Transition Planning Protocol and Procedures

For Young People with Developmental Disabilities

Hamilton/Niagara Region

Ministry of Children and Youth Services
Ministry of Community and Social Services
Ministry of Education

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THE HAMILTON-NIAGARA REGION TRANSITION PLANNING PROTOCOL, EFFECTIVE SEPTEMBER 2013

The Hamilton-Niagara Region Transition Planning Protocol is intended to be a living agreement that is regularly reviewed and updated in consultation with school boards and community service providers to ensure it remains current with any legislation, regulations, policy, resource or community changes.

1. INTRODUCTION

1.1 Policy context: A Provincial Transition Planning Framework

The Ministry of Children and Youth Services (MCYS), the Ministry of Community and Social Services (MCSS) and the Ministry of Education (EDU) are working together to establish processes that support integrated transition planning leading to a single integrated transition plan for young people with a developmental disability who are preparing to transition to adulthood.

A draft MCYS/MCSS Provincial Transition Planning Framework was introduced in 2011 to improve transition planning support to young people with developmental disabilities who are preparing to transition to adulthood.

Regional protocols were developed by MCYS/MCSS regional offices to guide local transition planning for young people with developmental disabilities in 2012.

On January 31, 2013 MCYS, MCSS and EDU issued a joint memo providing updated tri-ministry direction on integrated transition planning for young people with developmental disabilities.

Through integrated transition planning processes, young people with developmental disabilities will have a single transition plan that will inform educational planning and help the young person transition from secondary school and child-centred services to adulthood and help to prepare parents or guardians and other family members for changes.

To this end, regional protocols, one for each regional service area, guide Transition Planning. These protocols describe how Transition Planning occurs in each community and identify who is responsible for planning, developing and implementing individual transition plans.

1.2 Supporting documents

The policy directions that support the Transition Planning protocol initiative and the protocol design guidance are set out in the Framework. The Framework is available from your local Hamilton-Niagara regional offices of the ministries of Children and Youth Services, Community and Social Services and Education, along with the Tri-Ministry Implementation Guide.

In addition, the ministries of Children and Youth Services and Community and Social Services supported the development of plain language participation guides to support protocol development. The following guides are available from your local Hamilton-Niagara regional office:

- *A Transition Plan for Each Young Person: Planning for Young People with a Developmental Disability*
- *Planning for a Better Transition: A planning framework for young people with a developmental disability*
- *Tri-Ministry Implementation Guide*

All publications are available in French and English.

1.3 Local context

Integrated transition planning is for young people (age 14 and older) who meet the definition of having a developmental disability under any of the EDU, MCSS and MCYS legislation frameworks or agency criteria and who reside within the Hamilton/Niagara region inclusive of:

- Brant
- Haldimand and Norfolk
- Hamilton
- Mississaugas of the New Credit First Nation
- Niagara
- Six Nations of the Grand River

This protocol is inclusive of designated French language communities within Hamilton, Welland and Port Colborne, as well as the First Nations communities of Six Nations of the Grand River and Mississaugas of the New Credit First Nation.

In the education sector, schools may consider the target population to include students identified in other exceptionality categories besides Developmental Disability who have similar needs in cognitive or adaptive functioning (e.g. Communication – Autism, Multiple and Intellectual Disabilities).

Each of the four communities in the Hamilton/Niagara Region has a local *Contact for Children's and Developmental Services* that is the central access point for children's services funded through the Ministries of Children and Youth Services and Community and Social Services. The Contact organizations each have an established intake and referral process that will be followed when Transitional Age Youth are identified. The Contact organizations will oversee implementation of the Transitional Aged Youth Planning Protocol and are the first point of contact for service providers as well as individuals with a developmental disability under the age of 18 and their family or guardian.

Information on each of the four local Contact organizations can be found on the cover page of this protocol.

This protocol replaces previously developed Transition Planning protocols within individual communities between school boards, children's aid societies, and local service providers and integrates current community case resolution processes facilitated by local Contact agencies. An individual does not need to be receiving a funded service from the Ministry of Children and Youth Services or the Ministry of Community and Social Services in order to receive a transition plan.

Due to the volume of young people and adults who are eligible to receive integrated transition planning, children's lead agencies will prioritize integrated transition planning in the following order:

- Priority One: adults who are age 18 and over who are currently receiving children's residential services;
- Priority Two: Young people who are between the ages of 14 and 17 who are currently receiving children's residential services;
- Priority Three: Young people who are 14 and over who are receiving non-residential children's services (respite, counselling and treatment, family support services, etc.)

