adult Guardianship Act* was extended to the new agency, and it became a "designated agency" for adults in receipt of community living supports, pursuant to the *Designated Agencies Regulation*. The responsibility was reinforced in the original Letter of Expectations between the Minister of Children and Family Development and CLBC (July 1, 2005).

The *Adult Guardianship Act* applies to abuse, neglect or self-neglect in a public place, the adult's home, a care facility or any other place other than a correctional centre. Section 2 of the *Act* provides that adults are entitled to live as they want and should receive effective and non-intrusive support when they cannot care for themselves. Accordingly, adults may choose to stay in an abusive situation or decline assistance that is offered. However, if an adult is thought to be incapable of making that decision, then Part 3 of the *Act* determines how and when support and assistance may be provided.

In Part 3 of the *Adult Guardianship Act*, Section 46 provides that anyone can report suspicion of abuse or neglect to a designated agency. Section 47 creates a positive duty that the agency *must* investigate in situations where a concern has been reported, where the agency itself suspects abuse or neglect, or where there has been a report that the individual's representative has been hindered in communicating with that individual.

> **47** (1) A designated agency must determine whether an adult needs support and assistance if the agency
>
> (a) receives a report under section 46,
> (b) has reason to believe that an adult is abused or neglected, or
> (c) receives a report that the adult's representative, decision maker, guardian or monitor has been hindered from visiting or speaking with the adult.

Once the designated agency has investigated an allegation of abuse, if it determines that the adult does not need support and assistance it must take no further action and may advise the Public Guardian and Trustee. If the designated agency determines that the adult needs support and assistance, the designated agency may do one or more of the following:

- refer to available health care, social, legal, accommodation or other services;
- assist the adult in obtaining those services;
- inform the Public Guardian and Trustee;
- investigate to determine if the adult is abused or neglected and is unable to seek support and assistance.

Designated agencies, as established under the regulation, are required to respond to alerts of abuse directly, by investigating the situation, speaking with the individual concerned and involving them as much as possible in addressing their situation which may result in the need for provision of additional supports. Section 48 of the *Adult Guardianship Act* provides a designated agency with the power to conduct an investigation of abuse or neglect.

Under urgent situations, or in situations that cannot be resolved by more amicable means, section 51 sets out a number of options for proceeding, including taking no further action, referring to other services, and applying for interim court orders aimed at stopping the abuse or neglect.

8.2 Carrying out the statutory duty: issues

While the duties, roles and responsibilities are clearly set out in the *Adult Guardianship Act*, there has been some confusion in how this has translated into practice. In particular, there was not a simple fit with the new CLBC service delivery model given that there was no longer a single point of contact for each individual under the new service delivery model. Historically, a social worker was responsible for overseeing the health and safety of the individual under care. Each social worker had specific case files attached to specific individuals – individuals' cases did not overlap between social workers, and each person had their own designate. In theory, social workers were expected to have regular contact with their clients, and to be well placed to quickly observe and react accordingly to changing circumstances potentially affecting the health and safety of the individual (in practice, workload issues often prevented this from taking place as effectively as designed).

As noted elsewhere, CLBC's service delivery model altered the role of the social worker such that they served as either a quality analyst or as a facilitator, the latter being available to respond to requests from any individual within the jurisdiction of their Community Living Centre. This is in contrast to the old model where the focus was on service delivery and in responding needs of individuals within their portfolio of case files linked to specific, identifiable individuals. CLBC is no longer charged with service delivery *per se*, but rather to support individuals and to facilitate service delivery through other service providers and community supports.

One of the negative results of the movement away from case management is that CLBC staff are no longer mandated to have ongoing knowledge of specific issues particular to each individual. This is especially challenging when referring to people who are vulnerable and at risk of possible abuse.

The new service delivery model also resulted in some confusion in the implementation of guardianship duties. Although facilitators were mandated with the responsibility to investigate potential situations of abuse or neglect from the outset, in practice people often reported allegations to analysts. This highlighted challenges related to the division of social workers' roles between facilitators and analysts, particularly the loss of a single focal point of responsibility and contact. The lack of a shared sense of clarity regarding roles and responsibilities of staff with respect to allegations of abuse or neglect resulted in considerable tensions between CLBC, the Office of the Public Guardian and Trustee (OPGT), families and caregivers.

This lack of clarity regarding responsibilities was exacerbated, according to review participants, by a misunderstanding at CLBC of the role of OPGT with respect to adult guardianship. There seems to have been expectations at CLBC that the OPGT would provide support and assistance in terms of dealing with guardianship duties, and that it would play a more active role in training CLBC staff in how to respond, document or to monitor allegations of abuse. From the point of view of the OPGT, there was concern that CLBC proceeded on the presumption that OPGT was better positioned and had more power to address allegations of abuse and to investigate accordingly.

Over the past two to three years, these misunderstandings seem to have been largely resolved. OPGT has clarified that it does not play a role in training staff for investigating or monitoring adult guardianship situations. According to both CLBC and OPGT, there is now a better understanding that the OPGT itself does not have this expertise, and instead relies on the designated agency to address allegations and conduct investigations where appropriate. CLBC has now put in place a number of processes and procedures to clarify and support its roles and responsibilities as a designated agency, and has a more accurate understanding of the level of support that is available from the OPGT.

8.3 Steps taken to address issues

CLBC has taken appropriate steps to clarify its roles and responsibilities regarding adult guardianship, communicate this information to its staff, and educate staff regarding the steps that should be taken when issues arise. Key documentation that has been developed includes:

Adult Guardianship Policy (September 2006)

Describes the overall legal context and clarifies that “CLBC has specific legal obligations to provide support and assistance to adults who are eligible for CLBC services and who are being abused, neglected or self-neglected and whose ability to request or receive support may be limited…”

The policy sets out basic requirements regarding CLBC’s role in reporting abuse or neglect, receiving reports, determining the need for support/assistance, and responding when an individual has formal representation. The Practice Guidelines are referenced for more specific information about roles, activities and functions.

Adult Guardianship: Practice Guidelines (May 2007)

Guidelines provide more detailed information for CLBC staff, including specific steps to be taken in addressing situations where abuse or neglect may be taking place. Background information and direction is given with respect to:

- Identifying what constitutes abuse or neglect;
- Determining the roles of parties such as the police, medical health officers, service providers, the OGPT and CLBC itself;
- Completing the intake process: what to do when receiving a report; how to screen for abuse; how to address reports of financial abuse; what to do when the person resides outside the staff member’s catchment area; what to do if the individual has representation; and what to do when there are challenges in locating the individual;
- Undertaking an initial inquiry: determining whether the person requires support or assistance (a statutory requirement); how to assess the risk of harm; how to offer support/assistance; what to do if access is denied; and when and how to proceed with obtaining a restraining order;
- What to do if support/assistance are not accepted: when and how to proceed to a full investigation process; when and how to request an assessment of incapability; when and how to complete a formal Support and Assistance Plan; and
- Responding to emergency situations: what constitutes an emergency; options for addressing the situation; how and when to exercise extraordinary powers.

All steps noted above include practical advice on questions to be asked and options that should be considered in proceeding. The Guidelines also reiterate the importance of notifying health care professionals (when care is required) and the OPGT (when financial matters are at issue.

Adult Guardianship: Designated Agency Procedures

The Procedures document sets out step-by-step actions and options for CLBC staff to take with respect to intake, inquiry, investigation and emergency situations. It includes clarification of the roles of facilitators versus other CLBC staff, provides clear direction on partners that need to be notified, sets out options for addressing specific situations, and identifies documentation requirements.

It should be specifically noted that CLBC's adult guardianship documents provide clear delineation of adult guardianship-related roles and responsibilities; these fall almost exclusively under the purview of facilitators. Analysts are included in the policy only insofar as clarifying that they should refer matters to facilitators when an issue that involves potential abuse or neglect is brought to their attention, and that analysts have the responsibility to ensure appropriate monitoring and review takes place in situations where there are ongoing questions regarding an individual's safety and well-being.

CLBC is now in the process of establishing education modules to more effectively explain roles and responsibilities of staff with respect to adult guardianship issues. The agency is working with the Justice Institute of BC to develop and implement training with respect to interviewing and investigative skills. This will have applicability to the skills sets of both facilitators and analysts, as analysts perform investigative functions related to facility and service monitoring.

CLBC has also become an active participant in a number of collaborative information-sharing sessions that involve the OPGT and other partners involved in adult guardianship. In particular, facilitators and CPD managers are invited to participate in regular conference calls that are co-chaired by the OGPT and CLBC's Director of Quality Assurance. These calls are forums where CLBC staff can put forward issues they wish to discuss which range from large policy pieces to specific case consultation. Agendas are sent out prior to the call if specific items have been identified, and participation rates are good, averaging approximately 20 facilitators plus CPD managers. CLBC/OGPT teleconferences are now regularly scheduled, and occur approximately every six weeks.

These calls are a good step forward, but there is a degree of ongoing concern at the OPGT that it still tends to drive and play too active a role in the process. The enhanced training around adult guardianship that is now in process is expected to address this issue, and the implementation of regular forums within CLBC, dedicated specifically to identifying and addressing operational concern, should also serve to highlight the proactive role that CLBC should be playing as a designated agency.

In addition to the specific CLBC/OPGT teleconferences, the OPGT also coordinates teleconferences all for education in all designated agencies, which includes both CLBC and Health Authorities. These occur every three to four months, and are called at the discretion of the OPGT. There were earlier concerns that CLBC did not fully participate in these forums, even though a considerable amount of time was dedicated to discussing and resolving adult guardianship issues that arose between CLBC and the Health Authorities.

Indeed, the overlapping jurisdiction of certain aspects of health and community living services between the Health Authorities and CLBC was an important stumbling block that was identified as requiring resolution. All indications are that CLBC has taken on the responsibility of actively participating in teleconferences hosted by PGT to help educate designated agencies on their role under the *Adult Guardianship Act*. There has been increasing participation by CLBC staff in these teleconferences over time, and communications between the Health Authorities and CLBC have improved as a result of this participation.

The engagement of Dr. Brian Plain as Medical Consultant for Individuals with Developmental Disabilities was cited as a positive step forward in addressing overlapping concerns between CLBC and the Health Authorities with respect to adult guardianship responsibilities. This position is contracted by the Fraser Health Authority on behalf of all the Health Authorities. In addition to troubleshooting issues and encouraging better relationships between CLBC and the Health Authorities, this position is also seen as key in helping to articulate and document areas or situations of risk or concern with respect to individuals who may be in vulnerable situations. CLBC's *Adult Guardianship Practice Guidelines* specifically include direction to staff regarding when and how the services of the Medical Consultant should be engaged.

Finally, in addition to the establishment of clear practice guidelines and education modules to explain roles and responsibilities of staff with respect to adult guardianship issues, in June 2006, CLBC developed and posted a public information sheet on their website. This sets out information and avenues for people who suspect abuse of an adult with a developmental disability, to inform authorities and have the allegations investigated further. This is aimed more at the public who may have questions about what to do if they are concerned about possible abuse or neglect than at CLBC staff roles and responsibilities itself, but it is another example of CLBC action take to address adult guardianship issues.

8.4 Areas of ongoing concern

Regardless of the lack of clear policy direction, there has been some confusion on the part of CLBC staff with respect to their adult guardianship-related roles and responsibilities. One reason for this is a sense among some that the intervention and investigative role outlined in the *Adult Guardianship Act* runs counter to the new paradigm of choice and self-determination embodied in the CLBC service delivery model. Some staff also suggested that time and resource pressures prevent expedient and procedurally appropriate follow-up to allegations of abuse.

These are issues that will be addressed in part through the education initiative outlined earlier. Re-focussing the role of the facilitator to highlight community development and encourage ongoing contact with clients who are in need of greater support will also assist in this respect.

The most important outstanding issues relate not to CLBC staff directly, but to the service providers that are funded by CLBC. In many situations, these staff play an informal role in helping people open bank accounts, fill out their taxes, and access funding through other government agencies. This is support is highly valued, and without it the OPGT estimates it could have up to 3,000 more cases where it would have to step in and assume its formal guardianship functions. Despite this important role, there is a lack of guidelines in place to help service providers properly instruct and train their staff, and CLBC could play a helpful role – with the OPGT – in clarifying expectations for service providers and their staff.

Development of appropriate guidelines has been a matter of concern to the OPGT, which feels CLBC has been reluctant in its response to developing appropriate practice procedures. It should be reiterated that the OPGT expressed support for the overall approach of CLBC and is not calling for changes the system as a whole. It does, however, have concerns that the interests of the most vulnerable are at risk of being overlooked, particularly those who lack active and skilled family supports or other care networks.

8.5 Recommendations: Adult Guardianship

Taking all of the above into consideration, the following recommendations are made with respect to CLBC's role and responsibilities regarding adult guardianship.

Maintain designated agency status and functions

While there have clearly been adjustments required in the shift from MCFD to CLBC, our review suggests that CLBC has taken meaningful steps to address the issues at hand, and is now well aware of its responsibilities and duties as a designated agency. There are operational challenges associated with the loss of a mandated, case management role for social workers, but the recommendations made earlier regarding naming facilitators as ongoing points of contact will help ameliorate this issue. CBLC should continue as a designated agency, a designation that is also supported by the OGPT.

Enhance the proactivity of facilitators

Earlier recommendations were aimed at fostering predictable, ongoing relationships between facilitators and clients, and this should be particularly emphasized regarding those clients who are most vulnerable. The facilitator's existing roles regarding adult guardianship should be enhanced to encourage proactive inquiry and investigations into situations where an individual may be vulnerable to abuse or neglect. As noted above, this should not imply a mandated, *pro forma* contact as used to occur at MCFD – rather, it should promote and support greater action in dealing with situations of potential abuse or neglect.

Involve analysts in the process

While facilitators, as the point of contact for clients, should play the largest role in terms of adult guardianship, the role of analysts in carrying out the duties of a designated agency should not be overlooked. CLBC should develop and implement clear processes and procedures to encourage analysts to include monitoring for abuse and neglect as part of their regular contract and performance monitoring activities.

Mandatory education and training

CLBC has already embarked on comprehensive training for staff with respect to roles, responsibilities and duties as a designated agency for adult guardianship. It is recommended that this training be made mandatory for all facilitators, and that training include regular updates and refreshers. Analysts should also be provided with an orientation to CLBC's adult guardianship responsibilities. Staff should be encouraged to participate in joint initiatives with the OGPT, including those that involve important partners such as the Ministry of Health Services.

Develop and communicate guidelines for informal supports

CLBC-supported service providers play an important role in providing informal supports to clients, which is highly valued by both clients and the OGPT, but there is concern at the lack of supporting policy in this area. It is therefore recommended that CLBC work with the OPGT to develop of appropriate guidelines for service providers, focussing on what is and what is not appropriate, and what precautions should be taken when providing informal support that involves areas of potential conflict such as finances or health.

9.0 Policy Tools to Support the Service Delivery Model

9.1 Introduction

In order to be effective, CLBC's service delivery model requires the development and implementation of appropriate policy tools to help manage service delivery. This is particularly so because the guiding model is new and is in many respects groundbreaking. A sound, considered and appropriate policy framework is critical to ensuring that the service delivery system functions sustainably and in an integrated fashion.

Clarifications to the overall responsibilities of CLBC versus that of the Ministry of Children and Family Development (and, now, the Ministry of Housing and Social Development) were made in early 2008. It was determined that the role of the Ministry was to include directing CLBC with respect to cross-crown and cross-ministry policies, while reviewing and approving policy related to people with developmental disabilities, including the Catalogue of Services, the Guide to Support Allocation, and the Priority Ranking Tool Operationalizing policy was confirmed as CLBC's role.

As noted at the outset of this report, although CLBC's waitlist policy is a central component in managing the service delivery model, consideration of CLBC's waitlist policy and procedures are the subject of a separate review process. The importance of the waitlist policy and related items – primarily the Priority Ranking Tool – are recognized, however, and they are referenced in this section only with respect to providing context for discussion about the other policy tools and how they are used.

The focus of this section is on the most important policy tools and supports that are in place to assist CLBC in implementing its service delivery model. At the outset of this review, it was clarified that "consideration of CLBC's policy tools" was meant to focus on higher-level components rather than individual policies and procedures. Accordingly, we did not thoroughly review all of the individual policies that make up the organization's policy manual, but rather focussed on those factors that provide the main support to the service delivery model as a whole, primarily those relating to:

- Person centered planning;
- Guide to support allocation; and
- Catalogue of Services.

Consideration was also given to the overall policy framework that CLBC has developed and is in the process of implementing; and key tools recently developed with respect to homeshare standards and guidelines. Tools that support the process for estimating and allocating the costs of services, contract management, and other finance-related issues are included in a subsequent section ("On Sustainability").

9.2 Background

One of the primary motivations behind the development of CLBC's service delivery model was a desire to introduce predictability, equity, and objectivity to the process of determining what services would be funded for individuals, and what the level of funding would be for those services.

In the past, resources were too often allocated to individuals and families through a system that was largely *ad hoc* in nature. Under this system, a panel of MCFD's central and regional management assessed individual requests for support on the basis of narrative arguments that were put forward by field staff social workers. The requests were based largely on establishing imminent risk to health and safety, and were considered in isolation rather than as part of a coherent system. As a result, the system was not able to adequately consider the relative urgency of needs, and tended to encourage active advocacy on the part of field staff.

In addition, the *ad hoc* nature of the former system did not allow for a consistency of approach amongst staff and, rather than dealing with long-term planning for individual outcomes, it focussed on meeting short-term, often crisis-driven, needs. This was exacerbated, as noted elsewhere, by a lack of coherent, consistent, user-friendly administrative and information technology systems.

Three primary policy tools have been developed by CLBC to address this systemic challenge: the Individual Support Plan, the Guide to Service Allocation, and the Catalogue of Services. As noted above, the Waitlist Policy and its Priority Ranking Tool are also tools in addressing the challenges of the former service delivery system, but are the subject of a separate review process

9.3 Policy Tools to support Person Centred Planning

CLBC defines person centered planning as follows:

> A process, as well as a product, that is owned and controlled by the person (and sometimes their closest family and friends). There are no prescribed forms, tick boxes or checklists; the resulting support plan is totally individual and creates a comprehensive portrait of the person and what they want to do with their life. It brings together all of the people who are important to the person including family,

> friends, neighbours, support workers and other professionals involved in their lives.

The goal of person centered planning is to develop an Individual Support Plan (ISP), which sets out an individuals' strengths, gifts, community living and disability-related needs and personal goals, as well as the means for the person to meet their goals. As conceived, it is meant to guide both determination of CLBC-funded supports and services, and also the development and utilization of wider community and generic support services. CLBC defines the ISP as:

> A plan that adult individuals can develop on their own, or with the assistance of a CLBC facilitator, personal network members, friends or other trusted advisors that identifies how the person's disability related needs will be met, and what their goals are for living in the community.

As a process that is "owned" primarily by the individual and family and which may not involve the facilitator at all, person centered planning calls on CLBC to provide policy guidance both internally and for an external audience. In doing so, it relies on the facilitator's Practice Guide, which sets out approaches to be followed with respect to all of the functions set out in their job description, as well as three main policy tools: the *Individual and Child and Family Support Policy*; the *Discovery Goal-Based Planning Guidebook*, and a practical guide called *Developing an Individual Support Plan for an Adult*.

The first of these tools, the *Individual and Child and Family Support Planning Policy*, became effective in March 2008. In some senses it has the broadest application, as approximately 1,500 of the 1,897 plans that have been completed to date originate from the work of facilitators. The policy clearly sets out information in four key areas:

- When plans are needed;
- What plans must include (in seven categories of information);
- Situations where plans are not needed; and
- The procedure to be followed to complete and forward plans to analysts.

The policy is consistent with July 2007 operational changes that were aimed at streamlining access to services in emergency situations, when small amounts are requested (up to $5,000 per year), or when the request is for more than $5,000 per year but is time-limited and focused on specific goals. In these situations, or when a support request is being made in order to get the individual onto the waitlist, individuals are no longer required to go through the full planning process.

This change is aimed at ameliorating the original service delivery model, which required a full plan in order to secure almost any service – this was widely seen as onerous and inappropriate for situations where there was urgency, or where there was a request for only a small amount of funding. This has increased the system's flexibility and responsiveness, and is viewed as a positive development.

The policy also addresses one of the service delivery system's major design flaws in that people are now given an option of submitting a request for service and waiting until funding is available *before* engaging in planning or undertaking planning regardless of the availability of funding, and going on a waitlist for services until funding becomes available

The policy is also clear on when planning is required for adults:

- When the cost for requested services exceeds $5,000 per year and will likely receive funding within six months;
- When a different residential setting is requested;
- When a different vocational or community inclusion activity is requested; or
- When an immediate family member is identified as a potential service provider.

In addition, the policy seeks to address one of the fundamental challenges of the former system, where emergency services requests were made and funded based on risk to health and safety, but then never reviewed, thus becoming part of ongoing funding for the individual in perpetuity. In this way, urgent/emergency requests that may have been short term in nature were built into the process by being considered as a component of base service level needs.

Current policy requires review of the situation and completion of a plan where emergency funds in excess of $5,000 have been approved and it is anticipated that the service will be ongoing. In these situations, plans are to be completed within six months of the support being put in place. Closing this loop means that a CLBC analyst will review and consider the individual's situation with a view to establishing long-term service level needs, as opposed to emergency funding becoming part of the individual's ongoing base funding.

Despite clarity in the policy, some participants in this review indicated some confusion about when plans are and are not required, and this may be due in part to two factors: lack of a broader communication about the July 2007 operational changes that altered when plans are required; and the relatively recent development and posting of the policy to CLBC's website. As a result, there is still a relatively widespread criticism that the service delivery model requires planning in all situations, and has continued to inflate families' engagement and hope even when funding is not available. Clearer communications on this matter may be required, although it is also a matter of allowing for time for the system changes to be absorbed, understood, implemented and measured.

The policy references and is consistent with the other tools that are aimed at guiding the content of plans. A suggested format is provided, with a summary of the key points that should be addressed in seven topic areas (set out below). The policy is clear in noting that individuals, families, support networks and service providers who choose to complete plans on their own and submit them directly to analysts are supported in two respects: first, they can contact facilitators for guidance as needed (per s.4.2 of the policy), and second, they can refer to a resource called *Developing an Individual Support Plan for an Adult (*the *"Adult ISP Guide")*.

The Adult ISP Guide is a practical guide that sets out the sort of information that should be included in each of the following categories:

- Summary of the plan;

- Personal profile: age, abilities, strengths, current situation, how needs were met in the past, expected benefits of requested supports;
- Type and cost of supports: use of generic supports, support/contribution from family and friends, other sources of funding, personal goals, nature and range of specific CLBC-funded service requests. This section also provides eight CLBC service categories under which requested services can be organized;
- Method of payment: preference of a contract with an agency, individualized funding, or host agency;
- Safeguards: existing and planned-for strategies to ensure the individual's safety;
- Additional information to assist the analyst in understanding the individual's needs and personal circumstances; and
- Contact information.

The Adult ISP Guide has recently been updated to use plainer language, include stronger references to generic and informal supports, and provide information about how goals will be achieved and evaluated. In using the Adult ISP Guide, planners also have access to Discovery Goal Based Planning (DGBP) training. This is a course that includes a half-day workshop, a course guidebook, video materials and CLBC intranet resources that walk planners through the components of planning, from understanding the approach to completing the plan, to establishing appropriate measures and monitors. Completing the DGBP is mandatory for CLBC facilitators. As of the end of September 2008 100 staff (70%) had completed and passed the course, and the remaining staff will have completed it by the end of November 2008. DGBP is not yet offered outside of CLBC.

From a client's perspective, a key benefit that is offered by this approach is that planning is now based largely on goal-based processes, which give an outcome as the base for any plan. This moves away from just fitting people into programs, and builds on the idea that individual goals need to match up to a particular service.

A challenge with the planning process is the amount of time and energy required to fully complete a plan. CLBC management estimated that facilitators complete an average of two plans per month per facilitator, and others estimated that it takes an average of 20 to 30 hours to complete a plan. In complex cases, this may be justified, but many participants suggested that the lengthiness of the planning process has raised issues in a number of respects. As noted elsewhere, emergence in the planning process elevates the hopes and dreams of individuals and families – as it is directly designed to do. This has been problematic in the past, when funding was not available – a situation that CLBC has recognized and taken steps to address, as outlined above.

Additionally, there is concern that the planning process has moved away from the original intent of being a comprehensive life plan that *included* but did not *focus* on obtaining CLBC-funded supports and services. Although the language of individual ownership of plans is still highlighted, in practice ISP's have come to be seen as the gateway to CLBC funding. This has had a number of negative results, including a widely-perceived "rush" to get plans in place and the development of plans in unnecessary situations. These concerns have diminished with the operational changes noted above, which allow for funding without plans in certain situations, and the ability to go onto a waitlist and only enter planning when funding is available.

