COMMUNITY NETWORKS OF SPECIALIZED CARE
RÉSEAUX COMMUNAUTAIRES DE SOINS SPÉCIALISÉS
TORONTO REGION

Annual Report

2012 – 2013

Toronto Network of Specialized Care

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Prepared by:
Sandra Bricker, Coordinator
Toronto Network of Specialized Care
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Background

The Toronto Network of Specialized Care (TNSC) was established 6 years ago as part of the Ministry of Community and Social Services (M.C.S.S.) transformation agenda. The Community Networks were established to provide leadership. The TNSC is a partnership of organizations in Toronto that have agreed to offer time-limited, specialized services to individuals having a developmental disability, mental health needs and/or challenging behaviours. We are partnered with the Central Network of Specialized Care for training, education, research, videoconferencing and shared resources. Provincially we are connected to the three other networks (Northern, Eastern and Southern) through CNSC-Ontario for larger system issues which impact on the province.

In March 2012, the Toronto Network of Specialized Care held a planning meeting to develop a work plan.

The focus in 2012/13 has been on maintaining the specialized services (e.g., Clinical Conferences, crisis services, Healthcare Facilitation and Collaborative And Individualized Resource) and developing a new resource: the Alternative Level of Care Dual Diagnosis transition service, through collaboration with the Toronto Central Local Health Integration Network.

These and other supports inform the community of systemic and individual need.

1

Work Plan Report

Long-Term Intensive Support Strategy

The local system has an improved capacity to provide service to individuals who have long term high support needs.

- Dialogue has begun between the Toronto Network of Specialized Care (TNSC), the Ministry of Community and Social Services (MCSS) and the Toronto Central Local Health Integration Network (TCLHIN) regarding a systemic response to individuals with complex needs requiring long-term, high-support options including, but not limited to, residential supports.
- A proposal is being developed for a review of high-support housing models for individuals with complex needs.

B Expanded Treatment Continuum

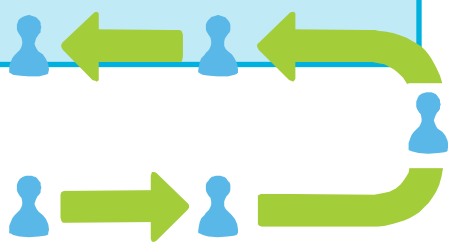
There is a range of programs offering treatment-based services that is highly individualized, time-limited and secure as a result of a base funding commitment.

- Collaborative And Individualized Resource (CAIR) funding has been annualized.
- Agencies are becoming familiar with Clinical Planning.
- A Clinical Facilitator and Resource Supervisor, as well as time-limited, flexible funding, are available to mentor, enhance and or backfill staff who are receiving training.
- TNSC has allocated $5,000 per year to top up funding.
- Evaluation occurred; targets were met for both indirect and direct service recommendations to be followed up on in 2013-14.
- Alternative Level of Care (ALC) funding from the TCLHIN was approved on an annualized basis to support people transitioning from inpatient hospital settings and Toronto transitional treatment beds; the target of supports to four to five individuals was achieved. A training package for enhancing behavioural skills was approved in principle.
- Behaviour Therapist position and flexible funding are components.
- Both initiatives are a partnership between TNSC, CAMH Dual Diagnosis Service and Griffin Centre.

C Engagement and Participation in the Toronto Service Continuum

Service Providers understand the benefits of the Network and the value of participation and as a result engage willingly in Network processes.

- Memorandums of Understanding continue to be negotiated.
- Clinical expertise is provided to monthly Clinical Conferences by members of the TNSC.
- Services along the specialized continuum are available based on capacity, with the exception of Residential Treatment, which is accessed via Clinical Conference.
- Day program, residential treatment and hospital assessment have been the most requested.



TNSC

D Maximizing Use of Fiscal Funding

The Network has a well-developed plan for the use of fiscal dollars.

- A fiscal request template was developed to allow the TNSC members access to funds which sometimes become available at year end.
- Members were polled to determine interest in applying for work plan-related requests.
- The GCSN applied for and was granted funding by the TNSC to support five additional individuals.

