HUMAN SERVICE PRACTITIONERS AND THEIR FUTURE EMPLOYMENT IN THEIR VARIOUS SUPPORT ROLES IN NEW BRUNSWICK SOCIAL AND PROTECTIVE SERVICES

Collaborative Group Process Report
Articulation Of A Service Delivery Model
March 2012

Executive Summary

The enclosed report follows up on recommendations stemming from a recent study relating to the future employment of human service counsellors in their support role for New Brunswick social and protective services. That study was commissioned on behalf of the Association of New Brunswick Family Support Provider Agencies (ANDFSPA) and funded by the Provincial Department of Post-Secondary Education,Training & Labor. Following the study, a report was submitted by the Team Plus Consultants in March 2011 in which they summarized the working conditions of human service practitioners in New Brunswick. The report included three interrelated recommendations to address the issues regarding the future of these paraprofessionals: articulation of a service delivery model; conducting a remuneration study; and standardization (improvement-upgrading) of the education and training of human service practitioners in New Brunswick. (Appendix A - Team Plus report))

Our report is the result of a functional and collaborative group process undertaken with the main objective of developing an understanding of the current delivery model and to clarify the role envisioned for human service practitioners in the delivery of publicly funded services. The participants in the process included senior government officials from three government departments: Health, Social Development and Post-Secondary Education, Training & Labor. The community based stakeholder representatives were from five provincial associations: The New Brunswick Association of Family Support Providers; the New Brunswick Residential Association; the New Brunswick Association of Supported Services and Employment; the New Brunswick Special Care Homes Association; and the New Brunswick Association of Social Workers. The perspective of the human service practitioners was articulated by the community representatives who were themselves human service practitioners and who collectively also represented agencies who employ over 5000 of these paraprofessionals in New Brunswick.

In the terms of reference for this collaborative problem solving process, the group was to identify those areas or aspects of the service delivery

model that are presently problematic for the efficient delivery of quality social services. In addition, we were to identify additional work needing to be done and identify resources required for recommendations 2 & 3 of the consultant's report concerning remuneration and training. In the view of this group, consisting of experienced government and community based representatives, we believe we know in general yet relevant terms, what needs to be done. Our report concludes with a recommendation for establishing a steering committee led by government. We believe the lead must be with government since the formulation of public policy, enactment of legislation and approval of budgets is within the responsibility and authority of government. We see the role of the steering committee as developing the terms of reference and providing direction to working committees charged with the elaboration and implementation of concrete, time-limited, and realistic action plans. To delay implementation for further costly research and enquiries unrelated to implementation, in our view simply involves an unnecessary and costly delay for government in acting upon what we now know and have agreed needs to be done. Implementation requires appropriate committees of government with community-based representation to develop the steps, time frames, and details for implementation

We recommend that this steering committee include representatives from the community-based sector as well as government. Their collective role would be to develop terms of reference for, and provide direction to, three separate working committees who for their part would elaborate objectives and action plans for the implementation of three goals:

A) That there be standardized training and education programs based upon a common core curriculum and qualifications for certification of all human service practitioners.

B) That remuneration match training, experience, and responsibility and that there be improvement in wages and benefits for human service practitioners including such benefits as sick leave, travel expenses, etc..

C) That a regulatory body for human service practitioners be established with supporting legislation that entails a defined scope of practice and standards of practice to which accredited human service practitioners and their employing agencies are to adhere, and that is to include a code of ethical conduct for practitioners.

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Articulation of the service delivery model for human service practitioners employed in various support roles in New Brunswick Social and Protective Services

1. Preamble

The recent consultant's report *Human Service Workers: A Report Regarding Their Working Conditions (March, 2011)*[1] documented serious and acute "labour" issues in the human service practitioner sector that cut across the different components of the province's social and health services delivery "system" and its government departments. Though the report showed strong evidence that these practitioners continue to be indispensable to the provision of most of the frontline direct services under the province's publicly funded social services, at the same time the report also found the following interrelated issues:

- ***Serious issues in recruitment and retention of quality practitioners.***
- ***Lack of clarity and uncertainty regarding the various roles of human service practitioners and the agencies that employ them within the social services delivery model.***
- ***Unattractive working conditions and low remuneration levels.***
- ***Uncertainty regarding the future of this field as a para-profession.***
- ***Lack of clarity as to the present and future training and education requirements for this field***.

The report made three interrelated recommendations:

1. ***Articulation of a service delivery model*** that defines the role envisioned for human service practitioners and the agencies that employ them in the delivery of publicly funded services.

2. ***Conducting a remuneration study*** for all human service practitioners, which would also address the relationship of these remuneration rates, to the rates and payment structures of the provincial government's service delivery contracts and purchase of service agreements with service delivery agencies.

3. ***Standardization (and improvement-upgrading) of the education and training*** of human service practitioners in the province.

Following the release of the consultant's report in March 2011, government officials and stakeholders met over the following months in order to discuss ways to partner in addressing the recommendations coming out of the report. The stakeholders were represented by the New

[1]Human Service Workers: A Report Regarding Their Working Conditions. Prepared by *Team Plus* for the *Association of New Brunswick Family Support Worker Agencies (ANBFSWA)*, funded by Dept. Post Secondary Training and Labour (PETL) under the Labour Market Research and Analysis Program, Contract # 001010132, March 2011.

Brunswick Human Services Coalition which is a coalition of the *Association of New Brunswick Family Support Provider Agencies Inc*. (ANBFSPA), *New Brunswick Residential Association (NBARA), New Brunswick Association of Supported Services & Employment (NBASSE)*, and *New Brunswick Special Care Home Association (NBSCHA)*. Each of these Associations has their own background and history. This Coalition has been formed to advance the cause of human service practitioners and their employing agencies, which cuts across different service sectors as it does government departments. The coalition member agencies are estimated to represent a sector employing approximately 5000 human service workers.

