THE TORONTO NETWORK OF SPECIALIZED CARE AND DEVELOPMENTAL SERVICES TORONTO

# Transition Planning

# Day 1: Youth Transitions

## Fri Feb 26, 2016

# Participant's Guide

## Table of Contents




COMMUNITY NETWORKS OF SPECIALIZED CARE
RÉSEAUX COMMUNAUTAIRES DE SOINS SPÉCIALISÉS

dsto developmental services toronto

# Introduction

## Overview

### Description

The Toronto Networks of Specialized Care in partnership with the DSTO Shared Learning Forum and ConnectABILITY.ca will develop a 3 part Certificate Series for direct support professional's to help meet the complex needs related to Transition Planning. It will be 3 training modules (Day 1: youth; Day 2: adult; Day 3 aging) that will cover a 3 month period and will include DS sector agencies as well as our community partners from Health, Education and Justice. The presentations will be available on video and access to the videos and supporting resources can be found on ConnectABILITY.

### Learning Outcomes

With respect to transitions across the lifespan and sectors, this 3-day event will help participants to:

1. Identify effective strategies to improve system access and navigation for clients and families
2. Use effective planning and decision-making to improve client wellbeing
3. Support client needs relating to their rights and lifestyles
4. Construct a network of individuals who can provide expertise and support

### Agenda

| Time | Activity |
|---|---|
| 9:00am | *Breakfast, Registration* |
| 9:30am | Introduction: Welcome, Overview, Activity |
| 9:45am | Transition Practices: Transitioning Out of High School<br>*We will take a short break at approximately 10:45am* |
| 11:30am | Young Adult Health Transitions – Primary Care, Community Resources and Care Planning<br>*We will break for a 45min lunch at approximately 12:15pm* |
| 1:45pm | Transition Planning: You're 18 and You have Rights<br>*We will take a short break at approximately 2:30pm* |
| 3:30pm | Wrap-up: Evaluations, Activity, Summary<br>*We will ensure we have you out the door by 4:00pm* |

### Case Study - Jason

During the day we will refer to the case of Jason (see below and on a handout in your package).

> Jason is a 18 year-old male who lives in a group home with 4 other young men. Jason is dually diagnosed with an acquired brain injury and bipolar disorder. Jason has been medicated for many years and hospitalized a number of times. Jason has not been able to manage successfully for longer than two hours in school with 1 to 3 support, he does better with one-to-one support and so has applied for a passport funding which he was just approved for. Jason's current group home does not meet his needs. Jason has begun to experience a change in his mental health status; he is not eating or sleeping and has lost a considerable amount of weight.

## Working Agreement

In order to ensure all participants have a safe and enjoyable learning experience, it is important that everyone agrees to some basic working principles for the next two days, including:

- Confidentiality will be respected; what is said in the room stays in the room.
- Diversity will be respected; everyone has different levels of knowledge and experience and is entitled to their point of view.
- Everyone will work to create a safe environment so people can feel comfortable sharing their thoughts; disrespectful language or actions will not be tolerated.
- We acknowledge that one approach often does not fit all and that the diversity that both informal and formal helpers bring to a situation can be a strength and an asset.
- Active participation will help to ensure an effective learning experience; however, individuals have the right to decline providing feedback if they are uncomfortable.
- Everyone will make every effort to arrive on time, return from breaks/lunch on time, and to stay until the end of the session.
- Everyone will turn mobile devices off or set on vibrate throughout the day; any calls that must be answered will be taken outside the room.

## Session Evaluation and Knowledge Transfer

- Your feedback is critical to help ensure the continued quality and effectiveness of this session. At the end of the day, please complete the evaluation form provided.
- Around three to six months after the course has been completed, we will e-mail you a brief online survey asking for your feedback about how you have applied the knowledge you acquired from the course and how you are doing on your personal commitments

# Welcoming Activity

## Self-Reflection

What do you hope to get out of this session?

