THE TORONTO NETWORK OF SPECIALIZED CARE AND DEVELOPMENTAL SERVICES TORONTO

Transition Planning

Day 2: Adult Transitions

Fri Mar 4th, 2016

Participant's Guide

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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 Planning in a Community Context: An Introduction to the CAIR Program *We will take a short break at approximately 10:45am*
11:30am	Sexuality, Relationships, Rights and Advocacy *We will break for a 45min lunch at approximately 12:15pm*
1:45pm	Introduction to Person Directed Planning *We will take a short break at approximately 2:30pm*
3:30pm	Wrap-up: Evaluations, Activity, Summary *We will ensure we have you out the door by 4:00pm*

Case Study - Samantha

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

Samantha is a 33 year old young woman who lives in a SIL (supported independent living) apartment on her own. She has Asperger's Syndrome and uses a wheelchair. Sam, as she prefers to be called, identifies as a lesbian. She and her girlfriend have been together for a few years. They would like to live together but they can't live in the apartment Sam lives in. They spend a lot of time together and work at the same McDonald's. Sam would also like to find a different job but is concerned about meeting new people and changes in her routine.

Working Together

Previous participants in our sessions have agreed to some basic working principles, as follows:

- Respect confidentiality; what is said in the room, stays in the room.
- Recognize diversity as a strength and an asset; participants may have different knowledge, experience, styles of participation and points of view.
- Make every effort to be timely, e.g., with breaks/lunch.
- What else would you like to add to ensure that the learning experience is enjoyable and productive for you?

_____

_____

_____

_____

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 Planning in a Community Context: An Introduction to the CAIR Program

Presented by:

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Agenda

- Introductions
- What is CAIR?
- Clinical Planning
- Transition Planning
- Wrap-up & Questions

Learning Objectives

1. Understand what CAIR is
2. Understand how CAIR can support complex cases with clinical planning and facilitation
3. Understand what are best practices in transition planning for adults with Dual Diagnosis

Case: Jimmy – see handout provided

The Collaborative And Individualized Resource Program

History of CAIR

- **2011**: CAIR piloted with MCSS funding, partnership between Griffin and CAMH initiated.
  - TC LHIN approached CAMH and a cross-sector Advisory Committee to develop a comprehensive plan for individuals with Dual Diagnosis & ALC
- **2012**: ALC service piloted with TC LHIN funding and incorporated with CAIR
- **2014**: Core funded service within CAMH ANS outpatient service, partnership with Griffin continues

Current State

- CAMH, Centre for Addiction and Mental Health
- Griffin Centre
- Community Networks of Specialized Care, Toronto Region

Funding

- CAIR Program: MCSS &TNSC
- ALC Service: TCLHIN

The CAIR Team

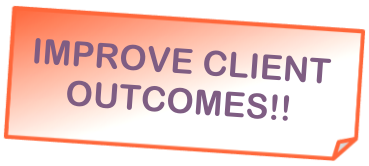
- Cynthia: Resource Supervisor H.BS; Griffin Centre
- Leo: Clinical Facilitator H.BSW, MSW,RSW; CAMH
- Olivia: Alternate Level of Care Behaviour Therapist M.ADS, BCBA; CAMH

What is CAIR?

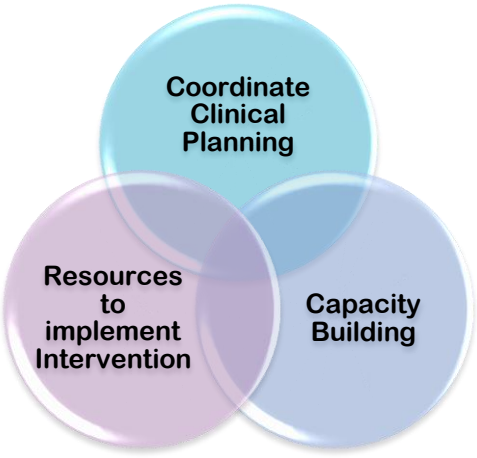
- A time-limited comprehensive intervention and clinical support for adults with a developmental disability and complex needs, who require flexible, innovative, and individualized response to be maintained in the community.

CAIR Mandate

1. Collaborate with client, agency & caregivers to develop an individualized Clinical Plan;
2. Provide short-term resources to implement the Clinical Plan;
3. Make use of ALC service as needed;
4. Enhance Caregiver and System Capacity;
5. Advocate for Systemic movement;

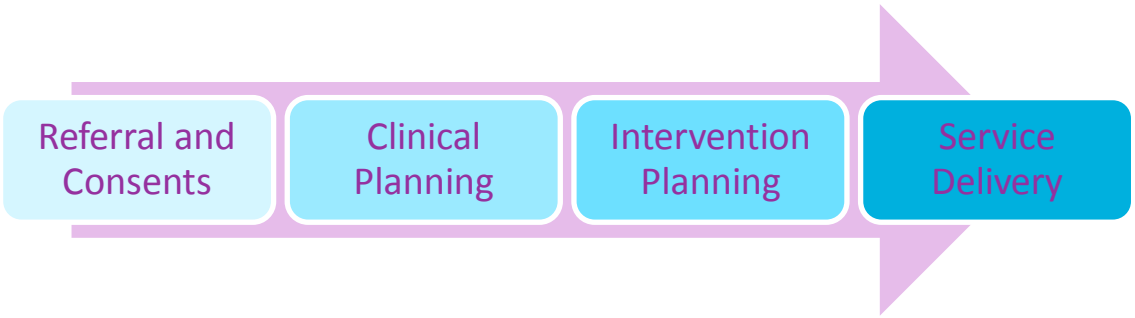


Elements of Service



Overall Goals

Service Pathway



Ongoing collaborative review

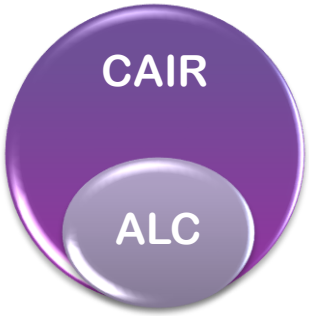
What Can CAIR Do?

- ✓ Collaborate with service providers to create and implement a Clinical Plan.
- ✓ Mentor and support existing Case Manager.
- ✓ Participate in organizational and treatment planning meetings.
- ✓ Provide updates to Clinical Conference.
- ✓ Share evidence-based resources
- ✓ Provide supports to assist the implementation of the Clinical Plan.