In November 2011, agreement was reached between representatives of the coalition group and senior government officials to establish a functional and collaborative time limited group process. Community based stakeholders and senior managers of three provincial departments agreed to participate in the process with Stuart Fairgrieve, deputy-chief of staff, acting as liaison with the Premier's Office, and Morel Caissie taking on the role of facilitator and chairperson. The task before them would be to address the first recommendation of the consultant's report, which is the ***Articulation of a service delivery model.***

2. PARTICIPANTS IN THE COLLABORATIVE GROUP PROCESS

Morel Caissie, Chairperson & facilitator

Hugh Williams, Project coordinator for the *New Brunswick Human Services Coalition*

Laurie Allain, President of the *New Brunswick Association of Family Support Service Providers*

Leonard Foster, Vice-president of the *New Brunswick Residential Association*

Wanda Steeves, Board Member of the *New Brunswick Association of Supported Employment*

Jan Seeley, President of the *New Brunswick Special Care Home Association*

André Lepine, Director of *Long Term Care & Adult Services* for Department of Social Development

Bill Innes, Director of *Child & Youth Services* for Department of Social Development

Barb Whitenect, Executive Director of *Addictions & Mental Health* for Department of Health

Diane Hawkins, Acting Director, *Employment Programs & Services*, Post-secondary Education, Training & Labour

Judith Morrison, Program Consultant*, Employment Programs & Services*, Post-secondary Education, Training & Labour

Miguel LeBlanc, Executive Director of the *New Brunswick Association of Social Workers*

Lori McKinney, social work practitioner in private practice

3. Terms of reference of the project:

a) have the identified partners commit to a time limited and results oriented collaborative process as a functional group;

b) develop a better understanding and articulation of the existing social service delivery model[2] and its present strengths and limitations;

c) clarify and define the role envisioned for human service practitioners and the agencies that employ them in the delivery of publicly funded services;

d) identify those areas or aspects of the service delivery model that are presently problematic for the community based sector, or for the efficient delivery of quality social services;

e) identify additional work needing to be done as well as resources required to address recommendations 2 & 3 of the consultant's report;

f) provide a written report that clearly states the group's agreed upon understanding of the existing social services delivery model.

4. Methodology

This report represents the results of our collaborative group process in articulating the service delivery model as well as the consensus achieved in regards to our recommendations. The methodology used for the collaborative group process included:

- Consensus was reached on the group process and objectives at the onset;
- representatives of DSD and Health presented an overview of programs and services relative to this project;
- representatives of the four community organizations forming the human services coalition presented their perspective of the service delivery model as it pertains to their respective work settings;
- a number of documents relating to standards and procedures were distributed for review and consideration;
- a nominal group technique was undertaken with the group to address the question of ***How best to ensure quality practice of human service practitioners working for the four community based organizations;***
- written notes of outcomes were prepared following each meeting of the group for adoption and subsequent distribution;
- a draft report was prepared by project coordinator and chairperson based on outcomes of discussions and presented to the group for discussion and revisions;
- the final report was approved by all participants after revisions.

[2] Because the group did not agree that there was any clearly definable model but that there was a social service system in which the participants were all part of, the term "model" will be understood to be interchangeable with the term "system".

5.Description of Service Delivery Model.

The collaborative group process started with an exercise to clarify expectations of all the participants in regards to the steps, activities, and points of discussion that would help the group articulate the service delivery model. Our first assumption was that though there is one social service system in NB, there is not one uniform service delivery model applicable to this project. Human service practitioners are in fact involved with different work settings, government departments, and community organizations. The group agreed to proceed with separate presentations by the three government officials representing Mental Health & Addictions Services; Long Term Care & Adult services; and Child & Youth Services. It was also agreed that the representatives of the four member agencies of the coalition would follow with their presentations as to their perspectives of the service delivery model. The presentations included distribution of documents and allowed for discussion and debate in order to obtain a common understanding of how the system works.

5.1 Special Care Homes

Long-term care services under the Long Term Care Program and the Disability Support Program assist frail and vulnerable seniors and adults with long-term limitations in their own homes and in alternate family living arrangements, or in a residential facility when in-home services are not an acceptable option. Because long-term care services are not insured under the Canada Health Act, the client is expected to pay the cost of support services. Clients who are unable to pay the full cost of these services may receive a subsidy through the Standard Family Contribution policy. Assessments for long-term care, disability supports and case management services are offered by DSD in partnership with the Extra-Mural Program and Mental Health Services. A financial assessment is also carried out to determine the eligibility of applicants for financial aid from the government as well as their user fees based on a family contribution policy.

The Disability Support Program designed to serve adults having various disabilities and who are under 65 years of age, involves a different approach to assessment and case planning than that used with seniors. There are facilitators employed by a non-government organization (New Brunswick Association for Community Living, NBACL) who serve as a case planning option for 15-20% of clients who choose this option for help in developing their case plans for individualized and personalized disability supports. It was noted that the minimum qualification for this facilitator role is someone who has obtained a human service counsellor certificate. The case managers are either DSD social workers or mental health professionals (social worker or nurse when client is of a community mental health center). There are over 18,700 individuals in receipt of long term care or disability support services in New Brunswick, of which 6,250 are in residential facilities and 4,350 are in nursing homes. (see Appendix B)

There are basically two types of residential care facilities available, when in-home supports are not sufficient or appropriate for the assessed needs of an individual requiring long term care services or disability supports: special care homes or community residences. Special

care homes are privately-owned and operated with only a few owned by non-profit organizations and managed by a board of directors. Special care homes are all licensed and monitored by DSD to ensure the proper care and safety of adults and seniors. Special care homes are inspected and issued Certificates of Approval each year. Special care home operators must adhere to specific standards in order to obtain and to maintain their licence to operate.

Both special care homes and community residences provide an environment where the physical, social and psychological needs of the residents are met by providing support in the activities of daily living; holistic care to residents, including emotional and behavioral supports; support in a manner so as to help the individual resident attain and maintain an optimal level of functioning, self care and independence; opportunities for residents to participate in community life. Special care homes admit both seniors and disabled persons while community residences offer care for adults who are mostly under 65 years of age.

Over 5,600 persons, of which, 3,820 are seniors live in 430 special-care homes. They may apply for financial assistance to cover all or some of the costs for their care. For clients in special care homes, the maximum amount of assistance covered by a government subsidy is $2115 per month. Surcharges covered entirely by the resident are permitted and most range from $50 to $400 per month with the highest surcharge being an additional $2100 per month. Special-care home owner/operators may also apply for a residential supplement of $16 per day for residents assessed at level 3 and waiting for a nursing home placement. The residents of special care homes retain from their payment to the special care home a comfort and clothing allowance of $135 per month to help pay for personal items, clothing, and some medications not covered by the New Brunswick Prescription Drug Program.

Special-care homes provide services to seniors and disabled persons who require low to moderate levels of care referred to as Level 1 and Level 2 care. These clients require the availability of supervision on a 24-hour basis related to their personal care and their activities of daily living. They do not need full-time nursing care. Provision and/or access to activities appropriate for age and skill level are required. Interventions may require some complexity in skills and knowledge concerning personal care, skill development and behavior management. Interventions will recognize deterioration in physical and mental health and behaviour and provide appropriate responses in various situations.

There are 6,300 licensed beds in the 430 special care homes in the province, of which approximately 945 are vacant as of December 2011. (see appendix C) There has been some restrictions on the licensing of additional beds for a number of years and new beds are approved where and when the vacancy rate falls below 20% in a region or sub-region.(see Appendix D)

Since 2007, some new specialized care beds have also been approved for level 3 clients who suffer from Alzheimer’s disease or dementia. In March 2012, approval was granted for the addition of 704 specialized care beds over the next five years. These specialized care beds will help reduce waiting lists in nursing homes as these clients do not require full-time

nursing care. They are medically stable, but they require additional supervision and help due to Alzheimer's disease or dementia. Interventions require specialized knowledge and skills; the use of specialized equipment may be necessary.

