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DEVELOPMENTAL SUPPORT SERVICES

COMMUNITY NETWORKS OF SPECIALIZED CARE
RÉSEAUX COMMUNAUTAIRES DE SOINS SPÉCIALISÉS
CENTRAL EAST

Mackenzie Health

A Cross Sectoral Approach to Supporting People with Complex Exceptional Support Needs

Cindie Evans, Specialized Transition Coordinator
Whitney Faragher, Health Care Facilitator
Samantha Airhart, Behaviour Consultant/Justice Specialist- Justice Clinic

OADD April 2023

OVERVIEW

- Community Networks of Specialized Care – Central East
- Complex Support Coordination
- Specialized Transition Coordinator
- Health Care Facilitator
- Dual Diagnosis Justice Coordination
- Justice Adapted-Dialectical Behaviour Therapy Specialist
- Justice Applied Behaviour Analysis Specialist
- Case Studies
- Resources

Community Networks of Specialized Care (CNSC)

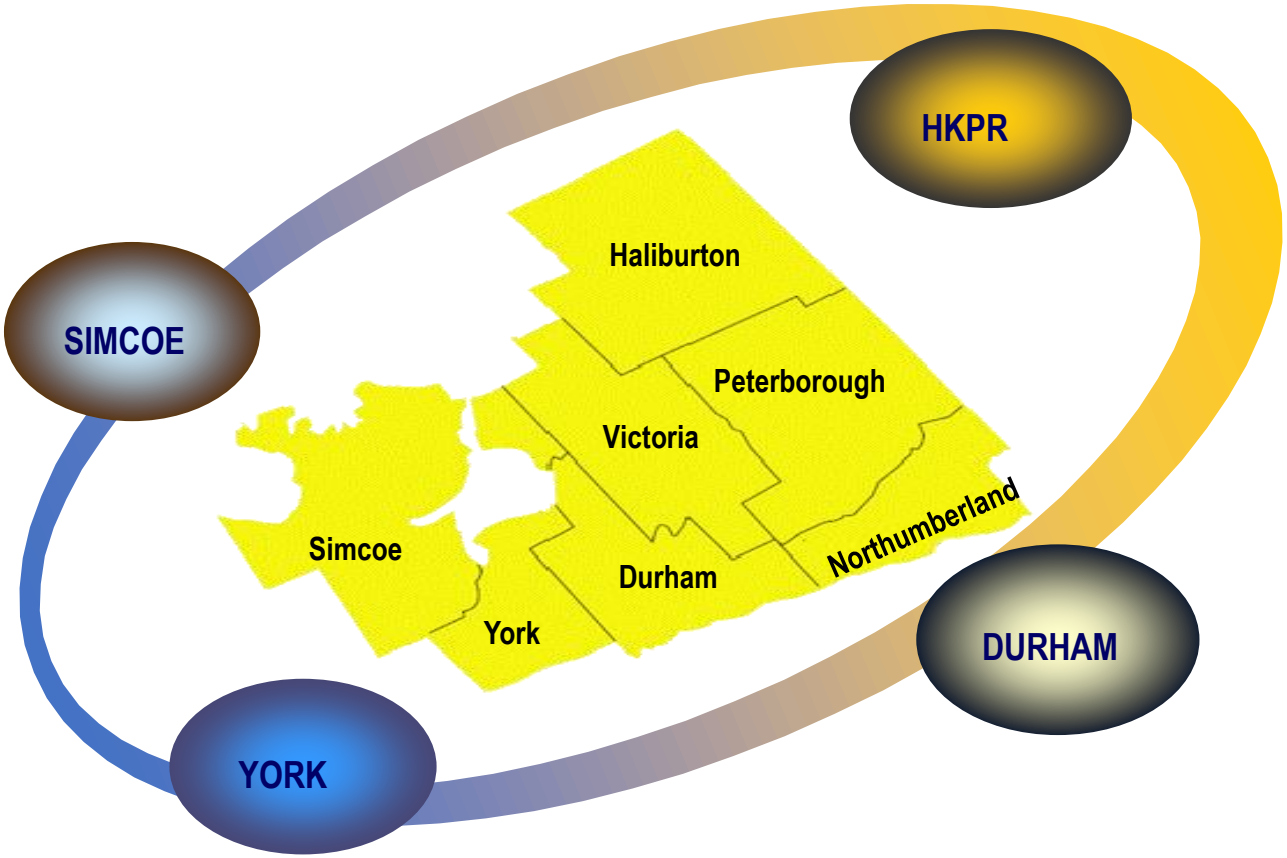
Mandate

To support adults with developmental disabilities and high support and complex care needs by:

- Coordinating support and service within and across sectors, by providing complex support coordination for individuals;
- Acting as a resource to service agencies, Developmental Services Ontario and local planning tables (including urgent response and service solutions / case resolution);
- Building system capacity to better support individuals with complex needs through education, mentorship and support to other case managers and service agencies; and
- Providing provincial coordination of videoconferencing and French Language specialized resources.

Key Functions & Roles in Central East

Community Networks of Specialized Care – Central East (CNSC – CE)