_____

_____

_____

If you were to describe to a fellow participant the work you do in two to three sentences, so that they could understand what kind of help or assistance you could give them in the future, what would you say?

_____

_____

_____

## Table Discussion

At your tables, take turns introducing yourself (name, title, agency); briefly mention the kind of work you do and/or services you provide and share what you hope to get out of the session.

# Transition Practices: Transitioning Out of High School

## Presented by:

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## Agenda

- Ministry of education mandated items (Mary Ierullo)
- Transition Planning for exit out of high school (Michelle Murphy)
- DSO eligibility (Melanie Randall)

"Transition planning is an important process for all students" Learning for All, 2009

## Ministry of Education Mandated Items

### Ministry Requirements for Transition Planning in Ontario Schools

- Transition Planning Guide (2002); for all students starting at age 14 (Regulation 181/98)
- Policy Program Memorandum (PPM) 156, for all students with an IEP

### Graduation Options

- Graduation Requirements
  - Ontario Secondary School Diploma (OSSD)
  - Ontario Secondary School Certificate (OSSC)
  - Certificate of Accomplishment (COA)

### Programming to Prepare for Postsecondary

- Can remain in secondary until their 21st year
- High school is a 7 year program for those in a ME/DD program
- Programming is based on functional life/numeracy and literacy skills and preparing them to be part of the community
- Focus is on increasing independence, social skills and employment skills

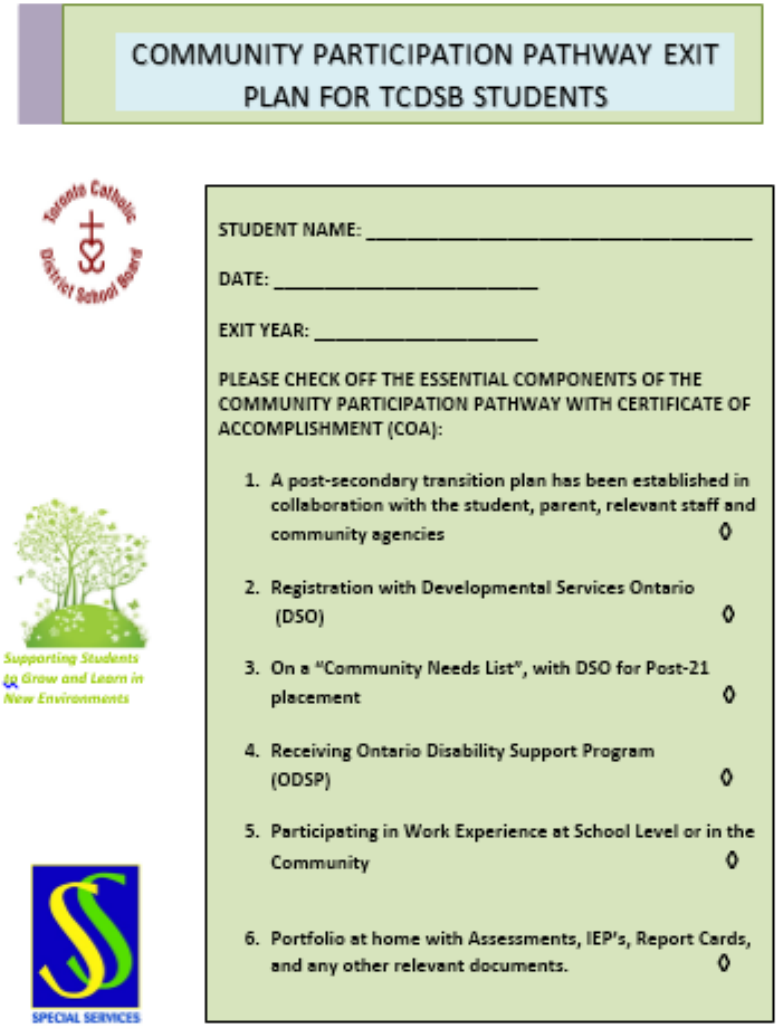
# Transition Planning for Exit Out of High School

