

## CENTRAL EAST NETWORK OF SPECIALIZED CARE MEMBERS

### Ministry Representation

Ministry of Community and Social Services  
Ministry of Health and Long Term Care

### Specialized Developmental Services

Community Living Huronia (*Lead Agency*)  
Kerry's Place Autism Services  
Residential Treatment Home - Access  
(*Sponsoring Agency Access Community Services*)  
Residential Treatment Home - Forest View  
(*Sponsoring Agency Community Living Ajax, Pickering and Whitby*)  
Residential Treatment Home - Pineview  
(*Sponsoring Agency Community Living Huronia*)  
Residential Treatment Home - Vita  
(*Sponsoring Agency Vita Community Living Services*)

### Tertiary Care / Dual Diagnosis Programs

Mental Health Centre Penetanguishene  
Ontario Shores for Mental Health Sciences

### Mental Health / Medical Providers

Canadian Mental Health Association, Barrie-Simcoe Branch  
Canadian Mental Health Association, Peterborough Branch  
Schedule 1 Hospital  
Victorian Order of Nurses

### Behavioural Services

Behaviour Management Services, York-Simcoe  
Lake Ridge Community Support Services  
Tri-County Community Support Services

### Case Management Services

Catulpa Community Support Services  
York Support Services Network

### Other Services / Regional and Tri-Regional Representation / Committee Chairs

Community Crisis Response Network Chair  
Central East Dual Diagnosis Education Committee Chair  
Central East Regional Case Resolution Chair  
Regional Network of Specialized Care Coordinator  
Regional Planning Chair  
Tri-Region Education and Research Coordinator  
Central Region Videoconferencing Coordinator



#### Central East Network of Specialized Care

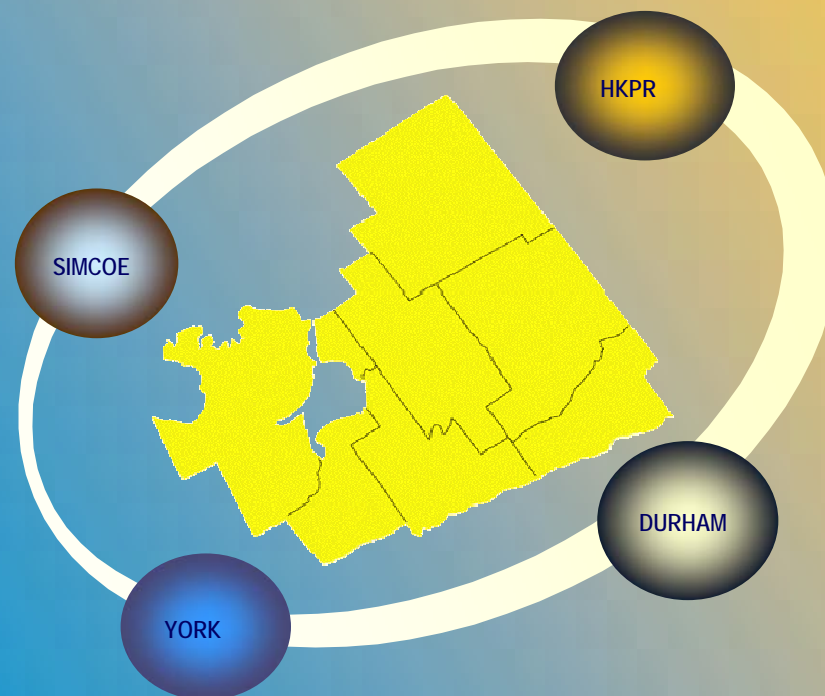
Address: #6 - 230 Aberdeen Blvd.,  
Midland, Ontario L4R 5N4  
Phone: (705) 526-0311 or (705) 526-5857  
Fax: (705) 526-4403  
Website: [www.community-networks.ca](http://www.community-networks.ca)



# Central East Network of Specialized Care

## PROCESS TO ACCESS SPECIALIZED RESOURCES

*Together we will build our capacity to make a positive difference for individuals in our communities with developmental disabilities and mental health needs and/or challenging behaviours who need timely access to effective clinical services*



April 2010

**BACKGROUND**

The Central East Network of Specialized Care is a partnership of community based organizations that work together to provide professional services, consultations, teaching, education, training, and research-related activities for adults with developmental disabilities and mental health needs and/or challenging behaviours.