What Can't CAIR Do?

- ✗ Fund or resource long-term supports
- ✗ Crisis Response

ALC Service and CAIR



All ALC Clients are CAIR Clients, but not all CAIR Clients are ALC!

What does ALC Mean?

An individual residing in a **hospital inpatient unit** or **treatment bed** who:

- Presents with **complex needs** but can be served in the community with appropriate supports
- Is **blocking** a hospital or treatment bed
- Must be medically/legally designated
- Face **barriers to discharge**

"You've completed treatment and you've got nowhere to go."

Eligibility for ALC Service

Client with an:

- ALC designation
- Dual Diagnosis
- Significant unmanaged behavioural issues including:
  - self-injurious behaviour
  - severe aggression
  - inappropriate sexual behaviours
  - exit-seeking

Service Includes…

- A Behaviour Therapist and flexible funds
- Maximum length of service = up to two years
- Mobile individualized clinical supports which can include:
  - Assessment
  - Treatment
  - Transition Planning
  - Staff Training

Clinical Planning

Video

- There are no quick fixes: Comprehensive assessment of how patients with dual diagnosis use the ER https://www.youtube.com/watch?v=qo8vLMi4yWY

Purposes of a Clinical Plan

Practice & Evidence Based Research suggest:

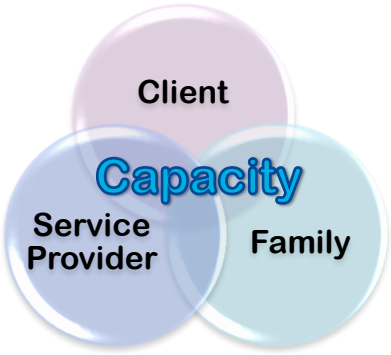
- Providing an overall picture or map
- Noticing gaps in the information about the service user
- Prioritizing issues and problems
- Thinking about lack of progress; troubleshooting; determining criteria for successful outcome

Main purpose in any setting:

- Identifying the best way forward and informing the intervention

Purposes of a Clinical Plan

- Achieving a consistent team approach to intervention
- Helping team, service user and caregivers to work together
- Gathering key information in one place
- Dealing with the core issues (not just crisis management)
- Drawing on and valuing the expertise of all team members



Example of a Clinical Plan

CLINICAL PLANS SHOULD:

(1)Identify Problems or Needs (2) Outline short/long term goals (3) Establish approaches and intervention to meet the goal

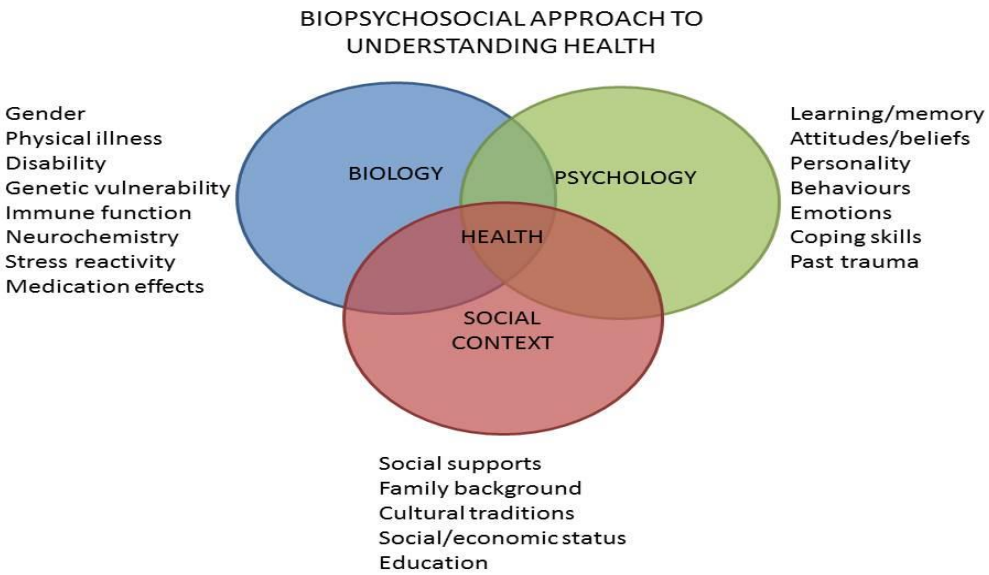
BIOLOGICAL ELEMENTS *(Medical, Physical, Genetic)*

*Have there been recent medical and dental exams? Any issues, treatment in progress? Is there a history of recurring medical/dietary/dental condition (digestive, ear, urinary, heart, respiratory, abscess)? Any noticeable change in eating, sleeping, physical routine/elimination, self care, energy level, mood, facial/communication/behavioral expressions? Any medication? Any side effects? What diagnosis? What else might be causing physical discomfort? Is there any syndromes/ predisposing genetic conditions? Any sensory limitations, sensitivity, vulnerabilities or disabilities (hearing, vision, sensitivity to touch, noise)? **What else?**

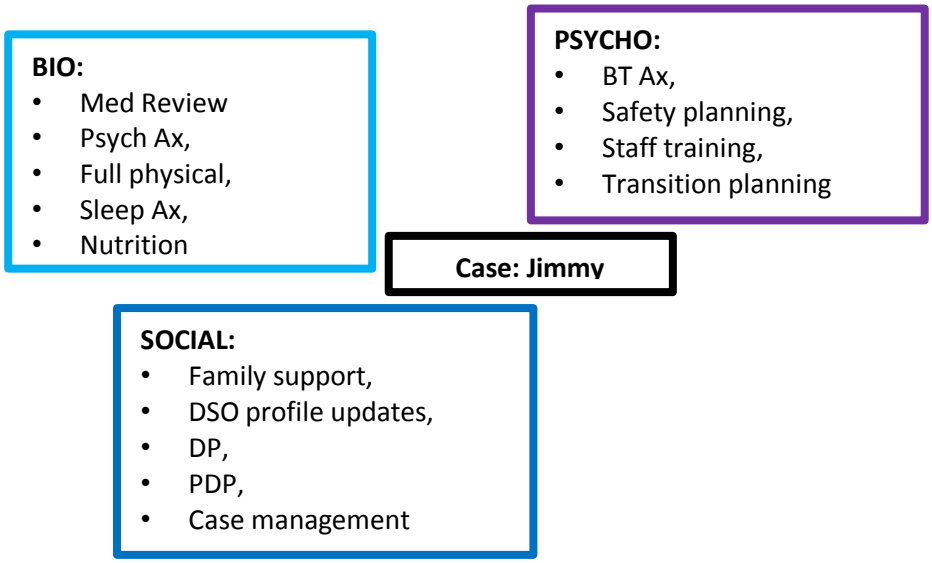
**Adapted from the "Over-to-U" tool developed by the Central Network of Specialized Care*