## Resources Developed by TCDSB and SPC to Support Transition Planning Out of High School

- Transition Out of High School: Preparing your Child For after High School
- Looking Ahead Together
- Transition to Postsecondary Pathways –Translating Research into Practice

## Transition planning at TCDSB

- Usually meet 3 times (grade 10, grade 12 and year 6 or 7)
- School, parents, student (when appropriate), community partners at the request of families
- Transition Packages and Exit Plan



COMMUNITY PARTICIPATION PATHWAY EXIT PLAN FOR TCDSB STUDENTS

Toronto Catholic District School Board

STUDENT NAME: _____

DATE: _____

EXIT YEAR: _____

PLEASE CHECK OFF THE ESSENTIAL COMPONENTS OF THE COMMUNITY PARTICIPATION PATHWAY WITH CERTIFICATE OF ACCOMPLISHMENT (COA):

1. A post-secondary transition plan has been established in collaboration with the student, parent, relevant staff and community agencies ◊
2. Registration with Developmental Services Ontario (DSO) ◊
3. On a "Community Needs List", with DSO for Post-21 placement ◊
4. Receiving Ontario Disability Support Program (ODSP) ◊
5. Participating in Work Experience at School Level or in the Community ◊
6. Portfolio at home with Assessments, IEP's, Report Cards, and any other relevant documents. ◊

Supporting Students to Grow and Learn in New Environments

SPECIAL SERVICES

# DSO eligibility

## Myths/Facts

_____

_____

_____

## DSO Toronto Region

- The single point of access for all adults with a developmental disability to access Ministry funded adult developmental services and supports

## The DSO's are responsible for:

- Confirming eligibility for services
- Providing information about Adult Developmental Services
- Completing an Application Package (ADSS/SIS)
- Matching adults to available Services and Supports

## Eligibility is Legislated

- DSO's confirm an individual's eligibility to receive services
- *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008*
- Must have an assessment by a Psychologist

## Application Package

- Application for Developmental Services and Supports (ADSS)
- Supports Intensity Scale (SIS)

## When and Why an Application Package

- New to the Sector – Since 2011
- Changing Needs – only for those who have already completed an application package.
- Migrated Individual Application package
- Urgent Application package – does not exist

Knowledge is KEY to ALL transitions

## Ministry funded services include:

- residential services and supports;
- community participation services and supports;
- caregiver respite services and supports;
- professional and specialized services; and
- person-directed planning services and supports.

## While They Wait – Reflection and Discussion

## Information

- Websites: www.dsotoronto.ca; www.dsontario.ca
- 1-855-DS-ADULT (1-855-372-3858)
- Local number: 416-925-4930

# Case Study – Jason: School Transition

## Self-Reflection

What are some considerations for Jason relating to his transitions?

What could you or your agency do to support Jason through his transitions?

## Table Discussion

Assume your table represents a community that will need to work together to support Jason though his transitions. How will you collaborate to support him?

What other information do you need and how might you obtain it?

What other people and/or supports do you need and how might you connect with them?

# Young Adult Health Transitions: Primary Care, Community Resources and Care Planning

## Presented by:

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Lindsay Wingham-Smith, MSW RSW
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## Learning Outcomes

- As a result of participating in this workshop, participants will be able to:
  - Use effective planning and decision-making to improve wellbeing of persons with developmental disabilities during transitions from youth to adult services
  - Identify and address primary care transition needs
  - Collaborate with community resources and plan for potential crisis in advance

> "Primary care is your main point of entry into the health care system. It is where your health care needs or concerns are initially assessed." (Ontario Medical Association, 2015)

## Importance of Recognizing Unique Health Issues for Developmental Disability Population (HCARDD)

### "I need a health care provider with experience in developmental disabilities"

- What are your thoughts about this statement?

