Coordinated Service Planning: Policy and Program Guidelines

Ontario's Special Needs Strategy for Children and Youth

June 2017

Ministry of Children and Youth Services

Ministry of Community and Social Services

Ministry of Education

Ministry of Health and Long-Term Care

Ontario

Table of Contents

Purpose and Application

Part 1: Purpose and Application

The *Policy and Program Guidelines for Coordinating Agencies* (the guidelines) provide operational guidance for Coordinating Agencies and partner providers delivering Coordinated Service Planning for children and youth with multiple and/or complex special needs, so that families[1] will have a more consistent service experience no matter where they live in Ontario.

The guidelines set out the Ministry of Children and Youth Services' (MCYS/the ministry's) expectations for the delivery of Coordinated Service Planning. MCYS has worked closely with the ministries of Community and Social Services (MCSS), Education (EDU) and Health and Long-Term Care (MOHLTC) in developing these guidelines.

The guidelines apply to all Coordinating Agencies, partner providers and individuals (Service Planning Coordinators) delivering the specific function of Coordinated Service Planning as identified by the Coordinating Agency, regardless of whether the individual delivers Coordinated Service Planning full-time or part-time. Coordinated Service Planning refers to the specific service outlined in this document that is characterized by the existence of a Coordinated Service Plan.

These guidelines build on the direction provided in *Coordinated Service Planning: Guidelines for Children's Community Agencies, Health Service Providers and District School Boards* (September 2014) and have been informed by locally developed Coordinated Service Planning proposals.

[1] For the purposes of the guidelines, the term "family" refers to a child's/youth's caregivers and guardians.

Vision and Goals

Part 2: Vision and Goals

The vision of the Special Needs Strategy is an Ontario where children and youth with special needs get the timely and effective services they need to participate fully at home, at school, in the community, and as they prepare to achieve their goals for adulthood.

The objective of Coordinated Service Planning is to provide children and youth with multiple and/or complex special needs and their families with a seamless and family-centred service experience.

As a result of Coordinated Service Planning, families and children/youth with multiple and/or complex special needs will:

- Have a clear point of contact for Coordinated Service Planning (their Service Planning Coordinator) and know who is accountable for developing and monitoring their child/youth's Coordinated Service Plan;
- Not have to repeat their stories and goals to multiple providers;
- Have a single Coordinated Service Plan that is responsive to their child/youth's goals, strengths, and needs;
- Experience a family-centred process that recognizes that each family is unique; that the family is the constant in the child/youth's life; and that they have expertise on their child/youth's abilities and needs; and
- Know that providers will be communicating about the needs and goals of their child/youth and will be working toward a set of common goals identified in the plan.

Coordinated Service Planning goes beyond regular inter-professional communication and collaboration that takes place when providers work together in an effort to ensure they are integrating practice and service delivery for children, youth and families. It is a support in and of itself that is intended to decrease family stress by providing families with a formal voice in the service planning process and by assisting families in navigating and coordinating services for their child/youth.

Coordinated Service Planning is based on the principles of family-centeredness, seamless information sharing, and inclusion (see Part 5 for more detail about the principles).

Target Population

Part 3: Target Population

The overall target population for Coordinated Service Planning is families of children and youth with multiple and/or complex special needs whose need for service coordination goes beyond the scope of inter-professional collaboration to address and who would benefit from the added support provided by Coordinated Service Planning. This could be due to the breadth and cross-sectoral nature of a child/youth's service needs and/or potential challenges in coordinating services because of factors affecting the whole family.

Children and youth under the age of 18, and young people between the ages of 18 and 21 who remain in school, are eligible for CSP. A diagnosis is not required to access Coordinated Service Planning.

Decisions around whether a family should receive Coordinated Service Planning will be made by the Coordinating Agency with input from the family, based on an assessment of whether the service will be beneficial to a child/youth and family, considering the factors below. Service Planning Coordinators and other trained staff involved in intake will work with the family to determine whether a family should receive service and at what level of intensity.[2]

If a child/youth and family will not receive Coordinated Service Planning and a formal Coordinated Service Plan, the Coordinating Agency should provide an explanation to the family and refer them, seamlessly through a warm referral[3], to any other appropriate supports that may be required.

The family will also be informed that if, in the future, their needs intensify, circumstances change or if new needs develop they are welcome to return to the Coordinating Agency to seek access to Coordinated Service Planning. With consent from the family, the Coordinating Agency will keep the family's information on file so it can be updated if the family seeks to access Coordinated Service Planning later.

Factors to Consider

Coordinating Agencies will consider the following child/youth and family characteristics and external factors when identifying whether or not children and youth and families should receive Coordinated Service Planning:

- Characteristics of child/youth with multiple and/or complex special needs
    - Children and youth with multiple and/or complex special needs are a sub-set of children and youth with special needs. These children require multiple specialized services (e.g. rehabilitation services, autism services, developmental services, and/or respite supports) due to the depth and breadth of their needs. They may experience challenges related to multiple areas of their development,

[2] See page 13 for more details on service intensity.

[3] A 'warm referral' is a process by which information that may have already been collected from families is transferred directly to the appropriate receiving agencies they are being referred to, so that the family does not need to repeat their story.

including their physical, communication, intellectual, emotional, social, and/or behavioural development and require services from multiple sectors and/or professionals. They are also likely to have ongoing service needs, such as severe physical and intellectual impairments requiring the use of technology.

- Characteristics of the family
    - Families of children and youth with multiple and/or complex special needs may be experiencing challenges in one or more of the following areas which may impede their ability to coordinate services for their child/youth with multiple and/or complex special needs:
        - Coping strengths and adaptability;
        - Health and well-being of other family members;
        - Literacy and/or language barriers; and/or
        - Other family/life events which may contribute to the family's level of distress.

