

Transitional Aged Youth with a Developmental Disability Community Protocol

Community Partners:

Brant organizations/members of the: Developmental Services Committee and Children's Services Committee
--

Brant Haldimand Norfolk Catholic District School Board Grand Erie District School Board
--

Haldimand Norfolk Organizations

Purpose of Protocol:

Youth and their families can benefit from the support of the community working together to develop coordinated transition plans to support the transition from children's services to adult services at age 18, as well as from an educational setting to community living, up to age 21. The purpose of this protocol is to assist Brant, Haldimand and Norfolk community organizations and school boards to develop a coordinated transition plan for each youth with a developmental disability.

The Protocol identifies the responsibility of the Children's Service system to actively engage with Adult Service providers in transition planning that considers the ideal plan for services and supports, as well as alternative options. It sets the expectation that the transition plan will include early planning, as well as consideration of the youth's interests and skills, future activities during the day, social life, how a youth will contribute to their community, where the individual will live, and identification of the supports and staffing required.

The Protocol ensures the adult developmental service system has information for planning by identifying the number of individuals who will be requiring adult developmental services as well as the needs profile of these individuals.

Background:

The transition to adulthood is a critical time because of the significant changes within a person and their environment. Transition planning is about a youth's life now and in the future, as well as how to best reach the future – the youth's life will be changing and it is important that the youth has opportunities to make choices. Planning should identify what the youth wants, what they need, how they want to do things, and who they want to help them. Collaborative practices between youth, family, service providers and schools are important to ensure transition plans create meaningful outcomes and a seamless process.

The stakeholders in transition are the youth, parents/guardians, school staff, service providers, and the community at large.

There are 3 phases of transition:

- **preparation**, which takes place during the youth's early adolescence
- the **transition** itself
- the **outcomes** where the young adult has met or is working towards the goals previously set.

Following are reference documents which are useful to consider for transition planning and coordination:

- "Creating a Good Life in Community: **A Guide on Person-Directed Planning**" by the Individualized Funding Coalition for Ontario – an excellent tool to help establish a plan
- Education Act (especially Regulation 181/98); Individual Education Plan
- Ministry of Education -Transition Planning: A Resource Guide 2002
- Ministry of Community and Social Services - Passport Guidelines 2006
- Ministry of Community and Social Services - Foundations Guidelines 2004
- "The Best Journey to Adult Life" for Youth with Disabilities

Best Practice Guidelines:

- **Collaborative practices are necessary to support transition:** the most successful transition plans involve working together to create meaningful outcomes and ensuring a seamless process; community agencies and schools communicate with stakeholders, assist with alternatives to the ideal transition plan, assist with providing experiential opportunities prior to transition, and assist with the transitions at age 18 and at graduation
- **Early and on-going planning and coordination is necessary:** youth and their parents/guardians receive regular support, starting at least by age 14, from community agencies and schools working together to develop a coordinated transition plan; this plan evolves annually
- **Information and resources are accessible** to all involved in the transition process; youth and their parents/guardians receive information on transition issues, community resources (including services) by at least age 14 and annually thereafter
- **A person-centered, strengths-based approach** to planning is necessary; collaboration involves the community, not just one organization; the goal is to help the individual first, not the agencies
- **Identification of a key community staff to be the "Lead" in coordination** is needed for some youth (Brant: refer to Community Service Collaboration Protocol)
- **Respect for the youth's own choices and autonomy;** youth and their parents/guardians are able to make informed decisions because preparation includes knowledge, skills, strengths and experiences
- **A receptive community and responsive adult service system;** youth is able to consider choices for active citizenship and involvement in meaningful work, leisure, and living environments; youth has alternative options available

- **Building capacity of people and communities enhances the transition process;** this includes the capacity of each individual, plus community resources, partnerships and opportunities
- **Youth, their parents/guardians and schools should develop linkages with local access agencies;** Contact Brant and Contact Haldimand/Norfolk (REACH) work with youth/families, school boards and community organizations to inform the development of transition plans, provide information, and complete referrals to services; the Contact agencies administer and assist with completion of the Passport funding applications
- **Community agencies should develop linkages with local high schools** to ensure families and teachers are aware early of the need for transition planning, the importance of the youth developing skills, the range of options in the community including services in the adult developmental system
- **Individual plans should build on transition plans developed by school boards**
- **Outcomes and experiences for transitioning to adult life should be built on for future transitions in life**

Roles:

Contact Brant and Contact Haldimand-Norfolk (REACH) agree to initiate transition planning:

- respond to families, local school boards, and service providers to support transition planning
- coordinate youths access to supports
- support youth in the application to Passport funding for community participation supports
- work with local communities to forecast service pressures and trends in the developmental services sector, as identified through transition planning
- provide information on transition planning to youth, families and staff
- annually notify agencies involved with transitional aged youth of the expectations for planning on the birth date of each youth

Community Service Providers agree to initiate transition planning:

- encourage individuals and families to call the appropriate Contact agency for information about transition planning and services, at a minimum when they are entering secondary school and/or at age 14
- assist youth and their families to develop a comprehensive transition plan, ensuring active engagement with other stakeholders including schools, children's services and adult services
- ensure the transition plan for each youth is coordinated by involving and/or ensuring updates are provided to Contact agency staff and other stakeholders
- assist the youth and family to develop other options to the ideal plan
- focus on building on each youths' skills and capabilities during the 'preparation' to transition

Grand Erie District School Board and Brant Haldimand Norfolk Catholic District School Board agree to initiate transition planning:

- encourage youth with a developmental disability and their families to connect with Contact Brant or Contact Haldimand/Norfolk (as appropriate by county) when entering secondary school and/or at age 14, and to liaise with the Contact agencies for information about transition planning
- commit staff to participate in an annual in-service session on transition planning, facilitated by the Contact agencies.
- consider involvement of the Contact agencies or community services in Individual Education Plans (IEP) to address transition plans, as well as any other opportunities to provide information to parents
- support applications to Passport funding through the Contact agencies for youth leaving school

The Children's Aid Society:

The Children's Aid Society has an additional responsibility for all **crowd wards** with a confirmed developmental disability of ensuring transition plans are coordinated early, and fully developed prior to age 18.

Brant Community Protocol Addendum

Evaluation:

The Developmental Services Committee and the Children's Services Committee will review the Transitional Aged Youth Protocol annually to evaluate the effectiveness of the process and protocol. Evaluation should include the number involved in transition planning and at what age, what was included in the planning, the involvement of schools and service agencies, and the outcomes for those that have transitioned.

Planning Process:

For the purposes of planning and coordination, Contact Brant will provide non-identifying information regarding wait list planning to the Developmental Services Committee.

Contact Brant staff will annually flag all youth with a developmental disability to current service providers to provide a reminder about the need for transition planning, as outlined in the Protocol.

The Brant community service agencies, including The Children's Aid Society of Brant, agree to actively engage in transitional planning as per the Transitional Aged Youth Protocol to ensure best practices in transition planning are met and are coordinated, including use of the Transitional Aged Youth Planning Checklist as a case management tool.

TRANSITIONAL AGED YOUTH with a DEVELOPMENTAL DISABILITY
Brant TAY PLANNING CHECKLIST

Youth's Name: _____

Date of Birth: _____

Transition Planning should identify what the youth wants, what they need, how they want to do things, and who they want to help them; planning should involve the youth, family, service providers and schools to ensure transition plans create meaningful outcomes and a seamless process. Youth require completed transition plans at age 18 when children's services end/adult services begin, as well as at the time of leaving school (up to age 21).
Insert dates annually that Outcomes are addressed in columns below:

Transition Plan Outcomes	Age 14	Age 15	Age 16	Age 17	Age 18	Age 19	Age 20	Age 21	Complete
The <u>ideal Transition Plan</u> is developed and <u>updated annually</u> - includes the youth's interests, skills & needs									
Plan includes what <u>activities</u> the young adult will be involved in during the day, such as work, volunteer, recreational, further education									
Plan includes the <u>social life</u> for the young adult in the future									
Plan includes how the young adult can <u>contribute</u> to the community									
Plan includes where the young adult will <u>live</u>									
Plan includes the <u>supports and staffing</u> needed									
Plan includes <u>services</u> and other <u>community options</u>									
Plan includes <u>opportunities to gain experiences</u> in community life to make informed choices for the future									
Plan includes <u>medical/health</u> care needs and supports									
A <u>coordinated transition plan</u> is developed or actively being developed between family, school and services									
<u>Alternative options</u> to the ideal Plan are developed									

	Age 14	Age 15	Age 16	Age 17	Age 18	Age 19	Age 20	Age 21	Complete
Contact Brant has been called to provide information on transition planning, services, and complete an intake; Contact Brant is called annually to update information									
Children's Services staff/school staff have involved the <u>Contact Brant Resource Coordinator</u> in at least one case conference/planning meeting <u>annually</u> ; the <u>priority</u> status has been identified and confirmed annually									
Contact Brant has identified the youth and the youth's priority in <u>system planning</u> for future adult services									
Contact Brant has completed an <u>SIS assessment</u>									
There is <u>active engagement of Children's Services and Adult Developmental Services</u> in transition planning through case conference meetings									
A ' <u>Passport funding</u> ' application for community participation supports has been completed through Contact Brant in January of the year youth is graduating from school									
An <u>application for ODSP</u> has been made prior to youth's 18 th birthday									
A coordinated plan has been developed for transition of <u>SSAH</u> from Lansdowne to Family Counselling Centre									
A coordinated Plan has been developed for transition of <u>respite and family support services</u> from children's to adult services									
The CAS Case Manager has a coordinated Plan developed with active engagement of Contact Brant and Adult Developmental Services for the transition of all Crown Wards with a developmental disability									

Attach details of the Transition Plan/ Transition Plan Outcomes:

Haldimand-Norfolk Community Protocol Addendum

Evaluation and Planning Process:

The Contact Committee of Haldimand-Norfolk, or a sub-committee thereof, will review the Transitional Aged Youth Protocol annually to evaluate the effectiveness of the process and protocol.