_____

_____

_____

> "…Persons with developmental disabilities have complex health care needs but often meet with difficulties when accessing appropriate services. Health care providers with little knowledge of how best to serve them pose another challenge." (Atlas on the Primary Care of Adults with Developmental Disabilities in Ontario, Lunsky et al. 2013)

### Challenging Issues: From Survey of Primary Care Providers…

(DDPCI, 2011)

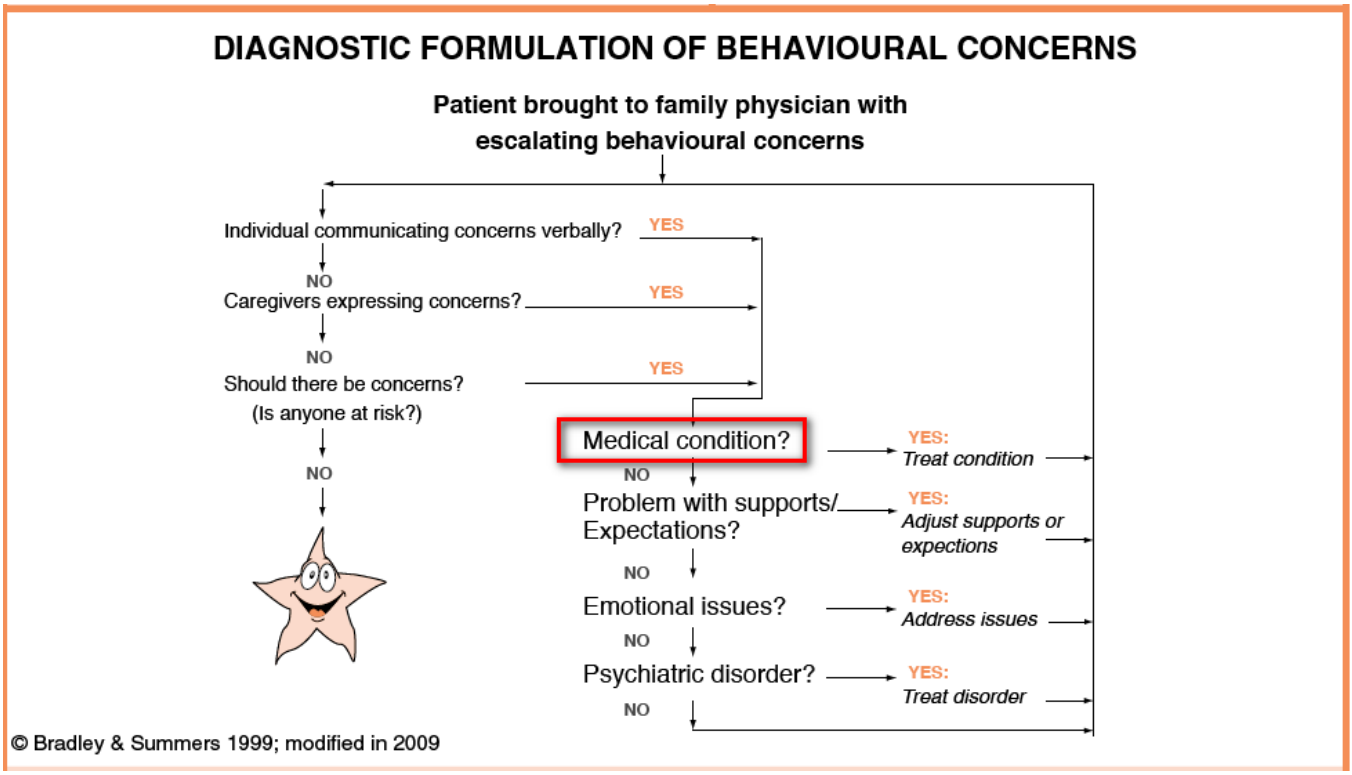
- Problems communicating, including consent
- Complicated medical issues
- Aggression and other "behavioural problems"
- Finding enough time
- Lack of educational materials to help patients understand
- Lack of community resources for psychosocial rehabilitation