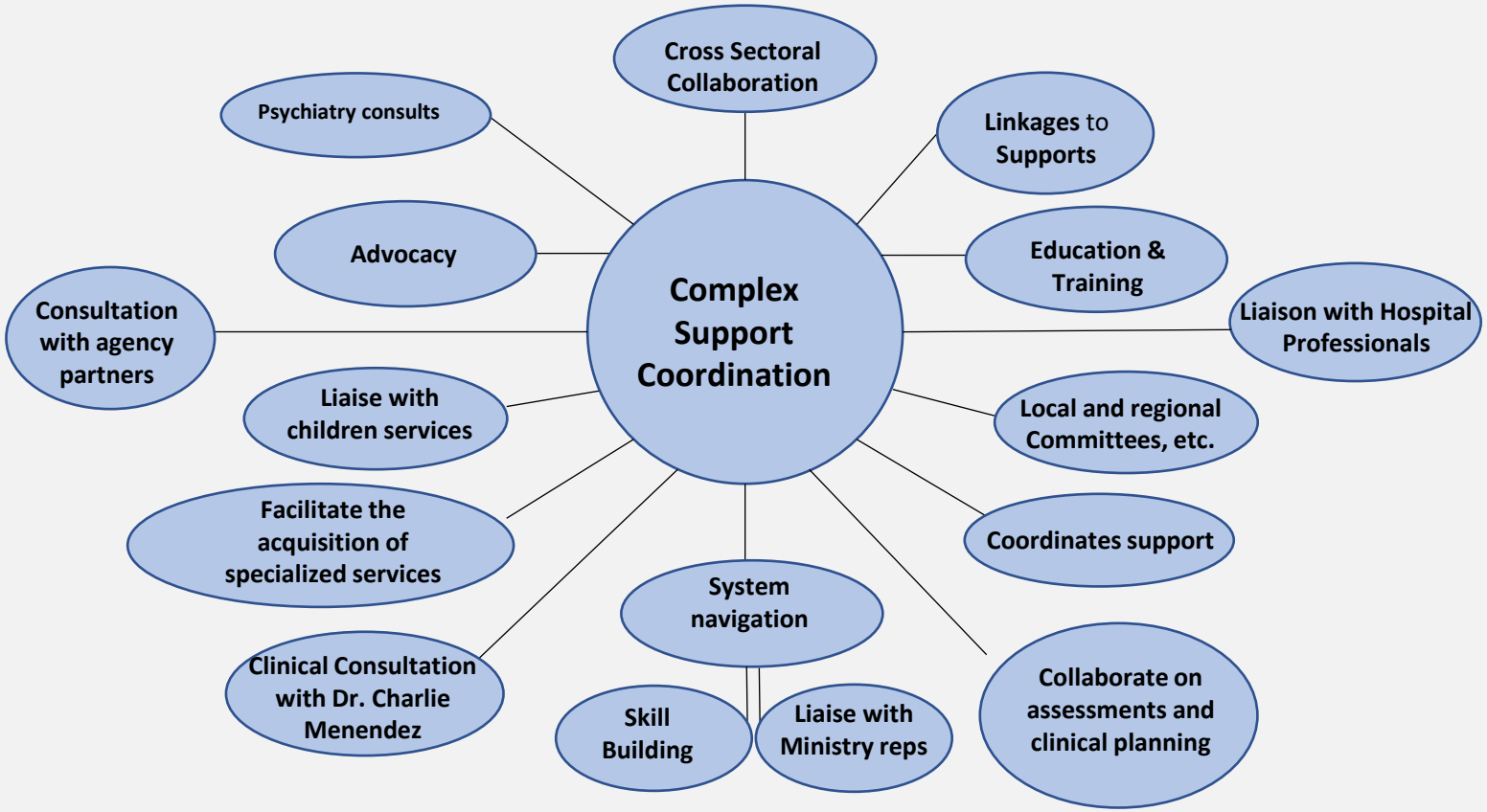
The CNSC – CE coordinates support for the quadrants of Durham, York, Simcoe and Haliburton, Kawartha Lakes, Pine Ridge

Target Population:
High Support & Complex Care Needs (HSCCN)

Criteria for a working definition of HSCCN:

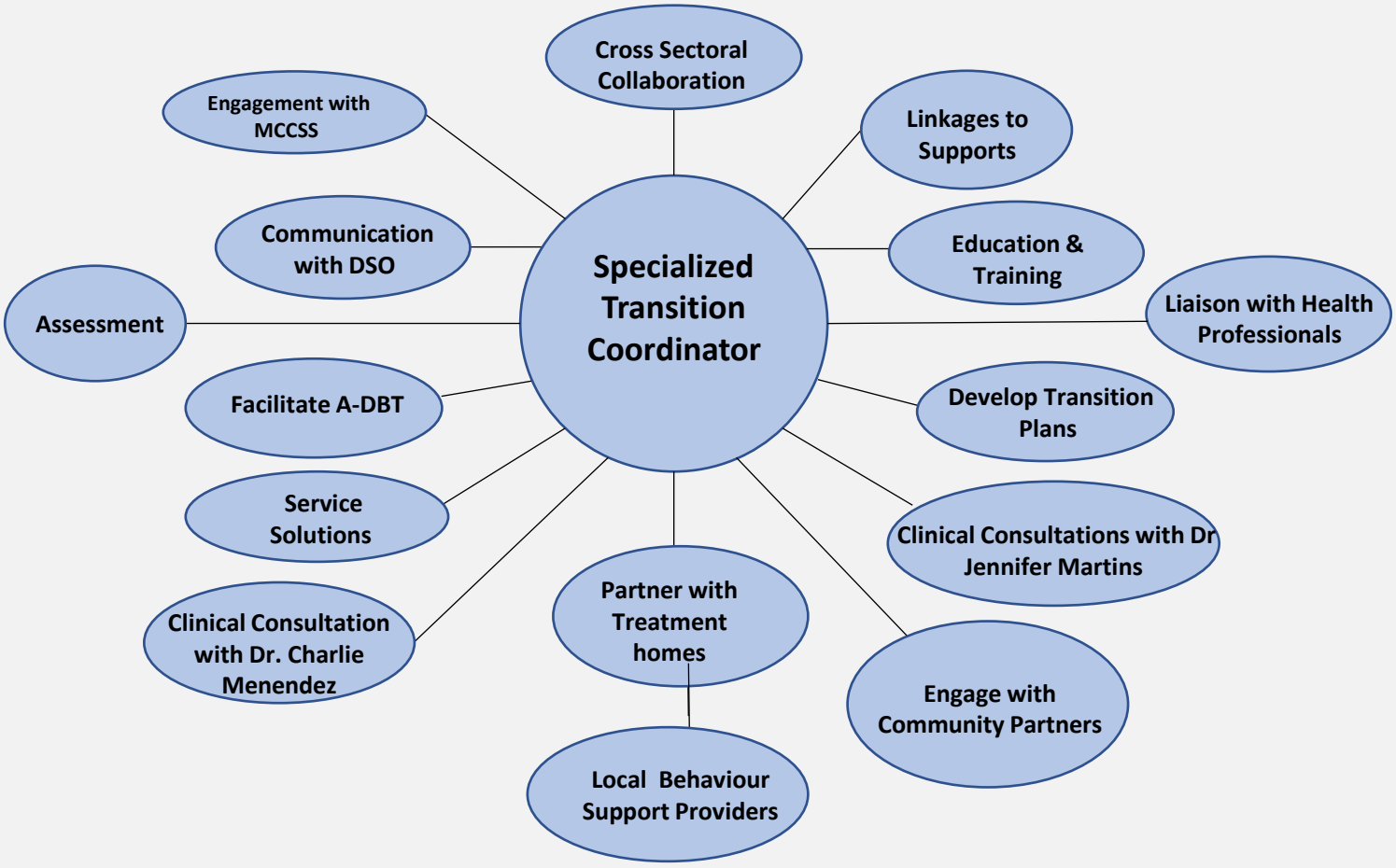
- Those with **extraordinary medical and/or behavioural support needs:** determined by scores on SIS sections 3A (medical; scores of 7 or greater) and/or 3B (behavioural; scores of greater than 10); *and*
- **High overall support needs:** individuals with overall SIS percentiles of greater than 70; *and*
- **Safety concerns:** the primary caregiver (family members and/or paid support persons) has concerns about the person's safety due to his/her medical and/or behavioural support needs (ADSS s6.3 and 6.5); *and*
- **Overnight support: O*nly to be applied for people with exceptional medical support needs*:** (*individuals with extraordinary behavioural support needs do not necessarily need to require overnight support in order to meet the HSCCN definition*)