Identify Presenting Issues or Needs	Short/Long Term Goals/Objectives	Approaches/Intervention/Task	Responsibility	Date Est.	Date Achieved
a-Oral Health	a-Promote good oral health, increase quality of life. Rule out any underlying condition that might be contributing to behaviors	e- Approaches/Intervention/Task: 1) Provide oral health hygiene education and supports (e.g. toothbrush, toothpaste) 2) Referral to ____ dental clinic by nursing staff (most recent referral is Sept. 24, 2014) 3) Client declined to get dentures (March 2014)	a-nursing staff/ dentist/ medial doctor	04/14	Ongoing
b-Schizophrenia/ developmental delay & anxiety	b- To ensure that CLIENT is receiving adequate medical care to address his health concerns and improve his quality of life	b- Approaches/Intervention/Task: 1) Effectively managed with Clonazepam, Quetiapine, Lorazepam (PRN , Loxapine(PRN) 2) consistent use of behavioral program 3) need for structure (Daily schedule; written contacts and routine) 4) Preparation and support through transitions (daily and future) Staff Training 5) assistance to organize belongings 6) assistance to set up and verbal prompting for ADL's as required	1)Psychiatrist 2)entire team 3)entire team 4)BT 5)entire team 6)entire team	04/14	Ongoing Ongoing Ongoing 05/14 Ongoing Ongoing

Bio-psycho-social Case Formulation



Case: Jimmy; Clinical Plan



Transition Planning

- How many people have been part of a transition?
  - Hospital to home?
  - To a day program?
  - How many have led a transition?

Why is this important?

- Another kind of clinical planning that requires time and effort
- "Stuck" in a treatment setting (ALC) for many months/years
- Cost on system(s)
- Having a dual diagnosis increases the likelihood of becoming ALC

Barriers to Discharge (Butterill et al, 2009, Puddicombe & Lunsky, 2007)

- Clients left out of discharge process
- Not involving both parties early-on in planning
- All parties not having good understanding of the others' service and capacity (hospital vs. community)
- Lack of high support housing options and flexibility
- Lack of capacity in the community

What makes a good transition?

- Tailored to the needs of individual
- Carefully planned
- Inclusive of family
- Appropriately timed
- Collaborative and shared accountability

ALC- TRIP

Case: Jimmy; Group Activity

- At your table, work with your team to create an individualized transition plan for Jimmy

_____

_____

_____

References

- Butterill, D., Lin, E., Durbin, J., Lunsky, Y., Urbanoski, K., and Soberman, H. From Hospital to Home: The Transitioning of Alternate Level of Care and Long-stay Mental Health Clients Health Systems Research and Consulting Unit, CAMH, September 2009.
- Puddicombe, J., & Lunsky, Y. Aggression and Dual Diagnosis: Implications for Ontario's Developmental Services. Journal of Developmental Disabilities. 13(1): 191-196.
- Viggiano, T., Pincus, H., and Crystal, S. (2012). Care transition interventions in mental health. Current Opinion in Psychiatry. 25(6): 551-558
- Good Practice Guidelines on the use of formulation: The British Psychological Society (2011) Standards of Practice for Case Management - CMSA

Case Study – Samantha: Clinical Planning

Self-Reflection

What are some considerations for Samantha relating to her potential clinical needs?

_____

_____

_____

Table Discussion

Assume your table represents a community that will need to work together to support Samantha to plan for her clinical needs. How will you collaborate to support her?

_____

_____

_____

Sexuality, Relationships, Rights and Advocacy

Presented by:

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Sexual Health Promotion and Disability

Sexual Health Philosophy and Guiding Principles

- Over the lifespan, sexuality may include the basic needs for touch, intimacy and connection, emotional expression, love and pleasure.
- We promote a satisfying, safe and pleasurable sexual life, while reducing harm, judgement, shame, guilt, coercion, and abuse.
- Choice to participate in consensual sexual activity and support decisions about whether, how and when to have children.

Sexual Health Promotion

We Are:

- Sex positive
- Inclusive of all gender identities and sexual orientations
- Client centered
- Inclusive/non-judgmental/respectful
- Pro-choice
- Evidence informed

What is sexuality?

- Sex goes beyond physical actions
- Many ways to have sex and be sexual
- Part of every life stage
- How we view our bodies and live in our bodies
- Pleasure and intimacy
- Relationships
- If or how we reproduce
- Gender identity
- Sexual identity

Sexual Health Promotion

- Train the trainer workshops & capacity development for service providers
- Workshops for participants on various sexual health topics (Relationships, Safer Sex, Birth Control, STIs)
- Support for teachers to implement the sexual health component of Ontario curriculum
- Resources and condom distribution