A potential concern that some participants highlighted was that, as planning is more understood to be a "gateway" to CLBC services, some families may come to regard the process as being more about negotiating a funding level rather than assessing and addressing individuals' hopes, strengths, and needs.

Finally, while steps have been taken to limit situations where families are planning without available funding, there remains some confusion and lack of transparency about how funding availability is determined. The current policy calls for a plan to be developed when requested services exceed $5,000 and "will likely receive funding within six months." It is understood that this process entails headquarters providing each of the 9 Quality Service managers with their budget for the year and the QS managers setting aside a) the amount required for existing contracts and b) a proportion for emergency and discretionary payment. Out of the remainder, the QS office consults the status of the waitlist and provides funding to those who rank highest in need according to the priority ranking tool (a score out of 100).

While this process is an improvement over the false elevation of hopes through planning before going on the waitlist, it still presents challenges. Specifically, planning still takes place without reference to a target budget. This is appropriate in terms of CLBC services being only one part of the individual's plan for community living, but it does not provide the planners with "goalposts" in order to frame their request realistically. It is recognized that this contrasts with the philosophical approach of funding following plans that are built on dreams and needs. However, it would provide greater certainty and predictability to planners, and is more in line with the approach of other jurisdictions such as Western Australia and the United Kingdom. It is recognized that this is an area where there is not yet consensus as to the best approach, as other commentators have noted that determining the availability of funds at the outset of the process could create a sense of entitlement and serve as a disincentive to examining alternative (non government-funded) service options.

9.4 Guide to Support Allocation

Once the ISP is finalized, it is sent to the Quality Service Analyst for review and analysis, to ensure that required information is provided. In situations where more information is required, analysts can contact facilitators or families directly. The primary policy tool that is used to translate individual's ISP into more specific services and funding level is the Guide to Support Allocation (the "GSA"). This tool provides guidance to analysts with respect to the amount of funded support that should be provided to an adult with a developmental disability, based on their disability related need. The GSA is included as Appendix 3.

The GSA was created with primary reference to a British model called In Control, which was designed as a self-assessment tool to assist people with intellectual disabilities to get a sense of the amount of support they could receive from their government system. Consideration was also given to the American tool Supports Intensity Scale (SIS), which is the most automated model (see Appendix 4). After considering these available alternatives, CLBC decided to develop the GSA by modifying the British model to suit CLBC's service delivery system.

The initial version of the GSA attempted to use a point rating system to measure the relative weight of certain aspects of support. Feedback indicated that it was difficult for staff to use the calculations to determine the disability-related needs of the person. CLBC felt that the tool would need a way to help determine if there were significant or extreme support requirements that should be considered when making cost allocations, but it could not easily calculate these without creating a tool that would require an extensive validation process. In addition, CLBC wanted a tool that would force a professional judgment instead of only applying a score-based determination of disability related need.

Accordingly, the way the GSA works and is configured is as follows: the analyst reviews the ISP and seeks to understand the individual's disability related need. A detailed analysis then takes place in ten areas:

- Communications
- Meeting Personal Needs
- Creating/Maintaining Relationships
- Making Day to Day Decisions
- Making Important Life Decisions
- Promoting Well-Being
- Work and Learning
- Being Part of the Local Community
- Complex Health Needs
- Complex Risks and Actions

In each category, the analyst provides a score of 5 (highest level of need) to 1. Guidance is given with respect to the criteria that would justify a score at each level in each category. The level is based on information submitted in the person's plan, and the analyst must make a professional judgement based on disability-related need based on the information in the plan.

The GSA also recognizes that some factors are not easily captured because while they are not necessarily about an individual's intellectual disability, they do impact the level of service that is warranted. These factors include mental health issues, physical disabilities, or complex needs. To address this, the GSA's "flags" provide a way to account for extreme circumstances that may drive costs higher than the developmental disability alone would indicate. Here again it is up to the professional judgment of staff to decide what influence the flag ultimately has on the allocation of resources.

When all ten areas are reviewed and a determination of need made in each, the analyst adds the total score and divides by the number of areas where scores were recorded. Flags are not scored and are excluded from the average score. Accordingly, a final GSA score can be something like: "Level 3, with 2 flags". This is then used by the analyst to determine the maximum amount of support that CLBC could provide, based on reference to the Catalogue of Services (see below). If these fall within the same range, the plan (or appropriate components of the plan) will be confirmed and the analyst with proceed to the contracting phase.

It should be noted that the focus of the GSA plan review is not supposed to be on "approving" the plan as a whole. Rather, it was designed more specifically to be used as a tool to confirm the appropriate level of CLBC support.

The GSA has some clear limitations. It does not work in emergency situations, for example. It is also not standardized in that it relies on the individual interpretations of each analyst. Although CLBC considered the use of purely standardized, logarithmic weighting tools[64] to determine disability-related needs and individualized budgets, this required that the assessing professional have a direct relationship with the individual in order to complete the assessment process. This idea was rejected because it was seen as potentially impacting the neutrality of the assessment.

Another issue that mitigated against the use of a purely standardized assessment was that in situations where families directly submit a plan without CLBC involvement, they would still have to engage a facilitator to complete the disability-related need assessment.

It is generally felt that the GSA is a useful policy tool, and a step in the right direction. It is based on sound research and best practices, but still leaves room for professional judgement. Importantly, it separates out disability-related needs from more urgent or crisis-driven needs. Historically, this was not the case, which presented considerable challenges in terms of determining and monitoring outcomes.

As noted in the Service Delivery Model section, the current situation where the analyst applies the GSA presents considerable operational challenges – based largely on the lack of first-hand experience with the individual and family, and the very common necessity of having to turn to the facilitator or the family to ask for clarification. This works counter to one of the main reasons for the new model, which was to reduce the requirement for families to tell their stories over and over. For this reason, we have recommended that CLBC examine the possibility of having facilitators complete the GSA stage, then help steer individuals and families through the funding assessment phase.

It is not yet clear how well the GSA has met the original goal of being a means of putting boundaries and creating consistency around decision-making relating to funding. The tool has been in use for only slightly over 2 years, and has played a part in determining the outcomes of the approximately 500 plans that have been submitted and reviewed by Quality Service Analysts. CLBC is now in the midst of conducting an initial assessment of the efficacy of the GSA, which will included recommendations for improving the tool and how it is applied. This is anticipated to be completed early in 2009.

9.5 Catalogue of Services

Closely tied to the Guide to Support Allocation is the Catalogue of Services, which is used by an analyst to identify the type and cost of available services, while providing the flexibility needed to develop new options. The catalogue is aimed at facilitating consistency in contracting, and promoting transparency and equity in the allocation of financial resources. It is attached as Appendix 5.

As noted elsewhere, CLBC inherited MCFD's service delivery system and suite of services when devolution occurred in July 2005. A large proportion of services remain subject to pre-existing contracts and, for this reason, the foundation of the Catalogue of

---

[64] Correspondence from CLBC, May 2008

Services is an adaption of the old MCFD range of services. These have been collected, reviewed, adapted and collected into a single document under five program categories: Home Activity, Community Inclusion Activity, Family Support, Program Coordination, and Professional Support.

Each program is further divided into service categories. For example, Home Activity includes Home Sharing, Live-in Support, Supported Living, and Staffed Residential services. Each service category includes a breakdown of GSA-determined levels of need, and each of these has a corresponding maximum funding level. For example, the Catalogue specifies that Live-in Supports for a person with level 3 disability-related need results in a maximum funding level of $1,221.87 and staffed residential services for level 5 need is set at a maximum of 280 staff hours/week.

Service levels are only available when it is appropriate. For example, cluster apartment living is only available to levels 1, 2 and 3, while staffed residential services are only available at the higher end of need: levels 3, 4 and 5. In addition, additional funding to the base level is provided for when there are flags indicated on the individual's completed Guide to Support Allocation. For example, home-based living (Home Sharing and Live-in Support) has a maximum base of $4,200 per month, plus an extra $3,000 per month where the individual's GSA identified flags in three or more areas.

Costs of services for home-based living were largely inherited from the MCFD system. While the lexicon of terms has changed, the rates applicable to them remain largely the same (for example, Home Share was formally known as PriCare, but the amount that is paid for the service remains unchanged). What has changed is the way that rates are determined – the Catalogue is aimed at moving away from complex formulas to a simple net payment level within each level of disability-related need.

For other categories and services, service levels were based on an assessment of what would be reasonable for CLBC to fund. Maximum dollar rates are not set; rather maximum services levels are noted. For example, level 3 community-based services can be approved to a maximum of 12 hours per week. CLBC determined these levels by examining global contracts with agencies, analysing what services those contracts purchased, and then working backwards to determine the average hours of labour per week per service that the contract would support (taking into account a 15% deduction for agencies' administration).

In undertaking this analysis, CLBC worked with service providers, examined existing contracts, looked at situations where there was agreement that services were being provided and funded as a reasonable rate. In adopting this approach, CLBC started with the premise that MCFD was appropriate in its costing models, which were based on extensive bargaining and negotiation. This was further tested against the real experiences of service providers. Considerable care has therefore been taken to ensure that catalogue service rates are, as much as possible, based on the real costs of specific services. If that premise is sound, CLBC has advanced consistency further, maintaining the basic costs per unit of services, and adding greater clarity, granularity and objectivity based on its individual needs-related assessments.

The basic premise behind this approach was that, instead of “buying” spots in agencies’ programs, payments could be made directly to the individual, who then decides how best to spend the allocation. Rather than being dependent on the ability of the individual to find a social worker who could most skilfully present their case, the level of funding would be based on an objective determination of the level of need, with a service/financial allocation that is standardized for people with similar levels of need across the province. In many respects, the sector is in the midst of evolving from a system of unrelated, independent benevolent payments to a more sophisticated industry that is based on standards and fairness.

The concept is a sound one, based on objective determination of appropriate levels of service. The practical challenge, however, is that CLBC inherited a legacy system with over $500 million in global contracts. Assurances that changes to existing services would not be made without the consent of clients means that this legacy system retains a strong influence over the system as a whole. This is changing little by little, as every new client goes through the new service delivery model and becomes subject to its standardizing policies.

Ideally, the policy tools that support the service delivery model will balance the assessment of long-term, ongoing disability-related needs with situations where there are more urgent, crisis-driven needs. This should also be able to ensure consistency across the province, much in the way that the health system recognizes individual need, but still expects a level of consistency in the way that individual’s health care needs are addressed and paid for.

For this reason, CLBC is infusing outcomes reporting into its contracting and contract management system. It is recognized that this will create an administrative burden for service providers, but steps are being taken to account for this in the Catalogue of Services, which will be amended to include a coordination function, the cost of which will be built into client contracts. This will improve the overall policy framework, allowing for the definition, monitoring, and reporting of outcomes specific to the client’s circumstances. In the past, a large global contract would be presumed to cover off the needs of a number of clients, without any ability to evaluate efficacy and make appropriate adjustments.

In terms of progress, the GSA and Catalogue are now substantively developed and have gone through one round of validation with service providers. CLBC has indicated that the two tools will be finalized and in full operation imminently. Required changes to the supporting IT systems are underway and anticipated to be complete in the next fiscal year, and full integration with the Contract Management System will occur late in 2009-10. This will provide CLBC with the capacity to track both individual and regional behaviour to monitor consistency and address variation through peer review.

A key assumption on which all of these policy tool rationalizations are built is that the underlying processes are consistently applied throughout the province. This is especially so with respect to the way staff apply the GSA, arrive at a determination of clients’ levels of need, and link to specific funding levels. Without consistency, the model becomes vulnerable to the same issues that were apparent under the old system: subjectivity in decision-making, inequity of funding levels, and the loudest voices (rather than the highest needs) receiving funding first. While it is too early in the process to report definitively on this issue, indications from CLBC are that it is aware of reported inconsistencies in application, and plans to address this through comprehensive staff training once the new integrated system is completed up and running.

Full integration of the Contract Management System will also assist in ensuring consistency throughout the system and across the province. Considerable work remains to be done in this area, however, before the benefits of this policy tool are fully realized.

9.6 Overall Policy Framework

As noted at the outset of this section, in early 2008 government clarified the relative responsibilities of CLBC and the Ministry, with government assuming a more active role in reviewing and approving policy related to people with developmental disabilities. While the focus of that review was on the policies outlined above, the work of CLBC with respect to its overall policy framework also bears some notice.

In June 2006, CLBC adopted an integrated policy model, focusing on five policy areas: service delivery; corporate service; human resources/labour relations; information and technology; and communications. The organization has committed to ensuring a consistent approach to policy in these areas, and a consistent reference to operational principles that bridge between CLBC's mission and vision and its day to day activities. These "policy foundations" are:

- Citizenship in Community: supporting individuals' rights and responsibilities through commitment to community inclusion;
- Individuals and Families First: encouraging meaningful participation in developing networks of support;
- Values into Action: demonstrating commitment to support and inclusion;
- Learning and Growth: remaining open to change, based on research and experience; and
- Accountability: to individual, community and government.

This overall framework has guided the development, adoption and implementation of a number of key policies, the following of which have been made publically available through the CLBC website:

- *Adult Guardianship & CLBC* (June 2006): outlines what to do if there is concern that someone with a developmental disability is being abused or neglected and needs assistance. Provides information about the role of CLBC staff in responding to concerns.
- *Adult Respite Direct Funding Policy* (September 2007): provides families with the option of receiving direct funding to purchase respite supports for an adult family member with a developmental disability living in the same household.
- *CLBC-Contracted Home Sharing Providers* (March 2008: CLBC has two policies related to contracted home sharing providers. *Approval of CLBC-Contracted Home Sharing Providers* provides guidance to analysts who are involved with the approval of home sharing providers. *Monitoring of CLBC-Contracted Home*

Sharing Providers provides guidance to analysts who monitor home sharing contracts. Both policies apply to adults who live in home sharing arrangements that are directly contracted by CLBC. A third policy, *Respite Guidelines*, covers respite which, when used effectively, promotes stability and reduces stress within home sharing arrangements. This policy also provides guidance to analysts who monitor home sharing contracts.

- *Complaints Resolution Process* (April 2008): Outlines the process for people to request review or reconsideration of a CLBC decision or action.
- *Eligibility for CLBC* (December 2006): clarifies the criteria and process used by CLBC to determine eligibility for its direct or funded supports and services. In addition, this policy addresses the need for consistency and equity in determining access to services.
- *External Reviews Policy* (October 2008): sets out the requirements for neutral third-party investigation of a situation, incident or service, that results in recommendations and possible action. This policy applies to CLBC Quality Service Managers, Quality Service Analysts, and the Director of Quality Assurance.
- *Individual and Family Support Policy* (March 2008): provides information about the role of CLBC facilitators in providing individual and family support.
- *Individual and Child and Family Support Planning Policy* (March 2008): outlines the content required in Individual Support Plans and Child and Family Support Plans and explains when plans are required for CLBC-funded supports.
- *Reporting Theft, Fraud and Corruption* (November 2007): provides a process for anyone, including the public, CLBC employees and other stakeholders, to confidentially report actual or possible instances of theft, fraud and/or corruption.
- *Service Provision by Family Members* (April 2008): outlines the exceptional circumstances under which an immediate family member can be paid to provide service to a relative who is eligible for CLBC supports.
- *Standards for Home Sharing* (March 2008): after a formal consultation process that invited feedback from key stakeholders, the Standards for Home Sharing were formally endorsed and adopted by CLBC in April 2007. These are now used as provincial guidelines for all home sharing providers.
- *Waitlist Policy* (July 2006): outlines what individuals and families can expect when they have received approval in principle for an individualized support plan but there is no current capacity to cover new or additional service costs.

Other policies are still under development and review and have not yet been posted. These include the policies on Individualised Funding, the Guide to Support Allocation, the Waitlisting policy, the Catalogue of Services. Once these policies and accompanying tools are fully developed, reviewed and approved by the CLBC board and government, the intent is to post them publically. In addition, as part of its policy development cycle, CLBC plans to review and potentially update all these policy statements in the current fiscal year. Reviews and rewrites of policy regarding Critical Incidents and Individualized Funding have been completed and will be released soon.

Some concern has been expressed about the updated policy regarding eligibility for CLBC services, arising out of a change in regulation that was promulgated in July 2008. This regulation, however, specified and supported the practice that had been in place at CLBC for several months: that eligibility is based on the use of the DSM IV by registered psychologists to arrive at a diagnosis of mental retardation. Although it is understood that work is underway at the central government level to re-examine the legal definition of eligibility, this has yet to be fully developed and/or announced. For the time being, CLBC's current Eligibility Policy is appropriate and consistent with government direction.

9.7 Recommendations: Policy Tools to Support Service Delivery

In summary, a review of the policy tools that CLBC has developed to support its service delivery model indicates that the organization has taken considerable steps forward to create a strong basis for a fairer and more predictable allocation of resources. The agency deserves credit for implementing a more open process, one that is based on objectivity and mitigating the effects of personal or political influence in the determination of funding levels.

It is challenging to make definitive conclusions about the longer-term appropriateness or efficacy of the policy tools and framework, as they have not been in place long enough to allow for robust, data-based testing or analysis. In addition, the policy tools are meant to support a significant shift in the way services are delivered and, in light of the large proportion of services that were inherited and remain in place under the former system, it will take time for the effects of the new policy tools and service delivery model to really take hold.

One of the key strengths of the new system is its attempt to base resource allocation on an objective, needs-based analysis. This process is still being refined and requires more time to be fully and consistently implemented across the Province. It is, however, a significant step forward and creates a framework to allow for longer-term, data-based planning.

Taking all of this into consideration, the following recommendations are made:

Rationalize planning processes

For CLBC's system to work as conceived, greater emphasis and utilization of generic, community services must become a reality over the longer term. Currently, indications are that the planning process tends to focus on CLBC-funded services, and it is often viewed by families as a hoop that must be jumped through. Accordingly, it is recommended that CLBC develop and implement consistent training for facilitators that focuses on the non-CLBC-funded aspect of planning, to encourage both staff and families to start thinking about options that go beyond the traditional government-funded support. This is an area where CLBC practice has not yet caught up to CLBC's model and communications.

CLBC has already recognized that in many situations, comprehensive planning is not necessary and can be detrimental to individuals and families. The ongoing revisitation of the appropriateness of planning processes and procedures is encouraging, and speaks to CLBC's willingness to examine its own procedures in an open and transparent way.

Query use of Guide to Support Allocation

As noted above, the GSA and Catalogue of Services, while in their infancy as policy tools, do show some promise for bringing consistency, objectivity and predictability to the assessment of disability-related need and in the allocation of resources to support those needs. It is unclear, however, why CLBC did not adopt one of the systems that have already been operationalized and tested elsewhere, rather than creating systems from the ground up.

Particularly in light of the recommendation that facilitators adopt the responsibility for applying the GSA, it is recommended that CLBC revisit the option of utilizing one of the established tools. If the concern previously was that the assessor needed to be someone who already had a relationship with the client, this should not longer be a concern since the facilitators should now be responsible for assessing disability related needs. If there are other concerns that outweigh the benefits of using tools that are already tested and accepted, these should be articulated and re-examined.

Provide consistent, comprehensive training for staff

While the Guide to Support Allocation and the Catalogue of Services are based on sound premises, the potential lack of consistent application of these tools presents a vulnerability to the system. This review suggests that staff is inconsistently trained, and that the tools are not being applied in a consistent manner across the province. Coupled with the recommendation that facilitators assume responsibility for applying the GSA, this provides an opportunity for CLBC to implement a comprehensive round of training and education to all facilitators and analysts with respect to the proper application of the GSA and Catalogue of Services.

A key component in this endeavour is to ensure that managers are also employing a consistent approach to the application of the GSA and the Catalogue of Services. Accordingly, they should also be mandated to participate in training and refresher sessions to ensure that the equity, fairness and predictability the GSA and Catalogue of Services aim to bring to the system are consistently applied.

Attention to performance management.

There is a general recognition at CLBC that performance management is an area that requires greater attention and that, in large part, this is a component that is largely missing from the current contract management system. This is due in part to the system that was inherited, as well as to the underlying culture in a sector which has not traditionally favoured an approach that includes monitoring and management. It is recommended that performance management be brought to the forefront of contracting procedures and processes, and that CLBC build on the opportunity to infuse performance management into its technological infrastructure as well as its staff training and job performance assessments.

Clarify potential integration with government systems

As noted throughout this review, CLBC has made great strides in improving the information technology and management information systems that support the delivery of services to people with developmental disabilities in British Columbia. Given the general move towards greater systems integration, particularly in respect of the social services sector (e.g. government's Integrated Case Management system project), it is recommended that CLBC work closely with MHSD and other government partners to examine, clarify and implement where appropriate the potential benefits of greater systems integration.

Clarify government oversight of policy

The overall roles and responsibilities of CLBC and MHSD with respect to policy have been clarified: the Minister of Housing and Social Development sets the broad policy direction, which is executed by Ministry Staff, who review and approve policy. CLBC develops specific operational policies to reflect the broader direction and implements those policies once approved. There is not yet a clear process in place to implement this direction, however, and it is recommended that CLBC and MHSD work together to implement a formal review and approval process for the development of appropriate policy.

Undertake ongoing assessment

As noted in the preceding section, the policy tools that CLBC has developed and adapted to support its service delivery model are broadly speaking in their infancy. They show promise in bringing objectivity and consistency to resource allocation and service provision, but require a commitment to assessment, measurement and revision over time. CLBC should commit to ongoing assessment of the efficacy of its policy tools, including regular reporting to government, the Board of Directors, and to the public.

10.0 On sustainability

10.1 Introduction

One of the key motivations behind the devolution of service delivery from MCFD to CLBC was a belief that the proposed system would offer more predictability and overall sustainability than the historic model. From its earliest conception, arising out of the Community Living Coalition, the CLBC model was promoted as a means to "dramatically reform the system with efficiencies that would not impact the services available to individuals and families"[65]. The model that was originally put forward by the Community Living Transitions Steering Committee was also characterized as representing "the highest and best use of public funds, with greater accountability and increased value for money spent[66]". This arose largely from the belief that a cost-effective model would be possible in part through a number of key factors including:

---

[65] Community Living Transition Steering Committee (2002a):

[66] Ibid. (16-17).

- Individualized funding, which would create system efficiencies and greater flexibility;
- Increased role of families, including the ability to pay families for extraordinary care costs (with the thought that costs would be lower if the family undertook this care, rather than paying for professional support when was not necessary); and
- Increased use and reliance on generic community supports and services.

Originally, sustainability was based in part by the assumption that the new model of service delivery would allow for resources to be stretched further. A common analogy that was presented was that of patient-driven recovery from surgery, where there is strong evidence that allowing patients to administer their own level of medication rather than having professional supports do so results in lower use of medication, lower professional costs, and more expedient and improved degree of recovery. At its core, this requires two factors: trusting individuals to determine what is best from them, and moving to greater self- administration of services. Currently, there is an absence of hard data to accurately assess the scope and magnitude of anticipated savings.

Applying this to the context of community living, there was a belief that by giving control over services to the individuals that use them, fewer services would be used and there would be greater elasticity in the system. This is the base of CLBC's original vision for ongoing sustainability, and one that has been tested over the past three years by a number of highly restricting factors.

10.2 Sustainability: key challenges

In meeting the goal of greater cost containment and system sustainability, CLBC faces many demographic pressures. These are widely recognized and accepted, although it must be said that this is largely based on anecdotal information and conclusions arrived at through individual experience. Nevertheless, the following factors were cited almost universally by participants in this review as factors that are contributing to costs and challenging CLBC's efforts to ensure ongoing sustainability:

People living longer lives: Community support, technology and health services are extending the life expectancy of individuals with developmental disabilities and, as a result, increasing the overall population served by CLBC.

Aging client population: As individuals age, their needs generally become more complex and require greater support.

Earlier onset of age related needs: Individuals with a developmental disability experience age-related health issues up to 20 years earlier than the rest of the BC population. As a result, the baby-boom bubble impact of age-related demand is affecting CLBC earlier than in the general health care system.

Increasing age of family caregivers: Many individuals are currently supported by their family at home. The capacity of the family to cope diminishes as they themselves age and their health deteriorates, leading to an increasing number of older clients coming to CLBC for support. This is particularly acute with respect to housing and accommodation needs.

Increased expectations: There is an increasing number of children with developmental disabilities receiving government-funded supports. After having their child in full-time educational programs at school, when the child turns 19 parents find themselves without any supports and the child is at home full time. Just as the education system has experienced increasing demands from parents of children with special needs, so has CLBC experienced an increased expectation from parents for day supports for their children turning 19.

Higher Autism rates: Over the past few years, prevalence rates for autism in BC have increased significantly. These families customarily receive a relatively high level of funded supports, and expectations remain high when the child turns 19.

Improved eligibility: a number of high-profile court cases, particularly the *Fahlman* case[67], have challenged the current restriction of eligibility to people diagnosed with mental retardation under the DSM IV (an IQ of 70 or below).

Increased awareness: The creation of CLBC has attracted significant local, national and international interest. A number of legal challenges around eligibility have also elevated awareness. CLBC has also seen an increase in the number of older individuals newly presenting for CLBC services.