**** Working criteria to access Complex Support Coordination and Health Care Facilitation**


Complex Support Coordination
Cross Sectoral Collaboration
Psychiatry consults
Linkages to Supports
Advocacy
Education & Training
Consultation with agency partners
Liaison with Hospital Professionals
Liaise with children services
Local and regional Committees, etc.
Facilitate the acquisition of specialized services
Coordinates support
System navigation
Clinical Consultation with Dr. Charlie Menendez
Collaborate on assessments and clinical planning
Skill Building
Liaise with Ministry reps

CNSC – CE Complex Support Coordination

- Provides cross-sector coordination support for persons with complex needs (e.g., assessment, clinical planning, housing, planning tables), including:
  - Facilitation of the acquisition of required specialized supports and services
  - Coordinating support to enhance existing resources and services
  - Liaising with different sector partners
  - Assisting with system navigation, including urgent response and other planning tables


Specialized Transition Coordinator
Cross Sectoral Collaboration
Engagement with MCCSS
Linkages to Supports
Communication with DSO
Education & Training
Assessment
Liaison with Health Professionals
Facilitate A-DBT
Develop Transition Plans
Service Solutions
Clinical Consultations with Dr Jennifer Martins
Clinical Consultation with Dr. Charlie Menendez
Partner with Treatment homes
Engage with Community Partners
Local Behaviour Support Providers

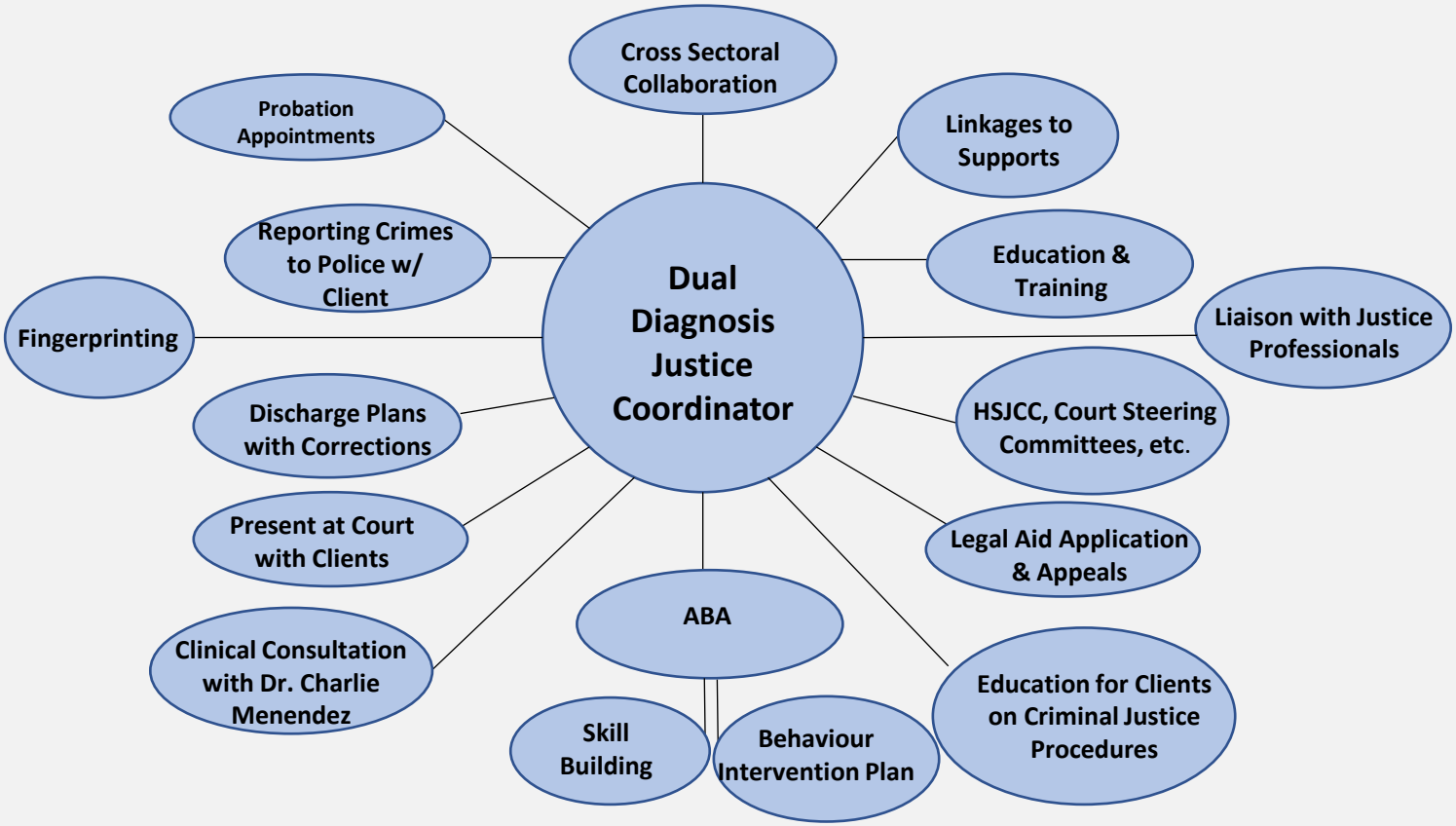
CNSC – CE Specialized Transition Coordination

