NAVIGATING DEVELOPMENTAL SERVICES FOR INDIVIDUALS WITH A DUAL DIAGNOSIS AND COMPLEX CARE NEEDS
9 DSO’s across the Province:

- Central East Region - York Support Services Network
- Central West Region - Sunbeam Residential Development Centre
- Eastern Region - Service Coordination des services
- Hamilton-Niagara Region - Contact Hamilton for Children’s and Developmental Services
- North East Region - HANDS TheFamilyHelpNetwork.ca
- Northern Region - Lutheran Community Care Centre of Thunder Bay
- South East Region - Extend-A-Family
- South West Region - Community Services Coordination Network
- Toronto Region - Surrey Place Centre
DSO Toronto Region

• The single point of access for adults with a developmental disability to access available Ministry funded adult developmental services and supports
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.
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 (this is resource dependant)
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 (DSO can help facilitate a referral to a psychologist if this information is not available.)
Eligibility Criteria

• Significant Limitations in Cognitive Functioning
• Significant Limitations in Adaptive Functioning
  • affect areas of major life activity, such as personal care, language skills, learning abilities, the capacity to live independently as an adult or any other prescribed activity
• History of these limitations prior to age 18
• Resident of Toronto
• Can register at 16 years old but cannot access services until 18 years old
You Will Be Asked For:

- Psychological assessment report
- Proof of Address - health card
  - ODSP stub
- Proof of Age - birth certificate
Application Package

- Application for Developmental Services and Supports (ADSS)
- Supports Intensity Scale (SIS)
Completing the Application Package:

• Assessors are trained and certified to complete the package in a standardized way across the province

• Participants include the individual who is eligible to receive services and (if possible) two other people who know that person well

• At the end the individual will have a Service and Support Profile
CONNECTING WITH A SERVICE NAVIGATOR

- The Community Liaison can help update the individuals profile.
- Answer questions about the Developmental Services and Supports available in Toronto.
- The primary role is to support front line and direct care community service staff in working with their clients and families to help better understand the DSO TR, the community supports and developmental supports that maybe available.
MATCHING AND LINKING TO DS SUPPORTS

- The client profile informs how the DSO TR matches support services by creating priority.
- Those highest in need are matched first based on our Legislation and directives by the Ministry of community and social services.
- We match to available resources.- as declared by the agencies that make up Toronto’s Developmental Sector.
CRISIS SUPPORTS

Griffin Community Support Network

DS Urgent Response

• The person’s unpaid primary caregiver (e.g. family member) is unable to continue providing care that is essential to the individual's health and wellbeing;
• OR,
• The individual has no residence or is at risk of having no residence in the very near future;
• OR,
• The individual's support needs have changed to such an extent that their current support arrangement may soon become untenable and their wellbeing is likely to be at risk;
• AND,
• The formal and informal supports are not available to reduce the risk of harm or address the need.
Griffin Community Support Network

Must:

- Support, maintain and sustain the individual’s living situations
- Be directed to situations requiring short-term supports (i.e., less than 90 days) and up to a maximum of $5,000 per request;
- Address the risks for the individual with a developmental disability and his/her family
TORONTO NETWORK OF SPECIALIZED CARE

Jennifer Altosaar
Coordinator
COMMUNITY NETWORKS OF SPECIALIZED CARE VISION IS THAT…..

Mental Health and Developmental Services are:

- INTEGRATED
- COORDINATED
- RESPONSIVE

What we want: Intentional, coordinated, strategic
THE ROLE OF THE NETWORKS IS ..... 

- To help services to work together.
- To help staff and families learn how to help through education and training.
- To promote research.
TORONTO NETWORK COMPONENTS

Specialized
- Clinical Services/Supports
- Case Management
- Crisis Response and Transitional Community Support
- Respite Services
- Residential Treatment
- Day Treatment
- Inpatient and Outpatient Hospital Treatment
MEMORANDUMS OF UNDERSTANDING ARE....

- Agreements from TNSC partners to provide a variety of specialized services.
- Based on the ability/capacity to provide at the time requested.
- Goodwill agreements.
**PATHWAYS FOR CLIENTS PRESENTING WITH URGENT AND / OR COMPLEX NEEDS**

**Urgent Response**

- Not resolved
  - Community Agency
    - "Can be involved for 6-12 months"

- Resolved

**Developmental Services Transitional Supports (DSTS)**
- Must:
  - Support, maintain and sustain the individual’s living situations
  - Be directed to situations requiring short-term supports (i.e., less than 90 days) and up to a maximum of $5,000 per request
  - Address the risks for the individual with a developmental disability and his / her family

- Developmental Services Ontario Toronto Region
  - DSO TR
  - DSO designates Urgent Response

**Service Resolution**

**Toronto Network of Specialized Care (TNSC)**
- Including The Region, MCSS, LHIN, Service Provider Committee (SPC)
  - Develop and implement the network partnerships
  - Establish, facilitate and support coordinated access to the range of specialized services and supports available in the TNSC and collaborative service responses, service resolution, including:
    - Collect, review, analyze and report relevant data and information as collected through network activities including gaps, barriers to service and system pressures.
    - Promote education and research that will increase knowledge of best practices that can inform system planning.