A great deal of the discussion around presentations of the service delivery models centered around the specific roles of staff as well as their working conditions since this was central to this project. A description of basic tasks performed by staff as well as a listing of services provided on behalf of residents presenting different needs brings to light the complexities in ensuring the safety, security and overall well-being of these residents. There are specific employment criteria for all staff members of adult residential facilities (see Appendix E). There is an expectation that owner/operators will recruit and retain qualified employees. The standards allow up to one year for the owner/operators to upgrade the training of new employees, unless an exemption is granted by the departmental coordinator. Standards also call for staff to demonstrate, through a training plan, how they intend to meet required qualifications. There is an acknowledgement among operators as well as departmental representatives who license the facilities that it is becoming much more difficult to recruit and retain qualified employees. The salaries offered are barely over the minimum wage and they have not increased for a number of years. The poor wages contribute to low morale of staff. As staff upgrade their training, skills and experience, a number of them leave to work for better wages and benefits in nursing homes or hospitals. The exceptions made in approving employees not meeting qualifications, as a temporary measure, are gradually becoming more prevalent, and this is ultimately affecting the ability of operators to provide quality care and supervision for their residents.

5.2 Community Residences

There are currently 28 non-profit organizations in the province operating 60 community residences providing services to approximately 400 clients. Community Residences provide services to adults who are for the vast majority under 65 years of age. These residents have high levels of need but do not require regular nursing care. They are disabled adults who require levels of care referred to as Level 3 and Level 4 care. In order to access a community residence, applicants must meet certain criteria as assessed by a social worker or mental health professional. Generally they must be persons requiring supervision twenty four hours a day and/or present behaviors and needs requiring specialized intervention. These clients would not generally be prospective residents for special care home facilities. Professional care/supervision related to physical/mental health condition is often required periodically. Prompting, guidance, assistance and performance of personal care, activities of daily living and health related activities are also required. Interventions require specialized knowledge and skills; the use of specialized equipment may be necessary. Counselling skills, behavior management through non-violent crisis intervention and similar skills, and the ability to keep a person engaged in their daily life are part of the job description.

For clients in community residences, the per diem rate for level 3 is $118 and for level 4 is $149. The residents also retain from their payment to the community residence a comfort and clothing allowance of $135 per month to help pay for personal items, clothing, and some medications not covered by the New Brunswick Prescription Drug Program. The per diem rate was established in April, 1997, to replace individual grants for each community residence based on their approved operating expenses and budgets. The challenge for many community residences since then has been in meeting those operating expenses when there are vacant beds for any extended period of time. It was noted that in some instances some community residencies admitted to having had to admit new residents who did not really match with their current residents because of the pressure to fill beds to make ends meet. The situation is exasperated by the inability to recruit qualified staff, to meet the special needs of these new residents, thus creating chaos and crisis that has a negative impact on the living environment and on the quality of care.

Community residences are almost exclusively not for profit organizations managed by boards of directors. Community residences must be approved and monitored by DSD to ensure the proper care and safety of residents and must adhere to the same adult residential facility standards as the special care homes. Staff qualifications requirements for community residences had been that of a human service counsellor or someone with a university degree with course work in psychology or social sciences. Over the years it had become difficult , if not impossible, for community residences to recruit and retain human service counsellors in consideration of the wages they could afford to pay with the current per diem rate. The Department of Social Development established new standards in consultation with the NBRA and the NBSCHA in 1999 whereby the employment criteria (appendix E) would be the same for community residences and special care homes.

In addition to the level 3 and level 4 clients admitted to community residences, there are those who have individual service plans listing needs requiring care and interventions, beyond the description of level 4, such as one on one care for 24 hours a day. This additional service is for the most part subsidized over and above the per diem rate by the department but nevertheless presents a challenge for community residences to provide the qualified staff. Turnover of staff has been reported to be as high as 60% in one year, in some community residences. These staff, who are predominately female, leave for better positions in nursing homes or as teaching assistants with union wages and benefits.

Community residence managers and staff have readily and openly admitted that the quality of care for residents in their facilities has become a serious issue. More and more individuals with high level needs are accessing community residences and the qualifications of staff may well have been lowered too much in order to balance the budgets. If quality human services are going to be assured, care providers in community residences will have to have pay equity and career opportunities that are just not there presently.

5.3 ADAPT centers and Vocational Support Services

Adult Developmental Activities, Programs and Training (ADAPT) is a program of the Department of Social Development. Through this program, DSD sets standards for, and provides funding to 39 agencies across New Brunswick who offer vocational, employment and training services to adult clients with disabilities. Of the 39 ADAPT agencies, 33 of them are organized under a province-wide association called the New Brunswick Association for Supported Services and Employment (NBASSE) .

Through a supported environment, ADAPT agencies provide services to long term care participants in a center or a community based setting. Participants are generally referred to the respective centers by case managers who are employees of DSD or a community mental health center. The participants are initiated to personal growth activities based on their interests and strengths. The programs provide a number of activities that meet the therapeutic, occupational and developmental needs of the participants. As a result of these services, families and guardians of the participants receive valuable hours of respite.
For each participant, the ADAPT agency develops, implements, and evaluates a current individualized support plan. This means involving the participant, the family, significant others, and the staff who will work with the participant. The planning process must include completion of strengths and needs assessments; short-term objectives that are person centered; have measurable objectives; and support services to meet those objectives. The outcomes of the program planning process must be documented and reviewed at least annually.
Each agency has a specific number of core funded seats for which they receive a yearly grant. There are currently 916 core funded seats province-wide. When a vacancy occurs, the agency informs the case manager and priority for the vacant seat is determined in collaboration with the agency and the regional long term care supervisor. Additional seats over the core seats can be funded by DSD on a case by case basis at a per diem rate of $33 and there are currently 255 purchased seats, province wide. In addition to the participants funded by DSD, a number of the ADAPT agencies also offer on a yearly basis employment assistance services or vocational placement programs to approximately 2000 individuals that are job ready. These services are funded on a purchase of service basis by the Department of Post-Secondary Education Training and Labor (PETL). The agencies that enter into contracts as providers of these services are selected through a tendering process.
ADAPT agencies must adhere to prescribed standards which include employment criteria for the staff (see appendix F) as well as a staff ratio. The DSD ensures on-going compliance with program standards through annual visits and additional contacts as required. A recent study conducted by Allison Holland[3] and funded by PETL brought to light some major concerns in

[3] "Who Are We? An Examination of Adult Developmental Actvities, Programs, and Training Agencies In New Brunswick." Prepared by *Allison Holland* for the *New Brunswick Association of Supported Services*

regards to inadequate compensation and benefits to their staff. The study illustrated the difficulties in recruiting employees with required qualifications which in effect was threatening the future viability of many ADAPT agencies. Representatives of NBASSE also spoke to their concern that the fact that the recruitment of qualified staff was getting more and more difficult, and how this would ultimately affect the quality of service offered by their agencies.