There is wide recognition that the key cost drivers for CLBC's adult community living services are demographic changes resulting in a larger client base and cost increases from contracted service providers (including newly awarded increases in compensation for services). There has been an expressed concern that the planning process has raised expectations beyond those that may be affordable or sustainable.

The financial pressures for CLBC are considerable, and the anticipated elasticity in the system has not been realized as quickly as anticipated, due to the continued effect of global contracts and the lack of uptake for individualized funding that was noted earlier in this report. The return of children's services to MCFD will have a further impact on the system's elasticity and flexibility, as it will result in the loss of staff who were designed to serve both children and adults, particularly in smaller offices where staff resources are limited.

The most influential factor in terms of sustainability is clearly the fact that CLBC as a crown agency is responsible for a fixed budget. This may be self-evident, but in fact managing to a budget is a departure for this sector. Under MCFD, Community Living Services operated from a health and safety perspective which led to a situation where urgent requests were commonly funded on the basis of crisis response. In practice, this often led to budget overruns, which were justifiably funded because they were essentially emergency response. Due to the lack of outcome setting and performance monitoring, these overruns were, in general, simply rolled into the next year's budget, becoming an ongoing base service. MCFD was also able to take advantage of its ability to prioritize funding out of both its children's and adults' services budgets, which created another degree of flexibility.

CLBC does not enjoy the same flexibility. Rather, its budget is set on an annual basis, and it is up to the agency to determine how to best allocate funding to meet both urgent and ongoing funding requests. This is a very different approach, and one that requires a much higher degree of planning, predictability, and data analysis. With respect to

---

[67] Fahlman, by his guardian *ad litem Fiona Gow v. CLBC et al*, 2007 BCCA 15

sustainability, this presents clear parameters and expectations and calls on the agency to be both more creative and more responsible in its budget decisions.

One effect of having to manage a fixed budget is that CLBC has had to face the reality that it cannot be all things to all people. Originally conceived out of a strong advocacy position, CLBC now finds itself defending difficult budget decisions to the community that still expects the agency to be at the forefront of challenging government. Accepting its position as a crown agency with a responsibility for managing a government budget, rather than acting as an advocacy agency with responsibility to publicly arguing for a larger budget, has been a difficult transition – one that has clearly had an effect on the relationships and trust that some parts of the community living sector have with CLBC.

Managing family expectations is a key component in CLBC's ongoing sustainability. This is especially challenging in that families play a preeminent role in the CLBC philosophy and approach to service delivery. There is an inherent challenge in responding to increasing service delivery demands, when the entire CLBC philosophy is built on honouring family and individual needs. Many in the community have expressed frustration, for example, that CLBC continues to use language about promoting individual choice and self-determination when in fact there are few options available in terms of funded services.

Making the paradigm shift that CLBC hopes to make will require time and patience, particularly with respect to the implementation and adoption of some measures which are aimed at longer-term systems sustainability. It will also require strong and effective leadership at both the governance and operational levels. Some of the key factors that are and will be relevant to CLBC's ongoing sustainability are outlined in the following section.

10.3 Actions taken to support sustainability

CLBC's overall approach to ensuring sustainability is based on three broad principles:

1) Gain control of current spending, in part by applying consistent analyses and allocations of funding;
2) Encourage greater interest in and application of individualized funding options; and
3) Broaden the base of supports and services, so that CLBC-funded supports are only one part of a person's community living plan.

Since its inception in 2005, CLBC has developed tools that are aimed at achieving increased value from its allocated funds, while also trying to enhance equity and consistency of application. Key initiatives cited by CLBC include:

- Waitlist and Planning Registry – to capture and monitor individual requests for service (outside the scope of this review);
- Waitlist Priority Tool – to assess the level of urgency of the individuals support need (outside the scope of this review);
- Guide to Support Allocation – to assess an individual's disability-related need (discussed above);
- Catalogue of Services – a guide to the level of funded support appropriate to the need (discussed above);

- Provincial Costing Framework – part of the Provincial Practice Guidelines, to ensure a consistent approach to contract costing across the province;
- Regional budget accountability - over multiple years such that over-commitments in one year must be absorbed in subsequent years;
- Increased focus on contract management including service re-design and unearned revenue;
- High-value contract review, whereby the 250 highest unit-cost individuals/contracts are opened for review and the application of the new resource and costing tools.

As noted above, some of these tools show considerable potential for rationalizing service delivery and, over time, to introduce system-wide efficiencies. The overarching goal is to introduce and implement a greater degree of standardization and fairness, and to provide CLBC staff with a rational basis on which to make their funding decisions. Rather than simply being in a position to say “yay or nay” to funding requests, the new tools provide analysts with objective criteria upon which to make equitable and consistent decisions.

Other factors that have been put into place in order to address concerns about the ongoing sustainability of the system are set out below.

10.3.1 Regional Budgeting

As explained above, under the previous system, service needs were identified by individual social workers who brought the requests of individuals and families forward at monthly regional staff meetings. The basis for providing funding was a threat to the health and safety of the individual. This led to the fostering of a sense of crisis, social workers were in a position of advocating for clients, and there was a lack of a fixed budget upon which to make longer-term decisions about funding. Community living staff and the Ministry itself were therefore in a constant state of reacting in a crisis-management environment.

One of the fundamental changes under CLBC has been the introduction of a fixed budget not only at the corporate level, but also at the regional operational level. Every year, regional offices receive a fixed allocation. Offices are directed to work to this budget allocation, using their own discretion and experience to balance longer-term services with meeting urgent and emergency requests. This puts the onus on regional managers to constantly monitor budgets and ensure sufficient funding remains in place, rather than on relying on the knowledge that overruns will simply be funded at the beginning of the next year and become part of their base funding, as tended to occur under the old system.

Where a region is able to manage its budgets well and end the year with a positive balance, it can retain that allocation for the next year and its budget allocation will not be reduced (any surplus is returned to General Revenue). Conversely, running a deficit budget is specifically prohibited, and if a region ends the year in deficit it must use its next year’s allocation to address that deficit before offering new services.

In addition, analysts attend regular regional meetings to review waitlisted and urgent/emergent requests and determine which services will be contracted and implemented. Meetings focus on discussion and analysing the degree of need, based on the more objective measures set out in the priority ranking tool and the Guide to Support Allocation. As they are not the ongoing point of contact for the family, the notion is that analysts' perspectives will not be unduly influenced by relationships, and their discussions will be supported by objective metrics.

A fixed, regional approach to budgeting is a new approach for this sector, and offers a number of clear advantages in terms of ongoing sustainability. It has also led to some criticism that regional offices are overly focused on managing their budgets and seem to be obsessed with saving money and "banking" unspent allocations. This has caused some difficulties in communications with the community living sector, particularly when contrasted with an ongoing focus on rhetoric about increasing choice and flexibility.

10.3.2 Costing Tools

One of the major challenges of the previous system was applying consistency and objectivity to decision-making about the availability and level of services that would be funded for each individual case. As noted elsewhere, social workers both assessed the level of support required and made decisions about recommended funding levels, without benefit of standardized guidelines. Individual situations and support needs were not independently assessed or measured against any systemic benchmark. Instead, there was a subjective assessment of urgency that was anecdotal and not easily comparable with other's needs.

In addition, the cost of services was negotiated in each region without any regional or provincial guidelines in place. There was no standardization as to the salary rates applied, coordination/supervision funded or administration fees charged. As a result, there was little consistency between regions with respect to the level of disability-related need or the level of support provided for a given disability related need.

To address this lack of standardization, CLBC is in the process of refining and implementing Provincial Practice Guidelines that are aimed at its procurement, contracting, costing and monitoring practices.

Provincial Costing Guidelines are completed and being implemented for staffed services, including residential services, community inclusion and other services that use paid employees for delivery of supports. They provide standards for all cost components, a standardized format and guidelines on ratios for supervision, coordination and administration. All contracts opened in the future for a service change will have the costing guidelines applied to ensure compliance with standards and to establish a detailed understanding of the expected inputs into the contract to improve the monitoring of value and the capture of unearned revenue.

For staffed services, the costing tool has been in place since December 2007 for new contracts for both unionized and non-unionized service providers. It was reviewed, assessed and updated in June 2008, taking into account feedback from service providers.

With respect to home-sharing, in July 2008 CLBC announced its intention to apply a costing framework. As with the staffed services costing guideline, the home sharing costing framework sets funding rates based on the assessed level of need of the individual (arising out of the ISP and application of the Guide to Support Allocation). Although an implementation date has not yet been determined, CLBC has indicated that the framework will apply only to new clients, and that existing contracts will likely be grandfathered.

CLBC's costing tools are the first concerted effort to introduce regional and provincial standardization to funding allocations, and provide clear guidelines to analysts. These tools are meant to ensure that approved funding covers the reasonable costs of services, that contract negotiations are undertaken in a consistent manner, and that the time and effort required by analysts to focus on contract inputs are reduced. They will allow, when coupled with the ability of PARIS to track analysts' records in terms of the levels of GSA assessments, for the generation of regional and cross-regional reports. Analysts that appear outside of the bell curve in terms of levels assigned will be reviewed through peer review of plans previously assessed by the Analyst, allowing for ongoing re-assessment to ensure consistency of practice.

PARIS will also track the cost of service requested, the amount approved in principle and the amount actually contracted for. This will allow comparison of recommended and contracted services to be made, analyst-by-analyst and region-by-region, relative to the GSA value assigned and the associated Catalogue of Service value.

While there is a general sense of support for the idea of a standardized costing tool, participants in this review also expressed a number of concerns with respect to its implementation.

Many providers felt that, particularly for smaller agencies, the costing tool is overly complex and in a format that requires ongoing intensive maintenance. In some cases, the tool actually collects more information than agencies themselves would use to analyze its operations. There has been some resistance to applying the tool by providers who feel that the tool does not facilitate better service quality or consumer satisfaction. For them, the costing tool is a prime example of where CLBC appears to be more focused on identifying and realizing cost savings, rather than offering wider choice and more broadly available services.

There has also been a concern that the costing tool has effectively unionized agencies that are non-union. Originally, the tool used CSSEA job descriptions and associated rates, and non-union agencies were expected to have terms related to wages, benefits, vacations, etc. mandated and capped at union levels. The latest version of the tool, however, de-links non-union agencies from CSSEA rates.

At a larger level, some concern has been raised that the costing tool is based on a cost-neutral outcome. Some service providers expressed resentment at CLBC expecting services to be delivered at cost, and are concerned that this represents a bias that unfairly impacts service provision, and endangers the viability of private and non-profit agencies. It is also these providers' position that this represents a radical change in government policy around contracting, as cost-based service delivery has not been the standard to date.

Finally, a number of participants expressed concern with the way that CLBC's costing tools have been presented and communicated to the sector. Although accompanied by statements that the goal is not "cost reduction", a review of the home based living costing framework indicates that, particularly for those who might opt to move from a staffed group home, there is a clear reduction in funding. Participants noted that this in and of itself may not be problematic, but rather if CLBC truly believes that this is a better option for people, it should be forthright about its intensions and the implications of change, including those around funding. The lack of transparency was cited by many participants, both families and service providers, as a major contributing factor to a growing lack of goodwill towards CLBC.

10.3.3 Contract Management

Another tool that CLBC is introducing in order to enhance ongoing sustainability and predictability into the community living system is its contract management initiative.

As noted elsewhere in this report, under the previous system it was common practice to collapse numerous contracts for supports services into one large global budget per service provider. This was done in part to facilitate contract administration, and resulted in contracts with very limited information on inputs or expectations. Contracts were renewed annually; generally all at year-end, and the bulk of the effort was directed to managing the paper renewal so that payments could continue uninterrupted.

Over the next year and a half, CLBC is introducing a new contract management system (CMS), which will change CLBC's approach to procurement and contracting. The CMS will allow CLBC to eliminate the focus on the paper-based processes and focus more on oversight and output/outcome monitoring.

The goal of the CMS is to systematically and efficiently manage contract creation, execution (including payment) and analysis for maximizing financial and operational performance while minimizing risk. It will encompass all activities that CLBC will engage in while entering into contractual arrangements with service providers, individuals, and others who interact with CLBC at a business/transactional level.

CLBC staff process approximately 10,000 contracts per year, with each contract being amended at least once over the course of each year. The process is administratively cumbersome and manually intensive. There are also a number of limitations to the current process including data capture, contract compliance, and performance monitoring and reporting.

Currently, CLBC uses three methods to produce and manage contracts – R/AP's (residential contracts), Word / Oracle (non-residential contracts), and PARIS (adult agreements). The systems used to manage contracts are not currently interfaced and, as a result, CLBC is unable to efficiently synthesize and collate data related to contracted services. One of the primary objectives of a CMS is to streamline these outdated and manually intensive processes to achieve cost savings and improve performance measurement.

CLBC has chosen to implement an off-the-self CMS, UpsideContract, which will be adapted for CLBC's requirements in order to establish a singular system for creating and managing contracts with service providers and vendors. Taken as a whole, the CMS will allow for a single system of records for all contracts; a clear process for staff to follow in developing contracts; and a consistent set of criteria to use for performance assessment purposes. It is anticipated that this will result in:

- Reduced reliance on a cumbersome paper-based contracting and invoice payment processing;
- Improved ability to monitor service provider performance and outcomes;
- Improved corporate reporting capacity for contracted services;
- Ability to efficiently interface with other CLBC systems (eg. PARIS, CAS); and
- Reduction in the duplication of work and the time required to create, modify and renew contracts.

Contract periods will be extended and "hard" review points implemented in the CMS, which will also include an electronic record of contract negotiation results and other related documents.

In terms of current status, the business requirements and rules have been developed for the CMS, which is currently undergoing systems testing. User acceptance tests are underway and CLBC is currently in the process of collecting and verifying data on the business type of its contracted service providers. As of August 2008, 2,921 service providers had contracts with CLBC for adult service delivery, in the following categories (by business type):

Table 8: CLBC Contracted Service Providers, by type

Business Class	**Service Providers**	**% Of Total**
Proprietorship / Partnership	2,192	75%
Microboard	350	12%
Society	209	7%
Incorporated	149	5%
Government Agency / Authority	21	1%
Total	**2,921**	**100%**

Although in a draft stage, the comprehensive Provincial Practice Guidelines for Contracted Services is anticipated to include an inventory of contract types and provide clarity on the scope of the CMS, clarity with respect to roles and responsibilities, and best practices guidelines to assist staff with new contracts, renewing and modifying contracts, and terminating contracts. It is also anticipated that the document will include guidelines for procurement processes and procedures as well as the costing guidelines that were outlined in the previous section. Provincial Practice Guidelines are expected to be complete and fully operational by the end of this fiscal year (2008/09).

As noted previously, an unknown factor with respect to the CMS is its relationship with the IT/MIS platform upon which it is based and with the more integrated systems approach that is now being adopted by government. This may present an opportunity for CLBC and government to realize greater efficiencies and through a more seamless infrastructure.

10.3.4 Contract Monitoring / Performance Measurement

In the past, the lack of adequate or industry-standard performance measures, the global nature of contracts, and the lack of a monitoring framework hampered the ability of government to ensure that contracts were being performed with the highest degree of effectiveness and efficiency. CLBC has undertaken a project aimed specifically at reviewing and improving contract monitoring, in hope of implementing a comprehensive and consistent contract monitoring framework.

Traditionally, contracts with service providers contained very little information with respect to performance expectations or measures. There were a multiplicity of contracts and, with the focus on crisis intervention and the assurance of health and safety, staff had other priorities.

Even with the devolution to CLBC, the initial focus tended to be on planning, rather than on service monitoring. Monitoring effectiveness has been challenging, as well, because of the structure of the legacy contracts, which did not identify individuals to be served, specific services to be provided, or outcomes to indicate a satisfactory performance of the contract's terms. This was exacerbated by the lack of adequate or appropriate IT/MIS systems and infrastructure.

CLBC has now embarked on the development of a Monitoring Framework, which is being developed by an independent public policy consulting firm - Perrin, Thoreau and Associates Ltd. Design criteria include:

- Outcome measures that are compatible and consistent with required indicators for accredited agencies;
- A reporting method that is seamless with other data collection processes;
- Focus on accountability and quality improvement to evaluate appropriateness of supports and services;
- Promotion of continuous improvement and learning; and
- Simplicity, flexibility, reasonableness, and practicality of implementation, allowing for adaptation to all types of service providers.

The framework will include a definition of outcomes and measures, a financial monitoring framework, and a reporting process. The project is currently in its framework development phase. Business requirements are expected to be developed and approved by the end of December 2008 and the system is anticipated to be operational within the next 18 months.

10.3.5 Unbundling and Individualized Funding

Although, as noted elsewhere, the use and uptake of individualized funding has been met with some challenges, as a concept and a long-term objective this remains central to CLBC's plans to ensure system sustainability. CLBC remains committed to using individualized funding not only to promote choice and flexibility, but also to create limited competition in the service provider market place to ensure costs do not continue to rise.

Individualized funding is seen as particularly important as a means of encouraging and promoting the viability of a wider array of service providers.

A key step forward in promoting individualized funding has been to try to understand what services, at an individual level, have been supported through the large, global-style contracts that CLBC inherited from the MCFD contracting system. The challenge was that those contracts contained little information about individual-level service and support expectations. Instead, the common practice was to provide an agency with a single contract, a large budget, and a general statement about the sorts of services that were expected.

To address this situation, in 2007 CLBC embarked on an initiative to “unbundle” contracts and separate out services. Under this initiative, a contract that may have previously covered a number of staffed group homes, day programs and life skills supports, was broken into a number of contracts specific to each type of service. This “unbundled” information is now available for all residential contracts, so that CLBC now knows the name of each individual served, their location, and the costs associated with providing their services.

With respect to non-residential services, CLBC investigated the possibility of examining each contract to try to identify each individual's share of that non-residential contract. Because of the number of participants in the contracts, the relatively small amounts involved and the inconsistent nature of many clients’ participation in programs, this would have been a very significant exercise. It would have also necessitated amending the contract every time one person left and another joined. After considerable discussion with service providers, it was agreed that it was not feasible to assign costs of non-residential contracts to individuals until someone wished to move, at which time the work would be done to identify the amount of funding to transfer. So the "unbundling" of non-residential contracts is now something that happens only when it is required – that is, when an individual wishes to transfer form one program to another. CLBC is in the process of developing the required policies and principles to be applied in these cases, including a determination of how the funds will flow. It is anticipated that CLBC will continue to identify the individuals served in a contract through the implementation of the Contract Management System, but it will not allocate actual costs to each individual.

Some information is now available, therefore, regarding specific contracts, according to the type of service provided, and by individual service provider. The important next step, in terms of facilitating individualized funding will be the development and implementation of policies to facilitate the portability of funding.

Broadly speaking, individualized funding has two components: directly funded respite, which is now available up to $5,000 without requiring completion of an ISP; and the larger, more complex individualized funding for ongoing service and supports. This latter category has been challenging for CLBC, as its 2008/09-2010/11 Service Plan suggests that a total of 25 individuals used individualized funding in 2006/07 and 28 in 2007/08. For the current year, the Service Plan indicates a target of 150 individuals for individualized funding – approximately 1.3% of the estimated total of 11,400 adults currently served.

CLBC has recognized that the uptake of individualized funding has not been as robust as it hoped at the outset. Understanding that system change requires a significant shift in the underlying funding arrangements, CLBC has enacted a number of initiatives to attempt to increase participation in the more individualized service delivery stream. The clearest example of these efforts is CLBC's Residential Options project.

Between September 2006 and March 2007, CLBC met with every person in a staffed residential resource, and spoke with family members, service providers, and others who were important to the individual clients. The goal was to identify individuals who were interested in exploring an alternative living arrangement to the traditional group home model, which costs on average $104,000 per client per year (versus home share, for example, which costs an average of $29,000 per client per year[68]).

In 2006, staffed homes made up 48% of CLBC residential services. Of these 685 staffed homes, 43% accommodated three persons or less, 52% accommodated four or five individuals, and only 5% had six or more individuals residing in the home.[69] According to CLBC, of the 2,435 individuals who participated in the Residential Options review process, 170 (7%) were identified as interested in exploring other options. Another 160 people (7%), were identified for follow-up at a later date. In 2006-2007, 89 individuals (4%), moved, many to another staffed resource. Twenty-eight individuals moved to homes that were not staffed resources.

This low degree of interest in exploring an option other than existing staffed homes has continued in the subsequent two years, with a total of 46 individuals participating in 2007/08 and 30 participating in 2008/09 to date. Although the savings inherent in a move from staffed residential to another housing option are considerable, in reality there has been small amount of savings due to movement in the other direction: in 2007/08, 28 individuals moved *into* staffed homes (due to increased complexity of need, changed family support circumstances, for example). The following table summarizes this situation:

Table 9: Residential moves – accommodation living (2007/08)

Fiscal Year 2007/08

A) Moves from Staffed Residential to Other	# Individuals	Annual Savings
Residential Options Project	17	$ 1,191,868
Other	29	$ 507,761
Total	46	$ 1,699,629
B) Moves from Other to Staffed Residential	# Individuals	Annual Cost
Total	28	$ 1,618,496

Year to Date – Fiscal Year 2008/09

A) Moves from Staffed Residential to Other	# Individuals	Annual Savings
Residential Options Project	9	$ 450,610
Other	21	$ 528,453
Total	30	$ 979,063
B) Moves from Other to Staffed Residential	# Individuals	Annual Cost
Total	20	$ 1,340,145

---

[68] See Table 4

[69] CLBC (2007b) – Residential Options Project Phase One Report

Although people in existing staffed homes may not be showing a high degree of interest in moving to a more individualized approach, CLBC has experienced greater success in its initiative to encourage new clients to explore home sharing as a residential option. Home sharing describes a situation in which an adult with a developmental disability shares a home with someone who provides ongoing support. Home sharing may be offered by local agencies or directly by CLBC. It is the fastest growing residential option within the province, having increased at a steady rate of between 7 and 10% over the last three years. There are now approximately 2450 adults who live in home sharing arrangements.

Over the past two years, CLBC has implemented a number of policy and procedural supports that have increased the confidence and awareness of home sharing as an option. In April 2007, CLBC adopted a set of Standards for Home Sharing to ensure that individuals who choose this option receive high quality support. The standards clarify the roles and responsibilities of home sharing providers and allow staff to assess whether providers are meeting established standards. At the same time, a Monitoring Tool and Health and Safety checklist provide best-practices based practical guides for both providers and reviews to use to ensure that an appropriate level of service is provided.

Home Sharing has been successful in part because of the active participation of service providers in the development and implementation of the plan. A standing Reference Group comprised of representatives from service providers (both not-for-profit and private sector) has a clear and meaningful role, ensuring that the principles are both reflective of CLBC's philosophy and approach, and supported by the people who are responsible for service delivery.

Home sharing, like individualized services in general, has a number of challenges. The biggest of these is a lack of incentive for those already in the system to move. As noted elsewhere, CLBC inherited a service delivery system that was based largely on group home environments that were created in response to the institutional downsizing initiatives. This money is connected to individuals and families who experienced institutionalization and who fought hard for *this* vision of community living (i.e. group homes, day programs, etc.).

For parents and individuals to make the choice to move to individualized services requires a clear incentive. Promoting the benefits of increased direct control over service decisions and increased flexibility has proven to have limited attractiveness, illustrated in part by the low participation rate in the Residential Options Program. A number of reasons were cited for the reluctance to participate in Residential Options.

Many participants in this review spoke of the hard reality that, when families see that a result of going into home share means a reduction in funding from $104,000 to $29,000, they worry about the long term implications should their child's needs increase. They are concerned about losing access to the larger pool of funding, or being unable to return to a staffed group home if the residential option doesn't work as anticipated. Participants also identified a concern that there is an underlying instability to home sharing, as the host family can simply end the arrangement at any time, thereby threatening the consistency and predictability that is so important for many individuals and families. There was also concern that moving to home sharing arrangements would negatively impact the availability and quality of existing group homes, particularly with respect to the associated services and supports that are available through economies of scale when more than one person lives in the same location.

This reluctance for change, or preference for the more traditional services, had an unforeseen impact to bringing about fundamental changes to the service delivery system. Faced with this reality, CLBC has two basic choices: they can either strongly encourage people to consider individualized residential options, or they can wait for the longer-term naturally occurring system changes that will transpire as legacy clients pass away and new clients – who are more likely to opt for home sharing and other individualized approaches – come into the system.

The first choice will allow for the "unbundling" of large global contracts with service providing agencies, thereby freeing up and creating surplus funds that would allow CLBC to address waitlists and lower costs. CLBC has made it clear in its communications around the Residential Options Program, however, that such systemic change will not take place unless families are in support. The agency is thus caught in a situation where it continues to talk about increased choice and flexibility, but does not have the practical ability to deliver because of the continued dominance of the large global contracts present in the legacy system and the continued reliance on staffed residential services.