- Provides coordinated transition plans for persons with developmental disabilities and high support and complex care needs to access specialized supports and services in Central East
- Provides flow through of persons ready for discharge from Community Networks of Specialized Care—Central East treatment beds, the Alternative Level of Care patients from Ontario Shores Centre for Mental Health Sciences and Waypoint Centre for Mental Health Care Dual Diagnosis Units and general hospitals, Waypoint Centre for Mental Health Care Forensic Units, and from hospital beds supporting those with complex medical needs into community settings
- Accesses coordinated specialized supports and services for the transitions plans so the person with complex needs can be successful long term in the community


Health Care Facilitation
Cross Sectoral Collaboration
Linkages to specialized care
Linkages to Supports
Mental health resources and support
Education & Training
Medical procedure support
Liaison with hospitals, health care professionals
Discharge Plans from hospital
Developmental sector Committees, etc.
Advocate for health supports
Ontario Health team collaboration
Health care planning
Clinical Consultation with Dr. Charlie Menendez
Home and community care connection
Skill Building
Medication Management

CNSC – CE Health Care Facilitation

- Supports and educates primary health care providers and non-developmental services agencies about people with complex and multiple needs. This includes developing and implementing resources and tools, such as the Primary Care of Adults with Intellectual and Developmental Disabilities 2018 Canadian Consensus Guidelines
- Provides support to developmental services agencies so they feel equipped to better address the health care requirements of people with complex and multiple needs.
- Identifies specialized training needs and gaps, and provides trends to agencies so they can support people with complex and multiple needs.
- Provides information to people with complex and multiple needs, caregivers, service providers and staff regarding community health care systems.


Dual Diagnosis Justice Coordinator
Cross Sectoral Collaboration
Probation Appointments
Linkages to Supports
Reporting Crimes to Police w/ Client
Education & Training
Fingerprinting
Liaison with Justice Professionals
Discharge Plans with Corrections
HSJCC, Court Steering Committees, etc.
Present at Court with Clients
Legal Aid Application & Appeals
ABA
Clinical Consultation with Dr. Charlie Menendez
Skill Building
Behaviour Intervention Plan
Education for Clients on Criminal Justice Procedures

CNSC – CE Dual Diagnosis Justice Coordination

- Supports collaborative contacts with community services for diversion planning including developmental services and mental health resources and services
- Provides partnership and planning with mental health court support workers, local correctional and custody facilities for appropriate discharge planning
- Provides a central point of contact for persons to be referred to mental health services and other community supports
- Coordinates a continuum of services based on client choice and need.

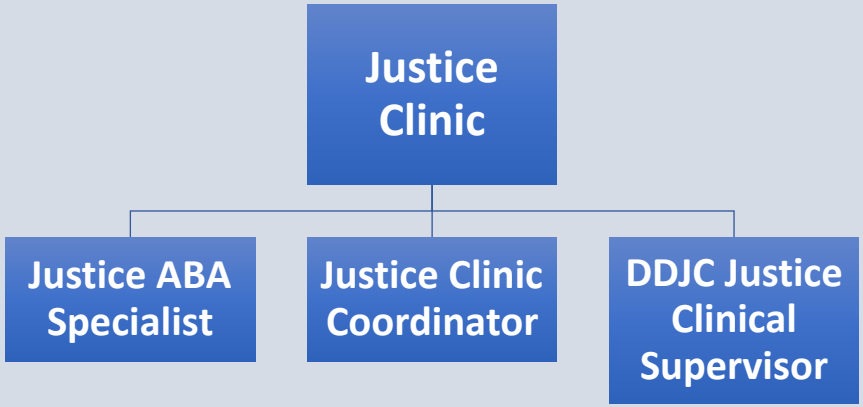
Justice Adapted-Dialectical Behaviour Therapy Specialist

- Lead facilitator of the A-DBT Justice Group
- Goals in A-DBT group are to enhance coping skills in the areas of mindfulness, emotion regulation, distress tolerance and interpersonal effectiveness
- Individual review and 1:1 A-DBT justice sessions provided when clinically necessary
- Provides overflow for DDJC support when DDJC's are at capacity

Justice ABA Specialist Role

- Focuses on implementing Applied Behaviour Analysis (ABA) Justice Plans to help support clients
- Works with the accused and victim/witnesses
- First step: conduct a Functional Assessment to assess what their specific needs are and goals for support
- Second step: create an individualized plan for each individual based on this assessment
- Collaborates with all professionals involved with the individual to ensure that skills can be generalized and/or specific goals that are appropriate for the client
- Clients **DO NOT** need to be DSO eligible to receive this service but need to have some sort of developmental disability (e.g., brain injury, Autism level 1)

Clinical Justice Program (CJP) Pillar I: Justice Clinic



- Our programming utilizes an evidence-based, **Applied Behaviour Analysis (ABA)** approach to create and implement ABA Justice Plans and Court Support Plans
- **Goal**: the individual can meaningfully participate in the justice system, no matter what stage
- **ABA Justice Plans** teach individualized skills
- **Court Support Plans** are a report that is provided to all parties involved in a trial and includes recommendations/accommodations to ensure the individual can participate in the trial and be able to provide their evidence

ABA Justice Plan Examples

Approaches/Steps to Advocating for Services

1. Ask daily guards and/or nurse for service that you require
2. Ask daily guards who you can speak to about what you need
3. Ask daily guards to speak with a social worker