This protocol will be accessible and publicly available through signatory agencies.

This protocol aligns with the Ministry of Education 2002 Transition Planning: A Resource Guide (Appendix B.)

1.4 Purpose of the protocol

The focus of this protocol is to provide young people with developmental disabilities with a planned and coordinated transition from childhood to adulthood. Integrated transition planning is for young people (age 14 and older) who meet the definition of having a developmental disability under any of the EDU, MCSS and MCYS legislation frameworks or agency criteria. In the education sector, schools may consider the target population to include students identified in other exceptionality categories besides Developmental Disability who have similar needs in cognitive or adaptive functioning (e.g. Communication – Autism, Multiple and Intellectual Disabilities).

The purpose of this protocol is to describe the Transition Planning procedures that will be followed by the signatory agencies and provider organizations. To this end, the protocol identifies the service providers and agencies that lead Transition Planning or contribute to planning for transition, including those who will plan with the young person and his or her family to prepare for changes.

1.5 Protocol comes into effect

This protocol comes into effect when a young person is identified for Transition Planning or when a young person requests Transition Planning support or a person acting on behalf of the young person requests Transition Planning support.

1.6 Signatories

Agencies and provider organizations that are party to this protocol agree to act in accordance with the guiding principles and to follow procedures set out in the protocol.

Protocol signatories work closely with colleagues from other agencies to help prepare young people to leave children's services, review adult service choices and, where appropriate, apply for adult services and supports.

Signatories to the protocol may change over time, and any government-funded entity could agree to an assigned role and choose to be a signatory at any point.

1.7 Initial signatories to this protocol

Name	Agency or Service Provider	Date	Signature
Brant			
Jane Angus	Contact Brant		
Andy Koster	Children's Aid Society of Brant		
John Forbeck	Grand Erie District School Board (GEDSB)		
Cathy Horgan	Brant Haldimand Norfolk Catholic District School Board (BHNCDSB)		
Shelley McCarthy	Family Counselling Centre Brant		
Rita-Marie Hadley	Lansdowne Children's Centre		
Cindy l'Anson	Woodview Children's Mental Health and Autism Services		
Sandi Montour	Ganohkwasra		

Diane Belliveau	Brantwood Centre		
Janet Reansbury	Community Living Brant		
Lynda Nicholson	Community Living Six Nations		
Arliss Skye	Six Nations Child and Family Services		
Helen Tobias	New Credit Health and Social Services		
Haldimand-Norfolk			
Leo Massi	Haldimand-Norfolk R.E.A.C.H.		
Janice Robinson	Children's Aid Society of Haldimand and Norfolk		
Patricia Morris	Community Living Access Support Services		
Stella Galloway	Norfolk Association for Community Living		
Susan Wavell	Community Living Haldimand		
Hamilton			
Lea Pollard	Contact Hamilton		
Lea Pollard	Developmental Services Ontario		
Vicki Corcoran	Hamilton Wentworth District School Board (HWDSB)		
Jackie Bajus	Hamilton Wentworth Catholic District School Board (HWCDSB)		
Alex Thomson	Lynwood Charlton Centre		
Cindy l'Anson	Woodview Children's Centre		
Loretta Hill Finamore / Brother Richard	Good Shepherd Centres: Brennan House		
Karen Smith	Community Child Abuse Council		
Kathy de Jong	City of Hamilton: Child and Adolescent Services		

Denise Scott	Wesley Urban Ministries		
Joanne Davis	Salvation Army: Grace Haven		
Paula Forbes / Linda Dayler	Catholic Family Services		
Sue Kennedy	Alternatives for Youth		
Rocco Gizzarelli / Ersilia DiNardo	The Catholic Children's Aid Society of Hamilton-Wentworth		
Dominic Verticchio	The Children's Aid Society of Hamilton-Wentworth		
Sherry Parsley	Community Living Hamilton		
Donna Marcaccio	Rygiel Supports for Community Living		
Marsha Newby / Colleen Fotheringham	McMaster Children's Hospital		
Kathleen Kitching / Colleen Fotheringham	McMaster Children's Hospital		
Bonnie Buchanan / Colleen Fotheringham	McMaster Children's Hospital		
Adele Tanguay	Centre de santé communautaire		
Niagara			
Kaarina Vogin	Contact Niagara		
Chris Steven	Family and Children's Services		
John Crocco	Niagara Catholic District School Board		
Kelly Pisek	District School Board of Niagara		
Ellis Katsof	Pathstone Mental Health		
Oksana Fisher	Niagara Peninsula Children's Centre		
Jim Wells	John Howard Society		
Heather Scott	Niagara Health System		
Marcel Castonguay	Centre de santé communautaire		
Brian Davies	Bethesda Children's Services		