**NETWORK GOAL**

To develop service delivery that is:

*ACCESSIBLE* ~ so that people and their caregivers / families can access the clinical services they need, when and where they need them.

*COORDINATED* ~ so that the services and supports from a number of programs, organizations, and sectors are working together with individuals and their families to make a difference.

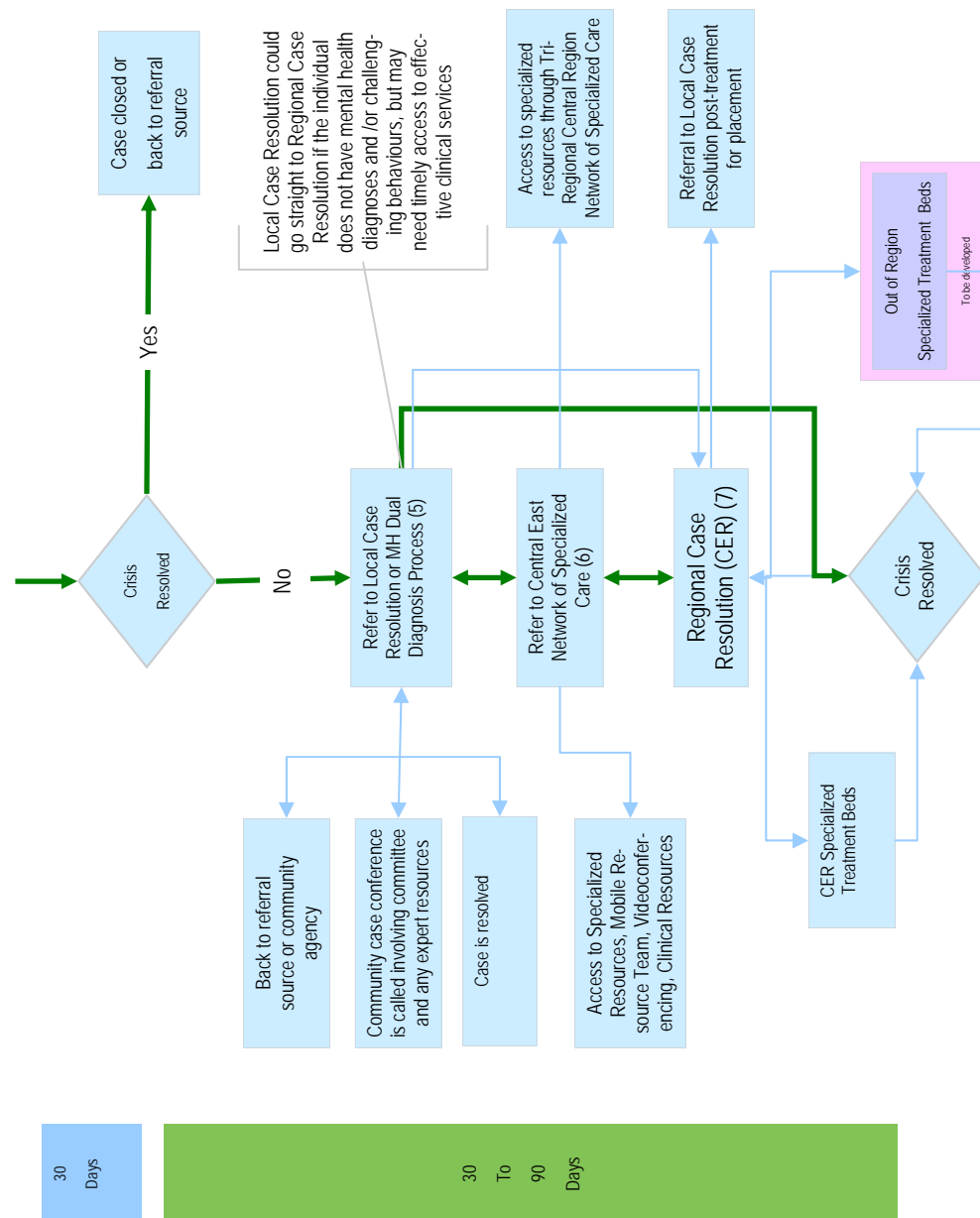
*ACCOUNTABLE* ~ so that we know the networks are actually making a difference.