**Network Coordinator**
- Identification of current needs
- Clarifies clinical vs. non-clinical
- Preventive Planning for Urgent Response (Triage)

**Client Referral**
- CAMH
- Hospital
- Developmental Service Agency
- Mental Health Agency
- UR
- DSTS

**Must be eligible through DSO TR**

**Service Consultation**
- Complex Non-Clinical Service Situations
  - Identify Gap
    - Consultation with Coordinator
    - Wait List
    - Community Meeting
    - UR
    - DSTS
    - Griffin Community Support Network-GCSN

**Clinical Conference**
- Complex Clinical Service Situations
  - Functions:
    - To provide consultation and recommendations to the client service team regarding situations presented by the TNSC Coordinator where there is not a need for CAR services and supports
    - To provide clinical consultation as required to the client service team and the CAR Facilitator
    - To confirm a clinical plan and advise on the required continuum of service to support it
    - To identify gaps to bring to TNSC Service Resolution by the Clinical Conference Chair(s) or Coordinator for resolution
    - To hear requests for treatment beds and to determine suitability
    - To receive updates from the CAR/ALC program
    - To receive updates from treatment bed providers on current resistors, Alternative Level of Care (ALC) and systems issues
# TREATMENT BEDS

- **29 in total (one bed offline)**
- **16 funded in Specialized Accommodation Initiative**

<table>
<thead>
<tr>
<th>Christian Horizons</th>
<th>Griffin Centre</th>
<th>Kerry’s Place</th>
<th>Vita CLS</th>
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<tbody>
<tr>
<td>4 Beds</td>
<td>11 beds</td>
<td>4 Beds</td>
<td>10 Beds</td>
</tr>
<tr>
<td>17-25 years of age Male Justice involved</td>
<td>18+ Dual diagnosis</td>
<td>18+ Autism Spectrum</td>
<td>18+ 5 – Step down 5 – Sex offending behaviour</td>
</tr>
</tbody>
</table>
SERVICE CONSULTATION

• Complex Non-Clinical Service Situations
• -Identify Gaps-
• • Consultation with Coordinator
• • Wait List
• • Community Meeting
• • DS Urgent Response
• • DS Temporary Supports
• • Griffin Community Support Network-GCSN
OTHER FEATURES OF THE TNSC

1. Clinical Conferences
2. CAIR – Collaborative And Individualized Resource
3. ALC (Alternative Level of Care) – Dual Diagnosis Program
4. Health Care Facilitator
5. Education and Training Events- DD and Justice Project
1. CLINICAL CONFERENCES
PEOPLE REFER TO CLINICAL CONFERENCE BECAUSE……..

- Individuals or families are experiencing difficulties accessing services due to complexity of situation.
- The individual has complex needs and requires multiple services.
- Service coordination strategies at the local level have been exhausted.
- Agency or Ministry mandates are barriers.
THE EXPECTATION OF THE SERVICE PROVIDER IS TO…..

- Use internal agency processes and resources.
- Investigate medical, psychological and social concerns.
- Consult with the TNSC coordinator.
- Submit a referral form if there are still barriers/problems.
STRUCTURE OF CLINICAL CONFERENCES

- Monthly, all-day meetings
- Referral forms are reviewed
- Presentation by referral source
- Recommendations generated
- Written recommendations sent to referral source within one week
REFERRALS TO CLINICAL CONFERENCE CAME FROM….
| Update Community Needs List | ✓ |
| Case Management | ✓ |
| Crisis Plan | ✓ |
| CAIR | ✓ |
| Crisis Referral | ✓ |
| Funding - Passport | ✓ |
| ✓ Health Related |
| ✓ Community Experience |
| ✓ Family Support |
| ✓ Legal |
| ✓ Clinical |
| ✓ Various Community Resources |
| ✓ Other |
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.
Elements of Service

Coordinate Clinical Planning

Resources to implement Intervention

Capacity Building
4. HEALTH CARE FACILITATOR

- Providing linkages to health care supports to individuals with DD, dual diagnosis and complex medical needs.

- Identifying and implementing strategies at a community and individual level to respond to health care needs.

- Supporting system linkages and effective integration of individuals with other support systems within the community, e.g., CNSC, LHINs, FHTs, CHCs, the CCAC and LTC system.

- Health care education and advocacy to develop knowledge of existing generic health interventions, services and gaps/disparities to support future system planning/navigation.
SERVICE RESOLUTION AT THE TNSC

It may be determined that the situation needs Service Resolution.

- Everything has been tried.
- A situation is so complex and goes beyond.
- Needs cannot be met with usual strategies.
- If multi-ministry assistance is required.
- If there are gaps in service.
IN SUMMARY

Coordination

Clinical Services

Case Management

Crisis Support

Respite Services

Day Treatment

Residential Treatment

In-/Out-patient

CAIR

ALC

Health Care Facilitation

Clinical Conference

Service Resolution

Education and Training and Research
RESOURCES

• http://www.dsontario.ca/agencies/dso-toronto

• http://www.community-networks.ca

• http://www.surreyplace.on.ca/primary-care

• https://www.porticonetwork.ca/web/hcardd
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