## Primary Care of Adults with Developmental Disabilities guidelines:

- "…Disparities in primary care exist between adults with DD and the general population. The former often have poorer health, increased morbidity, and earlier mortality.
- Assessments that attend to the specific health issues of adults with DD can improve their primary care…"

### DD Primary Care Guidelines, Tools for Primary Care Providers & Caregivers

- http://www.surreyplace.on.ca/Primary-care




### Transition Tools

- DDPCI Health Care Transition Tools and Resources for Families and Caregivers of Youth with Developmental Disabilities
  - Guide to preparing for transition
  - Readiness checklist & other resources
  - This document can be accessed on the Primary Care page of the Surrey Place Centre Website

### Video

- Dr. Bill Sullivan: Developmental Disabilities Primary Care
- https://vimeo.com/153777617

# Transitioning from the Pediatric to Adult Primary Care

## Examples of various primary care service models:

(www.ontariosdoctors.com/what-is-primary-care-and-how-do-you-receive-it (OMA, 2015))

- Solo/independent practice
- Group-based models:
  - Family Health Groups (FHGs), Family Health Networks (FHNs) and Family Health Organizations (FHOs)
- Team-based models:
  - Family Health Team (FHTs) and Community Health Centres (CHCs)
- CCAC's *Health Care Connect* program is also available to link individuals with appropriate primary care

## Primary Care Transition Support

- What have been your experiences with transitioning to solo practice model versus team-based model?

_____

_____

_____

## The Appointment - What Do You Need To Say?

- Presenting the problem:
  - "Why are you here?" in 1 sentence only
  - Why? Patient is interrupted after just 18 to 23 seconds

## DD Cares Tools – Today's Health Care Visit

- https://www.porticonetwork.ca/documents/38773/60468/Today's+Health+Care+tool_original/0225d60c-faaa-43e5-b8ce-e636bafd1ea9?intcid=search-results

## Advocacy Tools

- Help in the "detective work" of identifying possible underlying health issues contributing to complex behaviours; www.surreyplace.on.ca/primary-care
  - DD Primary Care guidelines
  - Health Watch Tables
  - Information collection tools:
    - Weight chart (& food diary)
    - BM chart, menses chart
    - Sleep chart
    - Seizure Package

## Community Networks of Specialized Care

- They bring together people from a variety of sectors including developmental services, health, research, education and justice in a common goal of improving the coordination, access and quality of services for these individuals who have complex needs.

The Networks link specialized services and professionals to pool their expertise to treat and support adults who have developmental disabilities and mental health needs and/or challenging behaviours

### Role of TNSC Health Care Facilitator

- Facilitate health referrals and linkages
- Support clients, family and staff with implementing health care planning
- Identify & develop strategies for navigating health services
- Clinical Conference
- CCAC Resources

## CCAC Resources

### Role of CCAC and Care Coordinator

(http://healthcareathome.ca)

- Person-centered assessment of needs and care plan development
- Work collaboratively with community partners, such as DS services, to create and implement a care plan
- Helps with accessing the services, supplies and equipment needed to meet the goals

### Transition Within CCAC

- Smooth transition from the Child & Family Team (<18) to the Adult Supportive Care Team (18-64)
- Working to develop pathways to start the conversation of transition in early teens
- Working closely with the DS sector to inform the conversation and build bridges