5.4 Family Support Provider Agencies

It is important to start the description of the service model, by making the distinction, between family support workers and home support workers. The scope of practice is quite different as are the basic qualifications. (see Appendix G) Family support workers must possess a post-secondary level certificate, recognized by a community college, with a specialization in a special needs/human services program.

Requisitions for family support workers are submitted to agencies under contract to DSD. Social workers develop case plans, which require the provision of direct services by family support workers in specific circumstances. It has been recognized under the multiple response model for child protection services, that the provision of family support services for low risk families with high needs helps to meet these needs before their situation becomes a high risk protection situation. The reforms in child protection services require a close working relationship with family support provider agencies to ensure a comprehensive outcome focused service provision. The success of the reforms and in particular of family enhancement services is dependent on the development of strong community support agencies and a willingness on the part of government and these agencies to partner in a collaborative and meaningful way. Family support workers are also assigned to work with adults with disabilities or children with special needs who require individualized and personalized supports.

The majority of these family support workers work with clients that are referred by a social worker through a requisition for service sent to the agency that employ them. A number of family support workers do not work full time while others complete their full schedule with home support services that are also requisitioned by DSD on behalf of their clients. Contracts for services are all on a fee for services basis as contracted with DSD, so there are never any positions contracted or requisitioned, instead there are only hours to be coordinated. A number of agencies must strive to combine enough hours to provide a full time work position in order to ensure some sort of job security to recruit or retain qualified employees. The hourly fee for service payment structure coupled with irregular work

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and Employment, funded by The Dept. of Post-Secondary Education, Training and Labour (PETL), June, 2009.

schedules also presents significant challenges for doing on the job training compared to other remuneration structures where there are paid positions of some type. Family support workers can be assigned a variety of tasks as outlined in the social worker's case plan and service requisition. They must be knowledgeable about the stages of child development, child rearing and parental skills. They must be knowledgeable about working with children or adults with special needs or with adults requiring interventions under the adult protection program. They must observe family interactions during delivery of services, in homes, groups, and parental visits. They must be able to react appropriately in a crisis situation. They must document visits, interaction between parents and children and note inappropriate behaviors. They must be prepared to provide evidence and serve as a witness in court. They must have good verbal and writing skills, possess good organizational skills; provide their own transportation; be able to work independently; act as a role model; be able to teach different skills and have flexible working hours as they often need to be available week days, evenings and weekends.

There are currently some 70 unionized human service counsellors with the required qualifications of family support workers who work in community mental health centers under the auspices of the two regional health authorities. However, in 2008, the 38 human service counsellors employed by DSD, who were also unionized employees, were either laid-off or redeployed and the services provided by them were contracted to community based agencies. There is a huge wage gap between these unionized employees and the 1000 human service counsellors employed by 36 private agencies. The majority of family support workers work for wages that are marginally over the minimum wage, and as well there are significant disparities in benefits and working conditions. It is also difficult to access training on the job. We can conclude that the bleak career outlook, does not provide a lot of incentive for someone wanting to work as a family support provider, to enroll in a NBCC certificate program, and pay tuition for one or two years.

The issue of wage inequity has been highlighted in a number of reports and studies. The basic rate of $18 per hour is paid to agencies and as an all-inclusive rate is substantially less than the wages paid directly to unionized employees providing the same or similar services. Agencies are facing serious challenges in fulfilling their contractual obligations to maintain an available and qualified staff component to carry out the work requisitioned by DSD with little or no advance notice of need, nor of cancellation of services. Agencies are often unable to provide the specific service requisitioned on behalf of DSD clients as they experience more and more difficulty in recruiting qualified family support workers.

6. Accountability & Quality Assurance for Practice of Human Service Practitioners

In keeping with the objectives for the process, the problem solving discussion, based largely upon meeting minutes and related notes to date, can be summarized as follows :

The government representatives did present thoroughly on their understanding of the service delivery system from their various perspectives. It was strongly acknowledged that based upon these presentations the group had the sense of being part of a service system that had achieved much and that was very important to the Province and its citizens.

The important question was then posed - **What roles do these human service practitioners represented in this process play in this system and are they necessary?**[4] The answer was simply stated as **"government could not provide services without them."**

There are in fact thousands of human service practitioners working for ADAPT agencies, special care homes, community residences, and family support agencies who provide direct service to thousands of vulnerable adults and children. These services are funded in whole or in part through government grants, per diem allocations or on a fee for service basis. The departments of Health and Social Development allocate hundreds of millions of dollars per year for the well-being and security of children, adults and families through partnerships with these organizations who provide the direct services that are deemed appropriate and essential.

The community based representatives for Special Care Homes, Adult Developmental Activities Programs and Training agencies, Adult Residential Sector (non-profit), and Family Support Provider Agencies subsequently described whom they represent and who are the employees they are concerned about, and they addressed the following questions : What do these workers do? What is the process of someone becoming

[4] **The question was raised as to the meaning of *human service practitioner*** – was it a generic term inclusive of all workers represented or is it more specific? It was clarified that for the purposes of this process the term serves as a generic term inclusive of all the workers employed in the community based services represented by the Coalition groups defined in the proposal's terms of reference. In addition, the question was raised regarding other human service workers who are not represented by the coalition. However, when these workers' situation is looked at closely we see that by comparison their working conditions tend to be better and that there has been some improvement in the past five years. Ex. Transition Homes, where the funding structure changed from 80% funding to 100%; Group Homes for youth, where basic wages for workers are now at the $14/hr to $15/hr rate, compared to the wage rates of the human services workers this exercise is concerned with who are working at much lower pay rates.

employed? And what issues these workers and agencies face in providing direct services?

From the discussions and descriptions of the current service delivery models, we concluded that there is a need to develop and enforce a clear scope of practice for human service practitioners whether we call them family support workers, personal support workers, residential support workers, or human service counsellors. We also concluded that there must be clarification of what the tasks and functions of each of these paraprofessionals entails to allow the public to have reasonable expectations of the knowledge and abilities that these human service practitioners bring to the work.