An additional challenge is that individualized funding relies on the individual's and family's abilities and skills to deal with a wide range of issues related to employment law, tax, and labour standards. Amongst younger families, this may be more of an expectation, but for others it suggests increased responsibility rather than an increase in choice and independence. CLBC and the sector have recognized this challenge and implemented a Host Agency option, which allows individuals to choose a service providing agency to act as employer of record.

To summarize, because of restrictions due in part to the legacy system and CLBC's assurances to the sector that it would not move families towards individualized approaches involuntarily, there is insufficient overall system flexibility to allow for the degree of choice that CLBC planned for and built its communications upon. This is recognized by CLBC, which emphasizes that "it will take a number of years to refine services so they respond to individual' and families' needs in a personalized and effective way…"[70]

Although individualized services are promoted as a fundamental component of the service delivery system, the only area that has shown demonstrable progress is that of home sharing. This initiative has been well supported in policy and procedures, which were developed with the active participation and support of service providers. Challenges remain however, in terms of monitoring, supervising, and managing the more personalized employment relationships between clients and caregivers. The concept that individualized funding can be a means for families to have more power, choice and self-determination is vulnerable to potentially shifting all responsibility to families, who are in many cases not equipped to service this role. The host agency model is one option that shows promise in this respect.

---

[70] CLBC (2008a) – 2007/08 Annual Report

10.3.6 Alternatives to traditional supports

Another prong in CLBC's effort to ensure ongoing sustainability is the increased use and reliance on alternatives to traditional supports and services. There are two facets to this: a shift from funded day services to employment, and the enhanced use of generic community services, as contemplated in the original model for CLBC.

With respect to employment programs, CLBC currently funds 54 agencies to help provide supported work opportunities for adults with developmental disabilities, and it is estimated that approximately 1,598 clients throughout British Columbia receive supported work program services and supports. A recent third-party review recommended retention and expansion of this program, which reports positive outcomes in terms of clients obtaining and maintaining employment with at least a minimum wage. Many of these programs had made a transition from older models, which relied more on a supported day program approach. Their expansion has been a positive development, not only from a community inclusion point of view, but also from a cost recovery and income-generation perspective.

In addition, CLBC recently announced its Customized Employment Demonstration Project, a joint and collaborative project between CLBC and the Ministry of Housing and Social Development which will provide customized employment services. The goal is to enable each individual to achieve employment – real work for real pay – that is best suited to them. The three-year Customized Employment Demonstration Project will:

- focus on individual employment outcomes, based on the principles of customized employment;
- ensure that any required employment/employer supports are in place and transition to natural supports;
- provide timely reporting against quality indicators;
- share knowledge amongst project participants;
- document best practices as a blue print for future services; and
- support leadership development and build community capacity.

Going forward, employment services provide a clear opportunity for CLBC to work more closely with service providers to identify options with employment strategies, and to help individuals build self-sufficiency and integrate into the community.

Better use of generic community services is also key to CLBC's service delivery model and for improving its ability to manage costs. The maximization of services that are widely available to every citizen was a key component and assumption on which CLBC based its vision of a "good life in a welcoming community." In reality, a wider use of such services has not yet transpired, in part due to CLBC's focus on getting its service system, staffing model, planning processes, and supporting infrastructure up and running over the last three years.

CLBC recognizes that this is an area that requires more attention, better training, and a more focussed approach. Its supporting infrastructure and IT systems now include consideration of generic community services, and plans are underway to emphasize this component of the facilitator role. Nevertheless, encouraging the community to play a greater role in community living, and developing incentives for people to participate in a more meaningful way will be a significant and ongoing challenge for CLBC.

10.4 Recommendations: Sustainability

Overwhelmingly, participants in this review talked about the very positive intentions of CLBC, which has been tempered in its communications by a focus on balancing the budget. This has been disappointing to many service providers, clients, and community partners, but reflects the reality that the community living sector must balance growing expectations and demographic pressures with the funding that is available. This will continue to be a factor, as British Columbia responds to current global economic challenges.

Exacerbating the issue is that, in some respects, British Columbia has established a “high bar” in comparison to other jurisdictions. This grew out of an unsustainable level of funding that attached to families around the time of de-institutionalization, when there was a much higher degree of funding available, with far fewer pressures on the system as a whole.

Many in the community seem to have believed that moving to devolution at CLBC would be an immediate panacea that would address all of their longstanding issues with government’s delivery of community living services. Devolution came with huge expectations and with an overarching rhetoric of enhanced choice and flexibility. Practical restrictions: increased demographic pressures, finite budgets, the reality of contract negotiations, growing pains in terms of both systems implementation and role definition, and the requirement of government to respond to other cost pressures (for example, health and education services), have challenged these expectations.

There is also a growing realization that while CLBC is an independent crown agency, it is also responsible to government for accounting how it allocates its resources. CLBC, like the health care system or the education system, must determine how best to allocate funds in an environment where there are always more demands than resources. It must also be more effective at building and fostering relationships with ministry partners and other agencies.

Taking these factors into consideration, the following recommendations are made:

Foster partnerships

There is a growing understanding that CLBC-funded services are only one part of the puzzle, and that its $700M budget is best viewed as one of a number of tools that can help bring about community inclusion, not an end unto itself. This is one area where CLBC can take some responsibility and play a lead role fostering the relationships within and amongst the community living sector, other government ministries, other community resources, and the private sector.

Many participants spoke of the opportunity for CLBC to become more active not only in talking about more inclusive communities, but also leading by example. Suggestions included playing a role in leveraging the funding that will be available through registered disability savings plans (while CLBC will not be able to access this funding, it will be in a position to take a lead role in supporting clientèle to access the grants).

It is also worth noting that fostering partnerships is the cornerstone of other systems that are innovative in their approach to delivering disability services. Greater outreach, becoming part of a wider web of services and creating a dynamic presence in the community is the general movement of leading systems such as those in the UK and Western Australia. Partnerships should play an equally key role in British Columbia.

Manage expectations and clarify mandate

A common message that was heard throughout this process was frustration at the leadership that has been provided particularly in terms of how it manages the expectations of the Community Living sector. Many participants expressed an understanding that community living services need to be planned for and allocated fairly, just as in any other sector. They expressed frustration that CLBC continues to promote what is widely seen as an unrealistic message around increasing choice without offering a counterbalancing message about the need for realism in terms of what can be expected from government funding.

This is one facet of what is widely seen as lack of clarity in the role of CLBC, and lack of consistency in its approach to government relations. CLBC should clarify, and clearly communicate, the boundaries of its role as a crown agency. It should be made clear to communities and to partners that the role of CLBC is to appropriately and competently allocate the resources that government provides for community living services, not to act as an advocate as would be proper for an agency such as the BC Association for Community Living. This message has not been clearly communicated to the community.

Foster inclusive practice and the use of generic services

Although at the center of the original CLBC idea of its service delivery model, there is a widely shared view that the last few years have been characterized by a notable decline in how open and welcoming services like recreation centres have become. CLBC – particularly its facilitator staff – have an opportunity to improve community linkages, and foster situations that will encourage better use of generic community services. CLBC should play a leading role in bringing together federal, provincial, and municipal-level partners, to make better use of the existing available resources. This is also an area where Community Councils are well positioned to play a stronger and more meaningful role.

Promote innovation

Innovation is often at the forefront of communications and discussions regarding community living services and is an area that presents CLBC with a number of real opportunities to foster sustainability. Fostering innovation will require working with a wider range of partners – the business community, health services and other sectors – and looking outside the CLBC lens. This will help create greater capacity to understand potential opportunities for innovation and operational integration.

Towards this end, CLBC should examine the possibility of creating a specific innovation unit, with a dedicated budget and a wider mandate than being responsible for providing grants to individual proposals. This unit could take the lead in researching and applying innovative options to help create an innovative, social-enterprise with a cultural overlay to the whole process. The Ministry of Health's

Innovation Fund department is an example that could be examined by CLBC and adapted to serve its own needs and challenges.

Engage service providers more effectively

Many participants in this process spoke of a lack of consistency in the approach of CLBC's management towards service providers. Relationships have been damaged, and for many there is a strong sense of mistrust – it must be noted that part of the reason for this strained relationship are the much more vigorous contracting management processes that CLBC has put into place and continues to improve.

However, service providers require incentives to help foster a switch to more individualized services and funding, and can play a much stronger role in this respect. Many spoke of their willingness to do so, if there is an honest discussion about the relative benefits as well as the drawbacks for moving to greater IF implementation. There also needs to be recognition that, for the majority of people who are in the community living system, the existing contracting paradigm is not individualized funding, and that this creates barriers to bringing about the systemic changes that CLBC is seeking to implement.

Maintain focus on contract reform and contract management

The CLBC contract management initiative, while in its early days, shows great promise. It is also a logical "next step" in the evolution to a more robust system of contract design, delivery, management and performance. By initiating and implementing more rigorous contract design and monitoring practices and procedures, CLBC will not only address one of the major weaknesses of the system it inherited from MCFD, but it will also put in place a fundamental component to allow for better system design, tracking, and evaluation. This ability, which has been lacking until recently, is a major factor in ensuring the ongoing sustainability of the agency.

11.0 Conclusion and key messages

Community Living BC assumed responsibility for the delivery of services to people with developmental disabilities in July 2005. It inherited the service delivery system of the Ministry of Children and Family Development, and has spent the last three years developing and implementing a new service delivery model. The new model was based on research, examination of other jurisdictions and, most importantly, extensive consultation with the community living sector itself.

Service Delivery Model

The new model has a number of key characteristics, including a focus on individualized planning, the separation of planning and funding responsibilities, greater emphasis and use of generic community services, and a movement towards individualized funding. Each of these shows some promise, but at the same time, a number of very challenging issues must still be addressed.

The inheritance of the MCFD system and its continued operation alongside implementation of the new service delivery model means CLBC is operating within two very different paradigms at the same time. This has resulted in two broad categories of peoples' views and experiences around CLBC. For those who were already in the system or who have received funding for services, very little has changed. Very few have moved to individualized funding, most remain in long-term residential situations, and there have been very few changes to service levels or arrangements for these individuals. This group appears to be relatively satisfied with CLBC supports and services.

For those who are not yet "in" the system, however, the experience has not been satisfactory. These individuals have developed high expectations and have had to partake in a detailed and intensive planning process, only to discover in many cases that there is simply no funding to meet their request and that they will be waitlisted for services. In cases where there is funding, the choice and flexibility that are stated cornerstones of the CLBC philosophy and communications is very limited in practice, where it exists at all.

CLBC's relationships with its clients, partners and community in general have often been strained, and many participants in this review spoke about their distrust of the agency. This is in part the remnant of a historic strain arising out of the community's ongoing advocacy that first led to de-institutionalization. However, it is also a specific result of confusion about the role of CLBC and whether it is an advocacy agency or an independent arm of government responsible for service delivery. Clarity on this point needs to be established and strongly communicated to the community as a first step in managing expectations and allowing for a realistic and transparent discussion of what the agency can and cannot do.

Community engagement is another area where expectations have been highly raised, but where little has been accomplished to demonstrate a difference on-the-ground. This is important, because greater utilization of a broader array of community and generic services is a fundamental component of the service delivery model. Without successful partnerships in the community, the fostering of a greater sense of responsibility and participation amongst them, with respect to people with developmental disabilities, it is difficult for some to see how the CLBC model can result in a system that is much different from the one that was inherited from MCFD. Strongly emphasizing and communicating the role of community and generic services – including ensuring that staff and Community Councils have sufficient skills and training in community development – is a key theme that underlies the recommendations that are made for improvements to the service delivery model:

1. Improve collaboration between facilitators and analysts
2. Introduce joint reporting in the CPD and QS streams
3. Introduce an ongoing point of contact where one is desired
4. Expand role of facilitator: planning to include application of GSA and discussion of waitlist
5. Expand role of facilitator: ability to approve limited services
6. Clarify role of facilitator: community development as well as planning

7. Clarify role of analysts to emphasize teamwork
8. Focus the role of Community Councils
9. Improve communications about the service delivery model

Adult Guardianship functions

With respect to its role arising out the Adult Guardianship Act, this was an area where CLBC has experienced some growing pains. Initially, CLBC seemed to have a misunderstanding of its own role and responsibilities, and a reluctance to proactively carry out its role as a designated agency. These issues have been recognized by CLBC, which is in the process of implementing appropriate policy, guidelines, and training for staff. Maintaining the focus on these areas and becoming more proactively involved in its guardianship responsibilities are challenges that CLBC will continue to address.

One area where the agency still needs to examine and appropriately address guardianship functions is with respect to the informal supports and services it provides. This part of CLBC's role is highly valued by the Office of the Public Guardian and Trustee, which supports the continuance of designated agency status. However, guidelines and policy are required for staff with respect to this informal support role that many of them play. The following recommendations are made regarding CLBC's role as a designated agency:

10. Maintain designated agency status and functions
11. Enhance the pro-activity of facilitators
12. Involve Analysts in the process
13. Mandatory education and training
14. Develop and implement clear guidelines

Policy Tools to support the Service Delivery Model

The Service Delivery Model is supported by policy tools in three key areas: individualized planning guidelines (Discovery Goal Based Planning; guide to creating an ISP); assessment of disability-related need (Guide to Support Allocation) and resource allocation (Catalogue of Services). These are aimed at both fostering individual assessment of need and allocation; and providing a rational, objective, consistent framework to make the required decisions.

While these tools show promise, it is too early and there is too little data to be able to make a definitive assessment of their efficacy. This difficulty is increased by CLBC's decision to develop its own tools, rather than utilize options that are already available. Conceptually, the tools are based in sound examples, adapted for CLBC's specific purposes. Operationally, there appears to be a lack of consistent training and application across the province, and addressing this discrepancy is one of the key factors that needs to be addressed. Recommendations made with respect to the policy tools to support CLBC's service delivery model are:

15. Rationalize planning processes
16. Query use of Guide to Support Allocation
17. Provide consistent, comprehensive training for staff
18. Attention to performance management.
19. Examine potential integration with government systems
20. Clarify government oversight of policy
21. Undertake ongoing assessment

Sustainability

Finally, CLBC has taken a number of steps to help ensure the ongoing sustainability of the CLBC model. First, it must be said that as long as CLBC is operating in its dual-paradigm manner, with such a significant portion of its funding tied up in legacy contracts, it will be constrained in moving towards full realization of the new model. This is particularly so with respect to individualized funding and the flexibility it can potentially bring to the service delivery system.

However, important initiatives such as the Contract Management System, contract monitoring, and implementation of costing guidelines have the potential of bringing new consistency, rigour and predictability to the service delivery system of the agency. And while data is still insufficient, early indications show that CLBC is having some success in reducing costs per client, as the set out in the following table:

Table 10: Average Costs

Average annual expenditure per supported individual:

Forecast	2008/09	$ 47,447
	2007/08	49,513
	2006/07	50,963
	2005/06	51,128
	2004/05	$ 51,257

To help ensure that CLBC's service delivery model is implemented in a manner that fosters sustainability and increasing fiscal flexibility, the following recommendations are made:

22. Foster partnerships
23. Manage expectations
24. Foster inclusive practice and the use of generic services
25. Promote innovation
26. Engage service providers more effectively
27. Maintain focus contract reform and performance monitoring

To summarize, the service delivery model of CLBC came into operations approximately three years ago with extremely high expectations, an ambitious legislative mandate, and a wide degree of support from the community. It has faced a number of challenges in the early phases of its operations, including a less than enthusiastic uptake in its individualized funding model from existing clients than it had hoped, some structural challenges relating to roles and responsibilities, fiscal challenges that will be further highlighted when children's services return to MCFD, and a lack of clarity of mandate and focus for service delivery.

All of these factors have contributed to a sense of "change fatigue"; a sense that was widely expressed from families, service providers, CLBC staff, and other community partners that took part in this review. There is also a widely shared sense that the system is much better than it was before, in terms of communication, participation, fairness and openness. This, and the underlying need for stability, led most participants to conclude that, while CLBC needs to make some considerable changes with respect to its service delivery model and overall approach, the model itself holds promise. It was their conclusion, and it is a conclusion that we support, that the system should be supported, required changes should be made, and ongoing monitoring for progress should be implemented.

Appendix 1: Participants in the Review Process

Organization
BC Association of Community Living (2 participants)
BC Family Net
BCGEU (5 participants)
Behavioral Solutions
Child & Youth Quality Assurance Advocate
Community Council Victoria (8 participants)
Community Living Agencies Network Society
CLBC Advisory Group - Employment Strategy
CLBC Board of Directors (4 participants)
CLBC HQ management and staff (12 participants)
CLBC Regional management and staff (10 participants)
CLBC Service Provider Reference Group (9 participants)
Developmental Disabilities Association
Disabilities Services Commission (LAC Coordinator), Western Australia
Family Support Institute
Families – Surrey (6 participants)
Families – Vancouver (10 participants)
Families – Victoria (10 participants)
Glendale (former ED, consultant to CLBC & community groups)
Interim Authority Board (2 participants)
Langley Association for Community Living
Medical Consultant for Individuals with Developmental Disabilities
Milieu Community Support Services
Ministry of Children and Family Development (4 participants)
Ministry of Education
Ministry of Finance (2 participants)
Ministry of Housing and Social Development (3 participants)
Office of the Public Guardian and Trustee
PLAN Institute for Caring Citizenship
Self-advocates – Victoria (7 participants)
Western Human Resources
Direct contact / fax / phone calls (~30 participants)
Responses to web based feedback/ questionnaire (82 participants)

Appendix 2: Inter-Jurisdictional Comparison

Introduction

The Individualized Funding model in BC was developed pursuant to the experiences of other jurisdictions, particularly the United Kingdom, United States and Western Australia, all of whom directly or indirectly built on the individualized funding/service brokerage pilot projects that were undertaken in BC between 1991 and 1996. In these pilot projects, geared for adults with developmental disabilities, planners acted as independent service brokers, connecting individuals with service supports. Money went directly to the individuals and their families.

While the pilot projects did not develop into ongoing programs in BC at that time, they did set the stage for further study and implementation by other jurisdictions, which saw the results as promising and worthwhile to consider for further application.

The following inter-jurisdictional review provides a summary overview of four jurisdictions: two that are known to have influenced the service delivery model developed and applied in British Columbia; a US-based system used to allocate resources; and the two jurisdictions proximal to BC, so that their approaches can similarly be contrasted with that of CLBC.

The experts in the disability services field, with respect to service delivery and individualized funding, form a small specialized group. Approaches innovated in one area are often adapted and used in other jurisdictions. The four jurisdictions reviewed are Western Australia, in particular with regard to their Local Area Coordination approach to service delivery; the United Kingdom, for their approach to individualized funding, direct payments, resource allocation and individual planning; and the United States system for their often applied methodology for determining needed levels of funding support (Supports Intensity Scale); and Washington State and Alberta, due to their potential influence and impact given their geographical proximity to BC.

Western Australia

Organizational Structure

The organizational structure for disability services in Western Australia is set up such that an independent Commission, the Disability Services Commission (DSC est. December 2003), an agency governed by the *Disability Services Act*, reports to the Ministry for Disability Services and is guided by a Board represented by people with disabilities, their families and communities. The Board receives advice and works in collaboration with Reference Networks on the ground in both the metropolitan and rural and regional areas. These reference networks are comprised of people with disabilities, their families, carers and service providers. The Commission provides a range of direct services and support and also funds non-government agencies to provide services to people with disabilities, their families and carers[71].

---

[71] Disability Services Commission (2008a).

The Commission is divided into six Directorates: Policy Planning and Information, Service Purchasing and Development (SP&D), Accommodation Services, Corporate Business Services, Country Services Coordination and Metropolitan Services Coordination.

- The Policy, Planning and Information Division functions mainly to promote access and to broaden community awareness about disability issues.
- The Service Purchasing and Development Division partners with individual families, service providers and the community. The division supports people through distributing available funds through transparent funding processes via the Combined Application process and Post Schools Options process and purchases disability-related services for people with disabilities. Funding applications for these programs are often applied for through the aid of a local area coordinator[72].
- Accommodation Services provides services in over 100 facilities and provides homes with necessary supports. They serve greater than 140 households (~570 people) mostly in suburban areas.
- The Metropolitan Services have two distinct branches: Local Area Coordination (LAC) and Individual and Family Support (IFS) who work with the LAC to support people who have an intellectual disability or autism and provide early childhood development services for school age children and family support for adults with developmental disabilities.
- The Country Services Coordination Division has three branches:
    - Country Resource and Consultancy provides early intervention services to children with autism and other psychiatric supports and strategies
    - Health Resource Consultancy support community-based health providers respond to people with disabilities and their families
    - Local Area Coordination[73]

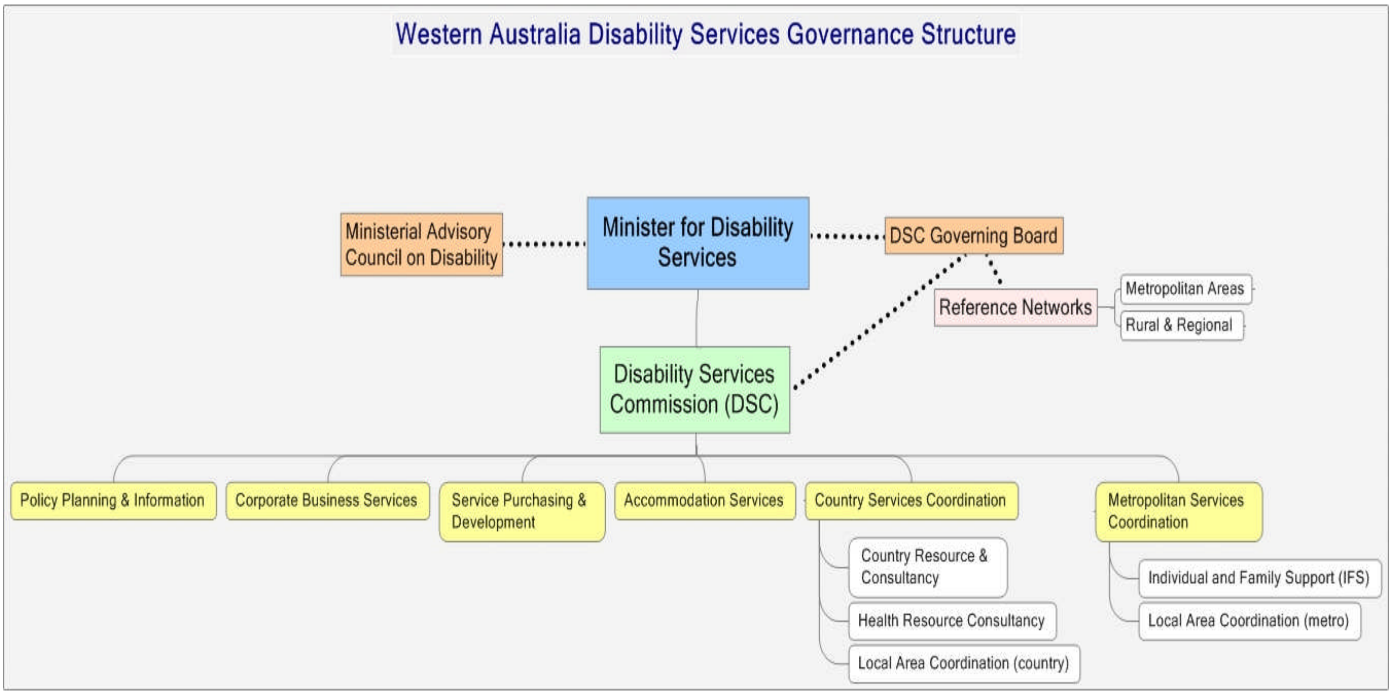
---

[72] An explanation of the role of the local area coordinator is described in a later section.

[73] Disability Services Commission (2008b)

The Organizational Structure including high level associated support functions are depicted in Figure A below:

Figure A: Western Australia Disability Services Governance Structure



Local Area Coordination Program

Western Australia was the first jurisdiction to actually implement a component of the self-determination model through the creation of the Local Area Coordination Program. The premise of the LAC approach was 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*[74]*.*

The program was based on the notion of using Local Area Coordinators to work as facilitators to help bridge the gap between individuals, service providers and the community.

The program was initially developed to serve persons in rural and remote areas surrounding Perth, Australia, who were distanced from conventional residential services in the city and who were, prior to the creation of the Local Area Coordination Program, relocated to group homes far from their families in order to receive the care they needed. The program was later expanded to metropolitan areas. It was evident that the greatest health and support threat for persons with developmental disabilities was removing or relocating them from their family and friends, who combined, provide approximately 70 percent of all assistance required by these individuals.

---

[74] Disability Services Commission (2003: 12).

The LAC Program contains elements of case management, personal advocacy, family support, community development and direct consumer funding. It is characterized by a fixed point of accountability to individuals with disabilities and their families caring for a family member with a disability, with each coordinator allocated a defined geographical within which to work. The geographical area corresponds to the number of people with a disability who are known to reside in a given area. The number of people who can safely be supported by one LAC is between 45 and 60. The higher figure is allotted to metro areas given that the remoteness between clients is less than in country areas.