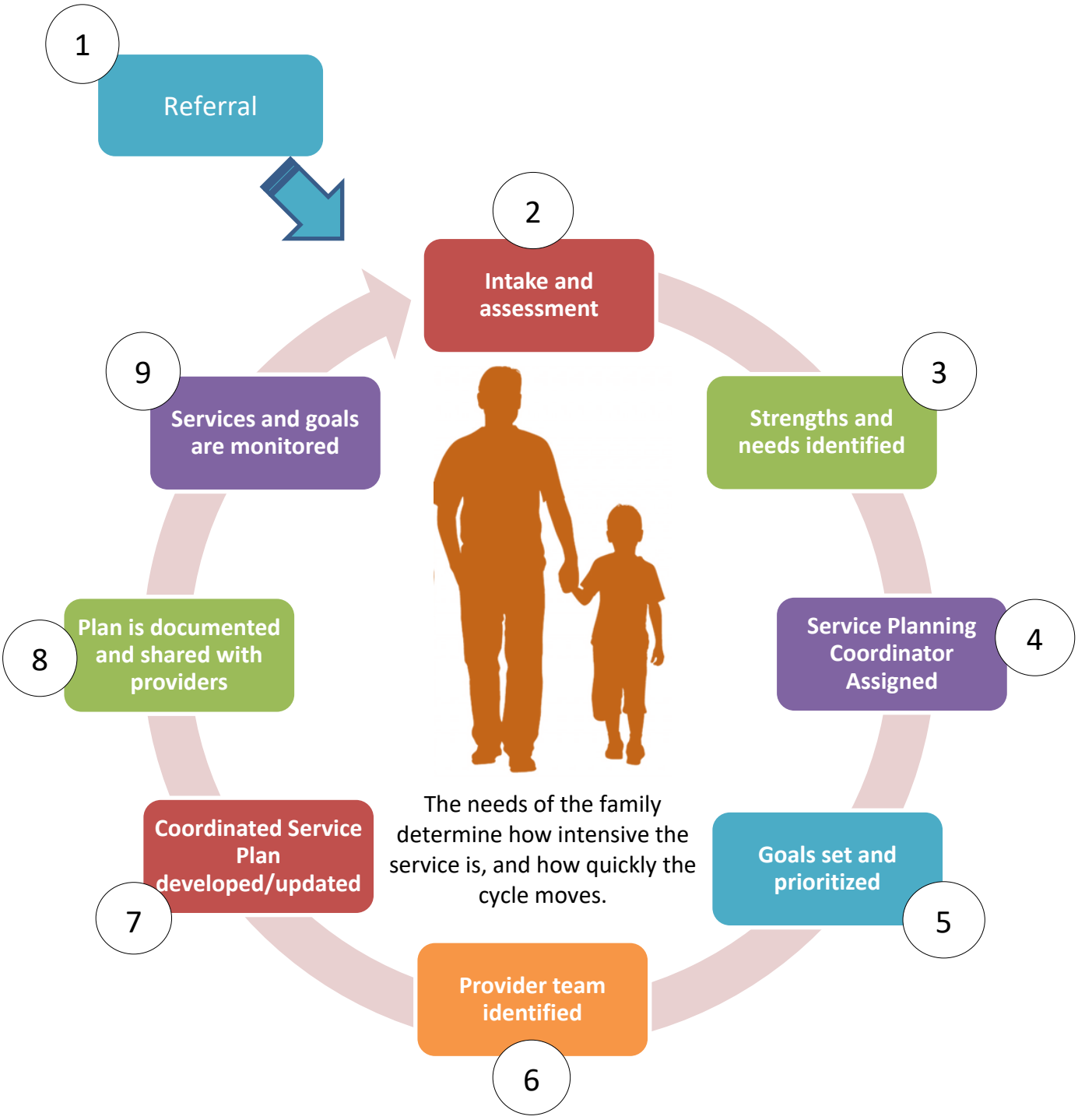
- External/environmental factors
    - Families of children and youth with multiple and/or complex special needs may also be experiencing challenges in the following areas which may impede their ability to coordinate services for their child/youth with multiple and/or complex special needs:
        - Limited social/community supports;
        - Competing demands of caregiving and employment; and/or
        - Financial instability.

For examples of children and youth and their families who may receive Coordinated Service Planning, please see Appendix A.

The Coordinated Service Planning Cycle

Part 4: The Coordinated Service Planning Cycle

Coordinating Agencies are expected to work with their partners to provide the following, in a clear and consistent way:



A family's file may be made inactive at any time during the cycle when the family and service provider decide that Coordinated Service Planning is no longer needed by the family.

A family can re-engage with Coordinated Service Planning if new needs develop or circumstances change.

The following describes, in further detail, the Coordinated Service Planning cycle, the key steps in the delivery of Coordinated Service Planning. This section illustrates the common service experience a family should be able to expect from Coordinated Service Planning across the province.

1 Referrals to Coordinated Service Planning

Referrals to Coordinated Service Planning can be made at any point a child/youth's needs are recognized to be multiple and/or complex. This could either be:

- early on, when developmental concerns are first identified, or
- when the family's situation changes, when new needs are identified, or when new services are added.

When any special needs service provider (and/or broader sector partner such as healthy child development, healthcare and child care providers as well as educators) recognizes that a family may need Coordinated Service Planning, they should explain what Coordinated Service Planning is and why it may be beneficial to the family. If the family is interested, with consent, their information will be shared with the Coordinating Agency for intake through a warm referral. Families can also self-refer to Coordinated Service Planning.

Referrals will, with consent, include information about the child and family, in order to ensure that the need for the family to repeat their story is minimized. At a minimum, this should include:

- basic information about the family (names, contact information)
- information about their strengths, needs and circumstances
- child/youth's strengths, needs and services

Referrals to Coordinated Service Planning should be made in parallel to referrals to other services, particularly if there is a wait for Coordinated Service Planning. Being referred to Coordinated Service Planning should not prevent a family from accessing other appropriate services. Coordinated Service Planning is not a required point of access or a gatekeeper and Service Planning Coordinators are not responsible for determining eligibility for other programs[4].

[4] Children/youth with multiple and/or complex special needs are expected to have a Coordinated Service Plan and the support of a Service Planning Coordinator prior to accessing service resolution processes. See Part 7: Service Resolution.

2 Intake and Assessment

When a family is referred to Coordinated Service Planning, they will be assessed to determine whether they should receive Coordinated Service Planning and at what intensity.

The Coordinating Agency will establish an intake procedure that allows a Service Planning Coordinator and/or other trained individual to work with the family to assess the family's needs and identify whether they should receive Coordinated Service Planning (see Part 3 more detail on characteristics of the child/youth and family to consider when making this determination).

Service Intensity

Coordinated Service Planning will be delivered at varying levels of intensity. When making a determination about whether a family should receive Coordinated Service Planning, the intensity at which the service will be provided should also be assessed (informed by family needs, strengths, and capacity):

- Brief supports - e.g. a Coordinated Service Plan developed and brief, time-limited supports from a Service Planning Coordinator
- Intermittent support – e.g. more intensive level of support during transitions and less intensity at other times
- Continuous supports

Decisions regarding how frequently a Service Planning Coordinator is engaged and how frequently the Coordinated Service Plan is reviewed and updated will be made jointly by the child/youth and family with the Service Planning Coordinator.

Family capacity may also change over time. Some families will develop the capacity for and interest in coordinating their own services, while others may access Coordinated Service Planning for the first time as a result of a transition or a change in the family's circumstances.

If the family must be placed on a waitlist for Coordinated Service Planning

Because Coordinated Service Planning is not a mandatory service, Coordinating Agencies may manage waitlists for Coordinated Service Planning if demand exceeds capacity. When multiple agencies are delivering Coordinated Service Planning in the service delivery area, there will be a single waitlist for Coordinated Service Planning (understanding that in large service delivery areas there may be regional sub-lists).

Families will be placed on a waitlist based on the date of first contact with the Coordinating Agency (i.e. during the intake process). When families with inactive plans need to re-engage with Coordinated Service Planning, they may be prioritized for access to a Service Planning Coordinator over families on the waitlist. Coordinating Agencies may develop further prioritization criteria or exceptions, for example prioritizing families who have plans from another service delivery area and have recently moved, families with needs requiring immediate response, or families in crisis.