E Education and Training

The Central Region has a well-developed, integrated, education strategy.

- Overall, **1,368** people received training in Toronto at 55 unique events.

Trainings have been conducted both locally and through Central Region:

- Effective Specialized Responses (ESR)
- Training in Partnership (TIP)
- Mental Health Act
- Unlocking the Mysteries of Challenging Behaviours
- Health Care Facilitator trainings

- *"This is one of the most helpful and practical training workshops I've attended. Excellent! Very informative."*
- *"Great information and thought-provoking reflection on our approach to our clients and their systems."*

Comments from ESR Training

2 2012-13 Clinical Conference Information

- There were **37** Clinical Conferences held in 2012/13.
- **136** people attended on behalf of the individuals. This includes family, teachers, doctor, police, lawyer, service providers and students.
- **57%** of people presented were between 18 and 33 years of age.

2012-13 Clinical Conference Information

System gaps and/or challenges seen:

- Treatment and safe bed blocking and ALC issue; 12 people are waiting for treatment beds, resulting from the unavailability/ lack of long-term options able to respond to the complexity of needs
- Training/capacity building is required.
- Coordination of supports; case management was reported as being a challenge for people with complex needs. Caseloads are large; clients with multi-service involvement require more intensive case management.
- Services and funding ending/decreasing at adulthood as demonstrated in the 57% of young adults being presented.
- Lack of seniors' housing options when there is an adult child.
- Young adults residing in long-term care.
- Stable environments are needed to accomplish clinical recommendations.
- Families' complex needs.
- Treatment bed staff being injured and off work.
- Accessible treatment locations.

The individuals who are in contact with TNSC specialized services are those who have, or could have, a combination of mental health and:

- Autism Spectrum Disorders with significant complex needs
- Sex offending behaviour resulting in conflict with legal authorities, requiring close monitoring
- General conflict with the law
- Personality Disorder traits that impact on community tenure
- Medical complexity requiring health professional support

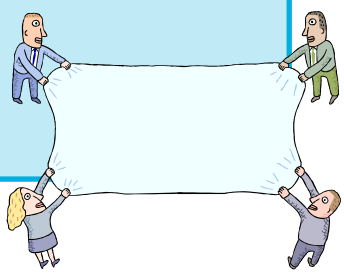
Coordinator Triage

Information calls = **15**

- Connections to Human Services and Justice Coordinating Committee (HSJCC), out of region connections (2), process information, DSO contact, not eligible for service, Toronto Police Service connection, children and adolescent services, education events, sex offending resources, Health Care Facilitator connection.

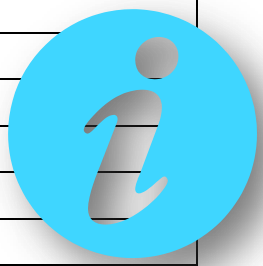
Contacts made on behalf of identified individuals = **54**

Recommendations/suggestions included the following:



13	Contact GCSN
12	Contact DSO
9	Update Community Needs List
5	Case management
5	Medical follow up
4	Contact CAIR
4	Contact CAMH Dual Diagnosis Resource Service
4	Contact Ontario Shores
4	Respite
3	Assessment
3	Connect with Health Care Facilitator
3	Develop crisis plan
3	Family work and supports
3	Hold case conference
2	Concurrent Disorders Support Services
2	Connect with respite
2	Consult with service-specific agencies
2	Contact CCAC

Additional Recommendations:
Refer to Behaviour Therapy, out-of-region resources, check Homes for Special Care, counselling, justice housing, mental health Case Management, PG&T, and recreation programs.



Treatment Beds Continuum

- There are 29 treatment beds (one is offline to support the higher needs of individuals being referred to the program).
- Of the 28 remaining, five admissions (vacancies and admissions carry over from one fiscal year to another).
- Ten people are ALC in the transitional treatment beds. One is from out of region; MCSS is aware of this.