Prior to the creation of the LAC model for service delivery, a team of individuals was sent from Perth, on a periodic basis, to address needs of individuals in rural and remote communities. There was not a specific, easily accessible focal point for persons with disabilities to obtain assistance or advice in an expedient manner, and local environments and community resources were not tapped into as often and were not as extensive as present[75].

LACs have provided a substantial boost to services for persons with disabilities. The LAC model serves not only to provide enhanced individual choice and self-care options but has, as an offshoot of this service, reduced some of the need for specific services provided by the DSC itself. LACs are the primary mode of choice for accessing DSC supports, services and funding, however, access to broader DSC funding offered through the CAP program or its component initiatives can be accessed through the Accommodation Services Branch or through the IFS branch in the case of metropolitan services. This latter branch works in close association with metro LAC.

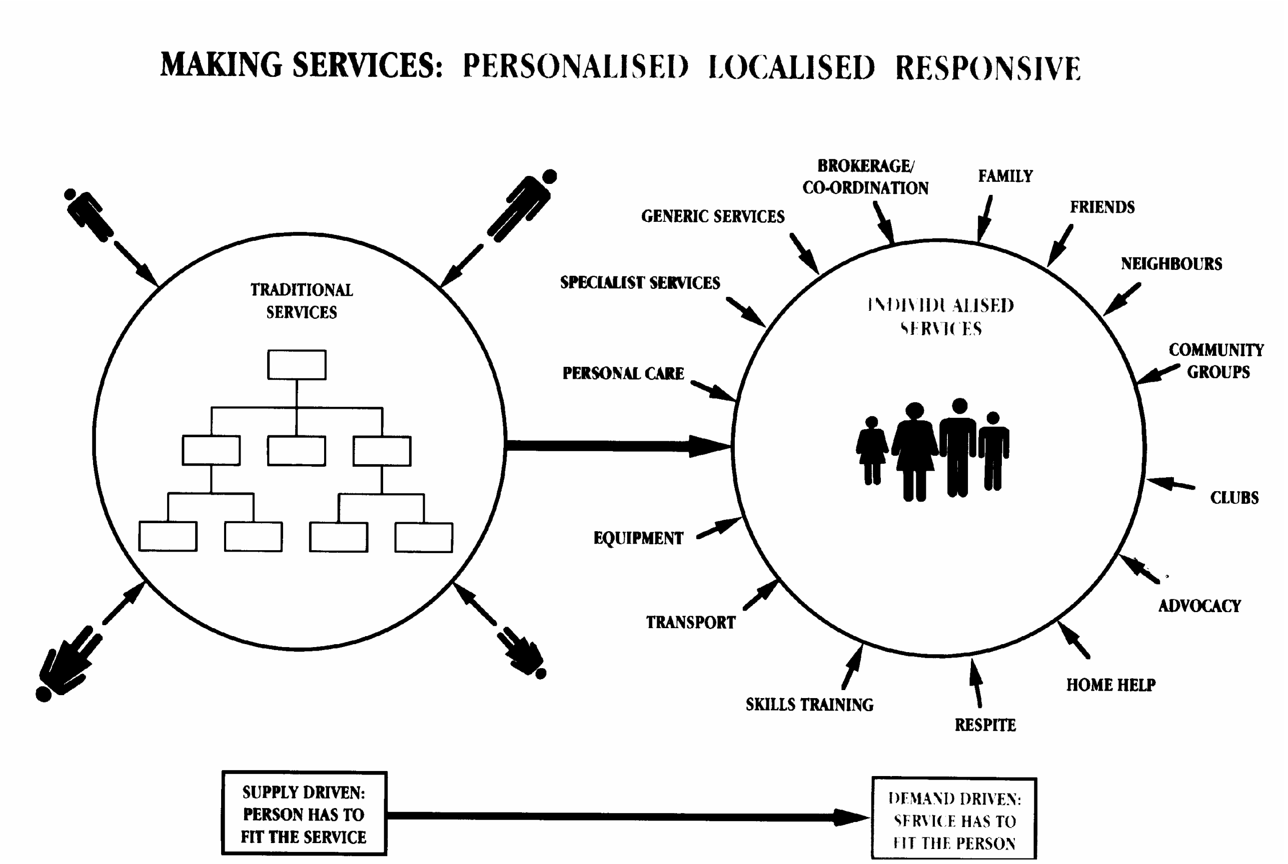
The LAC Program began as a single pilot project for people with disabilities in 1988 and was then phased in across country areas, with total rural coverage occurring in 1994-95. Separate pilots were undertaken in metropolitan areas in 1991 pursuant to evaluations undertaken in 1993 and 1996, following demonstration of positive qualitative and quantitative outcomes, approval was granted from the State Government to phase in Local Area Coordination across metropolitan areas through to 2000.

A graphical representation of the shift from a service-centered to a person-centered approach adopted by the LAC model is show in Figure 1 below:

---

[75] Bartnek, Eddie (2008a).

Figure B: Making Services Personalized



<u>Funding Supports and Services</u>

The Western Australian Local Area Coordination Program serves a dual role of supporting people with developmental disabilities and their families, and developing inclusive communities. Self-identified persons with disabilities[76] can acquire information and advocacy services from Local Area Coordinators, and persons with disabilities (as outlined by Commission policy[77]), can access the wider program which involves funding and placement assistance.

The Local Area Coordinator[78] operates as a service coordinator rather than a service provider. While the role of the LAC as facilitator is separated from the funding arm of

---

[76] These individuals are not captured in the system i.e., they do not factor into the registered number of persons with disabilities being serviced by LACs.

[77] Access to Funded and provided services (based on an assessment of need applied to people with a severe and profound disability); Local Area Coordination, Community-based support, Day options and Accommodation Services funded by the Commission for Disability Services; Access to Commission provided Services (based on assessment of need for people with an intellectual disability or autism); and, Access to Commission-provided services.

[78] Local Area Coordinators act in a similar capacity to facilitators in the CLBC model – working to connect individuals with generic and other community supports.

the Disability Services Commission, the (SP&D) Directorate, the LACs are able to act as a *conduit* for the provision of funding directly to people with disabilities[79] and their families. The actual provision of accommodation services (hostel, community residential and supported community living) are provided by the Directorate with the same name. Emergency funding and individual funding support may be available where services cannot be met through existing local supports and services.

Local Area Service Use Statistics

As of November 2002, there were 7,054 people with disabilities registered with the LAC Program with 6,149 people being actively supported on an ongoing basis through support planning and the like. At the time of the referenced report[80], there were a total of 124 LACs operating in 50 local offices:

- 10 metropolitan districts overseeing between 8-10 LACs for a total of 82 LACs;
- 42 LACs in rural areas.

In 2006, the program grew so that there were 144 LACs providing support to approximately 7,600 people with disabilities[81]. LAC use information over the past 18 years is summarized in the table below.

Table A: LAC Service Comparisons over time[82]

	1996/97	June 2002	November 2002
Number of LACs			124 (based in every metro area and regional centre throughout the state)
Consumers eligible for the LAC program	Intellectual Disabilities 3,122 Other disabilities 552 Total 3,674	Intellectual Disabilities 6,149 Other disabilities 1,002 Total 7,151	Total 7,380
LAC/#persons supported ratios	Accepted Ratio: Rural/Country = 1:40 Metro = 1:60		16% increase in the average number of people registered/supported by each LAC for ongoing since program inception[83]. Average (rural) = 1:62 Average (metro) = 1:64 17 LACs had ratios in excess of 1:70 (12 metro; 5 country)
General information and advocacy support			3,279 additional people in receipt of general support not leading to registration for ongoing services

---

[79] Not limited to persons with developmental disabilities

[80] Disability Services Commission (2003)

[81] Disability Services Commission (2007: 20)

[82] Disability Services Commission (2003)

[83] Ratios do not include additional people who sought provision of general information – individuals who self-identified as having a disability but weren't in receipt of any program funding.

Western Australia Funding Streams

Funding in the Western Australia model can occur through a variety of means:

1. One-off and emergency situational funding[84]; and
2. Formal application process, where recurrent funds, supplemental to regular generic community supports, are made available through the following streams:[85]
    - "Program Funding" - based on applying for funding administered by the SP&D[86]. These are recurrent funds which are initially applied for, through a Combined Application Process (CAP). The funds are based on needs for each 12 month period. The CAP provides the opportunity for a blended solution involving all three funding initiatives listed below. It also provides one single application point facilitating the process for all involved parties. The three types of funding under the CAP are:
        a. Accommodation Support Funding (ASF);
        b. Intensive Family Support Funding (IFS); and
        c. Alternatives to Employment (Adults) Funding (ATE).
    - "Flexible Family Support Funding" - non-critical/urgent recurrent grants to enhance family capacity and quality of life (up to $5,000). These grants require a formal application process but are evaluated in a simpler manner and by the LAC proper instead of the SP&D.
    - Small non-recurrent grants (few hundred dollars) - discretionary funding administered directly by the LAC.

All new programs funding through the Combined Applications Process is provided on an individualized basis and people have the choice of a range of shared management arrangements, including self management. The degree of decision making and responsibility is negotiated under the Shared Management model. Direct funding for smaller discretionary and flexible family support grants is available through the Local Area Coordination program, and approximately 1:5 people accessing LAC also receive direct funding[87]. All payments for personal care are received through direct payments[88]. In addition to this form of individualized funding, LACs provide the historical service support options of facilitating care through residential and non-residential services.

An Independent Priority Assessment Panel, which includes at least three non-DSC people (a person with a disability, family member of a person with a disability, a representative of a disability advocacy organisation, a representative of a service provider organisation) and one senior officer of the Commission, assesses all CAP applications. The Panel reports funding recommendations to the Director General of the

---

[84] Each LAC has $8,000 total to use for this purpose. Emergency funds are used as a last resort only if other community options are not available.

[85] Disability Services Commission (2006).

[86] Prior to 2003, program funding allocation could be implemented via LAC direct funding.

[87] Eddie Bartnik (2008b).

[88] Disability Services Commission (2007).

Commission for approval, and policy issues to the Individual Funding Management Committee for resolution[89].

Service Delivery Cost Comparison between models

In 2002, the average cost for service delivered through the LAC Program (i.e., Individualized Coordination) per user was estimated to be approximately $3,316[90]. This figure is in striking contrast to the cost per service user using other methods of service delivery; residential accommodation/non-residential services at a per capita cost of $61,944 and $3,899 respectively. Considering the proportion of individuals using the different types of services, when compared with the Western Australia benchmark of $29,329/service user[91], the program on the whole figured well[92]. The incorporation of individualized funding has helped reduced the average service delivery cost of LAC services. When compared with these other forms of service delivery which have led to increasing costs over time, individualized coordination has remained relatively static. While the total costs for the LAC grew from approximately $12 million in 1995-96 to approximately $23 Million in 2001-02 and then over $30 Million in 2007-08[93]; the overall service costs decreased from $4,827/service user to $2,469 in 2007-08[94]. Increasing emphasis was placed on providing smaller amounts of discretionary LAC funding to a larger number of people.

Additional measures are set out in Tables B, C, D and E below.

Table B: LAC Coordination figures 2003-2008[95]

Measure	***2003-04***	***2004-05***	***2005-06***	***2006-07***	***2007-08***
Total service users accessing LAC Coordination	6,981	7,169	7,605	7,836	8,285
Total service users accessing LAC Direct Consumer Funding	1,465	1,547	1,521	1,521	1,470
Average cost/service user accessing LAC Coordination[96]	$2,367	$2,393	$2,427	$2,542	$2,469
Average cost/service user accessing LAC Direct Consumer Funding[97]	$7,853	$7,673	$7,360	$6,772	$6,563
Total cost ($'000)	$28,032	$29,027	$29,655	$30,219	$30,101

---

[89] Disability Services Commission (2006).

[90] This includes costs associated with direct funding and not just operation of the LAC Program.

[91] Average cost per service user based on total number of people registered and number of people using each type of service delivery model.

[92] Disability Services Commission (2003)

[93] Disability Services Commission (2007).

[94] ibid

[95] Disability Services Commission (2008c)

[96] Small grants plus operating costs

[97] The cost/ service user differs from pre-2003 figures in that operational costs were factored out. Larger than the Flexible Family Support Funding ($5,000 max.) because some legacy funds from the CAP program are included in these figures. The majority of larger CAP packages have been transferred to service providers but some are still undertaken by the DSC through the LAC.

Table C: Disability Support Services figures 2003-2008

Measure	*2003-04*	*2004-05*	*2005-06*	*2006-07*	*2007-08*
Total people with a disability receiving a service provided or funded by the Commission	19,401	20,109	19,632	20,750	20,507
Average cost/service user	$13,460	$14,014	$15,558	$16,115	$17,848

Source: adapted from 2007-2008 Disability Services Commission Annual Report

Table D: Individual and Family Support figures 2003-2008[98]

Measure	*2003-04*	*2004-05*	*2005-06*	*2006-07*	*2007-08*
Total IFS service users	164972	16840	16429	16421	16159
Total service users by IFS type:					
• Therapy services	6,344	6,966	6,861	6,446	6,339
• Day options	2,594	2,715	2,819	2,996	3,726
• Respite	2,594	2,771	2,846	2,973	2,893
• Family support	3,799	3,960	4,281	3,950	4,088
Average cost/service user	$4,681	$5,052	$5,362	$5,764	$6,358
Total cost ($'000)	$77,228	$85,077	$88,090	$94,644	$102,739

Source: adapted from 2007-2008 Disability Services Commission Annual Report

Table E: Accommodation Support Services Figures 2003-2008[99]

Measure	*2003-04*	*2004-05*	*2005-06*	*2006-07*	*2007-08*
Total accommodation service users	3,319	3,364	3,449	3,604	3,319
Total service users by accommodation type:					
• Hostel[100]	523	512	442	424	453
• Community Residential[101]	1,063	1,093	1,156	1,209	1,327
• Supported Community Living	1,907	1,848	1,908	2,068	1,663
Average cost/service user	$44,512	$46,711	$50,405	$54,346	$65,784
Total cost ($'000)	$147,734	$157,136	$173,848	$195,864	$218,335

Source: adapted from 2007-2008 Disability Services Commission Annual Report

Broadening Community Living Options under the LAC

Following a Ministerial review of the Local Area Coordination Program in March 2003 and as a result of the findings from the 2006 Sector Health Check (a review on how well funding was used and disability services provided) that emphasized the need to enhance community supports, Western Australia decided to expand the LAC Program through the development of a "Community Living Plan". This is a concept that frequently references the BC approach as a model for service delivery for persons with developmental disabilities[102].

This Community Living Plan was envisioned as a means to broaden the range of community living options available to people with disabilities and to explore inter-

---

[98] IFS data based on information provided by agencies. Duplication may occur if multiple services used.

[99] See note 33

[100] Out of home residential accommodation

[101] ibid

[102] Bartnik, Eddie and R. Woodward (2008a); and Bartnik, Eddie and R. Woodward (2008b). ".

jurisdictional innovation initiatives. Examples of community living options being investigated include: living independently as a part of a co-housing arrangement, living independently as a member of a neighbourhood network, home-sharing with a live-in support etc[103].

As a result of this new "plan" concept, budgeting was afforded to the Community Living Plan and the DSC subsequently developed a Community Living Support funding strategy to broaden and evaluate the range of flexible and innovative community living approaches available to persons with disabilities in Western Australia. This strategy will allow adults to live in their own homes in the local community, and will be built on community supports, as in the existing LAC program, but may be complemented by additional funding (up to a maximum of $20,000/annum) for community living support. A primary aim of this new plan is to build on existing networks and ensure that they can be maintained and supported.[104] Some applicants of this program may not be eligible for CAP funding which is focused on critical needs[105].

The LAC program was modeled with the focus of having communities and services centered at the community level. The LAC model, which was developed in the early 1990's, was adapted and has been used in Scotland since 2000. The UK is currently embarking on a program of community-focused work with Local Area Coordination and coordinators being a component of this extension of the current program.[106] *In Control*, the organization in the UK which developed the service delivery model used for the provision of services to disabled persons is discussed in greater detail in the next section below.

United Kingdom[107]

Self-directed support in the United Kingdom sprouted from the Independent Living Movement of people with physical disabilities, which campaigned in the 1980s and 1990s for the option of being provided with direct payments for supports and services, allowing them to choose how best to managed their own care.

In 1996, the *Community Care (Direct Payments) Act* was created. This Act gives local authorities, through their Social Service Departments, the power to make cash payments to individuals enabling them to arrange for their own support services, instead of having community care services arranged by local Social Service Departments.

In Control, the model program for self-directed support, was established in 2003 with the support of the Department of Health's Valuing People Support Team in the UK. *In Control* was set up to transform the social care system from service-centric to self-directed support focused. *In Control* is a partnership between citizens, local authorities, sponsors, ambassadors, service providers and with the Government and the Care Services Improvement Partnership, and it plays a pivotal role in supporting local

---

[103] ibid

[104] Disability Services Commission (2008d).

[105] Disability Services Commission (2008e).

[106] Scottish Government Publications (2007).

[107] Hatton, Chris, J. Waters, S. Duffy, J. Senker, N, Crosby et al. (2008). "A Report on in Control's Second Phase – Evaluation and Learning 2005 – 2007," C. Poll and S, Duffy (eds.), in Control. NOTE: This is the reference unless otherwise noted.

authorities in developing systems which deliver self-directed support. While it is up to each local authority to develop their own system for planning and funding for persons with disabilities, *In Control* is the major resource used to develop local authority governance transformation.

Self-directed support is a universal approach for the overall reform of social care. On December 10, 2007 the UK government put fort, "Putting People First", which is intended to ensure that personal budgets are available for everyone who is eligible for publicly funded adult social care support other than in circumstances where people require emergency access to provision of supports and services.[108] It is important to note that the UK groups all forms of disability: physical, mental and developmental together – persons with developmental disabilities are not separated from the mix in terms of the service delivery. The transformative approach is applied to all aspects of the social service delivery model and to some degree, the health care system.

The UK's model for self-directed support is based on a form of individualized funding which focuses on individuals receiving a personal budget that they control to meet their own care needs instead of using a service-led approach. In this model, there are two components, self-directed supports (individualized funding) and direct payments. They are not mutually exclusive although self-directed supports can be initiated without the requirement of direct payments to the individual. In addition to self-directed support, a key aspect of the new service delivery model is to create a healthy society that is better for everyone – community development being the key central theme.

Self-directed support developed directly from the lessons learned through the implementation of the earlier direct payments initiative. Studies demonstrated[109] that direct payments helped people negotiate better support, improved quality of life, enabled the development of better relationships between the disabled and their supports, and were more efficient than other service delivery models. However, certain shortcomings were noted, prompting the move towards the broader self-directed support allocation system.

Budgets for direct payments are set using an older "care plan and standard rate" system, not by using the more flexible and inclusive Resource Allocation System (RAS) which is described in more detail below. Local rules made this system restrictive for a number of reasons, one being that the management of direct payments were administered by authorities themselves which often had the effect of limiting the introduction of creative options for providing services. Individuals receiving direct payments were not necessarily made aware of or offered alternative systems that brought similar benefits.

This system was not an open and public allocation process (it was not clear as to who got what amount of money in their individual budget and why), and there was an absence of a standard measure to determine what was fair or normal. The system could be compared to somewhat of an "all-or-nothing" approach – there was little incentive for individuals to present aspects of what they could do independently of what was offered through traditional paid support systems such that this may result in no support being offered at all for aspects where they did need support. The result was inefficient resource use and the failure to properly address individual needs through self-

---

[108] Department of Health UK (2007).

determination. This old system (a system which is still present in some local authorities) used the following steps to evaluate how much assistance can be received:

1. The individual is assessed by a social worker or another professional, who defines needs;
2. The assessor will then identify which needs are being met by other people in the individual's life;
3. The assessor will then write up a care plan, which describes how needs will be met; and
4. The costs of the paid support in the care plan would be determined by the service that is selected.[110]

The self-directed support model involves setting individual budgets up front through the RAS so that people can plan creatively within their specific budget. Research from *In Control* has revealed that the process of allocating resources *before* drawing up a plan occurs in other countries across the world including Japan, Spain and Austria and certain areas in the US (e.g., Dane County, Wisconsin) and the State of Victoria (Australia)[111]. Furthermore, the use of an individual budget is not restricted such that as long as people are successfully meeting their assessed needs they can use the money for these purposes[112]. The shift is being made to move away from "how money is being spent" and towards, "the outcomes individuals achieve[113]." The aim of the RAS is to provide a resource allocation system that provides a fair and reasonable amount in a personal budget, is transparent in view of its approach to application and sustainable – allocations can be made on ongoing basis[114].

The UK model is not limited to providing funding to persons with developmental disabilities, although the original program, *In Control*, was created with this purpose in mind. Self-directed funding is currently available to the full spectrum of persons with disabilities and those needing supports within the social care system including: older persons, persons with mental and/or physical disabilities inclusive of adults and children. Person-centric planning is the consistent basis for In Control's support planning.

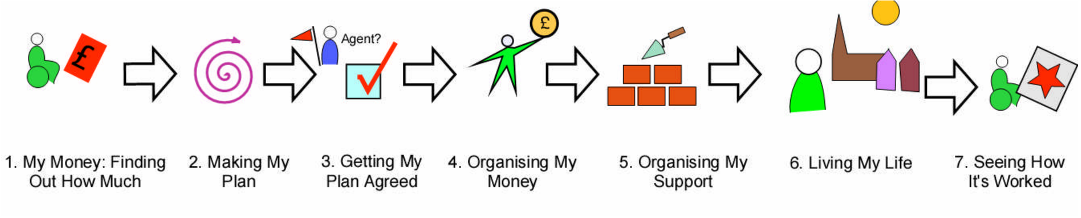
In Control developed a governance model along with a range of tools and guidance documents to assist local authorities in the development of their own, region and case specific programs for direct funding. The suggested *In Control* RAS seven-step plan for self-directed support and directed funding, used to decide who gets what amount in their personal budget[115], is as follows:

---

[110] Waters, John (2007).
[111] Duffy, Simon (2004).
[112] ibid
[113] Duffy, Simon and J. Waters (2007).
[114] ibid
[115] Where Direct Payments were not previously established. "If during the review process the person or the authority believes the package needs a proper re-assessment (perhaps because it seems insufficient or because the person is consistently under-using their allocation) then it will be appropriate to use the RAS to set the allocation. However it is important that local authorities consider carefully when and how any such review process is put in place" (Implementation Guide - Building upon Direct Payments as Key of the Wider System of Self-Directed Support Produced by the in Control's Yorkshire & Humber Forum Revised Version, June 2007 (p.8-9)).

1. Self-assessment – Completion of the self-assessment questionnaire (SAQ)[116] followed by analysis through a Resource Allocation System (RAS).
2. Plan support - Individual makes a plan of how he/she wants to get support.
3. Agree the plan - The Council checks to see if the plan makes sense -- specific amounts of money get tied to each component of the plan (e.g., housing, shopping assistance etc.) the personal budget get re-evaluated and adjusted if necessary to ensure that all components of the plan can be funded to meet needs.
4. Manage individual budget.
5. Organize support.
6. Live life.
7. Review and learn.

Figure C: *In Control*'s Model of Self-Directed Support, Version 4.0[117]



In all local authority programs in the UK, following the completion of the SAQ and determination of funding allotment (overall personal budget) through a RAS, the next step towards directed funding involves the development of personalized plans by the individual, with the assistance of social workers, families and friends. Following development of the plan, it is analyzed to help determine the appropriate level of *component funding support* respective of each identified goals (the breakdown of specific costs for each area based on the total amount afforded by the personal budget) and needs of the person as identified in the plan. This step also involves possible adjustment to the personal budget to determine whether the funding amount through the RAS is "fair" and "reasonable" to and if not, the plan is adjusted accordingly[118].

The SAQ measures how disability impacts on a person's life in a number of key areas. Each area is scored and the total is adjusted to align with the amount of support that could reasonably be expected from the individual's friends and family. This allows people with similar levels of needs in similar circumstances to be allocated the same level of funding[119].

The Resource Allocation System (RAS) focuses on determining independent funding for children exiting the child system entering into adulthood. RAS's are usually tailored not only to the geographic region (local authority), but are also often developed for different social groups (e.g., elderly, persons with physical disabilities) and at times, market

---

[116] A comparison of the questions used to help with determining funding allotments under self-directed support plans in various jurisdictions can be found in Table X: Comparison between Resource Allocation Models

[117] Waters, J. and S. Duffy (2007).

[118] Duffy, Simon and J. Waters (2007).

[119] Duffy S. and Waters, J (2008: 4).

adjustments are made to some RAS's in an attempt to standardize or equalize regional and group cost differences. In general, the model for setting levels for individualized budgets is based on the following methodology which flows from observations that there is normally an "implicit resource allocation process" in local authorities, and that it is a matter of making it explicit to allow for self-determination and to foster trust with individuals by showing them at the outset the budget they have to work within. The stages involved in the model development are outlined below:

1. The local authority identifies the price of the major service elements typically purchased;
2. The local authority identifies the typical service packages that were typically made available to individuals (e.g., receiving a place at a day care centre with some respite care is considered as a "package");
3. Through examination of price and distribution of the prevalent individual packages, funding levels for the system can be determined; and
4. Reflecting on existing allocation practice, the local authority can map assessment criteria to the given funding levels (normally six are required).