### Formulating Innovative Pathways

- Collaborative care planning
- Coordinated Care Plan

## Crisis Preparation & Planning

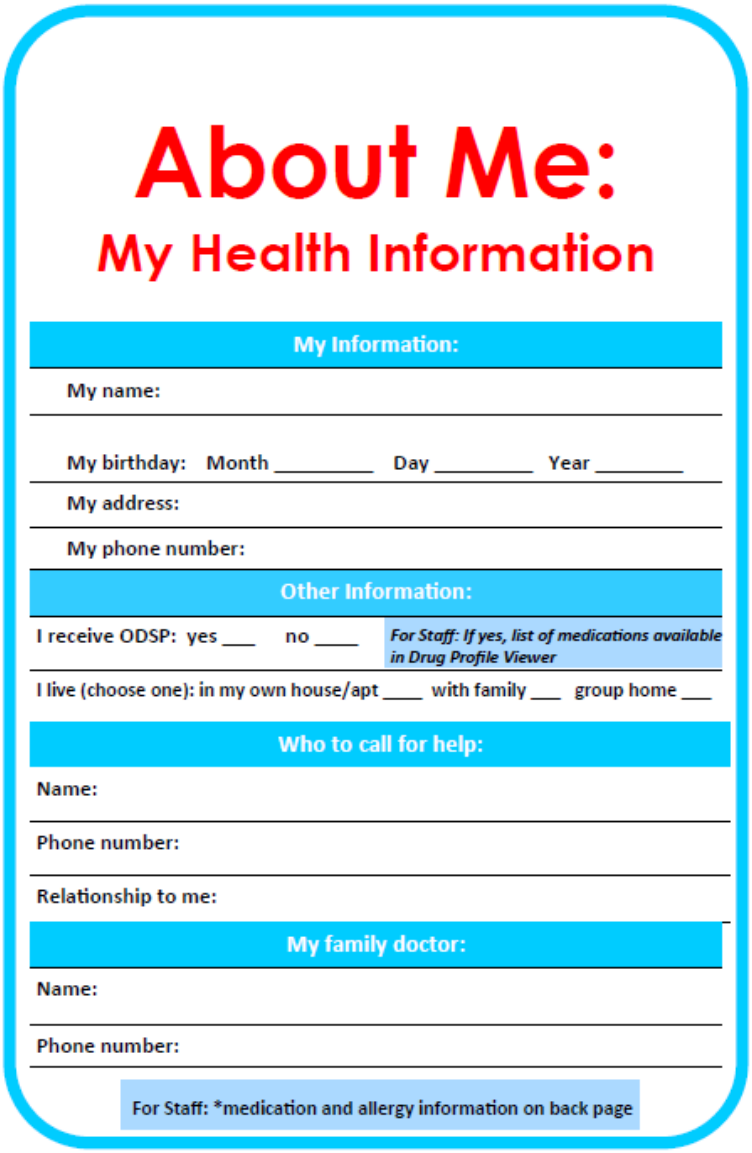
- Documented Crisis Plan
- Protocols or Action Plans to follow

| | |
|---|---|
| **Stage A: Prevention** (Identify early warning signs that signal increasing stress or anxiety.) | **Be supportive, modify environment to meet needs** (Identify de-escalation strategies that are helpful for this patient with DD). |
| **Stage B: Escalation** (Identify signs of the patient with DD escalating to a possible behavioural crisis.) | **Be directive** (use verbal direction and modelling), **continue to modify environment to meet needs, ensure safety** |
| **Stage C: Crisis** (Risk of harm to self, others, or environment, or seriously disruptive behaviour, e.g., acting out.) | **Use safety and crisis response strategies** |
| **Stage R: Post-crisis resolution and calming** | **Re-establish routines and re-establish rapport** |

## Crisis/Emergency Care Resources

([www.porticonetwork.ca/web/hcardd/resources/ddcares](www.porticonetwork.ca/web/hcardd/resources/ddcares))

- Forming collaborative relationships prior to and during emergencies/crises



# About Me:

## My Health Information

**My Information:**

My name:

My birthday: Month _____ Day _____ Year _____

My address:

My phone number:

**Other Information:**

I receive ODSP: yes ___ no ____ *For Staff: If yes, list of medications available in Drug Profile Viewer*

I live (choose one): in my own house/apt ____ with family ___ group home ___

**Who to call for help:**

Name:

Phone number:

Relationship to me:

**My family doctor:**

Name:

Phone number:

For Staff: *medication and allergy information on back page

### Emergency Department Prep

- Video: https://www.porticonetwork.ca/web/hcardd/resources/videos/caregivers

### Advocating In Hospital and During Discharge Transition Planning

- Offer informational support
- Advocate through:
  - SW
  - Unit Manager
  - Patient Relations
  - CCAC Care Coordinators

## Experiences

- What are some barriers to transitioning health care from pediatric to adult resources?