**NETWORK OBJECTIVES**

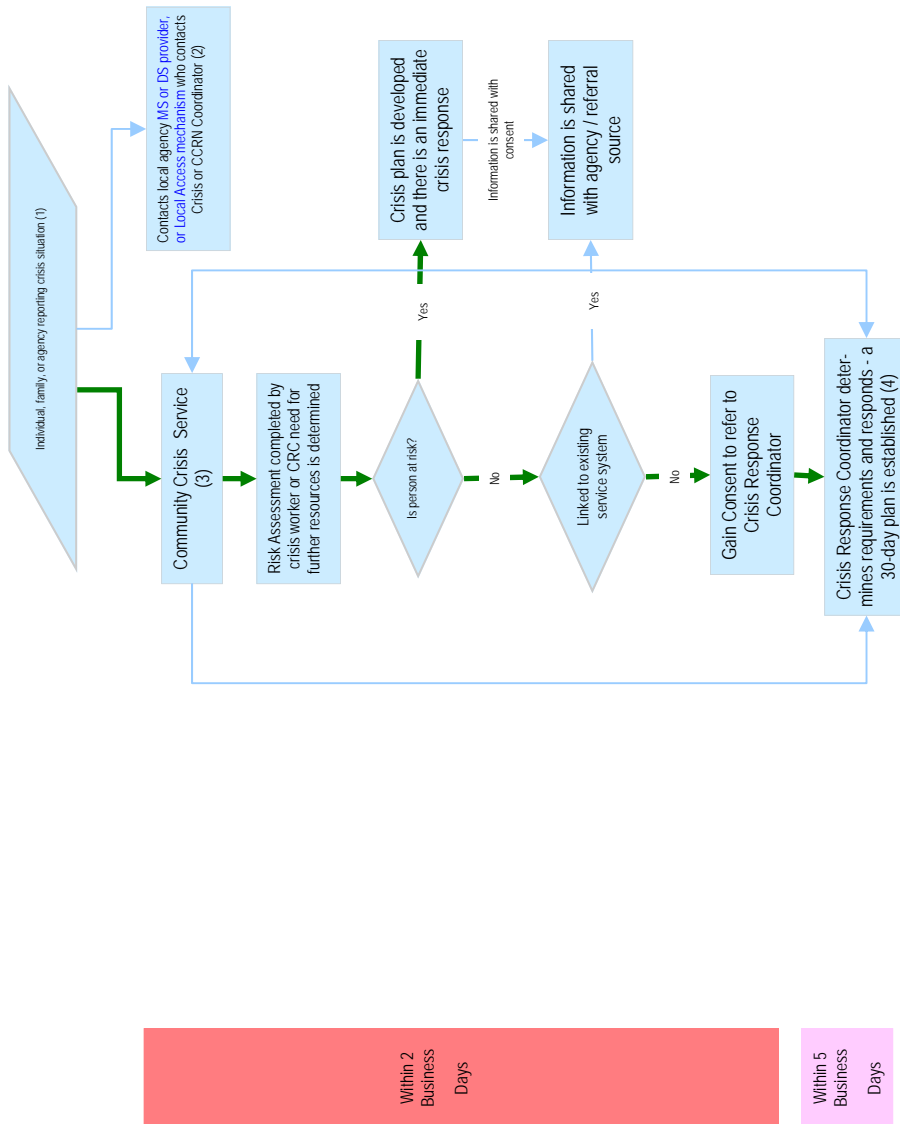
- Assist individuals and families navigate through the system
- Develop a range of treatment options for people requiring specialized services such as the Mobile Resource Team, Mobile Optimal Treatment Team, Community Crisis Response, Specialized Case Management, and/or Residential Treatment Services
- Offer specialized clinical services that match the level of need and allow support for the person in the least restrictive environment with early identification of clinical needs
- Increase the effective use of community resources throughout the Central East Region
- Identify priorities for services and/or supports of individuals with developmental disabilities and mental health needs and/or challenging behaviours throughout the Central East Region
- Increase the capacity of staff from different disciplines that have enhanced skills and knowledge, to assess, plan and treat through evidence informed approaches

**WHY COLLABORATE?**

- Service delivery is complex
- Resources are limited and not always connected
- More effective and efficient
- Learn best with people of similar interest
- Diversity of input



GENERIC MODEL



**NETWORK PHILOSOPHY**

The Central East Network of Specialized Care endorses the Bio-Psycho-Social model to service delivery.