3 Family strengths and needs are identified

The child/youth and his or her family are at the centre of Coordinated Service Planning. When a plan is initiated, the Service Planning Coordinator will gather key information about the child/youth and family through the following:

- discussion with the child/youth and family
- information shared by other service providers
- conducting a strengths and needs assessment

A strengths-based approach will be used to inform the development of the Coordinated Service Plan, including areas where children/youth and their families have strengths and areas where they could be supported. These can be functional strengths such as behaviour and problem-solving skills; or family, cultural and community strengths, for example the involvement of members of the extended family. A family's ties to a cultural community such as a First Nations, Métis, Inuit and urban Indigenous community should be identified as part of the strengths assessment to inform the Coordinated Service Planning process.

Family strengths and needs should be monitored and updated at regular intervals. As the needs and strengths of a family change over time, the intensity at which Coordinated Service Planning is delivered may be adjusted.

4 Assigning a Service Planning Coordinator

A relationship with a Service Planning Coordinator may be developed as part of the process of identifying and assessing needs and strengths. By the time a family is ready to set goals, a Service Planning Coordinator must be formally assigned/identified. Service Planning Coordinator assignments should take into account:

- family preferences
- existing relationships
- their needs assessment (because specific experience or expertise may be required)
- other factors (e.g. linguistic or cultural needs)

Families should be made aware who their Service Planning Coordinator is, what their role is, and that they are the key contact for questions about the plan.

5 Family and/or child/youth goals are set and prioritized

The family's circumstances, preferences, knowledge of their child/youth and goals will be the foundation of the planning. The child/youth's voice, preference and goals will also be central to Coordinated Service Planning, particularly as they mature and begin to prepare for adulthood.

Goal setting will be based on what the family and/or child/youth sees as the most important. Goals can be related to specific activities, therapies, or other domains of development (e.g. feeding oneself, attending a birthday party). Goals can also be prioritized based on what is most urgent for the family.

Initial goal setting can be done by the child/youth and his/her family with the Service Planning Coordinator or with the full provider team. Families and/or the child/youth (as appropriate) have the final decision over which goals are included in the plan.

6 Provider team is identified

A team meeting may be needed to develop the plan. Family members (parents/guardians), and child/youth as appropriate, are critical partners in Coordinated Service Planning and should be identified as equal members of the team. With family and/or child/youth consent, the team may include providers from outside the children's services sectors, e.g. from school, healthcare, child welfare. Examples of service providers that **may** be included are:

- speech and language therapists
- behavioural therapists
- occupational therapists
- special education teachers or other educators
- social workers
- healthcare care coordinator

Not all professionals involved in the child's services need to be at meetings, depending on the circumstances, the child/youth's needs, and the preference of the family. Families and/or the child/youth will determine which service providers should be invited to the meeting.

The team meeting should be held in a place that will be comfortable and accessible for the family. Supports to aid family involvement (e.g. a translator, support person, conferencing services) should be made available. Families are the critical player on the team, because they can provide information on their child/youth's interests, strengths, needs, and history that will form the foundation of the plan.

7 Coordinated Service Plan is developed

The Coordinated Service Plan is a written document for a child/youth with multiple and/or complex special needs and his/her family, as well as all service providers involved in his or her care. At minimum, the Coordinated Service Plan will contain the following:

- General information about the child/youth and family
- Information about the child/youth and family's strengths, needs and interests
- Child/youth and family vision/priorities (e.g. what is most important to the child/youth and family; what are their longer-term aspirations?)
- List of provider team members/agencies involved in providing service to the child/youth and their roles
- Goals, how each goal will be achieved and who is responsible for what

Families and/or the child/youth should determine which services are included in the plan with the support of the Service Planning Coordinator. The Coordinated Service Plan should aim to encompass every type of service that will be required by, or would be beneficial for the child/youth[5]. The Coordinated Service Plan supplements individual treatment plans by presenting a holistic view of the child/youth and their family.

Families can expect their Coordinated Service Plan to be a living document that grows and develops with their child/youth. The plan belongs to the family, and the Service Planning Coordinator monitors it on their behalf and works with them to update it. The needs and goals of children/youth and families will change over time, and so will their Coordinated Service Plan.

The goals and the vision of the Coordinated Service Plan should inform, and be informed by, all planning for services, supports and special education, including the Individual Education Plan[6].

Services are planned to meet goals

Families and/or the child/youth should clearly understand how services are being planned to meet the agreed-upon goals. Providers are encouraged to draw connections between services and articulate these to the family and/or child/youth. Service providers determine what services they will provide based on the policy/program requirements and their clinical judgment.

Service Planning Coordinators will work with the child/youth, families and providers to make sure families have the information they need to make informed decisions about services. It is the responsibility of the Service Planning Coordinator to understand, monitor, and document how services will support the achievement of the prioritized goals.

[5] May include therapy/rehabilitation, health services (including nursing), special education, respite, etc.
[6] The Coordinated Service Plan should complement, not replace, the child/youth's Individual Education Plan (IEP), and may be used as one source of information to help inform education program planning, including special education programming and/or services that a child/youth may need.

Coordinated Service Planning will be focused on the needs of the child/youth with complex and/or multiple special needs; however, Service Planning Coordinators should be aware of other needs the family has and should be able to make referrals to relevant services. The Service Planning Coordinator has the discretion to assist the family to help the child or youth achieve his or her outcomes, but is not required to coordinate services for the family that are outside the scope of Coordinated Service Planning.

8 Plan is shared with family and providers

Once the Coordinated Service Plan has been documented, the plan will be shared with child/youth and their family. The final decision about who should see the plan, or specific parts of the plan, rests with the family and/or child/youth.

With the consent of the family, it is the responsibility of the Service Planning Coordinator to make sure that the Coordinated Service Plan is shared with the relevant service providers. Service Planning Coordinators are responsible for communicating, with consent, about the child/youth's needs, strengths, family/youth's goals and priorities to service providers and educators.

9 Services and goals are monitored

In addition to regular communication with families, service providers should inform families that they can contact their Service Planning Coordinator when they:

- have a question about the plan
- think the plan should be adjusted
- want to adjust goals
- require additional supports
- need a new service

Service Planning Coordinators will make referrals/connections as new needs and potential supports are identified and/or call meetings with service providers when the family indicates that their goals have changed or that the plan needs to be adjusted. Where possible, the Service Planning Coordinator should connect with the provider on behalf of the family and facilitate a warm referral.

At a minimum, the Coordinated Service Plan will be reviewed with the child/youth and family **every six months**. Goals will be revisited and confirmed or revised each time the plan is reviewed.

Some families may require more frequent updates at varying times. Plans should be updated more frequently around transitions in the child/youth's circumstances or services, for instance, upon transition into school, high school or adulthood (see Part 5: Transitions).

Depending on the needs of the child/youth and family, at times, Coordinated Service Planning may be more intensive and the cycle may move more quickly.