Three independent criteria have been proposed to assist with mapping (step 4 above):

- Level of need: expressed as low, medium or high
- Family situation: expressed as whether they are living in the family home or not
- Complexity: expressed as either 'yes' or 'no'

A sample Resource Allocation funding table is found in Table F below.

Table F: Sample Resource Allocation System[120]

Level	Funds	Conditions	Possible indicators
1	Less than £2000	Low Level Need	Can keep themselves safe Can meet own personal care needs Can travel independently Can manage money with some help Can sustain involvement in activities
2	£5,000	Low Level Need **and** Complexity	Reduced ability to sustain involvement Possible mental health problems Needs regular help with bills and reading Possibly subject to bullying
4	£30,000	Medium Level Need	Needs guidance and direction Needs help cooking Can dress get dressed Can carry out personal care Does not need 24 hour support
5	£50,000	Medium Level Need **and** Complexity	Difficult behaviour Self-injurious behaviour Night-time epilepsy
5	£50,000	High Level Need	Need for some waking support at night Possible complex health needs
6	£75,000	High Level Need **and** Complexity	Very challenging behaviour

---

[120] Duffy, Simon (2004).

In 2008, more than three quarters of local authorities in England (122 of 150) were involved with *In Control* in trying to change their service delivery approach. More than twenty of those are already working towards using self-directed support as the approach for everyone needing social care support. In June 2008, 6,000 people were directing their own support, a considerable growth from 60 in 2005.

This model of providing budgets prior to plan development inherently leads to better use of funds as funding caps are established at the outset and individuals must therefore be creative in how their budget is spent and use other forms of non-funded support so that they can use their limited funding more effectively. Furthermore, the market has shown to be more efficiently managed in a system where there are clear funding baselines set and incentives to work within capped funds. As stated by Duffy (2004: 2):

> *The existence of a known financial constraint creates an environment of trust and realism within which those planning can move on to consider how to get the best possible support arrangement for the individual.*

From the *Report on In Control's Second Phase 2005-2007,* certain cost generalizations were made with respect to savings that have benefitted from the self-directed support model. Based on sample data from 10 local authorities for 128 individuals with personalized budgets, it was determined that 104 individuals previously used social care. Cost comparisons between the social support care model and the self-directed support model indicated that for people using this latter type of care they experienced an average cost reduction for services of 9%.

When data is included from those people who did not previously require social care (14 persons), the number of persons served by the self-directed support increased by 23% but the overall cost of the program only grew by 6%. It is acknowledged that this analysis is based on early data and is therefore biased towards higher than average cost services indicating possible room for more efficiencies (economies of scale) in larger packages of support in the future.

Other studies, in particular one entitled, *An Evaluation of the Cardiff and Vale Independent Living Scheme and the Implementation of Direct Payments*[121], note that cost comparisons of direct payments with conventional services vary as they are strongly dependant on rates paid for independent sector services in differing locales (e.g., wage in one area is $X and is static; the other is $X +2 with shift differentials). There are other additional costs and potential savings associated with direct payments but given variability as outlined above, findings in this study, consistent with a similar study in Norfolk, suggest that cost neutrality between systems is often the result.

Cost savings, while important, were not cited as the most important driving factor for the direct payment approach. Rather, the empowerment of individuals was the major focus. The support for this approach has been exemplified by the rise in uptake of direct payments in contrast to the traditional delivery model. Hampshire for example, demonstrated a shift in provision of services between 1985 and 2000 such that in 1985,

---

[121] Stainton, Tim and Stephen Boyce (2002).

78% of disability services were provided by the local authority and 22% were purchased by individuals; while in 2000 these figured flipped so that 36% of services were purchased by the local authority and 64% were purchased by individuals.

Regarding the economic impacts of individualized budgets on the costs of transactions for services in Oldham[122],

> *… When people organise their own support, they naturally do things more efficiently. This comes partly from people doing their own support planning and producing sensible plans. But it's because of the flexibility of individual budgets. If people have a change of circumstances they'll generally just manage it within their plan and allocation. They don't automatically come back to us – as they might have done – asking for a new funding decision or another care assessment.*
>
> *It's a bit like Ikea, which has built a business on low transaction costs because customers are willing to take more responsibility for the product.*

The in Control model for development of personalized budgets has also been adapted for use for children such that 18 Children's services are now using this model. In Control is also expanding the program to focus on health care supports by developing the system to focus on long term (chronic) conditions, mental health services, complex needs in children, dementia, and substance abuse.

Cost factors are different for each local authority as they each determine on their own whether to adopt self-directed funding and secondly, how their RAS system will be configured and budget subsequently allocated. Adoption of the directed funding approach is discretionary – local authorities can choose to develop a program and individuals can choose to apply for direct funding over traditional funding mechanisms. Eligibility for funding under the *UK Direct Payments Bill* is dealt with by way of regulation, with local health and social service authorities having considerable discretion in how they are implemented[123]. Irrespective of this local flexibility, self directed support is planned to be rolled out nationally in the UK by 2012 to promote service user choice and control.

Self-directed support has yet to have a noticeable effect in the UK as significant restructuring is still required and it is only when more local authorities begin to operate under this structure will a better analysis and positive cost savings be realized. Even considering that it will take some time before cost savings are more fully realized, the UK is still considering, in the spirit of "Putting People First", expanding the self-directed support model to others areas in the social services continuum:

- Community Development (applying the LAC model from Western Australia);
- Children with disabilities;
- People with long-term health conditions;
- People with variable conditions;
- People who are dependent upon drugs or alcohol;

---

[122] Davies, Paul (2008).
[123] Salisbury, Brian (1997).

- Education;
- Employment; and
- Housing.

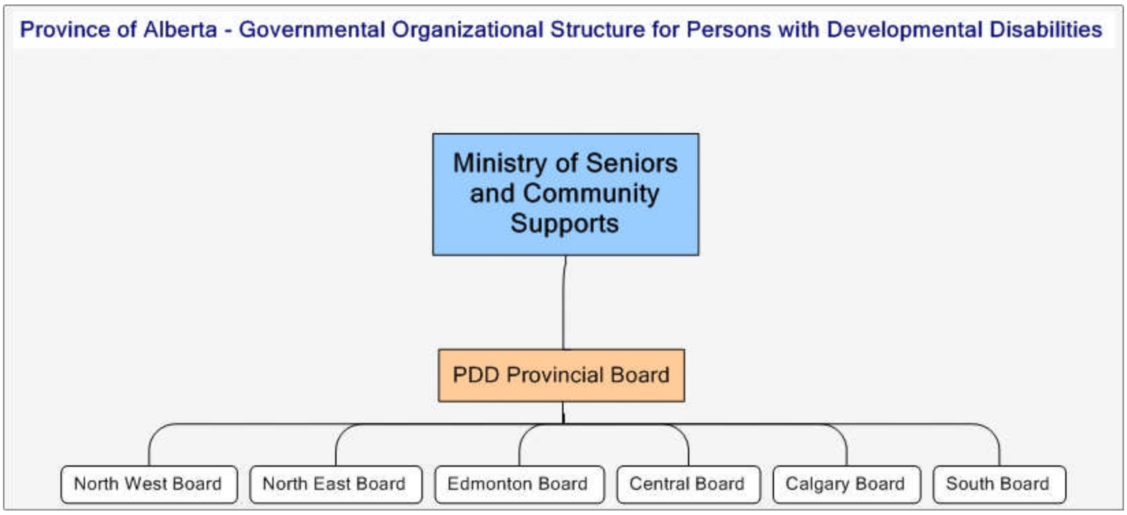
Alberta

The Persons with Developmental Disabilities (PDD) program, which is part of the Ministry of Seniors and Community Supports, provides supports to adults who have a developmental disability. Six community boards deliver local programs and work with adults with developmental disabilities, their families and guardians to identify needs. The boards also work with local agencies to provide services. The PDD Provincial Board members are appointed by the Minister of Seniors and Community Supports. The PDD currently supports approximately 9,100 adult Albertans. The focus is on supporting individuals with developmental disabilities to live fulfilling and inclusive lives in Alberta communities.

The Ministry is responsible for developing a provincial plan and policies, allocating funding to the six community boards, coordinating the delivery of programs and services and monitoring and assessing community boards in how they carry out their activities[124]. The Community Boards are responsible for overseeing and evaluating the implementation of regional plans for the delivery of supports, based on community priorities and on the direction of the Provincial Board.[125]

The Organizational Structure for operations with respect to persons with developmental disabilities is set out in Figure D.

Figure D: Alberta Organizational Structure – Persons with Developmental Disabilities



The PDD Mission is:

> *To create an Alberta where adults with developmental disabilities are included in community life.*

---

[124] Province of Alberta, PDD (2008a)

[125] Province of Alberta, PDD (2006a)

The core business areas for the PDD are:

- To enable adults with developmental disabilities to sustain quality lives;
- To recognize and support communities' capacity to include persons with developmental disabilities in community life; and,
- To ensure the community governance system is responsive and accountable to individuals with developmental disabilities and their families/guardians and their communities[126].

The PDD program delivers services consisting of four types of support mostly provided by community service providers whose services are contracted with Regions or with individuals, families or their guardians directly:

- Community Living Supports;
- Employment Supports;
- Community Access Supports; and,
- Specialized Supports[127].

PDD staff, as governed by each of their respective Community Boards, assess eligibility for services, work with individuals and their families to determine the types of supports required and help link individuals to services. Regional staff also manage contracts with community service providers and directly deliver 24-hour care and residential accommodations for individuals with complex care requirements in three regions.

There are seven principles which guide the funding of supports in the PDD Program:

- Individualization;
- Choice -- individuals can choose and change service providers throughout the Province;
- Equitability/Portability -- individuals can move between different areas in the Province and continue to receive comparable supports, services and funding;
- Flexibility -- services, supports and funding can be readily adapted to meet changing need;
- Effectiveness -- the services and supports purchased will meet identified needs
- Efficiency -- individuals are able to access funding, services and supports in a timely and responsive manner; and,
- Accountability -- Individuals and service providers will be held accountable for the expenditure of public funds[128].

With the increasing interest on the part of families caring for persons with developmental disabilities in directly hiring and managing paid supports as an alternative to hiring supports from the service provider sector, an advisory team of PDD and the Alberta Association for Community Living (AACL) was brought together in August 2005 to develop policy parameters to enable and guide this new form of service delivery. 'Family managed supports' was created with this purpose in mind[129].

---

[126] ibid

[127] Province of Alberta, PDD (2007a)

[128] ibid

[129] Province of Alberta, PDD (2006b)

Family managed supports is an option which must be made readily available in all regions with consideration given to minimize any risks that are identified. Funded supports must be in alignment with the Community Inclusion Supports Framework and must promote:

- Inclusion;
- Valued social roles;
- Personal growth for individuals; and,
- Maintenance of family relationships.

Core characteristics of Family-Managed Supports must be understood and agreed to before PDD can grant funding approval:

- The basis for making the choice is so that a close personal relationship can be formed with the individual rather than merely a professional relationship;
- Funds must be used to hire support people directly;
- The family becomes responsible for all aspects of employment (hiring, supervising and paying);
- There will not be remuneration for family member's time spent managing supports;
- Reimbursement for related out of pocket expenses may be negotiated; and,
- Restricted to managing supports for an individual with whom a close personal relationship already exists[130].

Principles of practices dictate that:

- The Family managed supports option is available to families unless there are documented concerns indicating that there are significant risks that cannot be readily addressed through this method of support;
- Funding concerns must be shared with the family
- Flexibility in approach is encourage
- Bureaucratic involvement will be limited to ensuring basic government accountability requirements are met
- Intended use of funds must align with PDD's principles for determining individual support needs
- Funding approval includes consideration of balance between personal choice and risks to all other involved parties[131]

Principles for determining individual support needs are based on the foundation principle that:

> *Individuals, with the assistance of their families and friends, are the primary source for identifying what is best for themselves and what kinds of support they require[132].*

Supplementary principles to help guide supports funding focus on ensuring that they assist individuals to be fully included and live meaningful lives in the community; are

---

[130] ibid
[131] ibid
[132] Ibid (p10-2)

adequate, flexible and individualized; assist in maintaining and building individuals' connections and relationships; and, promote continued growth, personal development and life-long learning.

In Alberta, individualized funding is provided by the Persons with Developmental Disabilities Community Boards. The amount of funding is determined by a plan that is ideally developed by parents, adults themselves and friends, often with the assistance of service providers or professionals, and submitted to the authorities for approval. The plan may attempt to address all of a person's needs (e.g., employment, support staff at home, recreation, etc.) or only some needs. Usually negotiations will take place in relation to how much funding will actually be provided, and to the nature of the plan and will be adjusted accordingly. There is an appeal process for disagreements over funding and/or the plan[133][134].

Person Centered Planning (PCP) is the basis upon which many plans are created. Plan models and tools appear to be independently created by each Community Board such that slight regional differences in approach may be present. In the Central Alberta region, the plan is used as the fundamental baseline upon which funding and supports are determined, matched and provided to the individual submitting the plan. The PCP Tool used in Central Alberta is used as guide to help individuals develop their individualized plan for support in application for funding. It is based on the following elements, however, the tool, which is only a guide, can be expanded upon or contracted as individual circumstances dictate. The tool is based on a situational assessment comprised of a number of components:

1. An exploration of the individual's relationships to others;
2. An exploration of the individual's current home, community connections, work activities, and natural and paid supports;
3. An exploration of an individuals interests, gifts, skills, and personal qualities
4. What the person is learning or would like to learn;
5. A look at what the person likes about their life and what they would change
6. A look at how to best listen to, or hear, the person;
7. An exploration of each individual's personal qualities, dreams, and opportunities for social roles and community connections that are to be appreciated or enhanced;
8. An outline of each person's opportunities and challenges and the resources that are available to that person to assist in achieving their visions i.e. family, community resources, PDD;
9. An exploration of an individual's Vision for their Life in the areas of home, friends/community and work/meaningful day activities and any other area that is important to them. This includes the identification of the outcomes that the

---

[133] Uditsky, Brian.

[134] According to section 15(2) of the *Persons with Developmental Disabilities Community Governance Act*, (RSA 2000, cp-8 s19; 2006 c25 s18): *"an individual who is receiving services or has applied to receive services by means of funding or resources allocated by a community board and is affected by a decision of that community board respecting those services may appeal that decision if the decision is not exempt from appeal under the regulations."*

individual wants to achieve in their life and the identification of the circles of support that are available to assist them in reaching those outcomes; and

10. An identification of how the individual's person centered plan will be reviewed including when, where, and with whom[135].

An Individual Funding Application allows for a determination of eligibility and establishes responsibilities for all parties. In the application, the individual, family/guardian and private trustee:

- Identify the specific type and volume of services they want;
- Identify the staffing model and cost for services requested;
- Determine whether they want to fully manage the services or use a service provider to deliver the services; and
- Directs the PDD Program Community Board where to provide funds (i.e., to the administrator or the service provider).

The term of the agreement for individual funding cannot exceed one year; an annual review of approved services is required[136].

Assistance in plan development and general access and information about community resources for persons with developmental disabilities are provided through the assistance of Community Supports Coordinators in each of the Community Board Regions. It is not quite clear whether the function of facilitator and funding assessor/contract provider play out as separate roles in all PDD regions.
In the South Alberta Region, there are independent roles for service provision such that a Community Connections Facilitator assumes a role which:

- Opens new doors and build community awareness that will assist people with developmental disabilities;
- Develops strong working relations with other community partners; and,
- Determine eligibility of new individuals.

While the Contract Coordinator:

- Ensures that regional PDD funded supports are reflective of PDD's mission and vision through the completion of the Monitoring Framework;
- Negotiate contracts and evaluate contracts; and,
- Consult with service providers around program innovations and efficiencies.

There are also positions for Family Managed/Contract Coordinators and Transition Coordinators[137].

Community Supports Coordinators are staff who can provide:

- Information about living and working in the community;
- Assessments of individual/family needs;
- Individual lifestyle planning and information about funding; and,
- Public awareness and education.

---

[135] PDD Central Alberta Community Board (2004: 9-10)
[136] Province of Alberta PDD (2007a)
[137] Persons with Developmental Disabilities South Alberta Board (2008).

Community Supports Coordinators are also knowledgeable about the local community and the resources, supports, and programs that are available to assist adults with developmental disabilities and their families and also focus on developing and arranging funding to support persons with developmental disabilities[138].

Based on the latest figures from the PDD website, Community agencies serve more than 90% of the individuals receiving PDD funding, while PDD's direct operations serve approximately 5% and families who hire their own supports represent the remaining individuals (5%). [139]

Alberta is currently undertaking a “community capacity initiative” both to help increase community awareness and understanding of community partnerships and opportunities to build inclusive communities and foremost, to develop, implement and evaluate innovative community initiatives set to enhance a community’s capacity to include and support persons with developmental disabilities. This extension is similar to the Innovation Framework and Networks being developed through CLBC.

United States

Since the 1950s, the trend among state developmental disabilities agencies has moved from institutionalization to community care. State approaches used to achieve this change in support systems vary as do their level of progress and success in this regard. The *Americans with Disabilities Act*, 1990 created a broader platform for community integration by making it a person’s legal right to access public settings and services, including community transportation services and recreational facilities.

Community based care for persons with intellectual disabilities, grew not only from the Act but out of the idea of meeting the needs of people with disabilities by focusing on quality of life issues such as: presence in the community; health and safety needs; personal growth and opportunity; and self-determination[140]. Family support is another offshoot of the community-based care approach. The US definition of ‘family support’ is similar to other jurisdictions and includes: home modifications, in-home/out-of-home respite care, sibling programs, family counseling, support groups, after-school care, educational programs, behavioral training and basically any service funded to assist family to continue to care for their child or adult child in the home. Support is offered through direct cash subsidies or vouchers to purchase needed services[141].

Family support began to take root in the US in the late 1970s and has continued to grow as an alternative to residential care (mainly in institutions) and community-based residential programs for people with developmental disabilities. In the early days, there was often no support provided to families caring for people with developmental disabilities at home. Families and other advocates brought to bear the fact that the majority of States’ resources were being spent on people in residential placement and that the needs of families taking on this home care responsibility were being ignored in

---

[138] Persons with Developmental Disabilities Central Alberta Board (2008).
[139] Province of Alberta, PDD (2008a).
[140] Davis, DeWayne, Wendy Fox-Grage, and Shelly Gehshan
[141] Parish, Susan L., Pomeranz, A., Hemp R., et al (2001).

the equation. In 1977, people in institutions and out-of-home care represented only 9% of the total population of people with developmental disabilities[142].

Between 1977- 98, the number of people with developmental disabilities in public institutions declined while the number of people in community residential programs increased two and half fold. Part of many states' community services efforts revolved around providing support to families to help prevent or delay placement into residential care settings[143]. The average cost of institutional care in the US in 1998 was more than six times the average cost of community-based care -- $94,348 for institutional care versus $14,902 for community-based care. This cost differential resulted in some states increasing their spending on services provided through community-based programs.[144]

In 1981, section 1915 (c) of the *Social Security Act* was amended to allow states to waive certain Medicaid requirements and allow for payment of federal matching funds for a defined set of community services and supports including: case management, homemaker services, home health aid services, personal care services, adult day health, habilitation and respite care for Medicaid-eligible people. This amendment, which created the Home and Community-Based Services (HCBS) Waiver program, created flexibility for providing support and services assistance for individuals who would otherwise be residing in institutional settings[145]. Other services, requested by the State because they are needed by waiver participants to avoid being placed in a medical facility (such as non-medical transportation, in-home support services, special communication services, minor home modifications, and adult day care) may also be provided, subject to Centers for Medicare and Medicaid Services approval at the Federal level. Flexibility is afforded such that states can design each waiver program based on the desired mix of waiver services that best meet the needs of the population they wish to serve. HCBS waiver service may be provided state-wide or may be limited to specific geographic locations[146].

States must independently develop their own waiver programs and must demonstrate cost effectiveness – ensuring that the average cost per person for HCBS care will not be in excess of the average cost per person for institutionalized care services. By 1995, all states had (except Arizona) had at least one such waiver program[147].

Between 1990 and 1998, the number of persons with mental retardation/developmental disability (MR/DD) who received services through the HCBS waiver program increased by more than 200,000, from 39,838 recipients in 1990 to 240,321 in 1998 – the number of people in care remained constant over a similar period.

In addition, the Robert Wood Johnson Foundation launched a cash subsidy program, *Putting People First: Initiative in Self-Determination for Persons with Developmental Disabilities*, in 1997. The initiative distributed more than $5 million to states that implemented pilot projects to reallocate state resources to assist those with MR/DD and

---

[142] ibid
[143] ibid
[144] Davis, DeWayne, Wendy Fox-Grage, and Shelly Gehshan
[145] ibid
[146] Workworld (2008).
[147] ibid

their families gain control over their own personal care needs. Nineteen states participated in the program, including Washington State.

Oregon provides a good example of how state self-determination initiatives are designed to help those with MR/DD in the USA. Oregon's developmental disabilities agency received $200,000 for two and one-half years to finance the Oregon Self-Determination Project whose goal was to help reduce the number of patients admitted to the state institution and limit access to the state's system of congregational care. The project involved creating a brokerage to dispense service funds and to identify and pay for personalized care and support for 60 people with MR/DD. Brokerage assistance was made available to both individuals receiving services in the community, individuals on waiting lists and families who already had family support funding. The brokerage helps those with MR/DD find and gain access to community supports, develops personalized support plans and individual budgets, and serves as an intermediary for financial and personnel contracts between beneficiaries and support personnel[148].

An overview of how BC's neighbour to the south, Washington State, addresses the needs of people with developmental disabilities, in context of the US funding support system through Medicaid and the Waiver Program and how they determine the level of support needs are briefly outlined in the section below. The American Association on Intellectual and Developmental Disabilities (AAID) is the body that created a tool to assist in providing needs-based supports for individuals with developmental disabilities called the Supports Intensity Scale (SIS) which is the tool employed by the State of Washington to determine support and services funding for persons with developmental disabilities.

Washington State

The Washington State Division of Developmental Disabilities (DDD) assists individuals with developmental disabilities and their families in obtaining services and supports based on individual preference, need, and which facilitate managing everyday routines and relationships that are part of all citizens' lives[149]. Approximately 33,000 people are served by the DDD[150].

The DDD falls under the jurisdiction of the Washington State Department of Social and Health Services and receives guidance from a State Advisory Committee (SAC) who provide input into DDD activities and programs with the aim of enhancing the quality of life for people with developmental disabilities. The Committee, which is represented by individuals who receive services from the Division or is a family member of an individual who is in receipt of such services:

- Assures that the division knows what people want through outreach and listening
- Provides input to the division on both long-term and short-term issues
- Promotes integration
- Supports the division's mission[151].

---

[148] Davis, DeWayne, Wendy Fox-Grage, and Shelly Gehshan

[149] Washington State (2008a).

[150] Washington State (2008b).

[151] Washington State (2008c).

Case Resource Managers (CRMs) are the Division's point of contact who assist clients and their families identify interests and support needs and aid them in accessing division services and navigating through the wide array of community resources to determine what they services they are eligible for and which services best meet their individual needs. Each individual is assigned a specific CRM.

DDD services are dependent on availability of funding and/or eligibility for the specific service. To determine service eligibility, an assessment must first be completed.

The Assessment Process[152]

The DDD Assessment process, which was implemented on June 1, 2007, has three main steps:

1. Intake and eligibility determination for new clients

Part of the eligibility determination process involves determining whether the individual can be assessed as having a developmental disability. In Washington State, developmental disabilities are defined as disabilities that are attributable to:

- Mental Retardation;
- Cerebral Palsy;
- Epilepsy;
- Autism; or,
- Another neurological or other condition closely related to mental retardation/ requires treatment similar to that required for individuals with mental retardation.

Which:

- Originated before the individual reached the age of eighteen;
- Have been continuous or can be expected to continue indefinitely, and
- Result in substantial limitations to an individual's intellectual and/or adaptive functioning.

A component of the eligibility determination process involves documentation and/or diagnosis by an authorized person that the person falls under the category and often includes results from evaluative tests such as IQ or other standardized adaptive behaviour scale assessments.

2. Assessment of the person's support needs

Once an individual is deemed eligible, based on the legislated criteria, the formal assessment process begins. The DDD Assessment is designed to measure the individual support needs of persons with developmental disabilities over a broad spectrum of life areas and activities. The DDD Assessment was built to describe the unique needs of people with developmental disabilities. This information is essential to understanding the needs of assessed persons and provides a tool to assist case resource managers in determining whether the individual is eligible for DDD services (specific information about potential waiver eligibility is also afforded through this process) and whether the case should follow to the next step of the process - developing individual support plans.

---

[152] Washington State (2008d) and Washington State (2008a).