_____

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_____

- What are some successful strategies that could help with overcoming difficulties during this transition?

_____

_____

_____

## Selected References


- Lunsky, Y., Klein-Geltink, J.E., Yates, E.A., eds. (2013). Atlas on the Primary Care of Adults with Developmental Disabilities in Ontario. Toronto, ON: Institute for Clinical Evaluative Sciences and Centre for Addiction and Mental Health. Retrieved from: http://knowledgex.camh.net/hcardd/Documents/HCARDD%20ATLAS.pdf
- Lunsky, Y., Lin, E., Balogh, R., Klein-Geltink, J., Wilton, A.S., & Kurdyak, P. (2012.) Emergency department visits and use of outpatient physician services by adults with developmental disability and psychiatric disorder. Can J Psychiatry, 57, (10), pp. 601-607.
- Ontario Medical Association (OMA). (2015). What is Primary Care and How Do You Receive It? Retrieved from www.ontariosdoctors.com/what-is-primary-care-and-how-do-you-receive-it
- Primary Care of Adults with Developmental Disabilities Canadian Consensus Guidelines (and tools): http://www.surreyplace.on.ca/Primary-Care

# Case Study – Jason: Health Transitions

## Self-Reflection

What are some considerations for Jason relating to his transitions?

_____

_____

_____

What could you or your agency do to support Jason through his transitions?

_____

_____

_____

## Table Discussion

Assume your table represents a community that will need to work together to support Jason though his transitions. How will you collaborate to support him?

_____

_____

_____

What other information do you need and how might you obtain it?

_____

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_____

What other people and/or supports do you need and how might you connect with them?

_____

_____

_____

# Transition Planning: You're 18 and You have Rights

## Presented by:

Sarah Lyttle

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Community Support Coordinator/Self-Advocates Council, Community Living Toronto
shutton@cltoronto.ca; 647-729-1205

Alex Cahuas

Fahima Zaman

### Three Things

_____

_____

_____

## What Are Your Rights as an Adult?

- With or without a disability, ALL adults have the SAME rights.
- Community Living Toronto's Bill of Rights Poster
  - There are 10 rights that were identified as being important to people supported by Community Living Toronto.

### Life Planning Principles

- Person-Centred
  - Person generated, directed and owned
  - Built on individual strengths, gifts, dreams and aspirations
  - Support are tailored and relevant to the individual's choices
- On-going
  - Is a flexible, open-ended and on-going process which enhances the individual's quality of life
- Individual Rights
  - Recognizes and respects individual rights, entitlements and responsibilities
- Diversity
  - Promotes dignity
  - Honours individuality, culture, and benefits
- Relationships
  - Fosters meaningful and lasting relationships with family, friends and community members
  - Values and strengthens involvement of a personal support network
- Inclusion
  - Facilitates participation in and contribution to community life


## Who's Voice is It?

- We need to validate, and support while we educate about rights and the law.
- As agency staff, we must follow the law in upholding people's individual rights to make decisions. It is their voice.

## Legal rights training for people

- Teaching people with intellectual disabilities about their right to make their own legal decisions

## Rights & ARCH Legal Education

- ARCH legal rights workshops for staff on capacity
- ARCH workshops for Self-Advocates Council and persons with intellectual disabilities
- Rights workshops for families … just emerging

# New Research

## Feature Study

- An exploratory study of the pre- and post-migration experiences of racialized immigrant youth with disabilities living in the Greater Toronto Area (GTA)
- Researcher:  Chavon A. Niles, PhD Candidate, M.A, B.Ed., B.Sc. (Hons)
- This study will explore the pre- and post-migration experiences of racialized immigrant youth (16-24) with disabilities in the Greater Toronto Area (GTA); their feelings of inclusion and exclusion; their access and participation (or non-participation) in education, health and human services.