Resources and Teaching tools

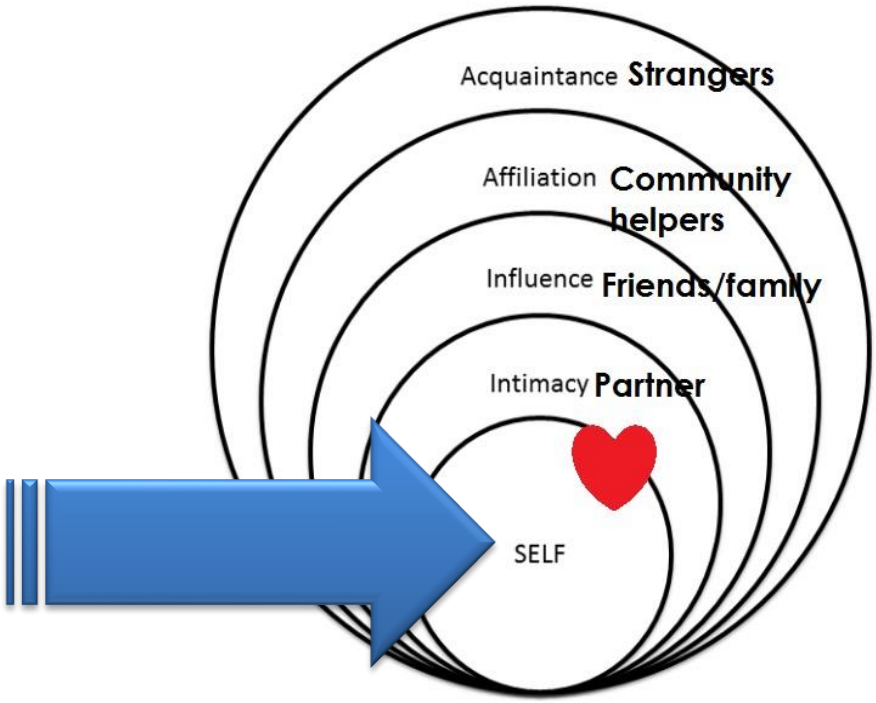
- No need to be an "expert"
- Don't need disability specific resources – adapt for your audience
- Visual tools: Sweedish cards, Sex Esteem and more
- Supports available from TPH, DSTO Relationship workgroup

Web Resources

- Toronto Public Health: Sexual health (lesson plans for teachers)
- Rainbow Health Ontario (LGBTQ specific) http://www.rainbowhealthontario.ca/
- Scarleteen http://www.scarleteen.com
- SexualityandU: http://www.sexualityandu.ca/

Tools for Teaching about Relationships and Sexuality

Your Support Circle



Key things to remember:

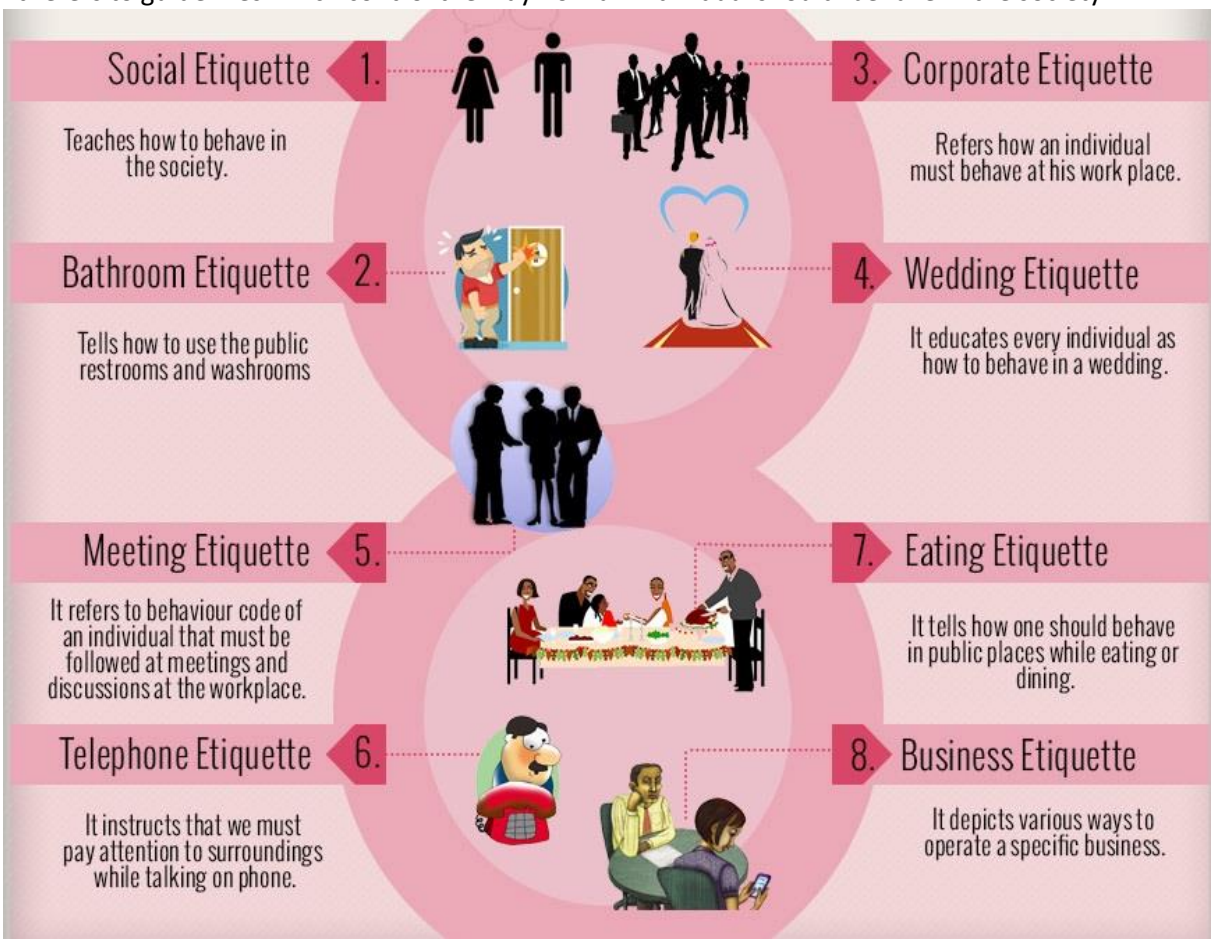
- Everyone has a right to sexual education
- Our space is always positive and welcoming
- All questions are great questions!

Tips to exploring you!

- What are your value/beliefs?
- What are your goals and what are your dreams? (explain the difference)
- What does love mean?
- What is self esteem?
- How do you feel about yourself?
- How to you learn to feel better about yourself?

Importance of Etiquette To Lead a Successful Life

- What is Etiquette?
  - Etiquette is the other word for good manners or a polite behaviour.
  - It refers to guidelines which control the way how an individual should behave in the society.



Handshake

- Can everyone please stand up and introduce yourself to the individuals around you……

Who is your type?

Different way to communicate

How to prepare for a date

What do to during a date?

How to support healthy sexual relationship?