The assessment is undertaken via a specially designed tool called the "Supports Intensity Scale" (SIS). The Supports Intensity Scale (SIS) is a nationally recognized and normalized assessment tool, developed by experts in the field of developmental disabilities, used to assess employment needs, help build the Individual Support Plan (step 3), determine need for community support, and highlight additional needs for community or informal support for people with developmental disabilities age 16 and older. The tool was designed by experts in the field of developmental disabilities specifically to identify the needs of people with developmental disabilities. There are plans for a future SIS scale to be developed for children under the age of sixteen[153].

This module also includes an assessment of caregiver needs, behavior issues, and protective supervision.

3. Determination whether person will have paid services or no paid services

If it is determined that the person is not eligible for paid services by DDD, the person receives a report on the assessment findings, and the case resource manager then provides information, assistance, and referral to community resources.

If it is determined that the person is eligible for paid services by DDD, the person will be asked questions by the CRM to determine need and the level of services that will be authorized resulting in a service level assessment, an Individual Support Plan (see below), on-going case management, and paid services through Medicaid or state-only resources. The case resource manager, using the information produced by the DDD Assessment, will determine the service level and authorize payment for client services[154].

The Individual Support Plan (ISP) describes the services individuals are authorized to receive. The case resource manager will print this plan and give it to the client following the assessment and planning session[155]. Paid services through the Division are based on the following criteria:

- Meeting eligibility requirements for the specific service;
- Assessed as being in need for the service; and,
- The funding available for the service[156].

Access to Medicaid State Plan services and Home and Community Based Waiver services (partial program funding provided by the Federal Government) are not limited by availability of funding providing waiver services were used in the past year[157]. Waiver services provide additional support when Medicaid State plan services and other supports are not sufficient. The DDD offers services under four targeted waivers Basic, Basic Plus, Core and Community Protection, each with specific limits on the afforded benefits, services and number of people that can be enrolled at any given time. Eligibility for waivers are based on a number factors:

---

[153] Washington State (2008e).
[154] Washington State (2008d).
[155] ibid
[156] Washington State (2008e).
[157] Washington State (2008f).

- The individual must be a client of the DDD;
- The individual must have a level of income not in excess of certain amounts;
- The individual needs level of care that would otherwise by provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) and has agreed to accept home and community services as an alternative (inherent in going through the aforementioned assessment process); and,
- The individual must have an ISP showing need for these waivers[158].

A description of Washington State's defined waiver services along with qualification criteria and funding amounts are outlined in Table 7 below.

Table G: Overview of the Division of Developmental Disabilities' CMS Waivers (excluding Mental Health Waivers), Washington State

Waiver Targeting Criteria	Services	Yearly Limit
Basic • Individuals on this waiver live with family or in their own homes. • The family/caregiver's ability to continue caring for the individual is at risk, but can be continued with the addition of services provided in the Basic Waiver. • The individual does not need out-of-home residential services.	**Aggregate Services:** • Behaviour Management and Consultation • Community Guide • Environmental Accessibility Adaptations • Occupational Therapy • Physical Therapy • Specialized Medical Equipment/Supplies • Specialized Psychiatric Services • Speech, Hearing and Language Services • Staff/Family Consultation & Training • Transportation	$1,454 per year on any combination of these services
	Employment/Day Program Services: • Person to Person • Supported Employment • Community Access • Pre-vocational Services	May not exceed $6,804 per year
	Sexual Deviancy Evaluation	Limits are determined by DDD
	Personal Care	Limits determined by the CARE tool as a part of the DDD assessment
	Respite Care	Limits determined by the DDD assessment
	Emergency Assistance	$6,000 per year (pre-authorization required)
Basic Plus • Individuals on this waiver require a higher level of services than those on the Basic Waiver and/or they require a service	Skilled Nursing and all of the services in the Aggregate Services package for Basic Waiver	$6,192 per year on any combination of these services
	• Employment/Day Program Services:	May not exceed $9,944 per year. In some situations, this limit may be increased to a maximum of

---

[158] Washington State (2008e). and Washington State (2008g).

Waiver Targeting Criteria	Services	Yearly Limit
that is not contained in the Basic Waiver, and • The individuals live with family or in another setting with assistance and are at <u>high</u> risk of out-of-home placement or loss of their current living situation, or • They require out-of-home placement and their health and welfare needs can be met in an adult family home or an adult residential care facility.	• Person to Person • Supported Employment • Community Access • Pre-vocational Services	$19,888 based on assessed client need and only with prior authorization.
	Sexual Deviancy Evaluation	Limits are determined by DDD
	Personal Care	Limits determined by the DDD assessment
	Respite Care	Limits determined by the DDD assessment
	Adult Family Home Adult Residential Care (Boarding Home)	Determined per department rate structure
	Emergency Assistance	$6,000, per year (pre-authorization required)
Core Waiver • Individuals on this waiver are at <u>immediate</u> risk of out-of-home placement; and/or • Have an identified health and welfare need for residential services that cannot be met by the Basic Plus Waiver.	Residential Habilitation, Community Transition and all of the Basic Plus services except: • Emergency Assistance; • Adult Family Home; and • Adult Residential Care services	Limited to the average cost of an ICF/MR for any combination of services necessary to meet assessed client need. Limits for Respite and Personal Care Services are determined by the DDD Assessment. Limits for Mental Health Stabilization Services are determined by a Mental Health professional or DDD.
Community Protection • Individuals on this waiver meet the DDD criteria for "community protection." • They require 24-hour, on-site staff supervision to ensure the safety of others. • They require therapies and/or other habilitation services. • The individuals agree to receive services from a certified Community Protection Residential Services provider.	All Core services except: • Personal Care, • Respite, • Community Guide, and • Community Access. *Note: Some definitions differ in this waiver.	Limited to the average cost of an ICF/MR for any combination of services necessary to meet assessed client need. Residential services are offered only by Community Protection Certified providers. Clients must agree to their Community Protection Individual Support Plan.

Source: Adapted from Home and Community Based Waiver Services – Division of Developmental Disabilities Washington State brochure

Approximately 67% of individuals registered with DDD live with their families and contribute their time and resources to cover expenses to keep their family member at home[159].

---

[159] Washington State (2006).

In November 2006 DDD and stakeholder representatives submitted a report to the Legislature requesting a new, combined Family Support program to better serve the needs of individuals. The legislature asked the Division of Developmental Disabilities (DDD) to consolidate its three Family Support programs (Traditional, Opportunities and Pilot) into a single program which it was instructed to do in April 2007 pursuant to the Substitute Senate Bill 5467. The transition from the current family support programs to the Individual and Family Services (IFS) Program was set to occur over time. Program transitioning began in July, 2007.

The intent of the new program is:

- To *partner with families* as care providers for children with developmental disabilities and adults who choose to live in the family home;
- To enable individual and family services be *centered on the needs* of the person with a developmental disability and the family; and
- To provide individuals and families with a *choice of services* and the flexibility to exercise control over resources provided to them, to the greatest degree possible.

The new program allows participants to use their allocation to pay for any of the following services as identified and agreed to following assessment and development of the Individual Support Plan (ISP):

- Respite Care;
- Therapies;
- Architectural and vehicular modifications;
- Equipment and supplies;
- Specialized nutrition and clothing;
- Excess medical costs not covered by another source;
- Co-pays for medical and therapeutic services;
- Transportation;
- Training;
- Counseling;
- Behavior management;
- Parent/Sibling education; and/or,
- Recreational opportunities.

Another change to the program is that allocations are based on need and four allocation levels have been delineated:

- Level 1 = $2000
- Level 2 = $3000
- Level 3 = $4000
- Level 4 = $6000

When the person's eligibility for the program is determined, the continuing eligibility may be time limited and subject to review[160].

---

[160] Washington State (2008h).

Appendix 3: Guide to Support Allocation

GUIDE TO SUPPORT ALLOCATION

Date Guide Completed:

Name of Individual:

Paris Identification Number:

Name of Writer of the Plan:

Address of where Correspondence is to be Directed to:

Name
Address
City BC Postal Code

Name of Analyst Completing this Guide:

GUIDE TO SUPPORT ALLOCATION

Overview

The "Guide to Support Allocation" is intended to support Quality Service Analysts to make a professional judgement about the level of support an individual requires based upon "individual disability related need" as outlined in an Individual's Support Plan.

Procedures

The Analyst reviews the plan and must answer the following questions before completing the Guide to Support Allocation.

- Is the plan complete?
- Is there a clear relationship between the goals stated in the plan and the proposed services to meet the disability related needs of the individual?
- Is the requested support the least costly alternative that will ensure quality service?
- Is the plan consistent with CLBC policy?

- The Analyst reviews the plan seeking to understand the disability related needs prior to completing the Guide to Support Allocation.

- When the Analyst has reviewed the disability related information in the plan a more detailed analysis should take place. There are 10 areas of consideration in making a final determination of level of support associated with the individual's disability related needs.
  - 1.1 Communication
  - 1.2 Meeting Personal Care Needs *
  - 1.3 Creating or Maintaining Relationships *
  - 1.4 Making Day to Day Decisions
  - 1.5 Making Important Life Decisions
  - 2.1 Promoting Well-being – Staying Safe From Harm *
  - 2.2 Work and Learning
  - 2.3 Being Part of the Local Community
  - 3.0 Complex Health Needs (Including Mental Health) *
  - 4.0 Complex Risks and Actions*

- In each area of the Guide to Support Allocation the Analyst must indicate what level of disability related need applies to the individual as described in the plan. There are at least 5 levels of need in each area. These five levels in each area represent the continuum of disability related need for the area.

- There are 5 areas where "Flags" (see * above) identify specific, extreme situations that are considered critical in determining the support needs of the individual. An individual may up to five "Flag" areas but careful consideration must be give to understand the underlying cause of the "Flag". In some situations a "Flag" may be warranted but the cause could be due to a health or mental health concern and not attributable to an individual's developmental disability. In these circumstances the Analyst should ensure that other supports or funding agencies' involvement is noted in the plan.

- When all 10 areas are reviewed and a determination of need is made in each area, the Analyst will add up the total score. The total score is then divided by the number of areas where scores were recorded. Note "Flags" are not scored and therefore the areas that they fall into are excluded from determining the average score as related to the disability related needs of the individual.

- When the Analyst has completed the review of the plan, application of the Guide to Support Allocation and determined the average score from the results of scoring of the 10 areas a final assessment of disability related need is required. The Analyst reviews all supporting information, including the influence of any "Flags" and assigns a level of disability related need based on the information provided in the plan.

- The focus of the plan review is not on "approving" the plan but on confirming the appropriateness of supports and services to be funded by CLBC, i.e. is the request reasonable and relevant given the disability related need of the individual?

- Occasionally, the Analyst may want to clarify points in the plan with the family, facilitator, or other planner but this is not a negotiation or a process to gather missing information. The plan should stand on its own and contain all the information the Analyst needs to make their determination of the disability related need of the individual presented in the plan.

- The Analyst communicates the determination that the plan has been accepted in principle and indicates whether there is there funding to implement some or the entire plan and what elements are placed on a waitlist for future funding consideration.

1. Nature and Impact of Disability

1.1 Communication

Needs	Choice	Level
◆ The individual has no verbal communication system and no formal augmentative communication system.	☐	5
◆ The individual has limited verbal communication system or uses an augmentative communication system to communicate wants, needs and desires.	☐	4
◆ The individual communicates with words, and simple sentences. The individual needs ideas presented in manageable ways to appreciate what is being communicated.	☐	3
◆ The individual expresses themselves well but needs others to be vigilant to keep the complexity of what is being asked to a minimum.	☐	2
◆ The individual advocates for her/himself independently.	☐	1

NOTES:

1.2 Meeting Personal Care Needs

Needs	Choice	Level
◆ The individual is unable to complete personal care tasks by her/himself and requires full physical and extraordinary[161] assistance during the day and night.	☐	🚩
◆ The individual can do minimal personal care tasks him/herself and requires someone to consistently guide and assist them during the day and /or at night. The individual is safe if someone is with them.	☐	5
◆ The individual can manage day to day to personal care as long as someone is there to provide constant guidance and assistance.	☐	4
◆ The individual may need support with personal care from time to time, but manages most routines independently.	☐	3
◆ The individual requires minimal assistance with personal care.	☐	2
◆ The individual is able to move independently in all environments without assistance.	☐	1

NOTES:

---

[161] Extraordinary refers to hourly support or more.

1.3 Creating and/or Maintaining Relationships

There are many types of relationships people have in their lives. This section is looking at non-family, unpaid relationships.

Needs	Choice	Level
◆ The individual is able to form relationships, however, these relationships result in the individual becoming victimized or abused. People have tried various ways to help them change, but there is still a very real risk of harm. A number of ways to mitigate this risk have been tried unsuccessfully.	☐	🚩
◆ The individual is able to form relationships; however, these relationships have previously resulted in the individual becoming victimized or abused. The ways people have tried to help the individual are working and there is less risk of harm right now.	☐	5
◆ The individual needs support to form and keep relationships. At present they have few or no relationships outside of the family home or current living situation.	☐	4
◆ The individual needs support to form and maintain relationships. They currently have regular contact with one or two people outside of the family home or current living situation.	☐	3
◆ The individual enjoys a full range of friendships and relationships outside of their immediate family but needs some support to maintain these.	☐	2
◆ The individual enjoys a full range of friendships and relationships outside of their immediate family and does so independently.	☐	1

NOTES:

1.4 Making Day to Day Decisions

Needs	Choice	Level
◆ Most decisions about day to day life are made for the individual. They require this level of support throughout the day.	☐	5
◆ The individual needs ongoing[162] support to make decisions but has partial[163] control over most day to day decisions.	☐	4
◆ The individual needs frequent support to make day to day decisions such as needing prompts to make decisions.	☐	3
◆ The individual needs intermittent support and guidance to make decisions about day to day activities.	☐	2
◆ The individual needs no support to make day to day decisions.	☐	1

NOTES:

---

[162] Ongoing refers to daily support but not throughout the day.

[163] Partial refers to an individual needing limited prompts in day to day decision making.

1.5 Making Important Life Decisions

Needs	Choice	Level
◆ Most life decisions are made for the individual and they will require this on an ongoing basis.	☐	5
◆ The individual needs significant ongoing support to make life changing decisions.	☐	4
◆ The individual needs limited ongoing support to make life decisions.	☐	3
◆ The individual needs some intermittent support and guidance to make decisions.	☐	2
◆ The individual needs no support to make decisions.	☐	1
◆ The individual has an appointed decision maker under the Representation Agreement Act, Patient Property Act (Committee) or Mental Health Act.	☐	n/a

NOTES:

2. Community Life

2.1 Promoting Well Being - Staying Safe from Harm

Needs	Choice	Level
◆ The individual needs extraordinary help from others to ensure they stay safe and don't come to harm, and there is a very real concern that their immediate health or safety is threatened.	☐	🚩
◆ The individual requires ongoing, hourly or more frequent, assistance from others and is willing to consider alternative decisions when offered.	☐	5
◆ The individual needs frequent daily assistance from others to ensure they are safe in the community.	☐	4
◆ The individual needs help from others regularly, but not daily, to make sure they stay safe in the community.	☐	3
◆ The individual needs intermittent help from others to make sure they stay safe in the community.	☐	2
◆ The individual is independent and safe.	☐	1

NOTES:

2.2 Work and Learning

Work and Learning activities are not confined to employment or formal educational situations but should be viewed in the broadest context. Work and Learning situations can be any activity where an individual is actively involved in a purposeful manner.

Needs	Choice	Level
◆ The individual needs continuous support to participate in work and learning opportunities.	☐	5
◆ The individual needs significant ongoing assistance to participate in work and learning activities.	☐	4
◆ The individual needs intermittent support to participate in work and learning activities.	☐	3
◆ The individual needs minimal assistance to participate in work or learning activities or to have more opportunities to participate.	☐	2
◆ The individual needs no support to participate in his/her work or learning activities.	☐	1

NOTES:

2.3 Being Part of the Local Community

Needs	Choice	Level
◆ Most of the individual's activities currently take place in the home. He or she needs continuous ongoing support and help to do things in their local community and will require this support on a long term basis.	☐	5
◆ The individual takes part in activities outside their home. They need support to do things in their community on an ongoing basis.	☐	4
◆ The individual takes part in one or two activities outside their home. With limited assistance they can learn to do some of these activities for brief periods on their own but shall require ongoing support.	☐	3
◆ The individual needs intermittent support to participate in the local community and uses many community facilities and regularly takes part in a wide range of activities. They may need support to do things in their local community, but once they are a part of these activities, they are able to do some on their own.	☐	2
◆ The individual engages the community.	☐	1

NOTES:

3. Complex Health Needs (Including Mental Health Needs)

Needs	Choice	Level
◆ The individual lives with significant, unstable, uncontrolled, complex health or mental health needs and requires support on an ongoing basis.	☐	🚩
◆ The individual lives with significant complex health or mental health needs that are stable but require ongoing support.	☐	5
◆ The individual lives with ongoing health or mental health needs and requires ongoing support to access health or mental health care services.	☐	4
◆ The individual's health or mental health is stable but requires assistance to access necessary health or mental health services on a regular basis.	☐	3
◆ The individual's health or mental health is stable but requires assistance to access necessary health or mental health services from time to time.	☐	2
◆ The individual's health and mental health are good and he/she can manage their needs without assistance.	☐	1

NOTES:

4. Complex Risks and Actions

Needs	Choice	
◆ The individual regularly does things that are dangerous or cause serious harm. People have tried various ways to help them change, but there is still a very real risk of harm. A number of ways to eliminate this have been tried unsuccessfully.	☐	🚩
◆ The individual regularly does things which can be dangerous or cause serious harm. The ways people have tried to help the individual are working and there is less risk of harm right now.	☐	5
◆ The individual frequently does things which people find difficult but there is no real danger to the individual or others. A change in the context of the individual's experience affects how the individual responds.	☐	4
◆ The individual intermittently does things which people find difficult but there is no real danger to the individual or others.	☐	3
◆ In the past the individual has done things which people find difficult or dangerous but there is no problem right now and this will remain so provided people understand the individual and support him/her to be non-violent and safe.	☐	2
◆ The individual no longer acts in ways that others find difficult.	☐	1
◆ The individual lives with the inherent risks of citizenship	☐	n/a

NOTES:

5. Allocation Level

The assessment of the individual's disability related needs is linked to the following four broad areas, each with equal priority.

- Nature and impact of disability
- Community
- Complex Health Needs (Including Mental Health)
- Complex Needs and Risk

There are five 'flags' which are factors which may indicate a higher level of support for a individual when considering the funding requested in the individual's plan.

For each of the broad areas above and the specific areas of assessment, fill in the level of support the individual requires.

Section	Title	Level of Support Indicated
1.1	Communication	
1.2	Meeting Personal Needs	
1.3	Creating or Maintaining Relationships	
1.4	Making Day to Day Decisions	
1.5	Making Important Life Decisions	
2.1	Promoting Well-Being – Staying Safe From Harm	
2.2	Work and Learning	
2.3	Being Part of the Local Community	
3.0	Complex Health Needs (Including Mental Health)	
4.0	Complex Needs and Risks	

Total Score

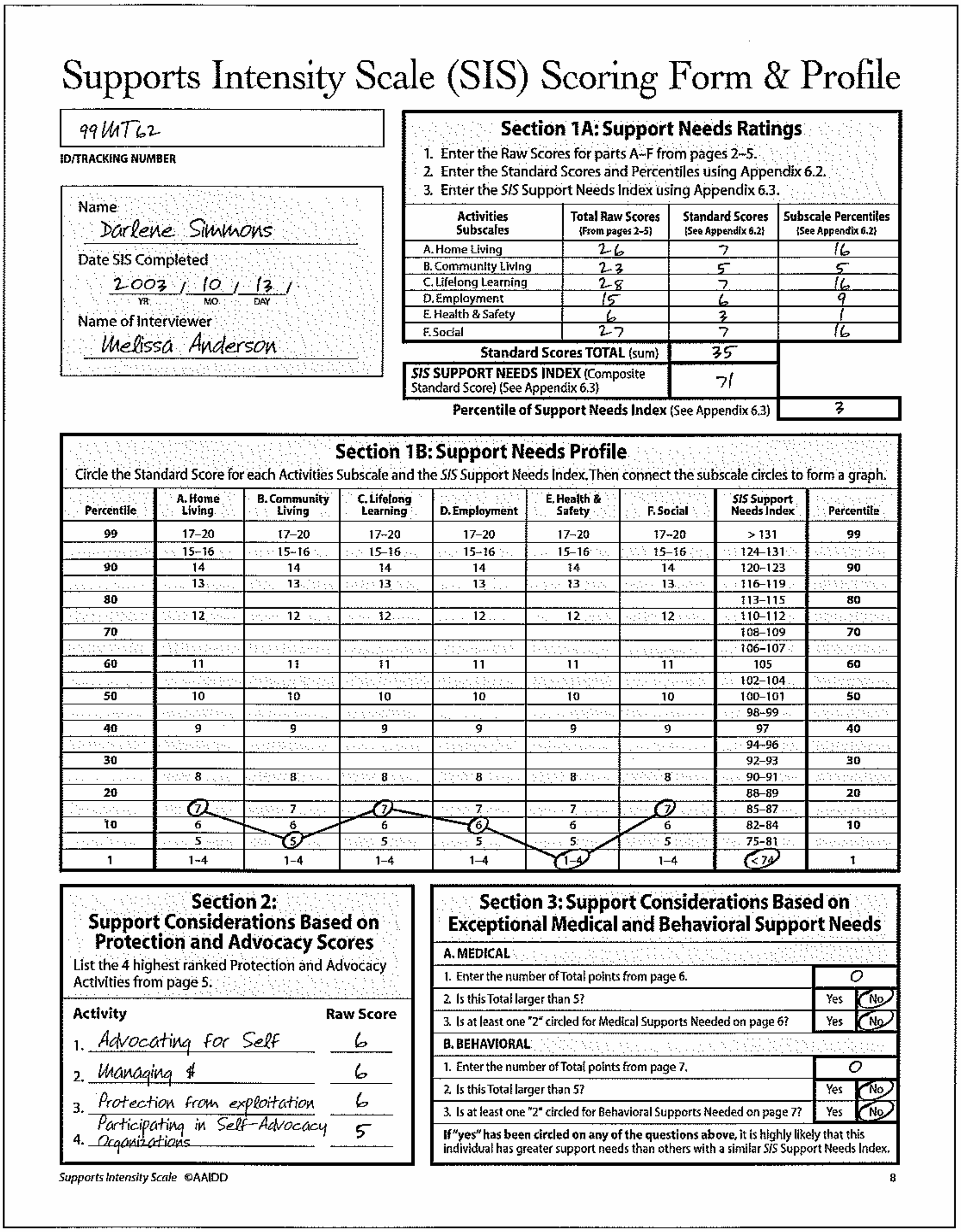
Number of Sections with Scores

Average Score (Total/Number of Sections)

The "Level" within which the individual's disability related need falls is based on the information submitted with the individual's plan. The quality service analyst must make a professional judgement of the level associated with the individual's fundamental disability related need. Actual resource allocations are to be based on a clear relationship between the goals established in the plan and the individual's disability related need. The level associated with the disability related need of the individual is then used to determine the maximum amount of support that CLBC could provide, as requested in the plan, and outlined in the Catalogue of Services.

Level of Disability Related Need	Assessed Level	Detailed Description Analyst Decision Making Rationale
Flags	🚩	
Level 5	☐	
Level 4	☐	
Level 3	☐	
Level 2	☐	
Level 1	☐	

Appendix 4: Sample Supports Intensity (SIS) Scale Scoring Form & Profile



Supports Intensity Scale (SIS) Scoring Form & Profile

99MT62
ID/TRACKING NUMBER

Name: Darlene Simmons

Date SIS Completed: 2003 / 10 / 13 / (YR / MO / DAY)

Name of Interviewer: Melissa Anderson

Section 1A: Support Needs Ratings

1. Enter the Raw Scores for parts A–F from pages 2–5.
2. Enter the Standard Scores and Percentiles using Appendix 6.2.
3. Enter the *SIS* Support Needs Index using Appendix 6.3.

Activities Subscales	Total Raw Scores (From pages 2–5)	Standard Scores (See Appendix 6.2)	Subscale Percentiles (See Appendix 6.2)
A. Home Living	26	7	16
B. Community Living	23	5	5
C. Lifelong Learning	28	7	16
D. Employment	15	6	9
E. Health & Safety	6	3	1
F. Social	27	7	16
Standard Scores TOTAL (sum)		35	
***SIS* SUPPORT NEEDS INDEX** (Composite Standard Score) (See Appendix 6.3)		71	
Percentile of Support Needs Index (See Appendix 6.3)			3

Section 1B: Support Needs Profile

Circle the Standard Score for each Activities Subscale and the *SIS* Support Needs Index. Then connect the subscale circles to form a graph.

