

Brant Coordinated Service Planning Protocol

1. Preamble

Through the Special Needs Strategy, Brant began implementation of the Coordinated Service Planning initiative in October 2016.

The goal of Coordinated Service Planning is to improve service experiences and outcomes for children and youth with multiple and/or complex special needs and their families. This is done through the support of a Service Planning Coordinator who will connect them to the multiple, cross-sectoral services they need as early as possible, and monitor their needs and progress through a documented Coordinated Service Plan that takes into account each child/youth/family's goals, strengths, needs, as well as all of the services that the child/youth is and will be receiving.

In developing the Special Needs Strategy, the Ministries of Education, Children and Youth Services, Health and Long-term Care, and Community and Social Services established 3 key elements for Coordinated Service Planning in every community.

- A single Coordinating Agency through which families can access coordinated service planning – in Brant this is Contact Brant.
- Dedicated Service Planning Coordinators who will facilitate coordinated service planning by working with children's services, health and education sectors.
- One Coordinated Service Plan that takes into account all of their goals, strengths, needs, and services that the child/youth is and will be receiving.

The Community Service Collaboration Protocol was developed by the Children and Youth Services Committee in the early 2000's. Similar to Coordinated Service Planning expectations, the Community Service Collaboration Protocol outlined that each staff involved in provision of services takes a role in establishing links among service providers and informal supports, across all sectors, and ensures coordination of the overall implementation of the individual's single plan of care. This Protocol has been revised to align fully with the provincial expectations for Coordination Service Planning.

2. Purpose of Community Coordinated Service Planning

Children, youth and families should receive coordinated service planning when they receive multiple services that ensures service providers are working together in a collaborative manner to meet their needs. Evidence states that coordination is central to the effective delivery of integrated services and helps overcome the challenges of numerous lengthy meetings, conflicting and confusing advice, not knowing who needs to talk to whom, and not being able to identify the right supports. Individual agencies will continue to provide their mandated services and will ensure coordination and collaboration with other involved services.

As a result of coordinated service planning, parents and children/youth with multiple and/or complex special needs will:

- Know who is accountable for developing and monitoring their child's coordinated service plan;
- Not have to repeat their stories and goals to multiple providers;
- Have a single service plan that is responsive to their child'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's life; and that they have expertise on their child's abilities and needs;
- Know that providers will be communicating about the needs and goals of their child working toward a set of common goals identified in the plan; and
- Have a clear point of contact for coordinated service planning.

Organizations will ensure that services for children/youth and their families are:

- coordinated and complementary, avoiding duplication and contradiction
- respectful of each family being unique, is the constant in the child's life, and is the expert on the child's abilities and needs (i.e., family-centered practice)
- Responsive to the identified priorities established by the child/youth and family in the Coordinated Service Plan.

Agencies will provide person-centered/ family-centered support. *King, Rosenbaum, & King, Interpersonal aspects of care-giving and client outcomes, Ambulatory Child Health 2, p.151-160, 1996*) describes this support as involving the following types of service provider behaviours:

- "respectful and supportive care
- coordinated and comprehensive care
- enabling and partnership
- providing general information, and
- providing specific information about the child"

Through the collaborative process of working together, service providers support integrated delivery of services for children/youth, including those with complex special needs. Children's Services and MCYS strive to support the child/youth in their home and/or in their community with the least intrusive supports, while aiming to prevent health and safety risks from occurring and/or escalating. Service providers are encouraged to be flexible within their mandates and work creatively within available resources to meet the needs of children and youth.

3. Guiding Principles:

This Protocol is based on the following Guiding Principles:

- Supports should focus on existing community-based services and recognize best practices.
- Integrated delivery of services with school and other sectors will support children/youth and their families having seamless services.
- Messaging by service providers to the child/youth and their family must be coordinated and consistent.
- Agencies working with a child/youth and their family will provide person/family-centered, strength-based service delivery and planning which enables children/youth/families to achieve and maintain a quality of life consistent with their values, priorities, strengths and preferences.
- Staff providing service to a child/youth will implement, deliver and coordinate services within their own agency's mandate, as well as regularly communicate with other agencies involved with the child/youth/family to develop a coordinated service plan as well as monitor outcomes.

- Confidentiality is respected, with information sharing based on consent and the principle of 'need to know'; sharing of information will support children/youth and their families not having to repeat their story multiple times.
- Service Collaboration offers a range of options from informal to formal – the continuum would be based on the child/youth/family's choice and needs.
- Staff involved in provision of services should be aware of and honour the existing community referral processes (e.g., case conferencing/case planning meetings, Case Resolution, RPAC, etc.), Protocols, and service agreements.
- Children/youth and their families will be fully involved in the development of their coordinated single plan of care which should facilitate the achievement and maintenance of a quality of life consistent with their values, priorities, strengths and preferences.