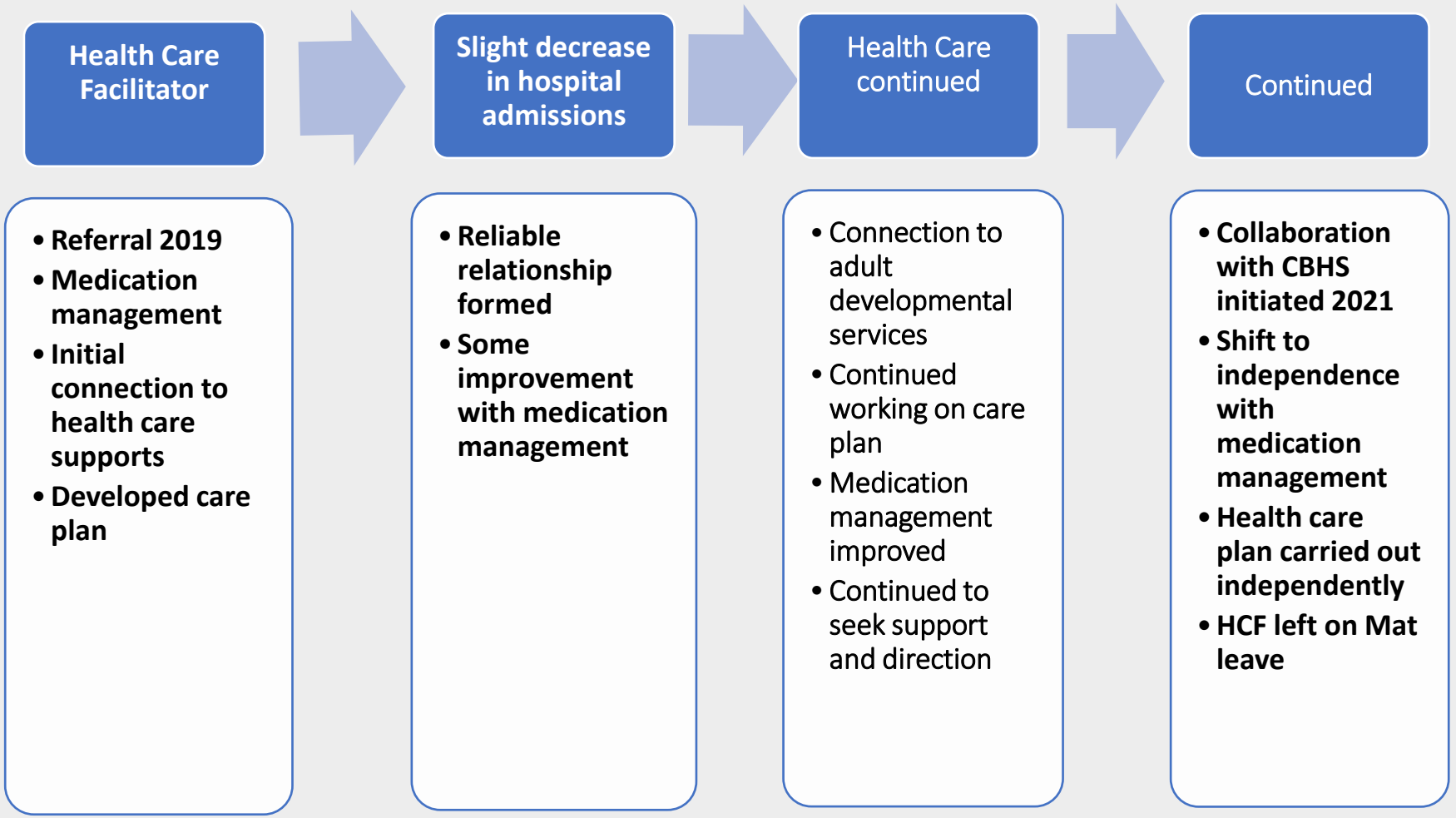
- **Rules and expectations of both in-person and virtual court**
- **Decreasing behaviours in the courthouse**
- **Rights and responsibilities for a victim/witness**
- **Adapting/individualizing mental health diversion curriculum (e.g., Anti-Theft, Anger Management, Boundaries, Partner Assault Response)**
- **Peace Bond conditions**
- **Probation order conditions to follow and self management schedule**

Case Study

- Mary is a 36-year-old woman
- Lives in a home with housemates and boyfriend
- Diagnosed with Developmental Disability, Depression, Urea cycle defect (Carbamylphosphate synthase 1, CPs1 deficiency)
- Cloak of competence
- Involved with Health Care Facilitator for medication management and linkages to health resources
- Involved with collaboration for ABA programming in health care
- Charged with assault with a weapon

Disclaimer: All names and identifying information have been changed to protect confidentiality

Case Study


Health Care Facilitator
Slight decrease in hospital admissions
Health Care continued
Continued
• Referral 2019
• Medication management
• Initial connection to health care supports
• Developed care plan
• Reliable relationship formed
• Some improvement with medication management
• Connection to adult developmental services
• Continued working on care plan
• Medication management improved
• Continued to seek support and direction
• Collaboration with CBHS initiated 2021
• Shift to independence with medication management
• Health care plan carried out independently
• HCF left on Mat leave

Case Study

Connecting with Behaviour Consultant/Justice Specialist

- HCF saw a need for more programming and individualized supports
- Connect with Behaviour Consultant to discuss if programming could be created
- BC agreed to pilot ABA programming with health care sector

Justice Specialist connecting

- Connected with Mary to see if she would be willing to work on some goals and she was agreeable

Potential goal for programming

- Discussed that goal of following a calendar for medical apts
- Discussed additional goal of teaching Mary how to create calendar apts and reminders in her phone

Case Study

Functional Assessment

- **Determined the specific goals, how she learns, gather any preliminary data on the goal**

ABA Implementation

- **Based on baseline data that was collected at Functional Assessment, Sam created an individualized ABA program**

ABA Implementation

- **Implemented program with visuals**
- **Continued with weekly meetings to ensure that Mary was staying on track and progress was made towards reaching those goals**