Inactivity and/or Discharge

Families may have periods where they need little to no Coordinated Service Planning, or come to a point where the family no longer wishes to access Coordinated Service Planning. In these situations, Coordinating Agencies may wish to categorize these plans as inactive, or consider discharge.

Inactive Plans

Plans may be categorized as inactive if there is no immediate need for service but the family would like the option to access Coordinated Service Planning at a future time. Plans will be categorized as inactive when there is no need for re-assessment, active planning or regular review of the Coordinated Service Plan.

Service Planning Coordinators will advise families that they may re-engage with Coordinated Service Planning again if their needs change (until the age of 21, if the youth remains in school). With consent, the Coordinating Agency will retain inactive files so that families may re-engage with Coordinated Service Planning, as needed, without having to repeat the intake process.

- The Coordinating Agency may take a coaching approach with families and other providers and a gradual approach to stepping down service prior to categorizing a plan as inactive.
- Agencies may wish to reach out to these families at anticipated transition points (e.g. entry to school, entry to adolescence or high school) to inform them they may re-enter Coordinated Service Planning to support them through the transition.
- Families with inactive plans will not be reported to the ministry as being in receipt of service.

Discharging

Youth are eligible for Coordinated Service Planning until the age of 18, or until the age of 21 if they remain in school. In addition to age, an agency should consider discharge when:

- Goals are met and the family and team is satisfied that Coordinated Service Planning is no longer required;
- The family leaves the catchment area. The agency will provide a warm referral and the current plan to the local Coordinating Agency in the new catchment area (with the consent of the family). The family should not be reassessed;
- The family cannot be reached after four documented attempts over two quarters through the best method of contact indicated by the family (families are expected to keep current contact information on file with the agency while they are receiving service); or
- The family requests discharge.

Principles of Coordinated Service Planning

Part 5: Principles of Coordinated Service Planning

Child, Youth and Family-Centered Service

Coordinated Service Planning is intended to be a supportive, proactive, responsive, and child-, youth- and family-centred service. This means that families and children/youth are actively engaged and their input is incorporated throughout the planning, implementation, delivery and evaluation of Coordinated Service Planning, as well as in the development and monitoring of their child/youth's Coordinated Service Plan.

Family-centred service recognizes that each child, youth and family is unique; that the family is the constant in the child/youth's life; and that the family has expertise in their child/youth's abilities and needs.[7] The family and service providers, and the child/youth as appropriate, work together to make informed decisions about the services and supports the child/youth and family receive. In family-centred service, the strengths and needs of all family members are considered.

Service Planning Coordinators are expected to facilitate the active participation of the child or youth in Coordinated Service Planning, including in goal setting. Child- and youth-centred service recognizes that young people will have a voice in the planning and delivery of their service. Service Planning Coordinators will recognize that young people may have different perspectives and priorities than their parents that should be respected during the planning and delivery of their services.

Providing child-, youth- and family-centred Coordinated Service Planning will require a cultural shift for many Coordinating Agencies and partner organizations. Coordinating Agencies and their partners are expected to embed family-centred service in their organizational culture. The extent to which Coordinated Service Planning is being provided in a child-, youth-, and family-centred way will need to be constantly monitored across organizations, with plans for capacity building and training as needed.

As part of child-, youth- and family-centred service, families can expect that:

- Family and child/youth strengths and goals are at the centre of the plan;
- The priorities and beliefs of children, youth and their families are treated with dignity and respect;
- Families and children/youth receive flexible, individualized service (including flexibility around meeting times, locations, and methods such as in person, over the phone, or via videoconference);
- Families, children and youth actively participate in Coordinated Service Planning, including goal setting;

[7] Canchild Centre for Childhood Disability Research (2003) Facts, Concepts, Strategies Sheet #1: What is Family-Centred Service? Retrieved from CanChild's webpage on family-centred service.

- Families and children/youth have access to appropriate information about services and processes;
- Families and children/youth will approve the Coordinated Service Plan;
- Families and children/youth are encouraged to include their broader extended family or circle of support in the plan;
- Families and child/youth involvement is supported (e.g. translation and accessibility supports are provided as required);
- Expectations regarding child-, youth- and family-centredness are understood by partner providers;
- The organization is working to entrench a culture of child-, youth- and family-centred service within their organization, the services they provide, and throughout the Coordinated Service Planning process; and
- Families and youth are engaged in formal ways (e.g. presence at governance tables/executive committees, in planning, implementation, delivery and evaluation) across the Coordinated Service Planning process.

Seamless Service and Information Sharing

Families will experience a seamless sharing of information as part of Coordinated Service Planning. With consent, information about a family's needs will be shared between providers. Families should not feel like they are repeating intake and assessment information or repeating their stories unnecessarily; however, families should be encouraged to share information with providers and have the opportunity to share their stories with new providers if they wish.

To enable seamless service, Coordinating Agencies are encouraged to promote the use of a common consent form across the service area and are required to seek consent for information sharing at the beginning of the Coordinated Service Planning process to minimize unnecessary duplicative consent seeking.

As required by legislation (including the *Freedom of Information and Protection of Privacy Act and Personal Health Information Protection Act, 2004*), information will be kept secure, shared securely, and appropriately. Ultimately, families and/or youth will decide what information is shared, when information is shared and with whom. Service delivery areas may choose to share information in a variety of ways (e.g. through phone or fax, using a shared electronic record, by mail) that meet their needs and build on local capacity.

Meeting Diverse Needs

The Coordinated Service Planning process will be inclusive, accessible, and culturally-appropriate. It will be respectful of the values and meet the diverse needs of children, youth and their families.

Coordinating Agencies are expected to consider how to make their services accessible to children and youth and their families who may require a range of physical, communication, and/or sensory adaptations.

Coordinating Agencies and their partners will work to understand the demographics of the population within the service delivery area and be responsive to the linguistic and cultural needs of communities within their service delivery area. Coordinating Agencies will engage with the different linguistic and cultural communities within their service delivery area and the service providers who serve them. Coordinating Agencies will incorporate input from these communities into the ongoing planning, delivery and local evaluation of Coordinated Service Planning.

Service providers will be aware of distinct approaches required to address the needs of First Nations, Métis, Inuit and urban Indigenous children and youth. At the local level, Coordinating Agencies are expected to work together with all local service providers to meet the needs of Indigenous children, youth and their families. This includes providing culturally-appropriate services and linkages and referrals to Indigenous service providers and other community resources.

Coordinated Service Planning will also respond to the service needs of French-speaking children and youth, and their families. The French Language Services Act identifies communities where specific services must be available in the French language. Coordinating Agencies, whether or not they are designated under the French Language Services Act, 1990 will engage with French-language school boards and French-language service providers to support the needs of Francophone children and youth with special needs and their families.

Transitions

Part 6: Transitions

Families can expect that Coordinated Service Planning will provide an opportunity for the family and service providers to plan for transitions. Coordinated Service Planning should not duplicate existing processes, but provide an umbrella under which other local processes can be coordinated and inform each other. For example, at key transition points, the Service Planning Coordinator can take the lead in calling inter-professional transition planning meetings and/or initiate conversations with the family about transition goals and needs.