4. Initiating Coordinated Service Planning:

- 4.1 For the majority of children and youth, service coordination is supported by community staff who provide service coordination functions within their professional role.
- 4.2 Each staff involved in provision of services takes a role in establishing inter-professional collaboration through communication with service providers across all sectors to ensure coordination of the overall implementation of each child/youth/family's Coordinated Service Plan.
- 4.3 Inter-agency communication will be initiated by community staff when a child/youth is identified as having involvement with two or more services or sectors. Interagency communication and coordination will be on-going.
- 4.4 Any service provider that becomes aware that there is more than one agency involved in providing services to a child/youth and their family will ensure Consent is secured, according to their own agency's Consent procedures, to allow agencies to communicate. The agency acquiring Consent will ensure current service providers are informed of the Consent.
- 4.5 When Consent is received, each staff involved is responsible to initiate communication within 2 weeks with other staff involved to:
 - identify their role, including goals, and
 - develop a plan for on-going communication and integration of services.
- 4.6 A clear identification of the primary Service Coordinator will be established amongst service providers, or with the assistance of the contact Brant Lead Service Planning Coordinator, based on family preference and agency expertise. The primary Service Coordinator should be identified to Contact Brant so that they can be clearly identified as the family's key contact in the centralized service coordination database.
- 4.7 Any staff providing service coordination will:
 - Provide the child/youth and family with information about available services and resources so the family can make informed decisions to best meet their needs
 - Support families to access the services that they need
 - Develop a single Coordinated Service Plan, using the community developed template with the family and all involved service providers

- Clearly identify what service coordination supports are and who is the family's key contact for any questions and developing their written Coordinated Service Plan
 - Not have to repeat their story to multiple providers
- 4.8 When the need for service coordination is beyond the capacity of the typical inter-professional collaboration, due to the breadth and cross-sectoral nature of the child's needs and/or factors affecting the whole family, a referral for a dedicated Service Planning Coordinator will be made to Contact Brant.

5. Outcome of Collaboration:

The outcome of the communication initiated for Service Collaboration will be an informal or formal documented action plan to ensure integrated service provision which will avoid duplication and contradiction. The action plan should be documented as per agency practice, could include a brief report developed by one of the service providers, or minutes from a case meeting. Key points to include:

- who is involved; who is responsible for on-going communication
 - goals and the integrated service plan for each service provider
 - timeframe.
- 5.1 Service providers should ensure on-going communication regarding significant changes including:
- goals and service plans
 - new services
 - discharge plans
 - coordinated and consistent messaging to child/youth/family
 - change in staff
 - crisis plan, if needed (Note: refer to the *Brant Safety Plan Protocol*).
- 5.2 There should be a continuum of collaboration:
- a. All staff involved are responsible to facilitate on-going communication through emails/phone calls/meetings (case conferences, case planning) to ensure coordination with other service providers
 - b. All staff involved are responsible to ensure minutes from meetings are distributed to all services involved and the youth/family, usually within one week of any meeting.
 - c. All staff involved are responsible to encourage collaboration among the child/youth/family and service providers.
 - d. All staff involved are responsible to ensure that children with complex needs where support needs are not easily met are identified to Contact Brant as "Emergent" or "At Risk" according to the Most in Need Summary tool (See Appendix A - Community Prioritization Process and the Most in Need Summary Tool).
 - e. When it is identified there are challenges in meeting the child/youth's support needs, all staff involved are responsible to ensure on-going case conferencing with all stakeholders, including Contact Brant, to address coordination. Contact Brant will assist in arranging a community response meeting that includes senior managers from service organizations.

- f. At the case planning meeting for “Emergent/At Risk” children/youth, a Lead staff must be clearly identified. Agencies will consider the following when discussing who will be the Lead:
 - may be based on which agency can take on the role at the time
 - may be the first service involved with the child/youth
 - may be based on the predominant needs of the child/youth and who has the most appropriate service/skills
 - may be the choice of the child/youth/family
 - the Lead may change over time based on the child/youth/family and service needs
 - the Lead will be Brant FACS when they have a mandatory responsibility in the situation.
- 5.3 Identification of a Lead does not preclude other agencies from continuing their responsibilities for on-going collaboration in their role of service provision and integration.
- 5.4 Contact Brant will assist the Lead in coordination of services, meetings or other community processes, as well as consultation regarding service options.
- 5.5 Contact Brant will provide data on the numbers and profile prioritized as “Emergent” and “At Risk” to the Brant Children and Youth Services Committee at least annually.

6. Community Collaboration and Complex Needs:

- When the community response meeting with senior managers is held, it is expected that creative solutions must be developed for these children/youth within the finite allotment of resources to reduce the immediate risk and support the child/youth and their family. Where the existing service system is not able to meet the complex support needs of the child/youth, and there is a clinical recommendation for a specialized service response, that child/youth may be referred to Case Resolution (refer to the *Case Resolution Protocol*).
- Contact Brant is the single point of access for children’s mental health services and children’s developmental services and assists children/youth/ families and service providers by providing information as well as accessing services through Intake and Referral. In this role, Contact Brant provides service coordination support to individuals/ families prior to the initiation of services, and once an individual is connected to service, assists service providers with community collaboration roles, including additional referrals.