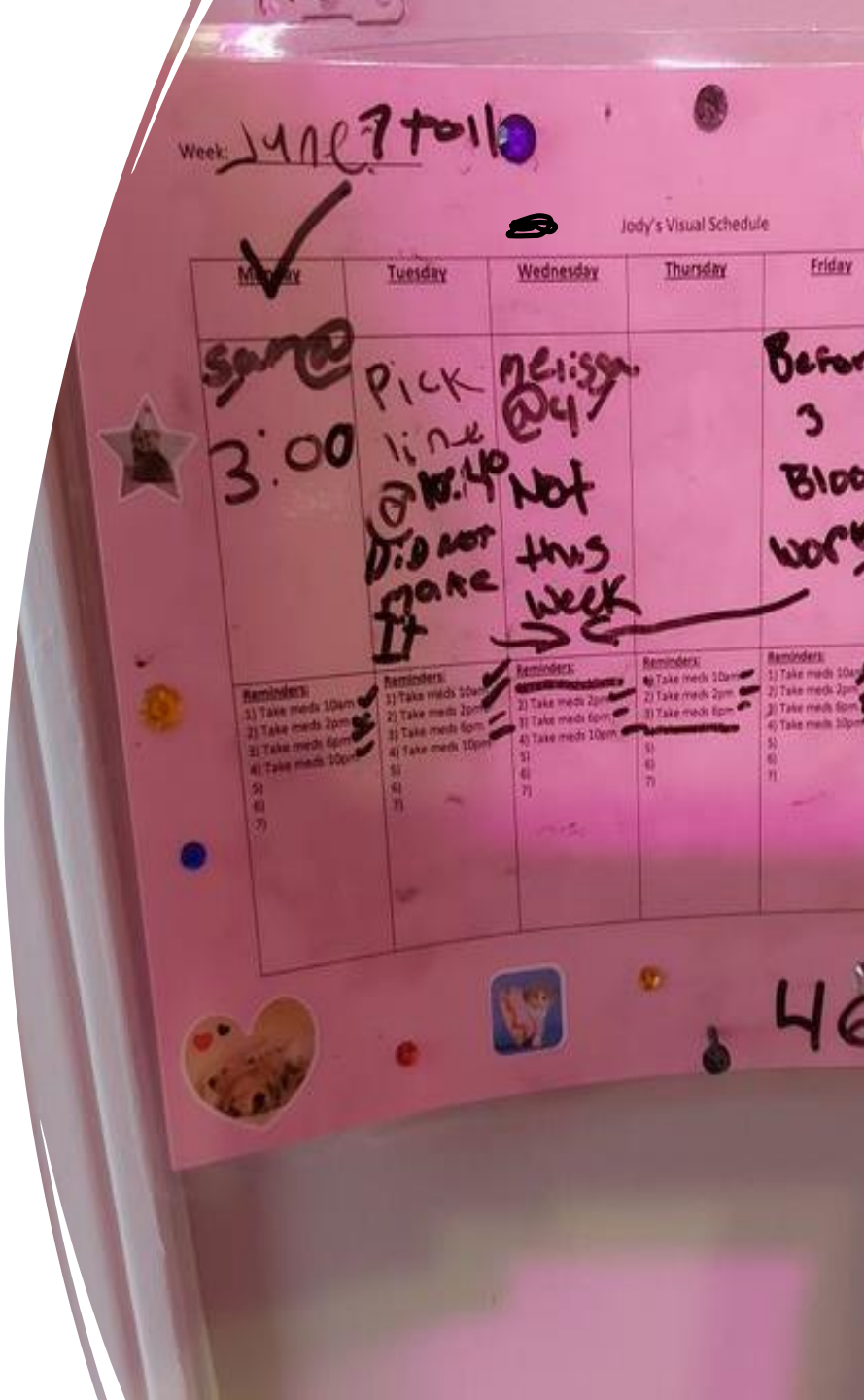
Goals for Mary's Programming

- Follow a medical calendar for appointments
- Mary did not need second goal of teaching how to put appointments into her phone