The transition into school will be critical for many children and their families. Service Planning Coordinators will work with preschool service providers and educators to plan for the transition. The Service Planning Coordinator will also provide information about any potential accessibility-related requirements or modifications required to facilitate the child's participation in school.

The need for Coordinated Service Planning during other transitions such as those related to life events (e.g. birth of a sibling, family moving) will be determined on a case-by-case basis and will similarly include any providers who will be involved both before and after the transition.

Transitions to Adulthood

Planning for the transition to adulthood is a broad, holistic, person-centred process that identifies a young person's goals for work, further education and life in the community. It outlines the actions that should be taken year by year to help the young person achieve these goals as well as the roles and responsibilities of the young person and others in carrying out these actions.

The intent of transition planning for adulthood is for all who support the young person to work collaboratively to prepare the young person and family for the transition to adulthood. The Service Planning Coordinator will be responsible for initiating the transition planning process at age 14. The transition plan will build on the existing Coordinated Service Plan by identifying the steps needed for the young person to attain their goals until the anticipated time of leaving school. The transition plan will be part of a young person's Coordinated Service Plan and will be shared with parents, the young person and all relevant providers. The transition plan is a living document that should be updated annually at minimum, or as required when circumstances and needs change.

Like Coordinated Service Planning, transition planning for adulthood brings together the young person and their family, as well as those who support a young person, such as district school boards and educators, community agencies, service providers and health care providers, to plan for the diverse transition needs and desires of the youth and their family. The process should be cross-disciplinary, collaborative, comprehensive and team-based with a focus on the young person's goals, supports and information needs.

A young person's transition plan for adulthood will identify:

- Goals for work, further education, and community living that reflect actual opportunities and resources that are likely to be available after the young person with multiple and/or complex special needs leaves school and are likely to be achievable by the young person, given appropriate and available supports;
- Actions that should be taken year by year to help the young person with multiple and/or complex special needs achieve their goals;
- Roles and responsibilities of the young person with multiple and/or complex special needs, family, and others in carrying out these actions;
- Expected outcomes within the planning process that should be evaluated by the integrated transition planning team at regular intervals or as needed; and
- Timelines for the actions.

Actions identified in the transition plan may include:

- Timely application to programs and services;
- Planning for access to available support services and equipment, and exploring possible work placements and/or post-secondary education;
- Investigating options for future financial support; and
- Developing specific skills, such as skills in the independent use of assistive technology, self-advocacy skills, or employability skills.

In 2014, the Ministries of Children and Youth Services, Community and Social Services and Education implemented integrated transition planning with local protocols in place for young people with **developmental disabilities** who are preparing for adulthood[8].

When a young person with a developmental disability has a Coordinated Service Plan, the Service Planning Coordinator will be responsible for initiating the integrated transition planning process, starting at age 14, in accordance with local protocols and working with the local Integrated Transition Planning lead agency and other partners (see Appendix C).

[8] Retrieved from joint MCSS, MCYS and EDU memorandum dated January 28, 2013 and titled "Integrated Transition Planning for Young People with Developmental Disabilities"

Intersection with Service Resolution

Part 7: Intersection with Service Resolution

Service resolution refers to a formalized, collaborative, cross-sectoral process geared to problem-solving, exploring service options, and developing creative service solutions to meet the multiple and/or complex special needs of the child/youth.

The needs of some children, youth and/or families may exceed locally available services. In these cases, a referral will be made to service resolution. Children, youth and families who require service resolution are expected to have a Coordinated Service Plan and have been supported locally as much as possible by the Coordinated Service Planning process, before being referred to service resolution. The Service Planning Coordinator will remain with the family throughout the service resolution process, to keep the Coordinated Service Plan updated, support the family through the process, and to help the family prepare for and then transition back to the local service system.

When a child/youth is in need of service resolution, the Service Planning Coordinator and Coordinating Agency will:

- Document in a child/youth's Coordinated Service Plan his/her needs that are beyond the locally available services and supports.
- Refer families to service resolution through a formal referral process that is transparent, documented, clear, available to families, and connected to other elements of the child and youth service system.
- Continue to work with the family and be responsible for the Coordinated Service Plan throughout the service resolution process.
- Work in partnership with the service resolution mechanism, other service providers, and other sectors, to explore all options for access to existing local and regional supports or services through the service resolution process.
- Work with the service resolution mechanism to modify/add to the Coordinated Service Plan based on the outcome of service resolution.
- Maintain responsibility for monitoring the full, updated Coordinated Service Plan (including any new services funded through complex special needs funding).
- When the goals outlined in the complex special needs-funded portion of the Coordinated Service Plan have been met, work with the service resolution mechanism to transition the child/youth back into the family home and/or the base-funded service system.
- If the plan is to transition a youth into adult services, the Service Planning Coordinator leads the transition and will work with adult services and supports, including Developmental Services Ontario where appropriate, to facilitate the transition.

Roles and Responsibilities

Part 8: Roles and Responsibilities

The Coordinating Agency

The Coordinating Agency is accountable to the ministry for the delivery of Coordinated Service Planning in the service delivery area. (For a map of service delivery areas, see Appendix B)

The single Coordinating Agency in each service delivery area will be responsible for:

- Ensuring the delivery of Coordinated Service Planning Cycle as outlined in Section 3.
- Managing all aspects of Coordinated Service Planning, including risk and complaints management (in relation to Coordinated Service Planning), privacy of information, records management, information management, and performance measurement of the Coordinated Service Planning functions within the service delivery area.[9]
- The performance of Service Planning Coordinators[10] in the Service Delivery Area, no matter where they are employed, including ongoing training, and reporting on the activities and performance of all Service Planning Coordinators in the service delivery area (see part 10).
- Ensuring that referral pathways are clear, particularly intersections with children's services, education and health sectors and other community organizations.
- Maintaining responsibility for monitoring and evaluating Coordinated Service Planning, including reviewing existing processes and policies, documenting decisions, and making changes based on ongoing performance monitoring, in keeping with the parameters of these policy guidelines, and other ministry policies/direction.
- Developing and maintaining relationships with cross-sectoral service providers and educators in the service delivery area in order to deliver Coordinated Service Planning, recognizing collaborative relationships and considering the expertise of educators and other professionals.
    - The Coordinating Agency will maintain clear processes for collaboration and information sharing among relevant providers in the children's services, education, and health sectors through formal agreements that address, at a minimum, how and when to refer families, share information and contribute to Coordinated Service Planning.
    - Developing a relationship with the local Child and Youth Mental Health Lead Agency for children and youth with mental health needs, and with the service

[9] Coordinating Agencies will not have authority to direct the provision of non-Coordinated Service Planning services provided by other agencies.

[10] Only applies to staff identified as a child/youth's Service Planning Coordinator, who is expected to fulfill the formal role of a Service Planning Coordinator, such as developing and monitoring a Coordinated Service Plan.

resolution mechanism(s) in order to support the needs of children and youth whose needs exceed locally available services.