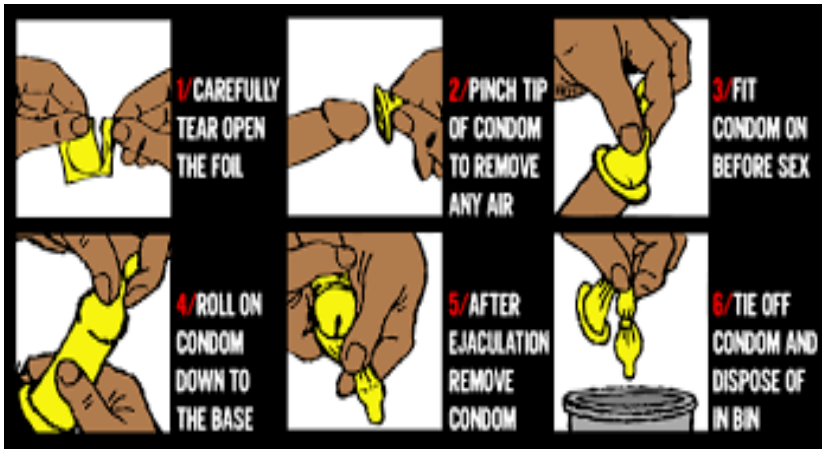
Time for the 'facts of life'

Let's have some fun!

How to support a healthy and active sexual relationship?

Let's have some MORE fun!

How to use a condom



If you are not comfortable.... Please ask for help

Case Study – Samantha: Relationships

Self-Reflection

What are some considerations for Sam relating to her relationships?

_____

_____

_____

What could you or your agency do to support Sam with her relationships?

_____

_____

_____

Table Discussion

Assume your table represents a community that will need to work together to support Sam with her relationships. How will you collaborate to support her?

_____

_____

_____

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?

_____

_____

_____

Introduction to Person Directed Planning

Presented by:

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MONTAGE SUPPORT SERVICES
Live your dream.

What is Person-Directed Planning?

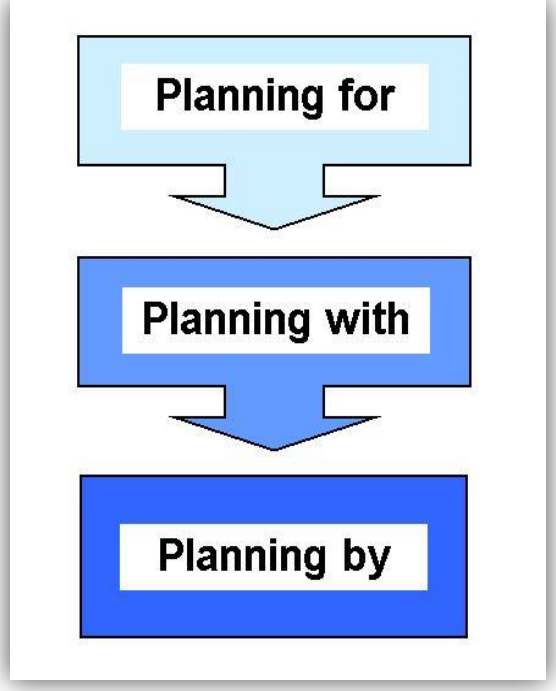
A Person-Directed Plan can help to:

- Create a direction
- Build relationships and inclusive communities
- It helps with transitions (graduating from high school, finding a new job, moving into a new neighbourhood)
- Most importantly, planning discovers goals and dreams

Person-Directed Planning is about the person and his/her life, now and in the future. Planning helps the person choose the actions to make things happen in his/her life.

Changes in How We Plan

- Over the years, Person-Directed Planning has evolved according to changes in society's social policies and significant movement in self-advocacy.



Guiding Principles of Person-Directed Planning

- Guiding Principles:
  - Person-Directed
  - Organic and Dynamic
  - Respects Individual Rights
  - Embraces Cultural Diversity
  - Builds Relationships
  - Inclusion
  - Community as a First Resource

Guiding Principles

Person-Directed Planning is Not:

- service or agency driven
- a group of individuals making decisions for the person
- focusing only on problems or challenges of the person
- having a meeting without the person present
- a tool for crisis planning

What is a goal?

- Why?
- Why?
- Why?
- And again why?

Commitment to Action!

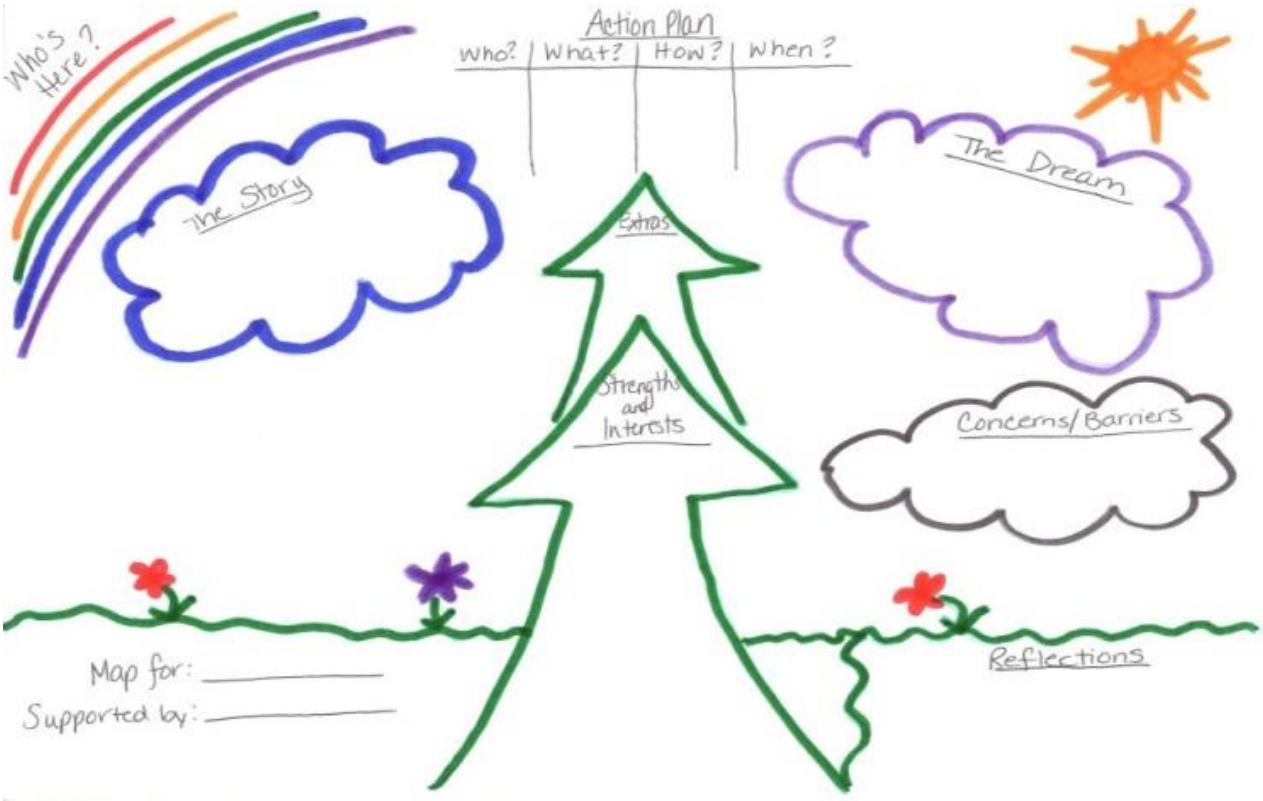
- What?
- How?
- Who?
- When?