A brief overview was presented of some of the commonalities in the community based direct service presentations and their review of practice standards; issues in hiring and retention, and issues related to qualifications and training. The fundamental importance of these workers for NB's social service delivery system was agreed upon, and it was further agreed that the problematic issue centered upon **the question of the quality in the personnel and their practice**. In order to explore more deeply and adequately what it means when it is said that **"government could not provide service without these workers,"** the group addressed the additional question **– Is it necessary that the work of these practitioners be performed according to some quality standard?**

The question of liability was raised in light of the admitted difficulty of organizations to recruit and maintain qualified staff to serve clients who are highly vulnerable with a variety of complex problems as identified in their needs assessments. One issue was relative to some human services practitioners currently employed not having the desired qualifications. Another issue was the shortage of qualified workers in terms of recruitment because the appropriate training was either not affordable or not available. Who is liable if a client is at risk or suffers because there is an issue of competency on the part of the direct service provider i.e., the human service practitioner?

Risk management was presented as an important consideration for the planning and delivery of health and social services. A number of advocates, program auditors and financial auditors have made the case over the years that that there is a need to be responsive to the increasing demands for safety and accountability. They have insisted that the risk management focus has to be system–based and not crisis orientated and individual provider-based. **Is it acceptable (under conditions of fiscal restraint) that market forces primarily rule over these human service practitioners and their performance**.[5] In terms of both organizational efficiency and value to the clients in

[5] There is an extensive body of literature and research that suggests that if community based level services are primarily ordered by market forces of supply and demand not only is there a real risk of the exploitation of workers who tend to be primarily women in this sector, but there is also a tendency for clients to be treated as commodities. (See Wolf Wolfensberger, The Principle of Normalization In Human Services (Toronto: NIMR, 1972); Harvey G. Simmons, From Asylum to Welfare (Toronto: NIMR, 1982); Stephen

receipt of services from the health and social service organizations, they have all made the argument that this is not an option.

The coalition representatives representing both employing agencies and employees described in some detail the technical and behavioral skills required to perform their respective functions. In articulating their respective experiences of the present service delivery models, the collaborative group was informed that there are a number of pre-requisites to working as a family support worker: knowledge of stages of development; child rearing and parenting skills; the ability to work in crisis situations and often independently; teaching skills, good verbal and written communication skills and the ability to be a role model for parents and children in difficulty. Similarly other human service practitioners working in special care homes, ADAPT centers and community residences must have skills in providing care and support to vulnerable individuals in a way that addresses their personal and often challenging needs.

The presentations and discussions identified observable effects in practices that are undermining the stated standards for competence and minimization of client risk. And closer analysis suggested that the context and quality of practice is introducing measurable inefficiencies in quality service delivery. It was agreed that standards do not guarantee quality but that they are conditions to be met. Ultimately quality is measured based on desired outcomes, indicators and accountability.

It was agreed that the **nominal group method** would be undertaken as a means and method to explore more specifically this issue as we put forward the following question:

How best to ensure quality practice of human service workers working for these community based agencies in NB?

The operative concept in this question is ***quality practice***. This needed some clarification and interpretation because it can be understood differently depending upon one's perspective and position within the social service system. Quality practice or actions can be defined 1) in behavioural terms of observable skills and competencies or 2) in ethical terms.[6]

Nominal Group Method for this collaborative group process :

J. Taylor, Ed., Community Integration for People with Severe Disabilities (Teachers College Press, 1987); Lisbeth Schorr, Common Purpose: Strengthening Families and Neighborhoods to Rebuild America (Toronto: Doubleday, 1997); Brian Wharf and Brad McKenzie, Connecting Policy to Practice In Human Services (Oxford University Press, 1998); see also the extensive body of research of the Canadian Center for Policy Alternatives.

[6] By ethics we are referring not only to adherence to a stated code of conduct but also to the character and intelligent judgment that is the source of a person's actions and decisions – this latter approach involves paying attention to the narrative unity and meaning in a person's working life within a recognized context of practice or tradition.

The nominal group method was agreed by the participants to be an effective way of structuring problem solving now that the group had reached a clearer grasp of, and agreement on the problem or issue as formulated in the focal question. The method was proposed as maximizing participation and minimizing domination of any one voice, set of voices, or perspective, because it involved both structured group discussion and individual reflection. Though some participants were unfamiliar with the method, it was agreed that it could assist us in collaboratively reaching evaluated outcomes that deliberately responded to the focal question the group was now better prepared for, and as well it could reflect fairly the weighted valuations of the participants' considered responses.

The agreed upon question was introduced. Participants each took the time to generate their own written ideas in some manner to the focus question. Ideas were shared one by one in a round-robin fashion. Each idea was posted without debate initially. Also this was the step where the dynamics of the collective effort at listing, generated new ideas not on one's original list. The round robin listing continued until there were no more ideas.

A serial discussion then followed as this was the opportunity for advocacy of one's favourite idea, or the idea posted that they liked best. This involved an exploration of both the strengths and weaknesses of ideas. Everyone was free to discuss any idea posted and it was at this point that the ideas became the ownership of the group and somewhat disassociated from their originator.

The next step was to proceed with an individual written selection of five favoured ideas with a ranking/evaluating of their five favoured ideas. Each vote or score was listed beside each idea. This allowed participants to see how many participants listed an idea among their top five as well as how high it ranked. The final totals gave us a measure of the strength of the idea within the group's collaborative effort.

The final step was a discussion of results. This allowed for feedback on the results – how did participants feel about the results and were they valid for what had been discussed and debated? There was also an agreement for certain items seen to be similar to be linked together under a common category.

Nominal Group Method Results

Question:

How best to ensure quality practice of human service workers working for these community based agencies in NB?

Evaluated/Weighted Outcomes:

1) That there be a regulatory body for human service practitioners; that there be an accountability framework for standards of practice; that there be competencies required for people providing services as human service practitioners; that there be a code of ethics and conduct for human service practitioners; and that there be technical competencies and minimum standards developed.

2) That remuneration match training, experience, and responsibility; that there be better recognition of previous experience of current workers for remuneration and training requirements; that there be incentives for workers to work with difficult clients; that there be improved benefits for human service practitioners (sick leave, travel expenses, etc.).

3.1) That there be standardized education programs; that there be standardization based upon a common curriculum and qualifications for all human service practitioners; that there be a core curriculum for all human service practitioners.

3.2) That there be access to affordable and accessible training opportunities; that there be implementation of a training strategy with access to government sponsored training; that there be sharing of resources between NGOs and government, ex. training opportunities; that there be recurrent joint training among government direct service staff and NGO staff within the regions.

4) That potential staff view human service practice as a career; that human service practice be a more desirable future for young people; that there be laddering of career opportunities for human service practitioners.

5) That there be development of and support for a network of experts and consultants based in direct practice; that there be access to regular supervision and coaching for human service practitioners.

6.1) That there be a better clarification of, and balance in the allocation of resources between direct service delivery and indirect service delivery.

6.2) That there be pay harmonization.

7.1) That Special Care Home operators have competencies in human resource management.

7.2) That there be increased monitoring and enforcement regarding adherence to the standards.

8.1) That there be realistic cost analysis of what it costs to run a NGO service.

8.2) That there be access to case managers for development and review of ISPs on a regular basis.