- Communicating expectations to partner agencies/organizations about how Coordinated Service Planning will work, including how other providers will be engaged in developing plans.

- Leading outreach and communications activities about Coordinated Service Planning, including:
  - Reaching out to families who may need the service.
  - Reaching out to local agencies that may have a role to play in Coordinated Service Planning, or may be a source of referrals.
  - Emphasizing that Coordinated Service Planning is a proactive support and that families should be referred (or self-refer), before they are approaching crisis whenever possible, so as to avoid experiencing crisis.
  - Collecting and making available to families up-to-date and transparent information about locally available services, including access, intake processes, and waitlist/wait times.
- Facilitating consistent knowledge sharing, both amongst service providers and with families of children and youth with multiple and/or complex special needs, regarding the delivery of Coordinated Service Planning.
- Capacity building within the Coordinating Agency and partner agencies.
  - Capacity building at the Coordinating Agency and its partners will be an ongoing part of the service and quality improvement process as new needs and opportunities for improvement are identified.

Service Planning Coordinators

Depending on local practice, some families may have a Service Planning Coordinator who delivers Coordinated Service Planning as well as another program or service. Other families may have a Service Planning Coordinator who provides Coordinated Service Planning full time. These guidelines apply to all Service Planning Coordinators, regardless of whether the individual delivers Coordinated Service Planning full-time or part-time. A family's assigned Service Planning Coordinator may change if their needs change.

With appropriate consent, Service Planning Coordinators in each service delivery area will:

- Develop a strengths-based Coordinated Service Plan that addresses the service needs of the child/youth, is driven by the goals of the child/youth and family and that will support participation at home, school and in the community;

- Facilitate the active participation of the child/youth and family in Coordinated Service Planning, including goal setting;
- Facilitate the exchange of information between relevant providers in the children's services, education, and health sectors in each service delivery area, to develop and maintain a single Coordinated Service Plan for the child/youth and their family;
- Connect families to relevant services and other community supports/resources in the service delivery area;
- Explore flexible and innovative approaches for service delivery to meet the needs of the child/youth and bring forward any barriers to innovation that may exist;
- Monitor, review, and update the Coordinated Service Plan, in collaboration with the child/youth and their family and relevant providers in the children's services, education, and health sectors, as the child/youth and family's needs and services change;
- Be knowledgeable and available to discuss the child/youth and family's concerns, if applicable, regarding the service plan, and
- Facilitate working relationships with providers in the children's services, health and educations sectors, in order to enable their regular contribution into Coordinated Service Planning and obtain and share relevant information regarding services for the child/youth.

The Service Planning Coordinator is not responsible for coordinating all services required by the family (e.g. adult mental health, settlement) but may provide contact information or initiate a referral to help families access other services and supports, where these services contribute to the overall goals for the child/youth and family. Where the Service Planning Coordinator will not be responsible for coordinating certain services, this should be communicated to the family.

Coordinated Service Planning Providers

Coordinated Service Planning Providers are agencies/organizations that employ Service Planning Coordinators within the service delivery area. These agencies/organizations will:

- Maintain formal agreements with the Coordinating Agency regarding agreed upon expectations with respect to the provider's role and how these providers will be accountable to the Coordinating Agency;
- Report through the Coordinating Agency on the activities of their Service Planning Coordinators;
- Support Service Planning Coordinators to participate in training required by the Coordinating Agency;
- Ensure that their Service Planning Coordinators are aligned with and supporting the service delivery area's process and model;

- Use any common tools or forms required by the Coordinating Agency; and
- Support families to have a consistent experience of Coordinated Service Planning across the service delivery area.

Coordinated Service Planning Participants

Coordinated Service Planning Participants are agencies/district school boards that provide services and/or supports to children and youth with special needs and that are expected to participate in Coordinated Service Planning. These organizations could be government-funded, community agencies, or district school boards and will have formal agreements with the Coordinating Agency regarding information sharing and participating in the Coordinated Service Planning process.

Coordinated Service Planning Participants will include, but should not be limited to, the signatory agencies to the local Coordinated Service Planning proposals:

- Children's Treatment Centres (CTCs);
- Children's agencies that provide inter-agency service coordination;
- Applied Behaviour Analysis (ABA)-based services and supports lead agencies[11];
- Autism Intervention Program (AIP) lead agencies;
- Community Care Access Centres (CCACs)/Local Health Integration Networks (LHINs); and
- District School Boards/School Authorities.

In particular, Coordinated Service Planning Participant organizations will, at a minimum, undertake the following activities. In some service delivery areas, participant organizations have agreed to involvement beyond the activities noted below:

- Participate in referrals to Coordinated Service Planning for families who need the service;
- Share information on their services with the Coordinating Agency;
- Participate actively as appropriate in the development of individual Coordinated Service Plans and in providing family-centered services according to the plan;
- Participate in the local governance structure for Coordinated Service Planning (either on the governance body or by providing input);

[11] Until the new Ontario Autism Program is implemented, beginning in June 2017.

- Participate in capacity building as needs and opportunities to improve Coordinated Service Planning are identified by the Coordinating Agency;
- Report information required by the Coordinating Agency for performance measurement and quality improvement;
- Explore flexible and innovative child- and family-centered approaches for service delivery to meet the needs of the child/youth; and
- Actively participate in issues resolution, as appropriate, with respect to the delivery of Coordinated Service Planning within the service delivery area when conflicts arise between providers or between families and providers.

Partners from the broader service sector (e.g. child care providers; municipal partners) may also contribute to Coordinated Service Plans from time to time. Depending on how frequently they are involved in Coordinated Service Planning, the Coordinating Agency may pursue a formal agreement with these providers or arrange to share information using the informed consent of the family.

Ministry of Children and Youth Services

Through Transfer Payment Contracts and quarterly reporting, MCYS Regional Offices will hold Coordinating Agencies accountable for the oversight and delivery of Coordinated Service Planning within the service delivery area.

- MCYS and MCSS Regional Offices will update contracts with Coordinated Service Planning Providers and Participants to include expectations regarding Coordinated Service Planning.
- MCYS will monitor the functioning of local Coordinated Service Planning systems and will bring cross-sectoral and/or provincial issues forward for inter-ministerial resolution as necessary.

Governance and Steering

Part 9: Governance and Steering

The board of the Coordinating Agency is accountable to the Ministry of Children and Youth Services for the oversight and delivery of Coordinated Service Planning within the service delivery area.

To enable oversight and collaboration, the Coordinating Agency is required to maintain a cross-sectoral collaborative steering mechanism to oversee the partnerships that support Coordinated Service Planning. The steering mechanism must have a Terms of Reference, developed in partnership with Coordinated Service Planning Providers and Participants.

Steering mechanisms will include a process for seeking input and feedback from the key partners in Coordinated Service Planning, including:

- Families who use the service;
- Children and youth who use the service;
- Service Planning Coordinators;
- Coordinated Service Planning Providers; and
- Coordinated Service Planning Participants;

The cross-sectoral steering mechanism for Coordinated Service Planning will also review performance measurement results at least annually and develop plans for improvement where necessary. The steering mechanism will prepare annual reports that describe how cross-sectoral partners are working together to provide seamless and child-, youth- and family-centred service experiences and plans for improvement where necessary. These reports will be signed by all members of the cross-sectoral steering mechanism and submitted to the MCYS/MCSS Regional Office at the end of each fiscal year. MCYS will share the reports with MCSS, EDU and MOHLTC.