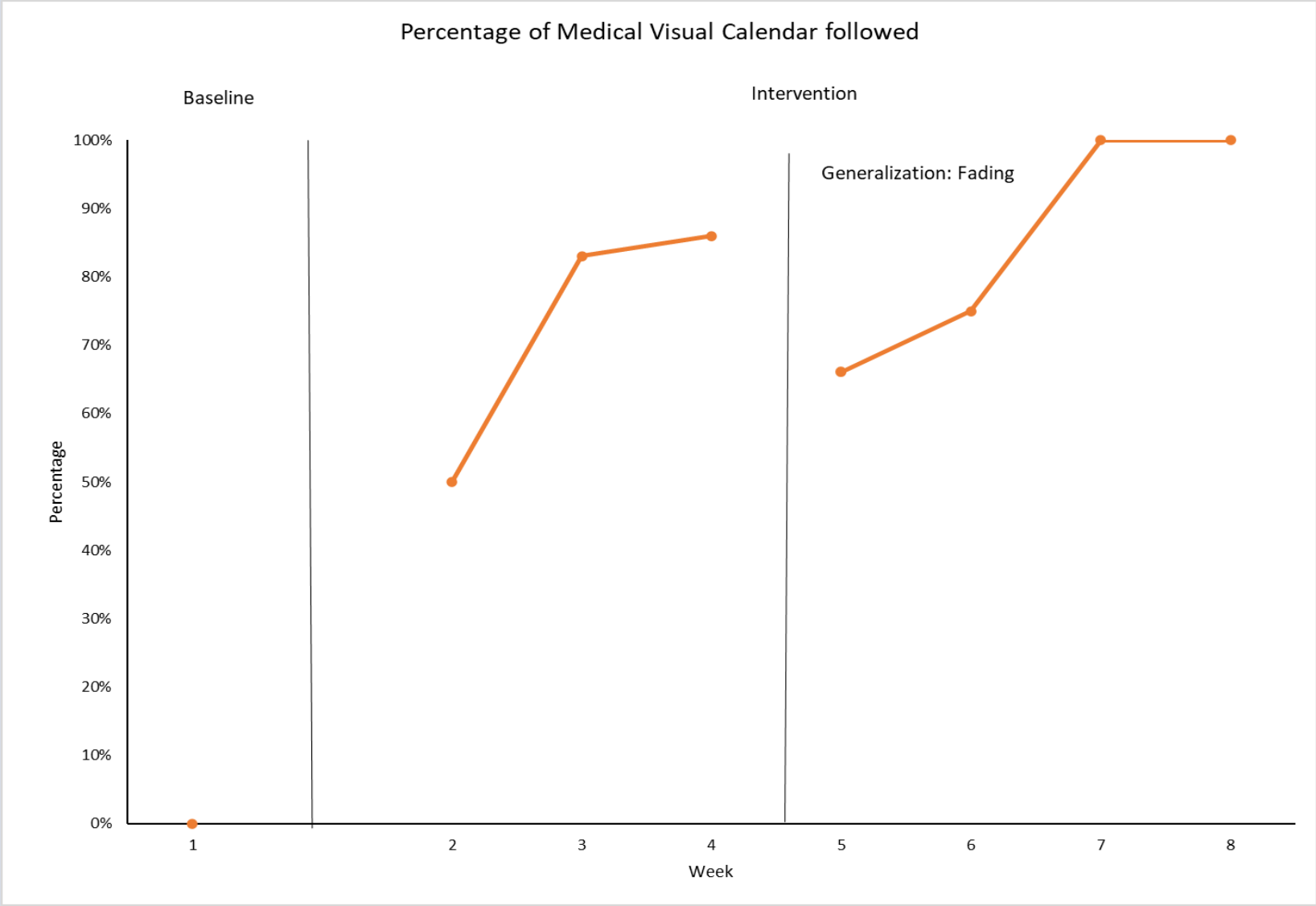
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Reminders:	**Reminders:**	**Reminders:**	**Reminders:**	**Reminders:**	**Reminders:**	**Reminders:**
1) Take meds 10am	**1) Take meds 10am**	**1) Take meds 10am**	**1) Take meds 10am**	**1) Take meds 10am**	**1) Take meds 10am**	**1) Take meds 10am**
2) Take meds 2pm	**2) Take meds 2pm**	**2) Take meds 2pm**	**2) Take meds 2pm**	**2) Take meds 2pm**	**2) Take meds 2pm**	**2) Take meds 2pm**
3) Take meds 6pm	**3) Take meds 6pm**	**3) Take meds 6pm**	**3) Take meds 6pm**	**3) Take meds 6pm**	**3) Take meds 6pm**	**3) Take meds 6pm**
4) Take meds 10pm	**4) Take meds 10pm**	**4) Take meds 10pm**	**4) Take meds 10pm**	**4) Take meds 10pm**	**4) Take meds 10pm**	**4) Take meds 10pm**
5)	**5)**	**5)**	**5)**	**5)**	**5)**	**5)**
6)	**6)**	**6)**	**6)**	**6)**	**6)**	**6)**
7)	7)	**7)**	**7)**	**7)**	**7)**	**7)**

Visual Schedule

- Two component schedule to include appointments but also include checklist for medication times



Graph


Percentage of Medical Visual Calendar followed
Baseline
Intervention
Generalization: Fading
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Percentage
1
2
3
4
5
6
7
8
Week

Case Study

HCF leaving

- Whitney was taking a leave and Sam continued to meet with Mary on a weekly basis and Mary was maintaining the skills until the new HCF was hired

New HCF introduced

- New HCF was introduced a few months later
- Continued with visual medical calendar
- Sam stayed on for a few months to ensure that skills were still being maintained with new HCF

New visual calendar for medication

- New HCF ended up taking visual schedule a step further to create a specific calendar for medication

Criminal Charges

- After discharge from ABA Programming had an altercation with a resident in the home and was charged with assault with a weapon
- Referral was made to Dual Diagnosis Justice Coordinator (DDJC)
- DDJC supported Mary through charges
- Court matters completed through mental health diversion, completed A-DBT justice group and now attending 3 year A-DBT program as continuation

Where is Mary now?

- Well connected to health supports
- Court matters complete through mental health diversion, completed A-DBT justice group and now attending 3 year A-DBT program as continuation
- Attends annual specialist appointments
- Follows up with medications, refills medication
- Continues to have some difficulty with remembering or adhering to medication regime
- Prefers support for medical appointments
- Will sometimes initiate follow up on her own
- Moving into supported living environment
- Decrease in hospital admissions

Transition to Supported Living

- Recognized the need for increase in supports
- Decided she wanted a change in environment
- Skills that Mary developed supported her with independence over her medication and diet management

Collaboration for New Tool

Medication Management Guide

- Background info/questions to ask
- Can’t do or won’t do?
- Who is supporting with meds currently?
- Do they have a blister pack?
- How are they currently reminded to engage in day-to-day activities?
- If it is a refusal create a checklist to gather as much information as possible

Medication Management Guide

Tier 1:

- Embedding in current calendar, system, cell phone alarm
- Health Care supports implementing skills teaching on education (medication schedule, names of meds and side effects)

Tier 2:

- Recommend using an automatic pill dispenser
- Collect data on why they are not taking medications
- Try to assist with rectifying the reason why they are not taking meds (doesn't like taste, texture, side effects- upset stomach)

Tier 3:

- Talk to family Dr about taking it at different times, reducing dose or schedule etc.?