9) That safety and security issues in working conditions be recognized.

7. **Relationship Between Government & Service Delivery Agencies**

The report submitted by Team Plus in March 2011 summarized the current conditions of employment for human service workers in New Brunswick and made three specific recommendations. The first recommendation was ***that the government articulate a service delivery model that defines the role it envisions for human service workers within this model. Furthermore that this service delivery model should also define the relationship the province intends to have with service delivery agencies that employ human service workers***.

There is always appreciation for any efforts of governments to consult with citizens before making policy decisions that affect their well-being. We especially applaud the efforts of government to engage citizens in decision-making. We would conclude that the establishment of a citizen engagement unit is an acknowledgement by this government that the traditional means for consultation which encourages advocacy and provides platforms for individual interests groups is not the most effective way to formulate policy. True citizen engagement fosters collaboration at all levels through an open process that encourages everyone to bring their ideas to the forefront. True citizen engagement is also a continuous process thus there is the need to have permanent structures or forums that encourage community capacity building.

The report entitled ***Home Support Workers – Raising our Voices Toward Workforce Adjustment Through Policy and Strategic Action***[7] was a joint effort of representatives of industry, government, stakeholders and citizens. They made specific recommendations in regards to the working relationship between government and the NGO's that provided employment opportunities for home support workers. Notably they called for the establishment of standing committees that could solidify a positive working relationship and entrench a culture of collaboration and partnership. They proposed two permanent advisory groups with representatives of stakeholders and key government representatives: an Education and Scope of Practice Committee and a second group on Workplace Safety & Labour Market Issues. These are concrete example of structures that we respectfully submit, could provide forums for true citizen engagement and government renewal.

8. Recommendations

Our recommendations are based upon the outcomes of the nominal group method which we believe contain a coherent and comprehensive set of guiding directions for addressing and answering the focal question this collaborative problem solving process identified after considerable discussion and debate: *How best to ensure quality practice of human service workers working for these community based agencies in NB?* Our recommendations should be read in conjunction with the full set of NGM outcomes above so that the full scope, significance, and implications of our primary recommendations as well as their interrelationship are grasped. We are cognizant of the fact that there have been a number of studies, reports, and labor market research and analysis over the last few years relative to the role of human service practitioners and their future employment in New Brunswick. We also recognize that we need to have a consensus and shared commitment between government and NGO's in regards to

[7] Home Support Workers Raising Our Voices: Toward Work Force Adjustment Through Policy And Strategic Action. Prepared by *Management Dimensions* for the *Home Support Labour Force Adjustment Committee*, funded by Dept. Post Secondary Training and Labour (PETL), Contract # 56952, January 2006.

what needs to be done and appreciate the collaborative process undertaken to achieve this consensus. We respectfully submit that it is now time to move to implementation. It is time to take action and to identify clearly what is further required in terms of data and outcome indicators so we can move forward with a concrete action plan to improve the current and future working conditions of human service practitioners in New Brunswick.

In the terms of reference for this collaborative problem solving process, the group was to identify those areas or aspects of the service delivery model that are presently problematic for the community based sector, or for the efficient delivery of quality social services. In addition, we were to identify additional work needing to be done and to identify resources required for phase 2 & 3, which would correspond to recommendations 2 & 3 of the consultant's report concerning remuneration and training. In the view of this group, consisting of experienced government and community based representatives, we believe we now know enough about the seriously problematic aspects of the efficient delivery of quality social services in this community based sector represented in this process. We know as well what, in general yet relevant terms, needs to be done.

We therefore proceed with a recommendation for establishing a steering committee led by government. We believe the lead must be with government since the formulation of public policy, enactment of legislation and approval of budgets is within the responsibility and authority of government. We see the role of the steering committee as developing the terms of reference and providing direction to working committees charged with the elaboration and implementation of concrete, time-limited, and realistic action plans. To delay implementation for further costly research and enquiries unrelated to implementation, in our view simply involves an unnecessary and costly delay for government in acting upon what we now know and have agreed needs to be done. Implementation requires appropriate committees of government with community-based representation to develop the steps, time frames, and details for implementation

We recommend that a steering committee led by government and including representatives from the community-based sector immediately be established by the Premier's Office to develop terms of reference for, and provide direction to, three separate committees who would elaborate objectives and action plans for the implementation of these three general goals:

- ***That there be standardized training and education programs based upon a common core curriculum and qualifications for certification of all human service practitioners. And that in conjunction with a standard core training curriculum for human service practitioners, that there be regular access to on the job training opportunities sponsored by government, and that there be a sharing of training resources between community based agencies and government with an emphasis on improving and renewing the quality of direct services in accord with best practices available.***

Some research has already been done in regards to core training curriculums and we need to build on that work to move to an action plan. The commitments towards public engagement as well as increased collaboration between government and NGO's should lead to concrete action plans for shared training resources as well as sponsorship of training opportunities.

- ***That remuneration match training, experience, and responsibility and that there be improvement in wages and benefits for human service practitioners including such benefits as sick leave, travel expenses, etc..***

This is a goal that could be achieved in building on the current initiatives such as the DSD wages and benefits committee for home support workers as well as the initiatives currently under way to establish pay equity for specific groups of workers, i.e. home-support workers and the human service practitioners who are employed in transition homes, community residences and child care facilities. If the Pay Equity Process is an effective and fair approach for action then the human service practitioners working in special care homes, community residences, ADAPT Centers or for Family Support Provider Agencies should be integrated into this process immediately, otherwise an appropriate alternative approach should be established.

- ***That a regulatory body for human service practitioners be established with supporting legislation that entails a defined scope of practice and standards of practice to which accredited human service practitioners and their employing agencies are to adhere, and that is to include a code of ethical conduct for practitioners.***

It is recognized that setting up a regulatory body is a longer-term goal considering the complexities and legislative requirements of this initiative. We wish to emphasize however the need for continued and enhanced program monitoring by the departments responsible for the development and enforcement of program standards. A regulatory body to accredit human service practitioners will serve to ensure public confidence in the work of the human service practitioners but there will always be a role and a shared responsibility for public service administrators and managers.

Appendix A

Human Service Workers

A Report Regarding Their Working Conditions

Prepared for ANBFSWA – March 2011

Executive Summary

This report summarizes the current conditions of employment for Human Service Workers in New Brunswick and provides recommendations for improving their working conditions.

Main Findings

The National Occupation Classification (NOC) 4212: Community and Social Services Workers covers more than 100 different job titles many of which are currently used in New Brunswick including: Human Service Worker, Human Service Counselor, Family Support Worker, Residential Support Worker, and Personal Support Worker. In spite of the differences in job titles, the qualification and educational requirements for entry-level positions are very similar.