FACTORS	AREA OF ASSESSMENT
BIO	Medical, Medication Reactions, Psychiatric, Neurological State, Syndrome
PSYCHO	Current psychological features (emotional, cognitive, behavioural issues)
SOCIAL	Physical, social and program environment

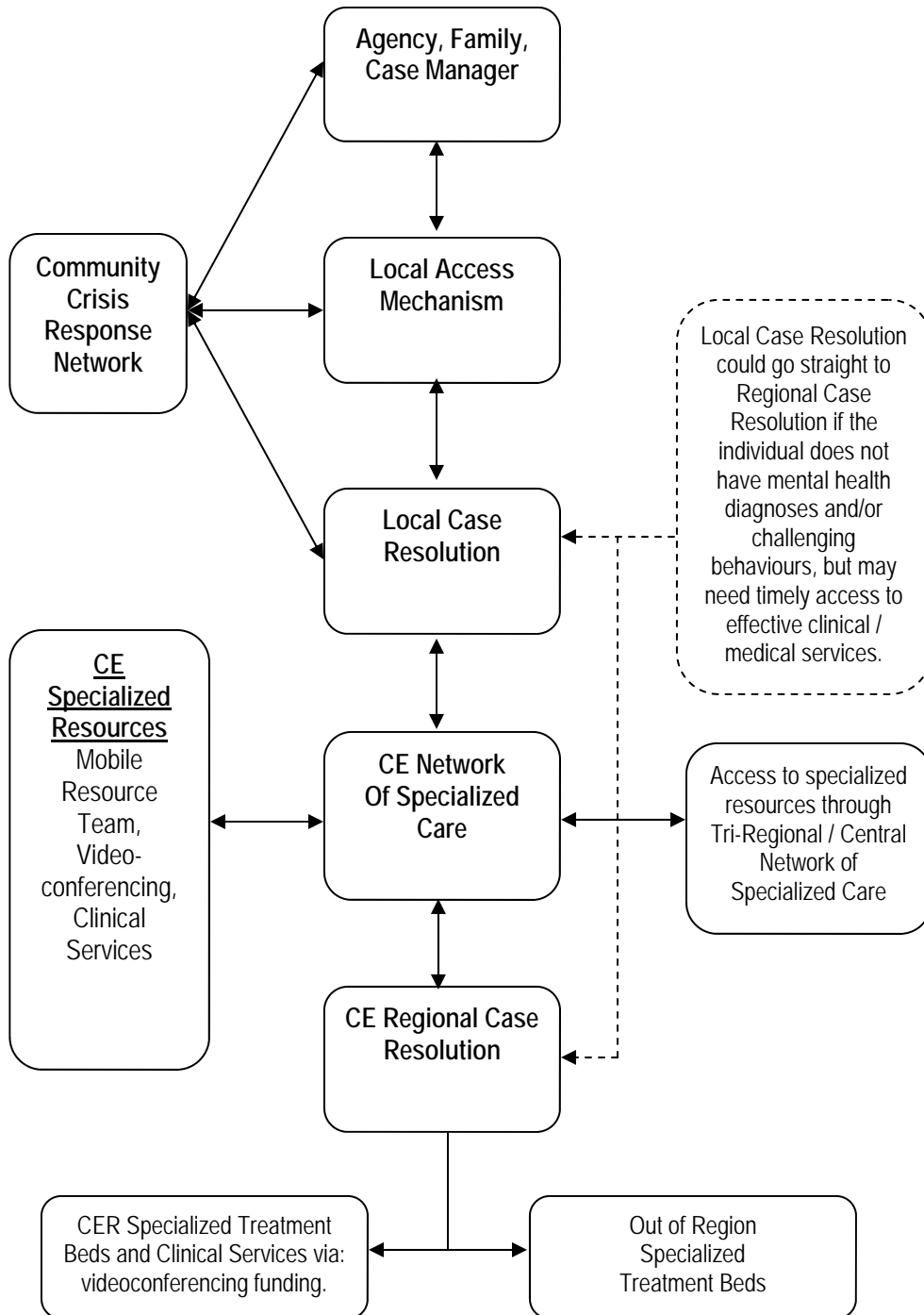
The Central East Network of Specialized Care strives to conduct all treatment activities within the ethical guidelines as articulated in the "Standards of Practice for Behaviour Analysis in Ontario" document, prepared by the Ontario Association for Behaviour Analysis Standards Development Task Force - November 1998.