Sarina Labonte	Community Living Grimsby/Lincoln, Lincoln and West Lincoln		
Andrew Lewis	Niagara Support Services		
Andrew Lewis	Niagara Training and Employment Agency		
Barbara Vyrostko	Community Living Welland/Pelham		
Vicki Moreland	Community Living Port Colborne		
Maureen Brown	Community Living Fort Erie		
Al Moreland	Community Living St. Catharines		
Kevin Berswick	Mainstream		
Jérôme Pépin	Conseil scolaire de district catholique Centre-Sud		
Corinne Freeman	Conseil scolaire Viamonde		

2. PROTOCOL GUIDING PRINCIPLES

This section sets out the guiding principles [established by the Framework] to be used as goals and benchmarks for developing and refining Transition Planning protocols.

2.1 Planning

- *Transition Planning is a dynamic and continuous process, accommodating changes in personal preferences, conditions and circumstances.*
- *The planning process considers all available and conceivable service scenarios.*
- *There is sufficient flexibility to adapt plans to accommodate or respond to changes in the person's situation or circumstances or changes in the person's needs and priorities.*
- *Transition Planning begins early, and continues until the transition is completed (which, for some young people, may be past age 18).*
- *Transition Planning is important because it is a means for centering planning on the needs of the young adult and informing them of adult service choices and application processes.*

2.2 Definition of responsibilities

- *The responsibilities of all parties to develop and implement individualized transition plans are clearly and explicitly outlined and the intended populations are clearly defined.*
- *Transition Planning processes and progress are documented for each individual, with regular communication among involved agencies and individuals during the transition period.*
- *The planning process is conducted in a manner that is respectful of the young person's autonomy and safeguards his or her rights respecting privacy and confidentiality, and capacity and consent.*

2.3 Person-centred

- *The person is involved in the planning process and, as much as possible, decisions about his or her care and services are driven by his or her needs, preferences, interests and strengths.*

- *A Transition Planning goal is to support the young person in ways that help him or her live in the community, maintaining and strengthening the young person's connections with parents, siblings and relatives, foster families and any other individuals who are important to the person, as well as connections with his or her community, culture and religion.*

- *The planning process provides the person with choices to support the development of self-determination and self-advocacy.*

- *Information on developmental services and supports, and on other social and health programs and services, is readily available and provided in accessible locations and formats.*

- *Transition Planning includes the involvement of people who are important to the young person, as determined by the young person.*

- *Transitional arrangements are implemented at a pace that takes into account the needs and preferences of the young person and in a manner that best promotes and preserves service consistency and quality.*

- *Service decisions consider the course of action that is least disruptive to the person.*