Treatment Bed Waitlist

- There are currently 12 people are on the treatment bed waitlist; the person waiting the longest has been on the list since October 2009 and requires an individualized residential setting and clinical supports, has been ALC at CAMH and has been turned down for day and residential vacancies.
- 75% of the people on the waitlist have Autism.
- One person has mobility issues – no treatment program has the ability to support.
- 50% are living at home (six people).
- 41% are Alternative Level of Care (ALC) in hospital (five people).

3

GRIFFIN COMMUNITY SUPPORT NETWORK (GCSN) – CRISIS

- 262 clients served
- Two residential safe beds blocked as of March 31, 2013

Themes/Trends from GCSN:

- Lack of funding to address language/communication supports in Toronto's diverse cultural community; leads to service barriers.
- Increasingly, individuals are diagnosed as being on the autism spectrum with accompanying, very challenging behaviours and communication barriers require long-term services.
- Youth diagnosed within the Autism Spectrum comprise a large proportion of current wave of referrals to the adult developmental sector.
- An increase of school-age youth (18-21) where their aggressive behaviours pose a problem to them staying in school. Schools are not equipped to manage.
- Safe beds blocked by challenging individuals being admitted to safe beds; often families are no longer able to cope with their son/daughter at home.
- The number of hospitals willing to serve individuals with complex needs is small, largely because the individuals are difficult to understand and treat, their needs are overlapping, they pose significant risk and liability and they are expensive to serve.
- As hospitals narrow their mandates to address their financial constraints, they are reluctant to admit these individuals, stating "it's behavioural" and sending the individual back into the community, resulting in a revolving door.
- Lack of appropriate and available resources are stretching families beyond their capacities; there has been an increase in the number of families simply refusing to take their adult child home.
- Families are being traumatized by their adult child's behaviour, as they are the recipient of the aggression and living in fear.
- Community agencies need higher staffing ratios and clinical resources embedded in the organizations to provide the inter-disciplinary programming and care required by these individuals.

4 COTA Health

- Justice case management: **15** people served
- Dual Diagnosis Case Management: **61** people served

Trends from COTA:

- Difficult to discharge individuals from service with COTA due to long waitlists.
- The emergence of more difficult behaviors among individuals being served.
- Waitlists for services through DSO.
- Waitlist for suitable housing or risks of losing what they have.
- Individuals often not wanting to identify with the developmental sector and therefore finding it even more difficult to find programs that can deal with them.

Trends from COTA:

- Limited access to specialized supports – specifically psychiatric, behavioural and clinical services.
- Barriers between the Developmental Sector and the Mental Health Sector.
- Lack of education within service sectors about what is provided by other sectors.
- Issues with getting housing for someone who has criminal charges against them – in the past seven months, at least two clients were turned down for vacancies due to charges.
- Funding for programs, e.g., Passport.

5 CAIR and ALC Dual Diagnosis Transition Service

CAIR

- **30** people were served in 2012-13.
- **30** system facilitation/capacity-building events.
- Targets were met and exceeded.

"CAIR holds much promise as an emerging evidence-informed practice that fosters improved client outcomes, aids in building caregiver capacity, and helps expand system capacity and collaboration." (CAIR final report, March 26, 2013)

The Collaborative and Individualized Resource (CAIR) was funded by MCSS as a two-year pilot. In April 2013, annualized funding was confirmed following a presentation of an evaluation to the Toronto Service Provider Committee and MCSS.

The goal of CAIR is to stabilize individuals in their community, enhance caregivers' ability to support individuals with complex needs and to build capacity of service providers in developing and implementing clinical plans.

The results of the evaluation indicated that the majority of outcomes met or exceeded targets. The area of satisfaction of CAIR services was slightly below target, which will be addressed in the coming year.

Some examples of the recommendations are as follows: to work with service providers more intensively, determining limitations which may impact on the service, feedback sessions, and continuous evaluation of service.

ALC Service

- There were seven referrals in 2012-13 and five have closed. One person has moved to a permanent residential setting; the other remains on the treatment bed waitlist due to mobility issues and lack of accessible treatment location.
- A proposal has been vetted by the TNSC regarding capacity building that will provide comprehensive training to behavioural consultants, residential supervisors, and front-line staff within agencies that receive Alternate Level of Care clients.
- A training package was developed using the Behavioural Skills Training (BST) model to provide staff with theory, rationale and hands-on competencies. The training has been conducted at a number of agencies (Kerry's Place Autism Services (KPAS), Surex, and META) and is designed to increase the capacity of receiving agencies to support ALC clients.