Embracing the bio-psycho-social model and the ONTABA standards, the Network assures ethical, effective treatment to the individuals receiving treatment in these environments.

Person Directed Planning is also integral to the Network's goals and objectives. It is an ongoing process that helps determine life paths. Person Directed Planning builds on dreams, strengths and capabilities while focusing on the development of relationships as well as ways a person can access community resources.

**ELIGIBILITY**

- 18 years of age or older
- Home community is within the Central East Region
- Individual has developmental disabilities and mental health needs and/or challenging behaviours
- All community resources have been exhausted
- Consent is required for assessment by the Mobile Resource Team
- Individual has a residence to return to or move to after the treatment period has been completed (preferably within his/her own community)
- Psychiatrically stable prior to an admission to a treatment home (a recent psychiatric assessment is required)
- Medically stable prior to admission to treatment home (recent medical assessment is required)
- Case Manager is assigned / identified



**CRISIS SERVICES AVAILABLE INCLUDE:**

- 24/7 crisis line support
- Mobile outreach
- Crisis beds (3 to 5 day stay)
- Developing crisis plans (if required)
- Brief service follow-up
- If the call is not deemed an emergency but the person is requiring an urgent response and crisis stabilization, the crisis line staff gathers more information (e.g. is the person already connected with a developmental service agency? Does he/she have a psychiatrist? Is he/she on medication? etc)
- The crisis service may provide 1 to 2 days immediate short-term case management services while accessing ongoing supports
- If the person has an intellectual disability and requires immediate services, a referral call will be made to the local Community Crisis Response Network Coordinator
- Through this entry point, one call to the existing local 24/7 crisis response telephone support line, provides timely entry to a seamless, accessible system of ongoing crisis services and planned intervention / supports for up to 30 days

**CRISIS RESPONSE COORDINATOR WILL:**

- Ensure that the person is eligible for services
- Determine that the situation is an immediate crisis situation
- Match the services and supports that will best meet the presenting needs of the individual experiencing a crisis and his/her family with those available within the Network of partners
- Set up a one-month plan of care within two (2) business days of first contact
- Ensure that a Case Manager is assigned to provide short-term follow up (30 days)
- Make referrals and linkages to any necessary long term supports

**SERVICE AND SUPPORTS MAY INCLUDE (however not limited to):**

- Clinical Assessment
- Medical review
- Behavioural consultation
- In-home supports
- Short stay out-of-home residential placement
- Day supports
- Short-term Case Management
- Flex funding is available for enhanced staffing and emergency needs



**COMMUNITY CRISIS RESPONSE NETWORK DISCHARGE:**

- The involvement of the case manager will be on a time limited basis
- The goal to have individuals engaged with appropriate services is within a four month period, during which time referrals / linkages to appropriate longer term supports will have been facilitated and / or the crisis resolved
- The Coordinator is the liaison between the Network partners and is responsible for maintaining good working relationships. It is the responsibility of the Community Crisis Response Network Coordinator to ensure that the individual receiving services is discharged on the agreed upon date and that appropriate follow up referrals are completed
- When a person's needs cannot be fully addressed within a short-term crisis response, each local Coordinator has formal access to the available resources of the other quadrants in Central East, and has a direct link (through permanent membership) to local case resolution committees and the resources of the Central East Network of Specialized Care

**COMMUNITY CRISIS RESPONSE NETWORK OBJECTIVES:**

- Person Directed, individualized approach
- Home based crisis support
- Access to a continuum of supports and services
- Inclusive and responsive to all individuals with developmental disabilities and mental health needs and / or challenging behaviours
- Flexible and portable services
- Build on existing services and partnerships

**ROLES AND RESPONSIBILITIES**

An individual must be eligible to receive developmental services: 18 years of age or older, developmental disability, mental health needs and/or challenging behaviours, and be a resident of the Central East Region. An individual may already be in service or new to the sector.