Contact Haldimand-Norfolk will provide non-identifying information regarding wait list planning to the Contact Committee and the Community Service Planning process for the purposes of planning and coordination.

Haldimand-Norfolk Referral Process:

MCSS/MCYS Developmental Services Agencies

**Children's Aid Society of Haldimand and Norfolk
Community Living Access Support Services
Community Living Haldimand
Contact Haldimand-Norfolk, Haldimand-Norfolk R.E.A.C.H.
Haldimand-Norfolk R.E.A.C.H.-Developmental Services
Norfolk Association for Community Living**

agree to:

- follow the current protocols regarding referrals. Service providers will keep Contact Haldimand-Norfolk informed of admissions, discharges and vacancies in services for the purposes of planning and coordination.
- work in collaboration with school staff to encourage their youths with a developmental disability and their families to connect with Contact Haldimand/Norfolk when planning to enter secondary school and/or at age 14, in an effort to plan for a smooth transition from school to adult community services, as well as from children's to adult services. The Contact agency will provide information to the school, service provider and family regarding services that the child/youth would be eligible for both currently and in the future.
- Work in collaboration with school staff in informing the youths' Individual Education Plan to address preparations for leaving school, as well as to provide information to parents on community services. Where a developmental service provider is not involved with the individual or available to the school, Contact Haldimand-Norfolk will be available to provide this assistance. It is important that all supports are consistent in identifying the "pathway" for each youth.
- facilitate an annual information session for school personnel around this Protocol. An information session with the Grand Erie District School Board, Brant Haldimand Norfolk Catholic District School Board, Contact Brant, Contact Haldimand-Norfolk, and developmental service providers. This information session will be facilitated by the Contact agencies.

- Contact Haldimand-Norfolk will ensure appropriate documentation is gathered for each new individual referred. This may include, but not be limited to: Common Tool for Intake(Referral Report), Confirmation of Diagnosis, Consent to Release/Obtain Information, and any other appropriate assessments. Contact Haldimand-Norfolk will send referrals to the appropriate agencies, based on individual and family preferences, and will place the individual's name on the waiting list for adult developmental services, where appropriate. Contact Haldimand-Norfolk will process referrals to the Passport program for eligible youths who are leaving school.
- As planning evolves and needs change, Contact Haldimand-Norfolk and/or involved service providers will update the intake information and appropriate referrals/wait lists on behalf of the individual and their family.

Children's Aid Society of Haldimand and Norfolk-Contact Haldimand-Norfolk

agree to the following (revised November 2007):

- All children with a confirmed developmental disability who are wards of the Children's Aid Society of Haldimand and Norfolk (C.A.S.) will be referred to Contact Haldimand-Norfolk (Contact H-N) for future planning purposes prior to their 14th birthday. to ensure planning for future services. Should the developmental disability be suspected and not confirmed, the CAS will arrange for an assessment to be completed (by a licensed physician or registered psychologist) to confirm the diagnosis.
- At age 14, the C.A.S. Case Manager will call Contact H-N to complete an intake for any child with a developmental disability. Contact H-N will place the youth on the "future needs" waiting list for appropriate adult services to identify the future needs for services, as well as identify the needs of these youths to the Residential Committee for future planning purposes.
- Contact H-N staff will attend at least one Permanency Planning meeting annually for each developmentally handicapped youth (beginning at age 16) in the care of the Children's Aid Society of Haldimand and Norfolk, update any intake referrals/wait list information, and ensure the Residential Committee is aware of future planning needs.
 - CAS Case Manager will notify Contact Haldimand-Norfolk Resource Coordinator of the next scheduled CAS Permanency Planning meeting (PP) for each youth.
- At age 17, Contact Haldimand-Norfolk, at the direction of the Residential Committee, will identify appropriate staff from adult Developmental Service agencies to the CAS Case Manager to invite to at least one Permanency Planning meeting for each child. The Permanency Planning meeting will focus on the transition to adult developmental services. Contact Haldimand-Norfolk will continue to update intake information, waiting lists, and the Residential Committee for planning purposes.

- At age 17, a developmental service provider Case Manager (or Community Service Coordinator) will be identified at the Permanency Planning meeting and will work with the CAS Case Manager to actively plan for the transition to adult services. Contact Haldimand-Norfolk and appropriate adult developmental services staff will attend all the Plans of Care meetings throughout the year. Contact Haldimand-Norfolk will continue to update intake information, waiting lists, and the Residential Committee for planning purposes.
- Upon placement in the adult developmental sector (at age 18), the agency providing residential support will assume co-case management responsibilities with the Children's Aid Society of Haldimand and Norfolk. Case management will be fully transferred to the Developmental Service agency providing service when the youth is financially independent of the Children's Aid Society of Haldimand and Norfolk.
- Contact Haldimand-Norfolk staff will assist the Case Managers in arranging community planning meetings upon request. Contact Haldimand-Norfolk will provide information to community staff about this process and options to support the transition process