Coordinating Agencies will also have formal agreements and/or Memoranda of Understanding with Coordinated Service Planning Providers and Participants covering the essentials of the service. At a minimum, these agreements will include:

- A shared vision and goals for Coordinated Service Planning;
- A common definition of child-, youth- and family-centred service;
- A commitment to the delivery of seamless and child-, youth- and family-centred Coordinated Service Planning;
- Roles and responsibilities;
- Referral processes;

- Information sharing processes;
- Dispute resolution processes among agencies;
- Processes for multiple sectors and agencies to collaborate in cross-sectoral Coordinated Service Plans;
- A commitment to exploring flexible and innovative approaches for service delivery to meet the needs of children, youth and their families; and
- How the Coordinated Service Planning Provider will be accountable to the Coordinating Agency for the delivery of Coordinated Service Planning.

MCYS- and MCSS-funded Coordinated Service Planning Providers and Participants (see pages 32 and 33) will have expectations for their participation in Coordinated Service Planning identified in their MCYS and/or MCSS service contracts.

Performance Measurement

10

Part 10: Performance Measurement

Interim performance measures, reporting requirements and timelines are being further developed in consultation with Coordinating Agencies.

Performance measurement will help Coordinating Agencies, the ministries and the public to understand whether Coordinated Service Planning is helping to achieve the vision of the Special Needs Strategy, which is an Ontario where children and youth with special needs get the timely and effective services they need to participate fully at home, at school, in the community, and as they prepare to achieve their goals for adulthood.

Performance Measurement is a shared responsibility of all participants in Coordinated Service Planning. Coordinating Agencies are responsible for determining how best to collect the data in accordance with provincial expectations, local practices and information systems.

All agencies participating in the delivery of Coordinated Service Planning will report on their activities and families' experiences with Coordinated Service Planning. Where measures require surveys of families and partner providers, agencies are required to include a copy of the tool they use with their reports. The ministry reserves the option to require a particular tool, questions or scale be used for these surveys.

Surveys developed to collect data on family experiences and/or service provider perceptions must meet the following requirements:

- The same survey must be used throughout the service delivery area;
- Surveys must be made available in both French and English;
- Surveys must include the ability to answer on a sliding scale (e.g. 1 to 5, not just yes/no); and
- Respondents must be able to answer anonymously – responses cannot be tied to identifiable information.

Appendices

Appendix A: Family Profiles

The following three scenarios demonstrate the type of needs that might lead a family to request or be referred to Coordinated Service Planning. They also demonstrate how different family circumstances could result in families receiving different intensities of service and less or more frequent contact with their Service Planning Coordinator.

Sample Profile 1:

A 15-year-old youth, diagnosed with Autism Spectrum Disorder when he was young, has been accessing multiple services and supports for many years, including mental health, autism, and behavioural services, respite and educational supports. The current service providers work well together, but there is no Coordinated Service Plan. Lately, his aggressive behavior has increased, and both his parents and the school are struggling with managing his behaviours and keeping other children safe from his aggressive outbursts.

Sample Profile 2:

An 8 year old, diagnosed with Dystonic Cerebral Palsy and Chronic Lung Disease (oxygen dependent) has also been diagnosed with Global Developmental delays. She was born at almost 29 weeks gestation and developed neonatal meningitis.

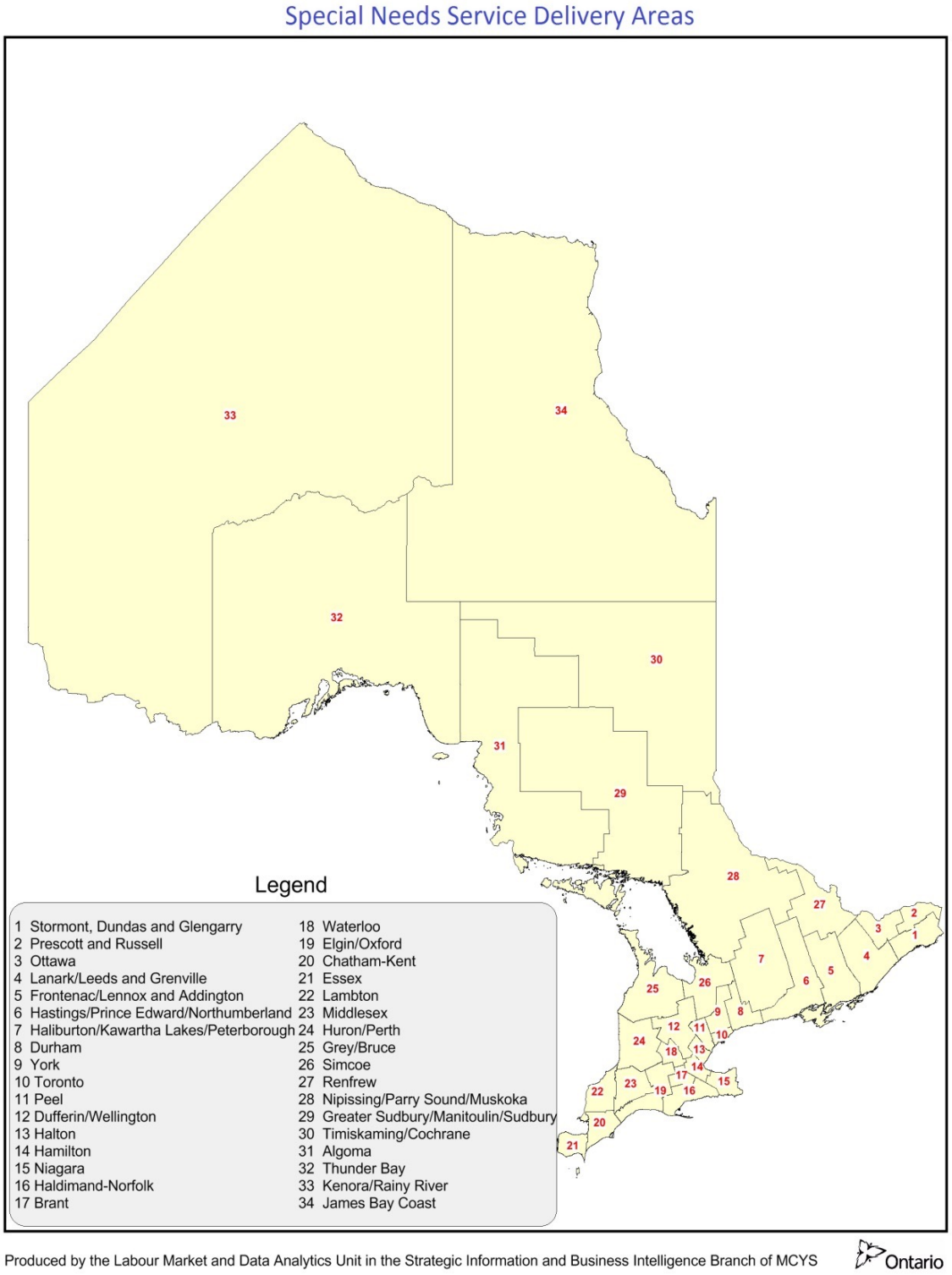
She is frequently hospitalized for pneumonia, usually in intensive care and has required intubation during some of those hospitalizations. Both parents are involved in her care but don't live together. She resides with her mother and an older sister. She requires hands-on care for feeding and other daily living activities and receives nightly nursing care. School attendance is sporadic due to her medical needs but when she does attend she receives assistance from an Educational Assistant and a Nurse. The youth receives 8 days of respite per month in the community.