Case Study

Brief History

- Mike D (25)
- Dual Diagnosis
- DSO Eligible
- SIS scores Overall 35, Med 0, Beh 6 *
- Raised by Single Mother
- Left school at 19
- Increase in challenging behaviour
- Support in place ODSP & Passport

Deterioration

- Lack of structure and routine
- physical altercations with mother in public
- 911 calls for support
- Brief hospitalization
- Mother expressing frustration on social media

Crisis Situation

- Significant physical aggression toward mother in public resulting in 911 call
- Police & EMS response
- In-patient admission to local PICU
- CSC linkage (MCCSS request)
- PICU agreed to inpatient medication review

Case Study

Complex Support Coordinator

- Engaged with local Behaviour support provider to explore FBA & develop crisis plan
- Consult with STC to work with hospital & transition plan

Engagement with Community

- Developed Brief Personal Profile
- Developed Complex Support Plan
- Advocacy with hospital to allow staff to implement support strategies
- Explore if Mike would benefit from Behavioural Treatment

Engagement with Systems

- Update local planning table
- Update service request with DSO
- Update MCCSS
- Mother advocating using social media, engaging with MPP & Ombudsman

Case Study

Outcomes → **Where is Mike now?** → **Future Goals**

- Multi-Year Supported Living Plan for community priority
- Hospital support for transition (observation, training, LOA)
- Local Community Living submitted budget for support
- Budget included ongoing behaviour support and counseling

- 3 years later – Mike is supported by the same Community Living
- Support has been adjusted as we learned from Mike
- Police involvement
- Ongoing counselling
- Wrap around support continues
- Regular communication and visits with family

- Consistent support with clear expectations
- Regular access to community activities
- Increasing independence
- Increasing emotion regulation

Complex Support Plan

Name: (DSCIS #) Mike D 300XXXXX	Initial Contact Date: 11/20/2019
Date of Birth:01/01/1998	
Individual's Contact Information: 705-123-4567	Preferred Method: [ ] Call [x] Text
Substitute Decision Maker:	If Yes, Contact Information:
Current Address: 123 Honeybee Lane, Whitby ON	

Type of Placement [ ] Group Home [ ] Supported Independent Living [ ] Long Term Care Individual [ ] Host Family

[ ] Family Home [ ] Individual Supported Living [x] Hospitalized/Homeless [ ] Other, please specify

SIS Overall:	35	Behaviour:	6	Medical 0	

Past & Present Justice Involvement: [x] Yes [ ] No

Details: Police have attended the family home on numerous occasions. The most recent, involvement was due to a significant aggression towards mom, within the family home, which resulted in Mike being admitted and formed into a psychiatric intensive care unit. Mom did not want charges laid.

Risk Assessment Score: 20-High

Complex Support Plan con't

Commitment to Complex Support Plan			
Complex Support Plan Reviewed with and Agreed By:			
Role	**Print Name**	**Signature**	**Date**
Person Referred Individual Signs (may require an 'adapted version')	**Mike Davey**		
Guardian/SDM/POA	**Mary Davey**		
Community Lead (Case Manager/Family/etc.)			

Description of the Person
Strengths
• Video games, Computers, Math, Art, Coding • Strong relationship with mom and a peer he met while in hospital. • Mike enjoys going for walks as well as going to the gym, he requires this to be a part of his daily routine, and otherwise, he will refuse to go if the option is given, as he thrives on structure and routine.
Mental, Physical and Spiritual Health
• Mike has the diagnosis of ASD and treatment resistant schizophrenia. Mike began to experience symptoms related to his schizophrenia at an early age, hallucinates when not well managed by medication. As a result Mike has been in and out of various hospitals for the past several years.
Essential Supports for Daily Living
• Mike would thrive in an environment where there was structure, routine, and expectations. Having a staff designated for him daily, to do his check-ins and be aware of any hallucinations and monitor for psychosis would be ideal. Mike does not need physical support with his ADL'S but rather, a visual schedule and staff prompts to complete it. • Mike would also do well in an environment with individuals who have similar support needs, as Mike identifies with having a Mental Health diagnosis oppose to a Developmental Disability.

Complex Support Plan con't

Housing

- Currently Mike is residing in in a Schedule One hospital, under a form. The hospital staff agreed it was not safe for Mike to return to the family home. The hospital feels Mike would benefit from a treatment home, prior to re-entering into community based supports.
- Historically Mike has spent a great deal of his life, in and out of psychiatric institutions due to his treatment resistant Schizophrenia.

Finances

- Currently receiving ODSP as well as Passport funding. Mom is the financial trustee for both.

Support Network

Name	Role in the person's life	Contact #
Cindie Evans	Specialized Transition Coordinator	
Melanie Powell	Complex Support Coordinator	
Mary Davey	Mom	
Stephanie M	SW-Psychiatric hospital	

Mutually Agreed Upon Goals

Summary

How would you define success in this situation?
Discharged from hospital to appropriate community placement with wrap around support. Mike would thrive in an environment with structure, routine and with a skilled support team on his developmental and mental health support needs.

Present to Dr. Menendez for trauma based support	Melanie	Dec 2019
Update: Presented to Dr. Menendez, recommendation to provide training to support team on Trauma based approach. CSC to provide dates to team and then book with Joanne.		Review Date Jan 2020
Update: Dr. Menendez, met with support team, in-depth conversation on best approach took place to support Mike, the team is to implement strategies given and to update CSC at next case conference. CSC to provide Dr. Menendez the feedback after implementation.		Review Date March 2020

COMMUNITY NETWORKS OF SPECIALIZED CARE
RÉSEAUX COMMUNAUTAIRES DE SOINS SPÉCIALISÉS

Central East Network of Specialized Care
330 Aberdeen Blvd, Midland, Ontario, L4R 5N4
Phone: (705) 526-0311
Fax: (705) 4403
Website: www.community-networks.ca

Brief Personal Profile

Individual (First Name last Initial):	DOB(MMDDYYYY):_____ DSCIS # 300_____
Brief History:	
Developmental & Assessment History:	
Previous Supports Provided to Individual:	
Individual's Strengths:	
Current Challenges and Needs:	
Service / Supports Currently in Place:	
Application Package Completed (provide date):_____ SIS data: Overall___ Medical ___ Behavioral ___	
Support Needs Identified / Service Requests with DSO (include region):	
Environmental Considerations (include residential & day support needs):	
Community Partners / Support from Other sectors:	
Family Support / Involvement:	
Other Considerations:	

Takeaways

- Advocacy for persons with developmental disabilities and high support and complex care needs
- Collaborations amongst community partners
- Cross sectoral planning to provide seamless continuity of care

Resources

- Brief Profile
- Justice App https://justiceapp.community-networks.ca/
- Monitoring Charts Monitoring Charts – DDPCP (surreyplace.ca)
- Primary Care Guidelines Primary Care Guidelines – DDPCP (surreyplace.ca)

Questions

Thank You

Contact Information

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