- *"[CAIR] Facilitator was hands-on in supporting both the individual and his family. [CAIR] Resource supervisor managed staffing efficiently and accurately; they have a good knowledge of behavioral challenges."*

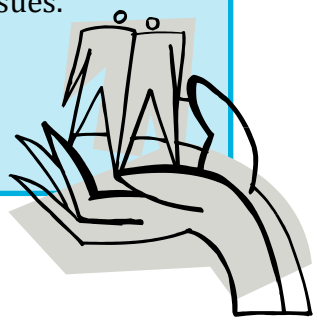
This was indicated as 'most helpful' in the survey responses by Care Provider #3.

6 Health Care Facilitator (HCF)

- Provided support to the Developmental Disabilities Primary Care Initiative (DDPCI) through the Clinical Support Networks.
- Promoted and assisted in the development of Primary Care tools.
- Facilitated education of primary care providers through a variety of means; provided **59** presentations to more than **800** participants.
- Developed and/or enhanced linkages and relationships with key sectors to improve access to health care services by providing support to approximately **60** clients and their teams.
- Is an active member of the Clinical Conference team.
- Identified needs around the Regulated Health Professions Act and chronic health issues such as Diabetes, Nutrition and Dual Diagnosis.
- Maintains a healthcare provider inventory.
- Is a member of the Provincial HCF working group, DDPCI planning committee, Central Region Research and Education committee, Seniors Health Knowledge Network – Aging and DD Community of Practice, DD Cares – Emergency Department Project.

Gaps/Challenges:

- Training for residential providers regarding health awareness as it pertains to developmental disabilities.
- Awareness of healthcare professionals in understanding the unique primary, secondary and tertiary care needs for people having developmental disabilities, dual diagnosis and behavioural issues.
- Clients and families struggling with transitions from children to adult service, adult to senior health services.
- Clients access to specialized, consistent, clinical services due to complex presentation.



7 Linkages

TNSC members are actively involved in many committees: some of these include:

- Developmental Services planning tables: Service Provider Committee, Developmental Services Access Committee, Community Needs Advisory Committee.
- TC LHIN Mental Health and Addictions Network, ALC Advisory
- Toronto Human Services and Justice Coordinating Committees
- Central Region – Education, Research and Training, and Videoconferencing

- Provincially through the CNSC-Ontario, Specialized Accommodation, Justice Case Managers, Health Care Facilitators working group
- Ontario Association on Developmental Disabilities (OADD)
- National Association for the Dually Diagnosed (NADD)
- Seniors Health Knowledge Network – Aging and Developmental Disability Community of Practice
- Health Care Access Research in Developmental Disabilities (HCARDD)
- Developmental Disabilities Primary Care Initiative (DDPCI)

8 Summary of Gaps or Themes Identified at Clinical Conference and Service Resolution

Health-related Issues

- Young adults in long-term care.
- Hospitals unwilling to admit those deemed to have behavioural issues; leads to multiple emergency visits.
- Health system has limited knowledge of developmental, dual diagnosis and behavioural needs; limited preventative health care, overuse of psychotropic medications.

Long-term Resources

- Waitlists for the range of services.
- Stable housing environments to accomplish clinical recommendations with well-trained, consistent staff and appropriate staff ratios.

Transitional Issues

- Treatment and safe bed blocking and ALC issue; 12 people are waiting for treatment bed.
- Transitional-aged youth – services and funding ending/decreasing at adulthood.
- Lack of seniors' housing options when there is an adult child who needs care as well.

Specialized Community Supports

- Coordination of supports; case management was reported as being a challenge for people with complex needs; case loads are large, clients with multi-service involvement require more intensive case management.

Capacity

- Training/capacity building, within and across sectors.
- Families' complex needs; cultural, trauma, burn out, lack of capacity.
- Current DS system is experiencing individuals with changing and higher needs due to mental health, health and aging issues.