Sample Profile 3:

An 18-month old has just been identified by a pediatrician as having delays in speech and language, social and motor development. The parent is a single parent with 3-year-old twins.

> **Note**: The child and family in Sample Profile 3 may or may not receive Coordinated Service Planning, depending on other circumstances in their lives. Because their case is less complex, they may receive less intensive Coordinated Service Planning or a warm referral to other services with an invitation to return to the Coordinating Agency if their circumstances become more complex.

Appendix B : Map of Service Delivery Areas



Special Needs Service Delivery Areas

Legend

1. Stormont, Dundas and Glengarry	18. Waterloo
2. Prescott and Russell	19. Elgin/Oxford
3. Ottawa	20. Chatham-Kent
4. Lanark/Leeds and Grenville	21. Essex
5. Frontenac/Lennox and Addington	22. Lambton
6. Hastings/Prince Edward/Northumberland	23. Middlesex
	24. Huron/Perth
7. Haliburton/Kawartha Lakes/Peterborough	25. Grey/Bruce
	26. Simcoe
8. Durham	27. Renfrew
9. York	28. Nipissing/Parry Sound/Muskoka
10. Toronto	29. Greater Sudbury/Manitoulin/Sudbury
11. Peel	
12. Dufferin/Wellington	30. Timiskaming/Cochrane
13. Halton	31. Algoma
14. Hamilton	32. Thunder Bay
15. Niagara	33. Kenora/Rainy River
16. Haldimand-Norfolk	34. James Bay Coast
17. Brant	

Produced by the Labour Market and Data Analytics Unit in the Strategic Information and Business Intelligence Branch of MCYS.

Appendix C: Roles and Responsibilities in the Integrated Transition Planning Process

Coordinating Agencies have specific responsibility to initiate the integrated transition process implemented by the Ministries of Children and Youth Services, Community and Social Services, and Education. This process connects closely with Individual Education Plan (IEP) processes and adult services. Outlined below are the roles and responsibilities for the parties involved in the development of an integrated transition plan for a young person with developmental disabilities who also has a Coordinated Service Plan:

Roles and Responsibilities in the Integrated Transition Planning Process

Service Planning Coordinator

- Identify individuals with in their 14th year (and up) who have a Coordinated Service Plan and require a single integrated transition plan.
- Provide information to the parent/young person about integrated transition planning.
- When the young person is about to turn 14, ask the parent/young person if they would like an integrated transition plan.
- Identify and contact the school IEP lead (as designated by the principal) to begin the integrated transition planning process that leads to a single integrated transition plan as part of the IEP process.
- Identify and contact relevant children's services providers to participate as part of the integrated transition planning team.
- Identify and contact the young person's Community Care Access Centre (CCAC) case manager (if applicable) to participate as part of the integrated transition planning team.
- Identify other relevant health service providers and invite them to participate as part of the integrated transition planning team.
- Ensure that the proper consents are received from the young person with multiple and/or complex special needs and their parent/guardian in the integrated transition planning process.
- Seek to ensure that all parties understand and are in agreement with the integrated transition plan and have all the information they require, including any accessibility-related requirements/modifications that should be provided to the school.
- Participate, as required, in meetings regarding the single integrated transition plan which identifies the young person's health care needs, goals for work, further education, employability skills and community living.
- Working with the school IEP lead, support the young person and their parent/guardian to participate throughout the integrated planning process.
- Incorporate the single integrated transition plan as provided by the school IEP lead to the parents (and student if 16 and older) into the Coordinated Service Plan.
- Lead the ongoing review, and, with the young person, family, and integrated transition planning team, and update the integrated transition plan at regular intervals or as needed.

- Provide a copy of the Coordinated Service Plan, which includes the single integrated transition plan, to all relevant parties, including the parent (and student if 16 and older).

Schools

- Begin integrated transition planning at age 14 as part of the IEP process. The school IEP lead is designated by the principal.
- Establish, participate in and contribute to integrated transition planning teams.
- Working with the Service Planning Coordinator, provide opportunities for the individual and their parent or guardian to participate throughout the integrated transition planning process.
- Establish a process for the school IEP lead to contact/link with designated community agency staff person to begin the integrated transition planning process, if appropriate.
- Ensure that the proper consents are received from the young person with multiple and/or complex special needs and his/her parent/guardian to initiate the integrated transition planning process.
- Provide information to the family/young person regarding application to the DSO, if applicable.
- Provide a copy of the IEP, which includes the single integrated transition plan, to the parents (and student if 16 and older) and include a copy in the student's Ontario Student Record (OSR).
- Establish a process for the single integrated transition plan to be reviewed and updated as required.

Children's Services Providers

- Participate in, and contribute to the integrated transition planning team.

Health Service Providers (e.g. primary care, Local Health Integration Networks, Community Care Access Centres)

- Participate in, and contribute to the integrated transition planning team.

Developmental Services Ontario (DSO) Organizations

- The DSO is the primary point of contact for public inquiries about MCSS-funded adult developmental services and supports for persons with developmental disabilities in accordance with the Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008 (SIPDDA).
- DSOs will also provide a single point of access for persons with developmental disabilities to MCSS-funded adult developmental services and supports in Ontario.

- Upon request, the DSO organization will provide information to the integrated transition planning team or to the school / school board on the services and supports that may be provided by community agencies in its geographic service area.
- They will employ qualified assessors to administer the Application Package with each eligible applicant to assess support needs. The Application Package comprises the Application for Developmental Services and Supports (ADSS) and the Supports Intensity Scale® (SIS®).
- Qualified assessors may administer the Application Package with applicants from the age of sixteen who, with the exception of the age requirement, meet the criteria for MCSS-funded adult developmental services and supports in accordance with the Act.
- Provide the Service Planning Coordinator with a contact/link with person-directed planners/facilitators in the community where available, to continue the integrated transition planning process for individuals with complex care needs until the transition to adult services.
- A representative from a DSO and/or adult DS agency will be available to provide information to integrated transition planning teams about eligibility criteria, the application process and relevant community-based services for adults with a developmental disability. They will also be available to provide advice on elements that should be considered as part of planning transitions to adulthood and they can attend transition planning meetings as required.