## What is Being Explored?

- The story of immigrant youth with disabilities
- The gap in service for immigrant youth with disabilities
- Intersectionality of race and disability

## Preliminary Findings

- A lack of understanding of how to deal with racialized immigrant youth in the disability sector and a lack of understanding of how to deal with disability in the settlement sector
- Culturally different understandings of disability in the Global South compared to the Global North
- Some youth do not understand why they need to self disclose or self identify as having a disability to access services they need
- Other youth are comfortable and see the label as a way to be recognized and receive the support they need.

## Contact of Researcher

- Chavon Niles, HBSc, BEd, MA; PhD Candidate -Social Justice Education; Ontario Institute for Studies in Education, University of Toronto; chavon.niles@mail.utoronto.ca / 647 993 9362

# ARCH Videos

- It's Your Life
- It's Your Money

# Keep our eye on the prize

- Often the decisions of the person with the disability will be different than that of their family member.

We tend to vilify Parents

## Human Rights: Engaging Families

- Focus Groups and interviews with family members of someone with an IDD (74 family members in total)
- Family members asked for legal education about the rights of their sons and daughters

## Engaging Families

- Must remember….
  - The family lives in the context of disability also.
  - They have had to advocate for their son or daughter from birth.

Change is a process, not an event.

# Transition-Age Youth Leaving Foster Care

## Sarah Lyttle


## Case Files

- 3 Binders of My Life

## Ministry extended the age of "Youth"

- 18 different homes between 4 years old and 23 years old.
- The transition from youth to adulthood is extremely stressful
- It can lead to anxiety, depression, drinking

## Entering Developmental Services

- I had to meet with multiple agencies to see what the options were. Was a lot of pressure.

## Turning 21

- On my 21st birthday
- I got on ODSP and moved into a bachelor in Wasaga Beach….

## Not enough support

- It became very stressful with no supports in the bachelor.
- I had nowhere else to go
- Because of my anxiety I went back to Foster Care…

## Living on my own with agency support

- Community Living told me there was a place available in Toronto.
- I couldn't take it anymore at the foster house, so I accepted the move to Community Living Toronto.

## Pictures of Sarah

- Sarah, 7 or 8 years old  at an access visit
- Sarah on the left at an access visit
- Grade 8 graduation
- Grade 12 Graduation
- Sarah's mom and dad
- Foster Care File# 145420
- A poster on my wall.  It pretty much defines me

## Rights Transitioning to ODSP

- Public Guardian & Trustee
- I was told I had to have PG&T

### Depo-provera birth control

- They put me on it when I was 14
- Just got off it at 23


## Person-Directed Planning Rights & Families

- Break into two groups A) staff B) family
- Take a moment to discuss with your table what you think COULD have happened to have better supported Sarah.

_____

_____

_____

## Case Study – Jason: Rights Lens

### Self-Reflection

What are some considerations for Jason relating to his transitions?

_____

_____

_____

What could you or your agency do to support Jason through his transitions?

_____

_____

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### Table Discussion

Assume your table represents a community that will need to work together to support Jason though his transitions. How will you collaborate to support him?

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What other information do you need and how might you obtain it?

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What other people and/or supports do you need and how might you connect with them?

_____

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_____

# Wrap-Up

## Evaluation/Feedback

Please take a few minutes to complete the feedback form if you haven't already done so.

## Personal Commitment Activity:

### Self-Reflection

Based on what you have learned today, identify two or three things that you are going to make a personal commitment to do or try in the next three to four months.

_____

_____

_____

What supports will you need to help enable you to be successful in achieving your commitments?

_____

_____

_____

### Table Discussion

What are some things you are already doing well regarding supporting people through transitions?

_____

_____

_____

What are some "quick wins" around transitions that would be manageable with the current resources you and/or your agency have?

_____

_____

_____

We hope you have found the day useful and enjoyable. Thank you for attending!