While some human service workers do not have any formal post-secondary training, the majority has completed either a one-year or two year training program. The related programs offered in English at the New Brunswick Community Colleges are the Human Service Worker one-year program and the Youth Care Worker two-year program. The programs offered in French are all two-year programs: Techniques d'intervention en services communautaire: enfants et adolescents; Techniques d'intervention en services communautaire: adultes; and Techniques d'intervention en délinquance.

Human Service Workers provide services to the most vulnerable in our communities: the disabled; people who are mentally ill; vulnerable and at risk children, women and families; people under the care of the province; the aged and infirm; and those unable to care for themselves. Human Service Workers are the "eyes and ears" of social workers – implementing and following-up on care plans; and they are the people who provide court-order services such mandatory supervision of parental visits.

Currently, there is no provincially defined scope of practice for people working as Human Service Worker and job responsibilities vary greatly depending on the work setting. Work activities may range from providing interventions for at-risk individuals, developing parenting programs, designing and implementing behaviour management programs, utilizing assessment tools, providing life skills coaching and support for people with disabilities living in the community, helping people to attend appointments, developing programs and providing supervision in group home, and in some cases, providing personal care.

While some human service workers are self-employed, the majority are employed by agencies or non-profit organizations. Most agencies and non-profit organizations either provide contract services or are funded in whole or in part by provincial government departments or agencies. Human Service Workers who are employed by the two Health Authorities, or in some provincially funded residential settings are unionized employees represented by CUPE.

Agencies who provide services on contract to the Department of Social Development are compensated at the rate of $18.00 per hour of actual time spent with a client. This rate must cover all overhead expenses incurred by the agency – including direct interaction with the Department – as well as training and benefits paid to employees. Therefore, the vast majority of human service workers in New Brunswick are paid minimum wage or slightly higher. Those working as supervisors in group homes are often paid less than minimum wage. The only exception to this are the very few unionized Human Service Counselors who work for the provincial health authorities. The wage rate for this CUPE group, as of January 2011 is $19.92 - $21.45 per hour.

Both employees and employers agree that human services workers employed by agencies that provide services on behalf of the Province of New Brunswick are not appropriately compensated. Low wages are identified as a barrier to both the recruitment and the retention of workers. This is the single most important concern related to the working conditions of human service workers. Many employers report that if there is not immediate attention to this problem they may no longer be able to provide services due to the lack of qualified staff. Many employers and employees expressed feelings of frustration and despair that this well-documented problem has not received appropriate attention.

Recommendations

It is recommended that the provincial government articulate a service delivery model that defines the role it envisions for human service workers within this model. This service delivery model should also define the relationship the province intends to have with service delivery agencies that employ human service workers.

It is recommended that the provincial government conduct a pay equity study for human service workers (similar to the study recently completed for home support workers) and develop a plan to address the pay inequities. Changes to rates of pay and conditions of employment will need to be reflected in service delivery contracts with agencies and other non-profit agencies.

It is recommended that the training provided for human service workers be standardized for both the English and French community colleges and the recommendations of the report “Needs Analysis for Social Service Worker Diploma Program” prepared for the department of Post-Secondary Education, Training and Labour by Orion Marketing Research in 2009 be implemented.

Appendix B

Social Development

LONG TERM CARE/DISABILITY SUPPORT PROGRAM --- Number of cases

12/31/11	Nursing homes	Adult res. facilities	Home	Total
Clients 65+	3939	3820	4420	**12,179**
Clients -65	418	2431	3709	**6,558**
Total	**4357**	**6251**	**8129**	**18,737**

Appendix C

At the end of Dec. 2011, the maximum number of vacant beds in special care homes for L1 and L2 residents was 945. In reality, the number of available beds was lower because of the following factors-: 1. Does not take into account the number of private-pay residents admitted without a full LTC Assessment 2. Does not take into account the number of dedicated emergency beds 3. Some operators have rooms that could be used for double occupancy, but only use those rooms for single occupancy.

In terms of rate increases per classification:

a) The per diem rate for grandfathered special care home residents went from $28.87 in March 1997 to $31.62 in April 1997, to $36.18 in Jan. 2005, and eventually to $36.59 in Jan. 2007. The number of grandfathered residents went from 3,365 in March 1997 to 0 since 2008.
b) The per diem rate for L1 special care home residents went from $36 in April 1997, to $42.59 in Jan. 2007, to $74 since April 2007. The number of L1 residents went from 0 on April 1, 1997 to 1,154 in March 2011.
c) The per diem rate for L2 special care home residents went from $68 in April 1997, to $70.59 in Jan. 2007 to $74 since April 2007. The number of L2 residents went from 0 on April 1, 1997 to 4,218 in March 2011.

	Grand	L1	L2	Total	Avg per diem
31-Mar-97				3365	$28.87
31-Mar-98	2808	348	412	3568	$36.25
31-Mar-99	2217	648	820	3685	$40.49
31-Mar-00	1761	923	957	3641	$44.41
31-Mar-01	1435	956	1253	3644	$47.00
31-Mar-02	1152	937	1563	3652	$49.70
31-Mar-03	968	810	1850	3628	$52.32
31-Mar-04	821	765	2092	3678	$54.20
31-Mar-05	721	710	2291	3722	$55.88
31-Mar-06	372	643	2778	3793	$59.81
31-Mar-07	26	678	3353	4057	$73.76
31-Mar-08	0	763	3449	4212	$74.00
31-Mar-09	0	866	3647	4513	$74.00
31-Mar-10	0	1087	4126	5213	$74.00
31-Mar-11	0	1154	4218	5372	$74.00

Social Development expenditures for special care home residents have increased from $17.6M in 1996-1997 to $81.9M in 2010-2011.

Appendix D

Special Care Home - Level 1 and Level 2 Beds DEC 2011

Region	**Sub-region**	**Approved**	**Résidents**	**Vacancies**	**% vacant**
1	Monton/Dieppe/Riverview	1232	1058	174	14,12%
	Cocagne/Buctouche	407	336	71	17,44%
	Sackville/Cap Pelé	405	360	45	11,11%
		2044	**1754**	**290**	14,19%
2	Saint John	535	468	67	12,52%
	St. Stephen	118	104	14	11,86%
	Sussex	159	136	23	14,47%
		812	**708**	**104**	12,81%
3	Woodstock	215	176	39	18,14%
	Fredericton	453	371	82	18,10%
		668	**547**	**121**	18,11%
4	Grand-Falls	188	161	27	14,36%
	Edmundston	489	404	85	17,38%
		677	**565**	**112**	16,54%
5	Campbellton	384	327	57	14,84%
	St. Quentin	114	102	12	10,53%
		498	**429**	**69**	13,86%
6	Bathurst	**531**	**439**	**92**	17,33%
7	Miramichi	140	128	12	8,57%
	Neguac	147	128	19	12,93%
		287	**256**	**31**	10,80%
8	Tracadie	225	187	38	16,89%
	St-Isidore	140	119	21	15,00%
	Shippagan	250	194	56	22,40%
	Caraquet	112	101	11	9,82%
		727	**601**	**126**	17,33%
Province		**6244**	**5299**	**945**	15,13%

Appendix E

Department of Social Development
Standards and Procedures for Adult Residential Facilities
(Special care homes and community residences)

Qualifications requirements
Candidates seeking employment in an adult residential facility must have taken one of the following training programs if they want to provide direct care to residents with Level 1, 2, 3 and 4 care needs.