**INDIVIDUAL, FAMILY, AGENCY, CASE MANAGER MAY:**

- Place a call to the local case resolution committee. Anyone seeking help may call the mental health crisis service local 24/7 toll free crisis line and be linked to service
- The crisis line staff gathers information and conducts a mini-assessment on the urgency of the crisis situation and determines whether the caller requires emergency assistance. The existing services have protocols established with local hospital crisis services, ambulance and police
- Provide proof of consent for the Community Crisis Response Network to review the situation and accompanying information, and provide supporting information regarding the situation if possible

**ONE YEAR - RESIDENTIAL TREATMENT**

For adults with developmental disabilities and mental health needs and/or challenging behaviours who require stabilization and treatment in order to access and/or maintain existing community supports and resources, or either transition from a secured institutional setting (i.e. jail, mental health facility), prior to being placed in the community.



**PINEVIEW**



**FOREST VIEW**



**SIMCOE**



**YORK**



**DURHAM**



**HKPR**

**LONG TERM - RESIDENTIAL TREATMENT**



**VITA**

For adults with a history of significant sexual offending behaviour (may also have other criminal/inappropriate social and/or aggressive behaviour).



**ACCESS**

For adults with significant behavioural needs that require long-term clinical supports and interventions.

**REFERRAL PROCESS**

An individual must be eligible to receive developmental services: 18 years of age or older; developmental disability, mental health needs and/or challenging behaviours; and a resident of the Central East Region; may already be in service or new to the sector. If admission to a treatment bed is requested an agency/caregiver must be identified to receive the individual back into care upon completion of the treatment plan. If no agency/caregiver has been identified the home quadrant of the individual must assume responsibility to identify a placement upon completion of the treatment plan.

The Mobile Resource Team may be accessed for a range of clinical services, outreach services and/or training. Clinical services include, but are not limited to: behavioural consultation, psychiatric nursing, speech and language, physiotherapy, and occupational therapy.

**INDIVIDUAL, FAMILY, AGENCY, CASE MANAGER WILL:**

- Make a referral to the Local Case Resolution committee access mechanism
- Complete the referral package
- Provide proof of consent for the case resolution committee and the Network to review the referral package
- Provide supporting information regarding the referral if possible

**LOCAL CASE RESOLUTIONS COMMITTEE WILL:**

- Confirm eligibility
- Assess the referral and the individual's current situation
- Identify and implement possible resolution supports and timeframes
- Identify a case manager
- Identify immediate interim steps, resources required and implement to support the individual
- Determine whether all local resources have been exhausted
- Authorize the case manager to refer the case to the Central East Network of Specialized Care for consultation / resources

The local case resolution committees have the overall responsibility to identify, plan and prioritize access to all local resources (e.g. residential programs, day programs, clinical services, etc.). The local case resolution chairs may refer a case directly to the Central East Regional Case Resolution committee if the individual does not require network resources but needs timely access to effective clinical / medical services.

In addition to crisis response, the Crisis Coordinators\* have also taken on the role of the Dual Diagnosis Justice Case Management position. They provide support to individuals who are in conflict with, or at risk of being in conflict with the criminal justice system, to access community based developmental/mental health services to minimize their involvement with the criminal justice system. They will work in partnership with the court support workers and discharge planners.

The Central East Region has four Crisis Response Coordinators, one in each quadrant. The coordinators are employed by a service delivery agency within their quadrant. It is aligned and linked with the Central East Network of Specialized Care.