Profiles - Getting to Know You

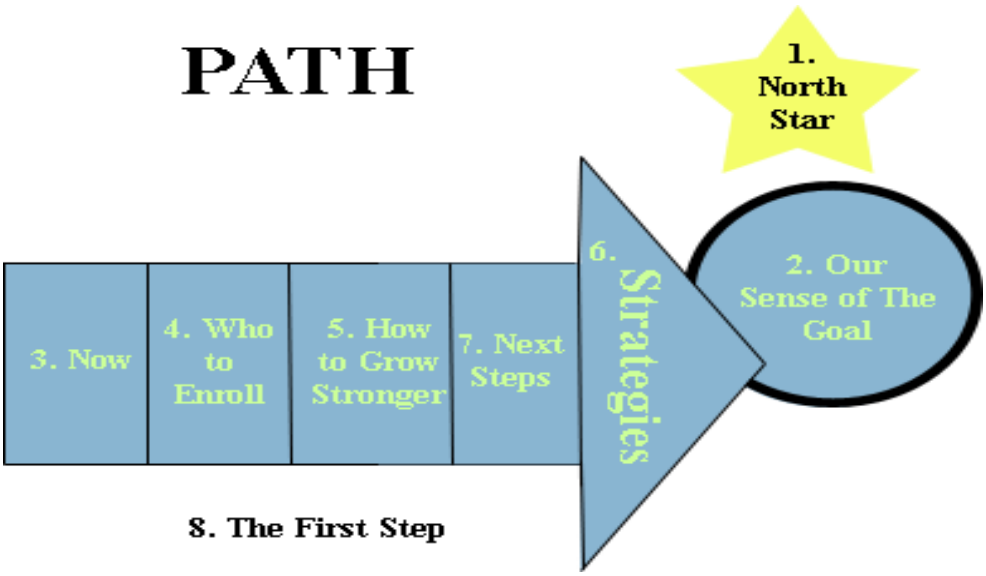
- About Me
- My Life
- Important people in my life

Examples of Planning Tools

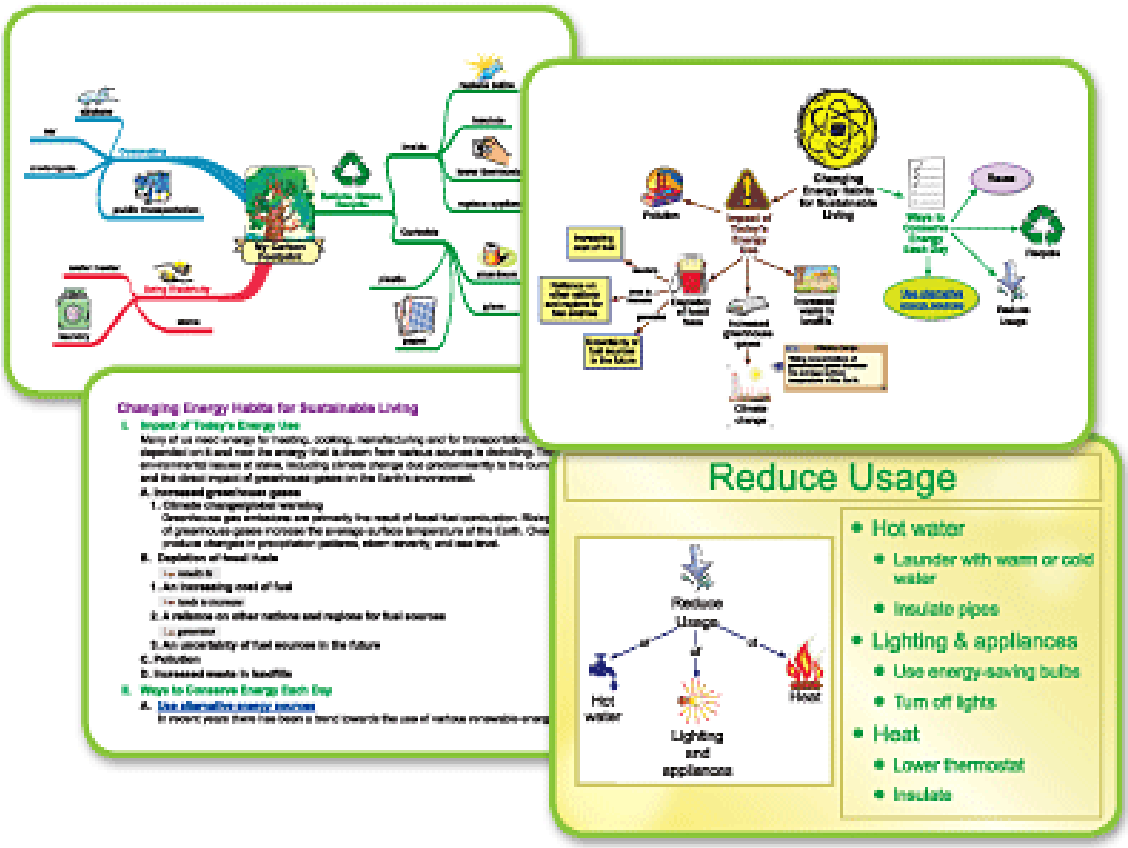
- MAPS (Making Action Plans Succeed)