- Home Support Worker Program, or
- Special Care Home Worker Program, or
- Health Care Aid Program, or
- Human Services Program, or
- Nursing Assistant Program

Operators must try to fill positions with qualified employees at time of hiring.

When the operator can show that attempts to recruit qualified employees have been unsuccessful, operators have up to one year to ensure all staff meet the required training. These staff must be under the supervision of qualified staff, unless an exemption by the Coordinator is granted. Staff should demonstrate, through a training plan, how they intend to meet the required qualifications.

Services
Client with Level 1 or level 2 Care Needs
A care/service provider must be present on a twenty (24) hour basis for the provision of supervision, assistance and performance of personal care, activities of daily living and/or instrumental activities of daily living. Provision and/or access to age and skill related activities are required. Interventions may require some complexity in skills and knowledge concerning personal care, skill development and behaviour management. Interventions will recognize deterioration in physical and mental health and behaviour and provide appropriate responses in various situations.

Client with Level 3 Care Needs
Presence of a care/service provider on a twenty-four (24) basis. Supervision, assistance and performance of personal care, activities of daily living and health related activities. Professional care/supervision related to physical/mental health condition may be required periodically. Provision and/or access to activities appropriate for age and skill level. Interventions require specialized knowledge and skills; the use of specialized equipment may be necessary.

Client with Level 4 Care Needs
Presence of a care\service provider on a twenty-four (24) hour basis. Prompting, guidance, assistance and performance of personal care, activities of daily living and health related activities. Professional

care/supervision related to physical/mental health condition may be required periodically. Provision and/or access to activities related to age and cognitive or behavioural skills. Interventions require specialized knowledge and skills: the use of specialized equipment may be necessary.

The Standards and Procedures for Adult Residential Facilities can be accessed on Internet at: http://www2.gnb.ca/content/gnb/en/departments/social_development/seniors.html

Appendix F

Department of Social Development
Adult Developmental Activities, Programs and Training (ADAPT) Standards

Qualifications requirements
Agency staff must have the skills and knowledge to meet the needs of the participants.

Agencies should base the qualifications for direct service staff on the current state of knowledge in human services, including Human Service Diploma or High School Diploma, plus continued education in

- Social Role Valorization
- Behavioral Support
- Program Planning
- Individual Support Plan

Current staff of agencies who do not have the required qualifications must be under the supervision of qualified staff. Agencies may hire new employees without the necessary qualifications when

- reasonable efforts to hire qualified employees are unsuccessful
- training plans show how employees will meet the qualifications within a specified period of time

Agencies staff must have a valid standard Emergency First Aid and Cardio Pulmonary Resuscitation (CPR) Certificate

Services
Service provision refers to valued activities offered to Adult Developmental Activities, Programs and Training participants. These activities are for therapeutic, occupational and developmental purposes.

Valued activities address the following areas of need

Academic	Refers to cognitive learning activities, for example, math, reading, writing, and discrimination skills.
Leisure/Recreation	Refers to activities for diversion, relaxation and personal fulfillment, for example, drop in center, bingo, outings.
Self Help	Refers to activities to teach or maintain personal care needs.
Social	Refers to activities to enhance personal interaction and relationship development skills.
Life Management	Refers to activities to enhance personal autonomy, emotional well-being, and conduct in a variety of situations.
Work Related	Refers to activities to enhance skills required for work tasks, for example, safety, hygiene, customer relations, and quality assurance.

Communication	Refers to activities to promote the expression and reception of ideas, concepts and thoughts.
Health/Physical Development	Refers to activities to promote and develop physical wellness, motor skills and coordination.

Appendix G **Family Support Worker Standards**

Family Support Workers must be nineteen (19) years of age or older, have a high school diploma and possess a post-secondary level certificate, recognized by a community college, with a specialization in a special needs/human services program.

Practice Standard 12 – Equivalency

The service provider agency must ensure that any Family Support Worker employed by the agency on the date of approval of these standards must have successfully worked in the field for 5 years if they do not meet the requirements stated in Practice Standard 11. Any employees hired after that date must meet the training requirement in Practice Standard 11.

The service provider agency must ensure that training received from outside New Brunswick is equivalent to the requirements stated in Practice Standard 11.

Practice Standard 13 – Competencies

Refer to Section 3.1 Provision of Qualified Staff.

Family Support Workers must be aware of

- **stages of child development**
- **child rearing and parenting skills**

- crisis intervention, suicide prevention, substance abuse
- problem solving, time management, stress and behavior management techniques
- nutrition, psychology, psychiatric problems, human rights, health issues, functional assessments, adult learning principles, report writing and cultural/social awareness
- available community resources
- integration of special needs
- personal values and limitations

As well, Family Support Workers must

- possess verbal, listening and writing skills
- keep and maintain a current written record of involvement
- be observant
- possess good organizational skills
- use good judgment and common sense
- manage situations if inappropriate behaviors occur
- maintain working relationships with social workers and other disciplines
- solve problems independently, and utilize existing and other community resources to ensure all avenues are investigated to assist clients
- perform coaching functions

Guideline

Family Support Workers should observe the children when providing service. As well, they should report any concerns to the Case Manager as soon as possible.

Responsibilities

Practice Standard 14 – Responsibilities

In accordance with the individual case plan, Family Support Workers have a number of responsibilities.

Family Support Workers must provide

- **structured research based programs for children, for example, self-esteem, sexual abuse prevention, anger management**

- **individual services for children, that is, socialization, skill training, activities for children with special needs**
- **instruction on Independent Living Skills for Adult Clients, for example, using public transportation, finding accommodations, appropriate sexual behaviour, social skills, communication and budgeting for items such as lease, telephone and hydro**
- **Case Managers with assistance in gathering the information for life books**
- **families with assistance in implementing rehabilitation plans for children with special needs**
- **a summary of services for court purposes and testify at court hearings. Social Development will only financially reimburse agencies for the time that a Family Support Worker is testifying or is waiting to testify**
- **written and/or verbal reports as required by the Case Manager and as indicated in the service requisition**

Family Support Workers must supervise

- **activities between siblings, for example, arranging visits for siblings in separate foster home placements, or for siblings separated when one child is in care and other siblings are still at home**
- **Court Ordered visits of children in care of the Minister**
- **situation if inappropriate behaviors occur during visitations or interactions between children**