Durham	Durham Mental Health Services .....	683-9124
HKPR	Canadian Mental Health Association—Peterborough .....	745-6484
Simcoe	Catulpa Community Support Services .....	733-3227 ext. 334
York	York Support Services Network .....	898-6455 ext. 271

The Central East Region Coordinator provides administrative functions as established within the existing Community Network of Specialized Care infrastructure. The overall governance of the Crisis Response Network is through the Central East Region Developmental Services Planning Committee

**COMMUNITY CRISIS RESPONSE NETWORK ELIGIBILITY:**

- 18 years or older (16 years or older for intensive case management)
- Must have developmental disabilities and mental health needs and/or challenging behaviours
- Involved with, or at risk of involvement with the criminal justice system
- Home community is within the Central East Region

**COMMUNITY CRISIS RESPONSE NETWORK GOALS:**

- The goal of the Community Crisis Response Network is to intervene early and provide urgent supports to stabilize the person or situation and to avoid the need for more intensive intervention. The Community Crisis Response Network utilizes a person centered, individualized approach to service
- To provide timely, flexible and appropriate crisis response service to individuals, their families or caregivers experiencing a psychosocial or situational crisis
- To have individuals engaged with appropriate services within a four-month period, during which time referrals, linkages to appropriate longer term supports will have been facilitated and / or the crisis resolved

\* Crisis Coordinator also refers to Community Mental Health Worker / Dual Diagnosis Crisis Response

## VIDEOCONFERENCING

Videoconferencing enhances communication between people at a distance, reduces travel and accessibility barriers to services, and permits an eco-friendly way for people to come together for learning/training, meetings, and clinical needs. In most cases there is no cost to the user to access videoconferencing services.

### WHO MAY ACCESS VIDEOCONFERENCING SERVICES:

- Staff, clinicians and consultants who work with Networks of Specialized Care Partners
- Community service providers
- Families of individuals with exceptionalities
- Individuals receiving supports or services from any Network partner
- Mental Health Services, Developmental Services, and Health Care Providers

### USES FOR VIDEOCONFERENCING SERVICES:

- Clinical appointments, medical visits, treatment and follow-ups
- Case conferences, multi-disciplinary reviews, assessments, evaluations
- Administrative meetings, committees, strategic planning sessions
- Education, training and personal professional development
- Court visits, family visitation, specialized services

### HOW TO ACCESS VIDEOCONFERENCING SERVICES:

Access is a quick and easy email or phone call away. Contact Linda Bruce, Regional Videoconferencing Coordinator, by email at: [lbruce@clhmidland.on.ca](mailto:lbruce@clhmidland.on.ca) or by calling (705) 526-0311 ext. 323.

## COMMUNITY CRISIS RESPONSE NETWORK

### BACKGROUND:

In April 2007 the Ministry of Community and Social Services funded the Central East Community Crisis Response Network to be fully operational as an innovative, cross sector, integrative service approach to support individuals, their families and / or caregivers experiencing a situational crisis. The Community Crisis Response Network is a capacity building model that utilizes current resources and existing (and new) working relationships across sectors. Crisis response is an active process that aims to provide relief from the immediate problem, crisis, symptoms as perceived by the individual or the individual's family / caregivers, as well as to prevent the condition from worsening.

### THE CASE MANAGER WILL:

- Complete the Network of Specialized Care referral package and submit to the Network Coordinator via the Network Executive Assistant
- Be the liaison with the MRT and other supporting parties (e.g. family, agency), in regards to the case
- Respond to queries and requests from the MRT for more information
- Be prepared to present at the CE Regional Case Resolution Committee if required
- Coordinate the recommendations from the CE Regional Case Resolution Committee within the timelines given
- Provide completion dates in regards to CE Regional Case Resolution Committee recommendations and submit to the CE Network of Specialized Care so that the individual file may be maintained
- Communicate with the Coordinator of the CE Network of Specialized Care in writing when withdrawing a referral
- Update the Local Case Resolution committee

*It is necessary to complete the full referral package to ensure that the Mobile Resource Team has all the information they require to make informed recommendations and to promote timeliness of decision making.*

### CENTRAL EAST NETWORK OF SPECIALIZED CARE:

The Network Coordinator and/or the MRT Coordinator are available for consultation and strategizing prior to a referral package being completed. This allows case managers to ensure that they have exhausted all of their local resources before making a referral to the local case resolution.