7. Responsibilities of Service Coordinators:

According to the MCYS document, “*A Shared Responsibility, Ontario’s Policy Framework for Child and Youth Mental Health*” (page 25), the service coordination role may involve the following tasks:

- Engaging the professional expertise of various service system partners in a collaborative and integrated approach to service planning and delivery
- Leading problem-solving discussions with local service providers regarding access to services, and the delivery of services and supports
- Identifying additional services and supports that may be helpful
- Seeking specialized assessments or services as warranted
- Assisting in the development and implementation of a discharge and/or transitional support plan

- Helping to ensure service continuity and preventing duplication (e.g., ensuring information is shared amongst service providers as much as possible within privacy constraints).”
8. This Protocol will be reviewed and approved annually by the Children and Youth Services Committee.

Community Prioritization Process (Based on the Brant Most in Need Tool)

If a child/youth is identified by any service provider as Emergent or At Risk, the staff should identify to Contact Brant and plan together to facilitate a case planning meeting with current staff and senior managers who have decision making authority, as well as other service providers who may be able to offer supports.

Following are the 4 levels of prioritization and appropriate action, as identified by the Brant community.

- a. **Maintaining/Planning** – services provided meet the needs of child/youth and family, or waiting for services is manageable.
Action: Response should be to continue provision of service and communicating with other services involved to ensure integration services, or continue on wait list for service.
- b. **Percolating** – multiple needs indicate that more services may be needed.
Action: Response should be continued provision of service and planning for additional services, communicating/collaborating with other services involved to ensure integration of services, and calling a case planning meeting as needed.
- c. **Emergent** – supports provided in community are stressing service system, or need more services; stressing family system; supervision needs not easily met.
Action: Response should be continued provision of integrated services and planning for additional services. Response should include calling Contact Brant to identify current situation and facilitate a community case planning meeting that should involve management and services/sectors not currently involved that potentially could provide supports/plan for use of resources; Contact Brant will provide assistance with coordination of complex cases. Response should ensure on-going communication/collaboration with services to ensure integration of services. Response should ensure there is a Lead community staff identified.
- d. **At Risk** – child/youth is in crisis or impending crisis; service system and family supports have been exhausted; system cannot meet all needs to keep child/youth and others safe.
Action: Response should be continued provision of integrated services and planning for additional services. Response should include calling Contact Brant to identify current situation and facilitate a community case planning meeting that should involve management and services/sectors not currently involved that potentially could provide supports/plan for use of resources; Contact Brant will provide assistance with coordination of complex cases. Response should ensure on-going communication/collaboration with services to ensure integration of services. Response should ensure there is a Lead community staff identified. Response may consider request for Case Resolution when there is a clinical recommendation for a specialized support to stabilize the situation.



MOST IN NEED SUMMARY TOOL Children's Services

Name: _____ DOB: _____

PRIORITY:

- Maintaining/Planning** – services provided seem to meet needs of child/youth and family, or waiting for services is manageable.
Response should be continued planning and integration of services.
- Percolating** – multiple needs; on the radar that more services may be needed.
Response should include planning and integration of services; referral to new services.
- Emergent** – stressing system, need more supports; stressing family system.
Response should include identification to Contact Brant; planning and integration of services; referral to new services; senior community stakeholders at case planning.
 - Stressing service system Supervision needs not easily met
 - Stressing family system School placement in jeopardy
- At Risk** – child/youth at high risk of harm to self or others; system services have been exhausted; family supports stressed.
Response should include identification to Contact Brant; planning and integration of services; referral to new services; immediate community case planning with senior community stakeholders.
 - System cannot easily meet all needs Supervision needs not easily met
 - Stressing family system School placement in jeopardy

SITUATION:

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Attention, impulsivity <input type="checkbox"/> Cooperativeness <input type="checkbox"/> Conduct/behaviours <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Addiction concerns <input type="checkbox"/> Self injurious behaviours <input type="checkbox"/> Family dynamics/situation <input type="checkbox"/> Abuse (past or present) <input type="checkbox"/> Trauma | <ul style="list-style-type: none"> <input type="checkbox"/> FACS involvement <input type="checkbox"/> Developmental disability <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> FASD/FAE Query <input type="checkbox"/> School issues <input type="checkbox"/> Sexual behaviours <input type="checkbox"/> Justice involvement <input type="checkbox"/> Complex medical <input type="checkbox"/> Other: _____ |
|---|---|

TIMING REQUEST FOR SERVICE:

Urgent = high risk/priority referral to services due to imminent risk of harm: to self to others

Referral = wait listed.

PROGRAM	Urgent	Referral

Person Completing: _____ **Date:** _____