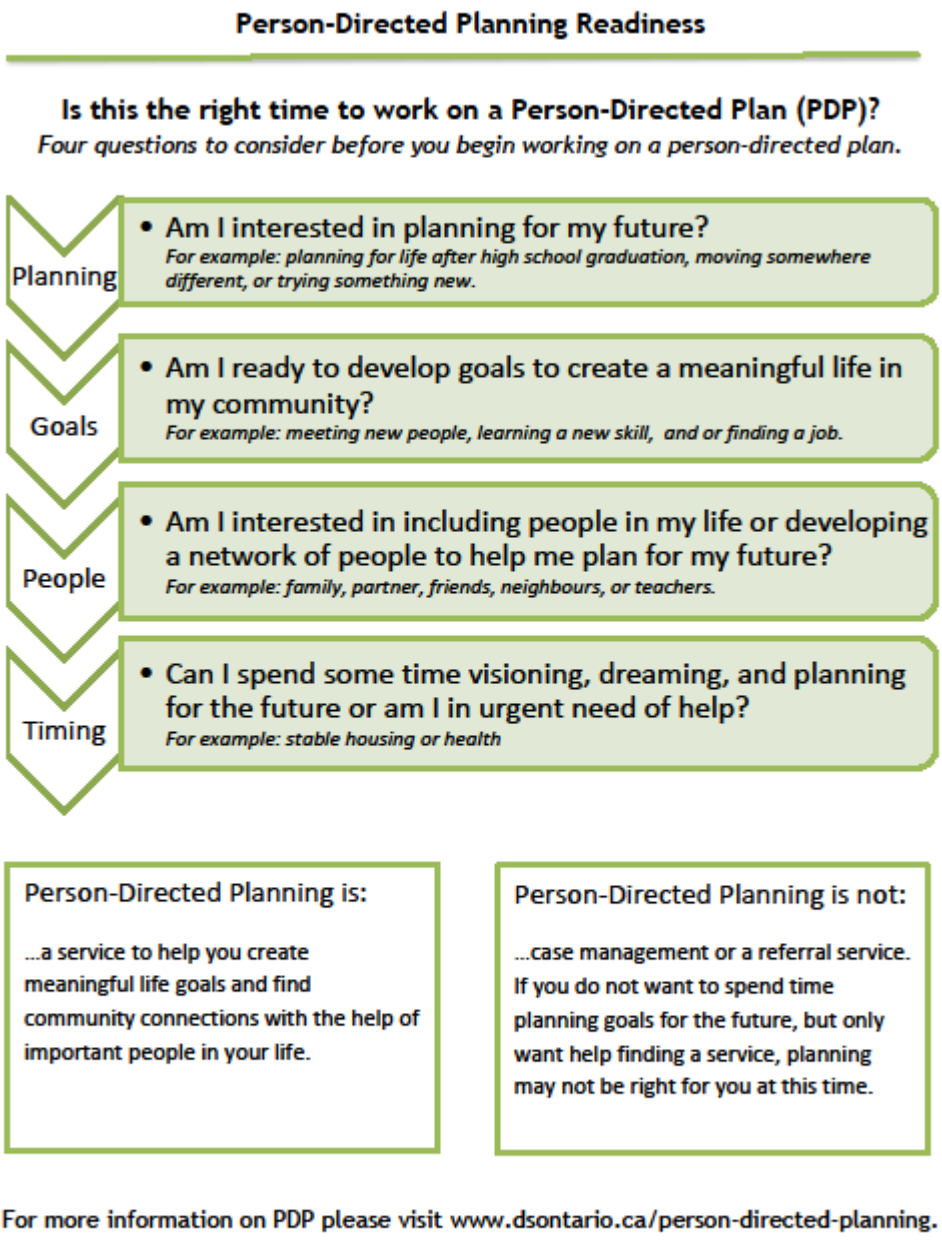
- PATH Planning Alternative for Tomorrow



- INSPIRATION SOFTWARE



Person-Directed Planning Readiness



Person-Directed Planning Readiness

Is this the right time to work on a Person-Directed Plan (PDP)?

Four questions to consider before you begin working on a person-directed plan.

Planning

- Am I interested in planning for my future?
  For example: planning for life after high school graduation, moving somewhere different, or trying something new.

Goals

- Am I ready to develop goals to create a meaningful life in my community?
  For example: meeting new people, learning a new skill, and or finding a job.

People

- Am I interested in including people in my life or developing a network of people to help me plan for my future?
  For example: family, partner, friends, neighbours, or teachers.

Timing

- Can I spend some time visioning, dreaming, and planning for the future or am I in urgent need of help?
  For example: stable housing or health

Person-Directed Planning is:

...a service to help you create meaningful life goals and find community connections with the help of important people in your life.

Person-Directed Planning is not:

...case management or a referral service. If you do not want to spend time planning goals for the future, but only want help finding a service, planning may not be right for you at this time.

For more information on PDP please visit www.dsontario.ca/person-directed-planning.

Resources to Facilitate Plans

- The Facilitator's Guide to Person-Directed Planning
- Creating a Good Life in Community – A Guide on Person-Directed Planning
- Connect*ABILITY*.ca
- Community Resources blog

Who's in your life?

Community Mapping

- See handout provided

Case Study – Samantha

Self-Reflection

What are some considerations for Samantha relating to her planning needs?

What could you or your agency do to support Samantha with her planning needs?

Table Discussion

Assume your table represents a community that will need to work together to support Samantha with her planning needs. How will you collaborate to support her?

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?

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!

THE TORONTO NETWORK OF SPECIALIZED CARE AND DEVELOPMENTAL SERVICES TORONTO

Transition Planning

Day 2: Adult Transitions – Fri Mar 4th, 2016

CAIR

Case – Jimmy

Jimmy is a 24 year old young man with Fragile X, Anxiety disorder, Intellectual Disability – severity unspecified and severe physical aggression. He is currently residing in a local Toronto Hospital to which he was first admitted in Feb 2014 through the ER due to severe risk to self and others. Since then he has been moved around the hospital as beds become available and as safety risks change over time. Currently he has landed in the General Psychiatric unit for the last 4 months and has 2:1 staffing supports while residing there. During each transition, Jimmy has responded by being unsettled for a couple of weeks affecting his sleep, eating and overall routines. His support staff also reported an increase in his scripting behaviour which includes repeating phrases from movies during these times as well.