Percentile	A. Home Living	B. Community Living	C. Lifelong Learning	D. Employment	E. Health & Safety	F. Social	*SIS* Support Needs Index	Percentile
99	17–20	17–20	17–20	17–20	17–20	17–20	> 131	99
	15–16	15–16	15–16	15–16	15–16	15–16	124–131	
90	14	14	14	14	14	14	120–123	90
	13	13	13	13	13	13	116–119	
80							113–115	80
	12	12	12	12	12	12	110–112	
70							108–109	70
							106–107	
60	11	11	11	11	11	11	105	60
							102–104	
50	10	10	10	10	10	10	100–101	50
							98–99	
40	9	9	9	9	9	9	97	40
							94–96	
30							92–93	30
	8	8	8	8	8	8	90–91	
20							88–89	20
	[✓ 7]	7	[✓ 7]	7	7	[✓ 7]	85–87	
10	6	6	6	[✓ 6]	6	6	82–84	10
	5	[✓ 5]	5	5	5	5	75–81	
1	1–4	1–4	1–4	1–4	[✓ 1–4]	1–4	[✓ < 74]	1

Section 2: Support Considerations Based on Protection and Advocacy Scores

List the 4 highest ranked Protection and Advocacy Activities from page 5.

Activity	Raw Score
1. Advocating for Self	6
2. Managing $	6
3. Protection from exploitation	6
4. Participating in Self-Advocacy Organizations	5

Section 3: Support Considerations Based on Exceptional Medical and Behavioral Support Needs

A. MEDICAL		
1. Enter the number of Total points from page 6.	0	
2. Is this Total larger than 5?	Yes	[✓ No]
3. Is at least one "2" circled for Medical Supports Needed on page 6?	Yes	[✓ No]
B. BEHAVIORAL		
1. Enter the number of Total points from page 7.	0	
2. Is this Total larger than 5?	Yes	[✓ No]
3. Is at least one "2" circled for Behavioral Supports Needed on page 7?	Yes	[✓ No]

If "yes" has been circled on any of the questions above, it is highly likely that this individual has greater support needs than others with a similar *SIS* Support Needs Index.

Supports Intensity Scale ©AAIDD 8

Source: AAIDD (2004), Supports Intensity Scale User's Manual

Appendix 5: Catalogue of Services

Program	Service Category	Service Sub-category	Payment Type	Frequency	Intensity	Amount of Service	
						Under 65 years	over 65 years
Home Activity	Home Sharing		Direct Payment or	Ongoing	Level 1	$703.00	$ 519.00
			Host Agency or	Ongoing	Level 2	$981.00	$ 797.00
			Service Provider	Ongoing	Level 3	$1,247.00	$ 1,063.00
				Ongoing	Level 4	$1,744.00	$ 1,560.00
				Ongoing	Level 5 a	Regional rates	Regional rates
				Ongoing	Level 5 b	Regional rates	Regional rates
				Ongoing	Level 5 c	Regional rates	Regional rates
				Ongoing	Level 5 d	Regional rates	Regional rates
	Live In Support		Direct Payment or	Ongoing	Level 1	$689.97	$ 519.00
			Host Agency or	Ongoing	Level 2	$961.44	$ 797.00
			Service Provider	Ongoing	Level 3	$1,221.87	$ 1,063.00
				Ongoing	Level 4	$1,709.64	$ 1,560.00
				Ongoing	Level 5 a	Regional rates	Regional rates
				Ongoing	Level 5 b	Regional rates	Regional rates
				Ongoing	Level 5 c	Regional rates	Regional rates
				Ongoing	Level 5 d	Regional rates	Regional rates
	Supports to Home Sharing/ Live In Support (Existence of Flags)		Direct Payment or	Intermittent, ongoing, or time limited	One or two Flags	up to $1000	
			Host Agency or		Two or three Flags	up to $2000	

Program	Service Category	Service Sub-category	Payment Type	Frequency	Intensity	Amount of Service
			Service Provider		Three or more Flags	up to $3000
	Support Living	Independent Living	Direct Payment or Host Agency or Service Provider	Ongoing Ongoing	Level 2 Level 3	up to 36 hrs/week up to 50 hrs/week
		Outreach Support	Direct Payment or Host Agency or Service Provider	Ongoing	Level 1 Level 2 Level 3	up to 7 hrs/week up to 14 hrs/week up to 21 hrs/week
		Cluster Apartment Living	Direct Payment or Host Agency or Service Provider	Ongoing	Level 1 Level 2 Level 3	up to 7 hrs/week up to 14 hrs/week up to 21 hrs/week
	Staffed Residential		Service Provider	Ongoing	Level 3 Level 4 Level 5	186 hours of staff/ week 230 hours of staff/ week 280 hours of staff/ week
Community Inclusion Activity	Individual Services		Service Provider or Direct Payment or Host Agency	Time Limited	Goal Specific	up to 5 hours per week
	Employment Services	Individual Placement	Direct Payment or Host Agency Service Provider	Goal Specific	level 1-4	
		Small Business	Direct Payment or Host Agency	Goal Specific	level 1-4	

Program	Service Category	Service Sub-category	Payment Type	Frequency	Intensity	Amount of Service
			Service Provider			
		Enclave Model	Direct Payment or Host Agency Service Provider	Goal Specific	level 1-4	
		Mobile Work Crew	Direct Payment or Host Agency Service Provider	Goal Specific	level 1-4	
		Group Model	Direct Payment or Host Agency Service Provider	Goal Specific	level 1-4	
	Community Based Services		Direct Payment or Serive Provider or Host Agency	Ongoing	Three or more Flags	up to 35 hours per week
					Level 5	23 hours per week
					Level 4	17.5 hours per week
					Level 3	12 hours per week
					Level 2	9 hours per week
					Level 1	3.5 hours per week
	Group Home Based		Service Provider	Ongoing	Three or more Flags	up to 30 hours per week

Family Support	Direct Family Support		Host Agency or Service Provider	Time Limited	Low	1 hour/ week
					Medium	2 hours/ week
					High	4 hours/week
	Respite		Service Provider or	Intermittent,ongoing or time limited	Level 1-5	up to 28 days per year

Program	Service Category	Service Sub-category	Payment Type	Frequency	Intensity	Amount of Service
			Host Agency or Direct Payment		Time Limited up to 5 days/week	up to 2 weeks/yr 2 hrs/day
	Adult Direct Funded Respite		Direct payment	Ongoing		$2800 per year
	Homemaker Service		Direct Payment or Host Agency or Service Provider	Time Limited	Goal Specific	up to 10 hours per week
Program Coordination	Respite Care Programs		Service Provider or Host Agency	Ongoing	Up to 50 individuals/FTE	40 Hours/ week/ Coordinator
	HomeSharing Programs		Service Provider or Host Agency	Ongoing	Up to 35 individuals/FTE	40 Hours/ week/ Coordinator
	Host Agency		Host Agency	Ongoing	8 staff/FTE Coordination	40 Hour/ week/ Coordinator
	Intentional Communities		Service Provider	Ongoing	Up to 25 Individuals/FTE	40 Hour/ week/ Coordinator
Professional Support	Psychological Consultation		Service Provider	Time Limited	Assessment	up to $150/hr
	Behavioural Consultation		Service Provider	Time Limited	Assessment	up to $60/hr

Bibliography

American Association on Mental Retardation (2004). *Supports Intensity Scale – Users Manual*

Bartnik, Eddie (2008a). Personal Communication, October 20, 2008.

Bartnik, Eddie (2008b). *Excerpt from LAC Book, unpublished*, personal communication Oct 12, 2008

Bartnik, Eddie and R. Woodward (2008a). *Community Living Concept Plan Stage 1 Report*, Disability Services Commission Western Australia

Bartnik, Eddie and R. Woodward (2008b). *Information resource for the Community Living Plan,* Disability Services Commission Western Australia

Boyd, B., Collins, V., & Gladstone, A., (2003). *Baseline Readiness Assessment of CLS Devolution*, December 19, 2003

Boyd, Bert (2004). Devolution of Services to Community Living BC – Updated Assessment of Readiness.

Boyd, Bert (2005). Devolution of Services to Community Living BC – Final Assessment of Readiness.

British Columbia Association for Community Living, *Evaluating Your Current Experience with CLBC*, April 2008

Chris Hatton, J. Waters, S. Duffy et al. (2008). *A report on in Control's Second Phase – Evaluation and learning 2005-2007*, Carl Poll and Simon Duffy (eds.)

CLBC (2005). A Consultation Document for Communities – Draft Three Year Strategic Plan

CLBC (2007). *2007/08 Service Plan*

CLBC (2007b). *Residential Options Project, Phase One Report*, June

CLBC (2008a). *2007/08 Annual Report*

CLBC (2008b). *2008/09 – 2010/11 Service Plan*

CLBC (2008c). *Schedule of Payments made for the Provision of Goods and Services ending March 31, 2008*.

CLBC (2008d). *2009/10 to 2011/12 Budget Plan – Organizational Overview* – prepared for Treasury Board Deliberation

CLBC (2008f). Innovation Framework -- Framework to Promote Innovative Thinking and Practice

CLBC (2008g), *Service Satisfaction Survey: Provincial Overview*

CLBC, *2006/07-2008/09 Operational Plan – Summary of Year 2 highlights and key year 3 objectives and measures*, Unknown

CLBC, *2009/10 to 2011/12 Budget Plan*

CLBC, *A Guide to Individualized Funding: Supporting Choice and Innovation*, Unknown

CLBC, *Action Alert: Community Living Supports & Services Face Devastating Cutbacks*, November 2001

CLBC (2008), *Advisory Group- CLBC Employment Strategy: Draft Terms of Reference*, January 2008

CLBC (2007), *Catalogue of Service- Adult Supports (Glossary)*, November 2007

CLBC (2008), *Costing Framework: Agency Networked Home Sharing For Discussion Purposes*, July 2008

CLBC (2008), *Developing an Individual Support Plan for an Adult*, February 1, 2007

CLBC (2007), *Discovery Goal-Based Planning Guidebook*, 2007

CLBC (2008), *Family- Managed Supports: Project Report*, March 22, 2008

CLBC, *Government-CLBC Accountability Model*, Unknown

CLBC (2005), *Guide to Support Allocation*, June 5, 2005

CLBC (2008), *Guide to Support Allocation*, January 10, 2008

CLBC (2008), *Health and Safety Monitoring Within Home Sharing: Update for the Board of Directors*, May 2008

CLBC (2008), *Individual and Child Family Support Planning Policy*, March 2008

CLBC (2008), *Individual and Family Support Policy*, May 2008

CLBC (2008), *Interview Questions*, August 2008

CLBC (2008), *Personal Profile (re: Plan A)*, October 8, 2008

CLBC (2008), *Personal Profile (re: Plan D),* October 8, 2008

CLBC(2008) , *Personal Support Plan*, June 2008

CLBC, *Policy Foundations and an Integrated Policy Model for CLBC*, Unknown

CLBC (2006), *Policy Statement and Outline*, June 2006

CLBC (2008), *Provincial Costing Framework for Discussion Purposes*, May 2008

CLBC (2008) , *Provincial Costing Guidelines For Staffed Services*, June 2008

CLBC, *Resource Allocation & Resource Management Tools: Comparison of New Service Delivery Model with Prior Processes*, Unknown

CLBC (2008), *Review of Community Living BC – prepared for Treasury Board*, January 2008

CLBC (2007), *Service Accountability and Safeguards Advisory Committee: Terms of Reference*, February 2007

CLBC (2008), *Service Provider Reference Group: Terms of Reference*, March 2008

CLBC (2008), *Service Provision by Family Members-Adult*, April 23, 2008

CLBC (2007), *Successful Practices in Home Sharing Provincial Working Group: Terms of Reference*, April 2007

CLBC, *Terms of Reference for Community Councils*, Unknown

CLBC (2008), *The CLBC Waitlist Development and Next Steps*, June 2008

CLBC (2005), *Transition of Financial and Facilities Management Services*, September 2005

CLBC (2008), *Unbundling, Portability and Individual Funding: Shifting the Paradigm*, September 2008

Community Living Coalition (2001a). *Transforming Community Living Services, A Proposal to the Minister of Children and Family Development*

Community Living Coalition (2001b)*, A Policy Framework to Guide the Implementation of Individualized Funding for Community Living Services in British Columbia*, October.

Community Living Coalition, *Bulletin #1*, October 2001

Community Living Coalition, *Minutes- November 8, 2001*, November 2001

Community Living Coalition, *Minutes Nov. 15, 01*, November 2001

Community Living Coalition, *Transforming Community Living Services*, November 2001

Community Living Coalition, *Minutes- December 14, 2001*, December 2001

Community Living Coalition, *Minutes- January 18, 2002*, January 2002

Community Living Coalition, *Supported Child Care*, September 2003

Community Living Transition Steering Committee (2002a). *A New Vision for Community Living… A Vision of Choice and Change*, October

Community Living Transition Steering Committee (2002b), *Services to Children with Special Needs Planning Committee Final Report*, October.

Community Living Transition Steering Committee (2002c). *Furthering the Vision for Community Living: Next Steps*, November

Davies, Paul (2008). An interview with Paul Davies, Service Director, Adult Social Care, Oldham Metropolitan Borough Council and in Control, January 2008.

Davis, DeWayne, Wendy Fox-Grage, and Shelly Gehshan. *Deinstitutionalization of Persons with Developmental Disabilities: A Technical Assistance Report for Legislators*

Department of Health, (1997). *Community Care (Direct Payments) Act 1996.* HMSO.

Department of Health United Kingdom (2007). Putting people first: a shared vision and commitment to the transformation of adult social care

Disability Services Commission (2003). Review of the Local Area Coordination Program of Western Australia

Disability Services Commission Western Australia (2005). *Estimate of Requirement for Staff Support Instrument (ERSSI).*

Disability Services Commission (2006). *Combined Application Process Implementation Policy,* Policy I36 June.

Disability Services Commission, Western Australia (2007). *Disability Services Sector Health Check – A report on disability services*.

Disability Services Commission of Western Australia (2008a). *Disability Services Commission*

Disability Services Commission of Western Australia (2008b). *Organizational Structure*

Disability Services Commission, Western Australia (2008c). *Disability Services Commission, Annual Report 2007-2008*

Disability Services Commission, Western Australia (2008d). *Community Living*

Disability Services Commission, Western Australia (2008e). *Community Living Plan Bulletin (2008)*.

Duffy, Simon (2004). *Individual Budgets – An exploration of the advantages of individual budgets for disabled people and some of the challenges of implementation issues*.

Duffy, S. and J. Waters (2008). *RAS & Social Care Funding.* In Control, in Control Position Statement

Dunsmoor-Farley, D. & Moore, C. (2004). *Position Paper on Services to Aboriginal People with Developmental Disabilities and Special Needs*, March.

Durst, D. (2006). *Urban Aboriginal Families of Children with Disabilities: Social Inclusion or Exclusion?,* February.

Fahlman (2007). by his guardian ad litem Fiona Gow v. Community Living British Columbia et al, 2007 BCCA 15

Furthering the Vision for Community Living: Next Steps, November 2002

Hunter, Richard (2008). *CFO, CLBC - Personal Communications*, August 2008.

CLBC (2005). *Service Delivery Project Report*, March.

Letters Sent to Minister Gordon Hogg in Support of the Individualized Funding Initiative, December 2001

Ministry of Children and Families (2004). *Backgrounder: Community Living Authority Implementation Moves Ahead*, May.

Implementation Guide - Building upon Direct Payments as Key of the Wider System of Self-Directed Support Produced by the in Control's Yorkshire & Humber Forum, Revised Version, June 2007

Milowsky, F. (2004). *An Operational Examination of the Community Living Service Delivery Model*, September 2004

Ministry of Children and Family Development, *Baseline Readiness Assessment of CLS Devolution Level One: Outstanding Concerns*, November 2003

Ministry of Children and Family Development, *Baseline Readiness Assessment of CLS Devolution Level 3 Submission- Transition Implementation Plan*, November 2003

Ministry of Children and Family Development, *Community Living Services Transformation Process: Transition Steering Group- Mandate and Terms of Reference*, April 2002

Ministry of Children and Family Development, *Community Living Services Transformation Process*, April 2002

Ministry of Children and Family Development, *Community Living Services: Core Services Review*, November 2001

Ministry of Children and Family Development, *Implementation Plan: Core Services Review*, October 2001

Ministry of Children and Family Development, *Discussion Paper on Community Living Services*, October 2001

Ministry of Children and Family Development, *Joint Financial and Administration Devolution Working Group Community Living British Columbia*, 2005

Ministry of Children and Family Development, Position Description, February 2008

Ministry of Children and Family Development, *Report on Community Living BC Financial Systems- Risk and Controls Review*, June 2005

Ministry of Children and Family Development, *Website Submissions: Community Living Services*, December 2001

Ministry of Children and Family Development, *Website Submissions: Community Living Services Volume 1*, December 2001

Murray, Elaine (2005). *Service Delivery Project Report*

Noble, Bobbi S. (2008). *Community Living BC Background Report: Summary of Ideas and Issues Going Forward Towards Strategic Plan 2009/2010 to 2012/2013*, (Sept. 11, 2008)

Parish, Susan L., Pomeranz, A., Hemp R., et al (2001). *Family Support for Families of Persons with Developmental Disabilities in the U.S.: Status and Trends*, Policy Research Brief Volume 12, Number 2, June.

Perrin, D. & Thorau, K.(2008). *Project Outline and Workplan: Development of CLBC Monitoring Framework*, July 2008

Persons with Developmental Disabilities, Central Alberta Board (2004). *Person Centered Planning Guidebook*.

Persons with Developmental Disabilities Central Alberta Community Board (2008). *Supports Coordinators*

Persons with Developmental Disabilities South Alberta Board (2008). *Who we are*.

Poll, Carl, S. Duffy, C. Hatton, H. Sanderson and M. Routledge (2006). *Quantitative Evaluation finding from phase one piloting of In-Control: Spring 2004 to Summer 2005*, In-Control.

Province of Alberta, Persons with Developmental Disabilities (2005). *Provincial Board Business Plan 2005/06 – 2007/08*

Province of Alberta, Persons with Developmental Disabilities (2006a). Annual Report 2004/05

Province of Alberta, Persons with Developmental Disabilities (2006b). *Family-Managed Supports Project Report.*

Province of Alberta, Persons with Developmental Disabilities (2006c), *Top 10 Things You Need to Know…PDD's New Policy on Family-Managed Supports*

Province of Alberta, Persons with Developmental Disabilities (2007a). *Operational Policy - Community Inclusion Supports Framework*

Province of Alberta, Persons with Developmental Disabilities (2007b). *Seniors and Community Supports: Family/Guardian Satisfaction Survey 2006-2007 Provincial Report*

Province of Alberta, Persons with Developmental Disabilities (2008a). *Who we are*

Province of British Columbia (2002), *Community Living Service Authority Act*, July 2002

Province of British Columbia (2005). *Letter of Expectations between The Minister of Children and Family Development and Community Living British Columbia*, July 1, 2005.

Province of British Columbia (2005). *Press Release: Service Model Strengthened for Community Living BC*, January 2005

Province of British Columbia (2007). *Shareholder's Letter of Expectations between the Minister of Children and Family Development and the Chair of Community Living British Columbia*, March 29, 2007.

Queenswood Consulting Group, *Moving Towards Devolution- Record of Working Sessions, Issues and Arguments*, March 2004

Queenswood Consulting Group, Nowles, R., Briscoll, D., Stainton, T. & Davier, J., *CLBC Interview Notes*, September 2008

Robinson, E. (2008). *Community Living British Columbia Field Test of Planning Policy Project*, August 2008

Sage Group Management Consultants (2003). *Ministry of Children and Family Development: New Governance- Some Considerations*

Salisbury, Brian (1997). Some frequently asked questions about individualized funding and service brokerage.

Smith, S. & Gilberg S. (2005). *CLBC Transition Reference*, July 2005

Stainton, T., *CLBC Service Delivery Model Review Interview Questions*, Unknown

Stainton, T., R.D. Hole, J. Brown, C. Crawford and C. Yodanis. *Outcome Measurement of Community Living Services in British Columbia*, presentation

Stainton, Tim & Stephen Boyce (2002). *An Evaluation of the Cardiff and Vale Independent Living Scheme and the Implementation of Direct Payments (Chapter 3).*

Stalker, Kirsten, Margaret Malloch, Monica Barry and June Watson (2007). *Evaluation of the Implementation of Local Area Co-ordination in Scotland*, Social Work Research Centre, University of Stirling

Uditsky, Brian. *The Erosion of Individualized Funding*.

University of British Columbia (2008). *Adult Community Living Supports in British Columbia: An Exploration of Family Member and Self Advocate Enterprises*, Spring 2008

Unknown, *Families, Individuals and the Community: Empowering Individuals and Families & Changing Community Living Services*, Unknown

Unknown, Service Delivery and Governance Options, December 2001

Walman, B.(2002). *Furthering the Vision for Community Living: Next Steps*, November 2002

Washington State Department of Health and Social Services, Division of Disability Services (2006). *Report to the Legislature on State-Funded Family Support Programs, Chapter 518, Laws 2005, Section 205(1)(e)(iv)*

Washington State Department of Social and Health Services, Division of Developmental Disabilities (2008a). *Eligibility*.

Washington State Department of Social and Health Services, Division of Developmental Disabilities (2008b). *Current Biannual Budget*.

Washington State Department of Social and Health Services, Division of Developmental Disabilities (2008c). *State Advisory Committee.*

Washington State Department of Social and Health Services, Division of Developmental Disabilities (2008d). *DDD Assessment*.

Washington State Department of Social and Health Services, Division of Developmental Disabilities (2008e). *DDD Assessment – What it means to you.*

Washington State Department of Social and Health Services, Division of Developmental Disabilities (2008f). *Division of Developmental Disabilities*.

Washington State Department of Health and Social Services, Division of Disability Services (2008g). *Home and Community Based Waiver Services – Basic information regarding eligibility, access and services*.

Washington State Department of Health and Social Services, Division of Disability Services (2008h). *Individual and Family Services Program*

Washington State Department of Social and Health Services, Division of Developmental Disabilities. Division of Developmental Disabilities. *Fact Sheet: Division of Developmental Disabilities Waiver Plan.*

Waters, John (2006). *Self Assessment Questionnaire 2 (working Age Adults) RAS4*, in Control.

Waters, John (2007). *Resource Allocation System – (RAS) Discussion Paper*. In Control.

Waters, John (2007). *Resource Allocation System: Discussion Paper*, in-Control.

Waters, John and S. Duffy (2007). *Personal Budgets – A guide for local authorities on creating a local system of self-directed support.* In Control.

Workworld (2008). *Medicaid Home and Community-Based Services (HCBS) Waivers – Overview*.

Glossary of Abbreviations

ASF	Accommodation Support Funding (Western Australia)
ATE	Alternatives to Employment Funding (Western Australia)
AAID	American Association on Intellectual Disabilities
BCACL	British Columbia Association for Community Living
BoD	Board of Directors
CAP	Combined Application Process (Western Australia)
CAS	Financial Management System used by the BC Government
CEO	Chief Executive Officer
CLAA	Community Living Authority Act
CLAN	Community Living Agencies Network Society
CLBC	Community Living British Columbia
CLTSC	Community Living Transition Steering Committee
CLS	Community Living Services
CMS	Contract Management System
CPD	Community Planning & Development
CRM	Case Resource Manager (WA, US)
CSSEA	Community Social Services Employers Association
DSC	Disability Services Commission (Western Australia)
DDD	Division of Developmental Disabilities (WA, US)
DGBP	Discovery Goal Based Planning
DP	Direct Payment
DRN	Disability-Related Needs
DSM IV	Diagnostic & Statistical Manual (for mental disorders)
ERSSI	Estimate of Requirement for Staff Support Instrument (Western Australia)
FTE	Full-Time Equivalent
GSA	Guide to Support Allocation
HCBC	Medicaid Home and Community-Based Services (US)
ICF/FR	Intermediate Care Facilities for the Mentally Retarded (USA)
ICM	Integrated Case Management
IFS	Intensive Family Support (UK); Individual and Family Services Program (WA, US)
IF	Individualized Funding
ISN	Innovation Support Network(s)
ISP	Individualized/Individual Support Plan
IQ	Intelligence Quotient
IT	Information Technology
LA	Local Authority
LAC	Local Area Coordination (Western Australia)
MCFD	Ministry of Children and Family Development
MHSD	Ministry of Housing and Social Development
MIS	Management Information System(s)
MR/DD	Mental Retardation/Developmental Disability (US)
OPGT	Office of the Public Guardian and Trustee
PCP	Person-Centered Planning
PDD	Persons with Developmental Disabilities (Alberta)
QS	Quality Service

QCG	Queenswood Consulting Group
RAP	Resource and Payment System
RAS	Resource Allocation System
SAC	State Advisory Committee (WA, US)
SAQ	Self-Assessment Questionnaire
SIS	Supports Intensity Scale (US)
SP&D	Service Purchasing and Development (Western Australia)
SWS	Social Worker System
TB	Treasury Board
UK	United Kingdom
US	United States