### NETWORK EXECUTIVE ASSISTANT WILL:

- Check the referral package for necessary consents
- Request consents if they are not included in the package. The referral cannot be reviewed or forwarded to the Mobile Resource Team until consent is received
- Initiate a file and forward a copy of the full referral package to the Mobile Resource Team Coordinator
- Complete the Mobile Resource Team recommendations report and distribute to the Local Case Resolution committee, referring agency, case manager and master file
- Complete the CE Regional Case Resolution committee recommendations report and distribute to the CE Regional Case Resolution Committee members, referring agency, case manager, Local Case Resolution chairperson, the Mobile Resource Team Coordinator, and the master file
- Maintain referrals and outcome statistics / database
- Provide a 'bed status' report to the Network twice a year



**THE CENTRAL EAST NETWORK OF SPECIALIZED CARE COORDINATOR****WILL:**

- Forward the referral to the CE Regional Case Resolution committee if a treatment bed is recommended by the Mobile Resource Team
- Inform the appropriate treatment home manager/coordinator if admission to a treatment bed is approved.

**THE MOBILE RESOURCE TEAM**

The Mobile Resource Team is comprised of both local and regional specialized resources. The Mobile Resource Team may be able to support the local team and identify alternate strategies accessing additional resources.

The goal of the MRT model is to provide standardized recommendations for individuals with a developmental disability and mental health needs and/or challenging behaviours who are having difficulty living in their currently environments. An individual would typically receive one of the four following recommendations:

1. The individual remains living in their current environment with access to extra clinical services (i.e. behavioural consultation, psychiatric nursing, speech and language, physiotherapy and occupational therapy).
2. The individual may have to be hospitalized to obtain medical and/or psychiatric stability.
3. The individual requires treatment at one of the four residential treatment homes in the Central East Network of Specialized Care.
4. The individual should receive treatment in their existing living environment, utilizing the current staff supports as well as the Treatment Team.

The Mobile Resource Team Coordinator is available for consultation and strategizing prior to a referral package being completed. This allows the case managers the opportunity to ensure they have exhausted all of their local resources before making a referral for specialized services.

If the referral is a request for a treatment bed the Mobile Resource Team must review the completed package and make recommendations prior to the case being reviewed by the Central East Regional Case Resolution Committee.

**THE MOBILE RESOURCE TEAM COORDINATOR WILL:**

- Review the referral package
- Contact appropriate disciplines/professionals from the MRT based on the identified needs and schedule an initial assessment. This allows for a timely response so the referring party does not have to wait until the MRT meets
- Convene MRT meetings on a monthly basis or more often as required
- Make recommendations for purchase of clinical services

- Approve the MRT recommendations and forward to the CE Network of Specialized Care Coordinator. It may be recommended that further supports be attempted prior to consideration for admission to a treatment bed.

**THE TREATMENT TEAM:**

The purpose of the Treatment Team is to provide clinical supports to individuals with developmental disabilities and mental health needs and/or challenging behaviours who are having difficulties living in their current environment. The team is self directed and provides treatment based on the individual's clinical needs. The goal of this model is to provide treatment to the person in their existing living environment, utilizing the current staff supports as well as the Treatment Team. In addition, trained staff specializing in positive based behavioural supports will be available to liaison and mentor the community based staff / family in their home environment.

**CENTRAL EAST REGIONAL CASE RESOLUTION COMMITTEE**

The CE Regional Case Resolution Committee is comprised of the Chairperson, the four Local Case Resolution Chairpersons, Clinical Service Representatives, Ministry of Community and Social Services, the Central East Network of Specialized Care Coordinator and the Central East Network of Specialized Care Executive Assistant. This committee has the final approval for admission to the Central East Region treatment beds. The individual being referred must have been reviewed by the Mobile Resource Team with recommendations being generated prior to review by the Regional Case Resolution Committee if a treatment bed is being requested.

**THE REGIONAL CASE RESOLUTION COMMITTEE WILL:**

- Receive copies of the first several pages of the original referral package and any supporting documentation
- Set a meeting date and schedule the presentation of cases by case managers and relevant parties
- Participate in the review of individual cases making recommendations for further action, admission to a treatment bed or involvement of the Treatment Team
- Identify a treatment home if an admission to a treatment bed is approved.
- Ensure that the CE Regional Case Resolution Committee recommendations are distributed by the Network to the referring party, case manager, Mobile Resource Team, and manager/coordinator of the treatment home (if an admission is approved)
- Set a time frame for a subsequent review (if required) if the recommendation is for further supports within the home
- Ensure that the CE Network of Specialized Care Coordinator informs the Central Region Videoconferencing Coordinator if a request for clinical services via videoconferencing is approved