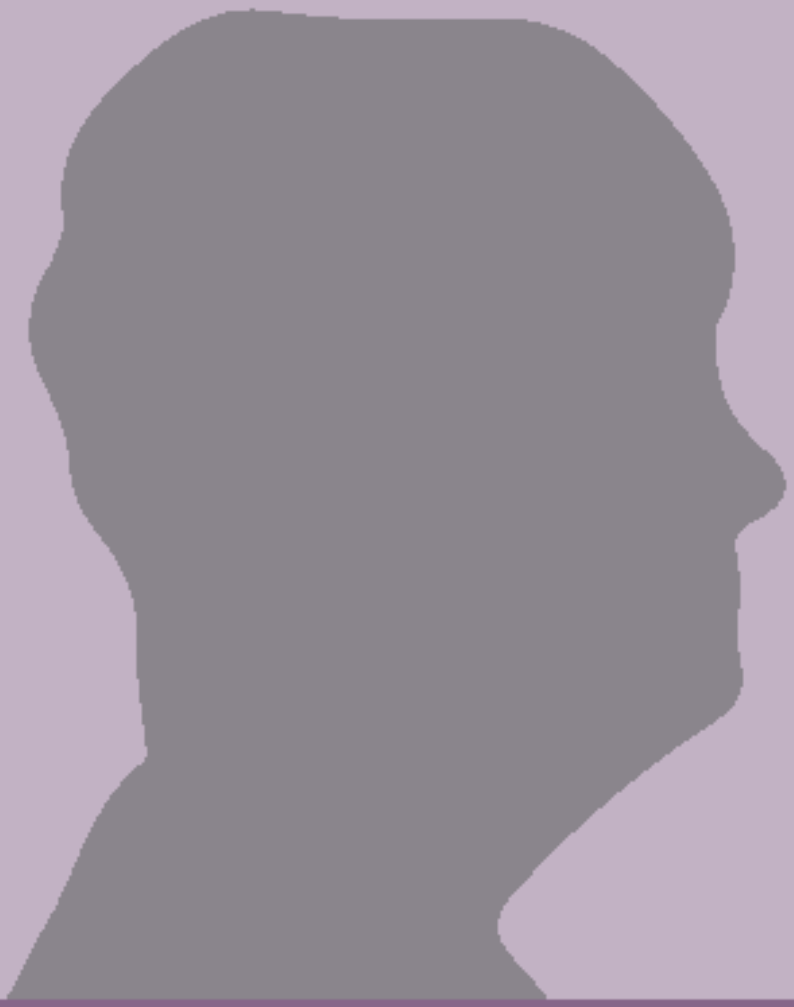
Summary

- 24 year old man
- Diagnoses: Fragile X, Anxiety Disorder, ID- unknown severity
- Severe physical aggression: punching, kicking, scratching, causing injuries
- ALC, in hospital for 7 months
- Parents deceased, brother is SDM
- Disruptions in sleep, eating and routines
- Medication review done; BT consultation available
- Just got pulled for a spot!

Jimmy is on a number of psychotropic medications and PRN medications in an attempt to manage the aggression and anxious presentation; however he still is injuring staff on a weekly basis. There is BT involvement on a consultative basis every 2 weeks. The BT is only working with the team to manage the behaviour and is struggling to implement any new strategies as there is high staff turn-over. He has also gained 20 lbs while in hospital and is at risk of developing diabetes. He has been labeled ALC as all initial treatment goals which include a medication review have been met. All other investigations can be completed within a community setting.

Jimmy is registered with the DSO and is high on the community needs list to be placed in a residential setting. He has no history of accessing or attending a day program. There is little known about how Jimmy learns and it is not clear where he is functioning at. He has not had a psychological assessment since he was 10 years old through the special education program at his school. His brother, James, is his SDM as his parents have both passed away and he has repeatedly expressed his frustration and worry for the future of his brother. He feels the pressure of coordinating the services involved at this point. James recognizes that home is not a viable option for his brother at this point. Just yesterday is brother got an email indicating to him that AT Support Services has a residential opening that is being offered to him. Finally some movement! The placement is an apartment with 1:1 staffing and 3 other residents within the building. How can we make this transition work?

Day 2



Samantha

Samantha is a 33 year old young woman who lives in a SIL (supported independent living) apartment on her own. She has Asperger's Syndrome and uses a wheelchair. Sam, as she prefers to be called, identifies as a lesbian. She and her girlfriend have been together for a few years. They would like to live together but they can't live in the apartment Sam lives in. They spend a lot of time together and work at the same McDonald's. Sam would also like to find a different job but is concerned about meeting new people and changes in her routine. What are some things to consider in supporting Sam? What are some ways to help plan for these changes?

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Transition Planning

Day 2: Adult Transitions – Fri Mar 4th, 2016

Community Mapping Exercise

Community as Neighbourhood (Where you live: ex. Greek Town)	**Community as Personal Networks** (Meet-up groups, co-workers, family, etc.)
Community as Associations of Common Interest (Ex. Book clubs, sports team, faith groups, etc.)	**Community as Third Places** (Coffee shops, Bars, Church, Community Centres, etc.)

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Notes

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Participant Self-Reflection

We encourage you to use this page to keep track of key points, action items, and connections you make at today's event and hope that you will refer to it once you are back on the job to help reinforce your learning.

Key Points: Use the space below to make note of key points, insights, or take-aways that stand out for you during the day

Connections: Use the space below make note of any new people you meet today that you may want to connect with in the future

Action Items:

a) Use the space below to make note of key actions you want to take to apply what you learned once you are back at your job

b) What are some of the challenges you anticipate in trying to carry out your action items? How might you address these?

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Session Evaluation

1. **Overall, I found today's session to be:**

1	2	3	4	5
Poor		Average		Excellent

Please explain why you chose that number:

2. **The overall relevance of today's session to my practice was:**

1	2	3	4	5
Poor		Average		Excellent

Please explain why you chose that number:

3. **What will you do to apply your learning in your work?**

4. **What I found most useful about the session:**

5. **One message to the organizers:**

6. **Other comments?**

Thanks for your participation! Your comments will be collated.

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