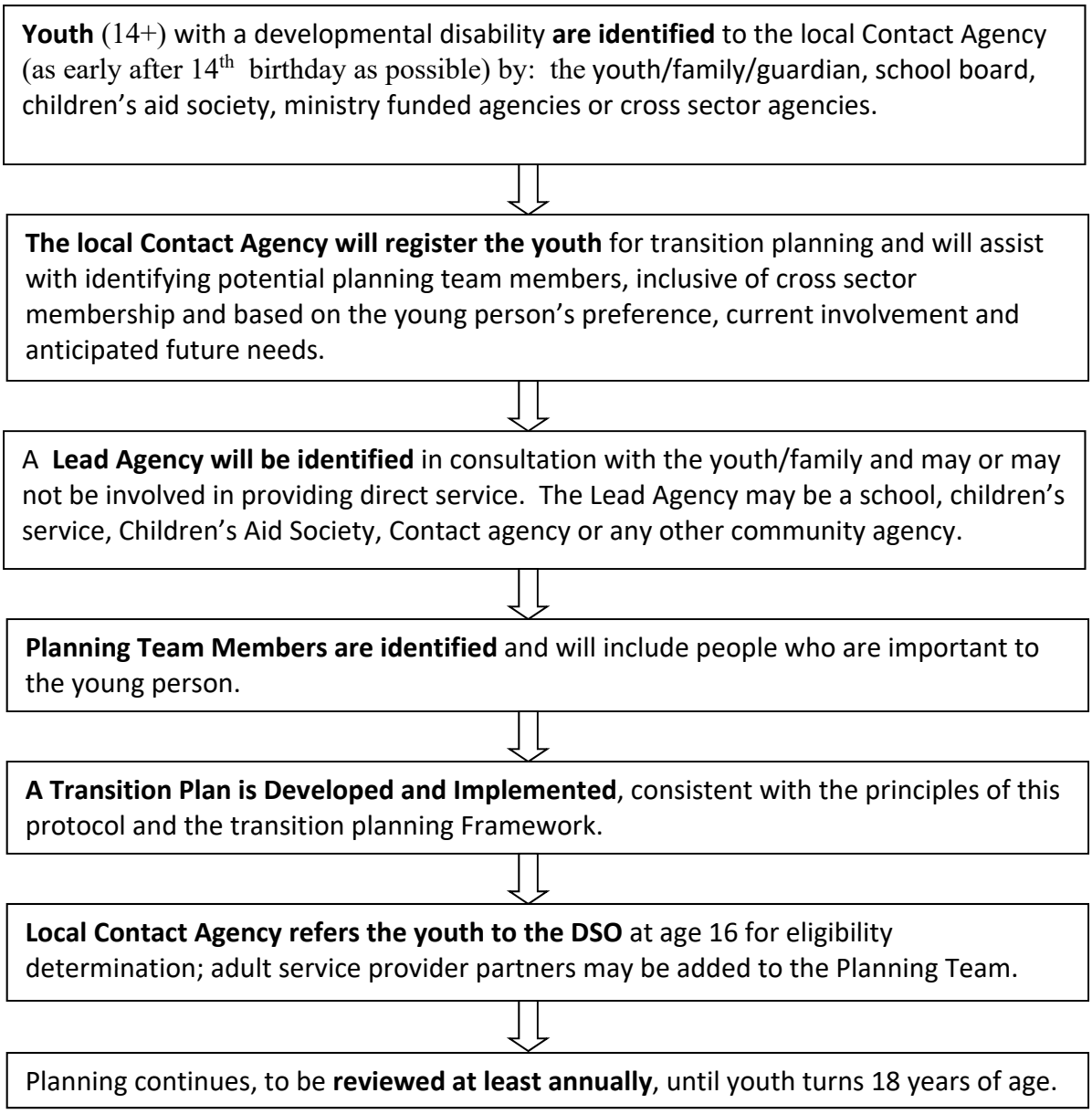
2.4 Collaboration

- *Information sharing and communication among service agencies and the ministries are integral to developing a coordinated service plan to support transition[1], subject to any applicable legal requirements or restrictions.*

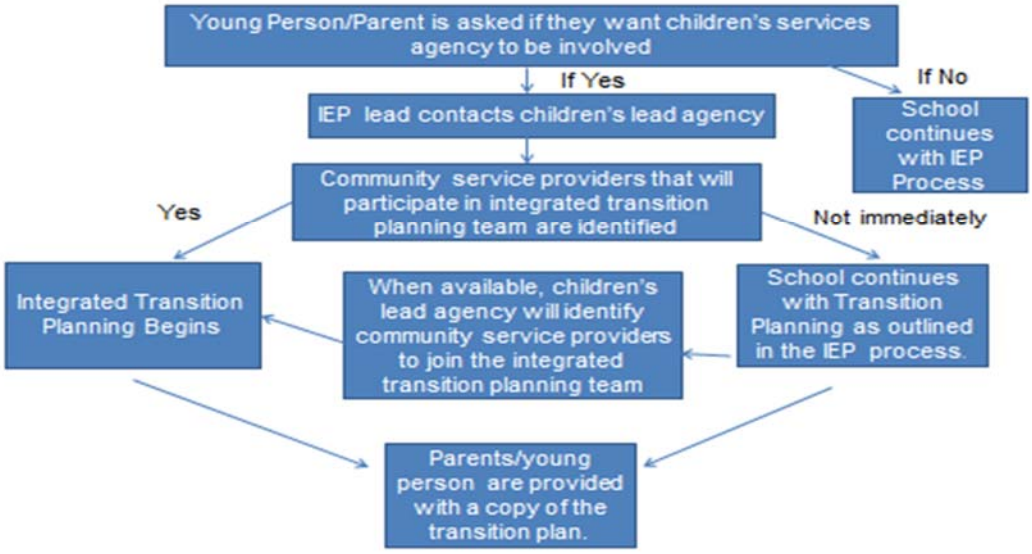
[1] *Personal information, including personal health information, is shared with the consent of the young person or his or her legal guardian or substitute decision maker.*

Schematics

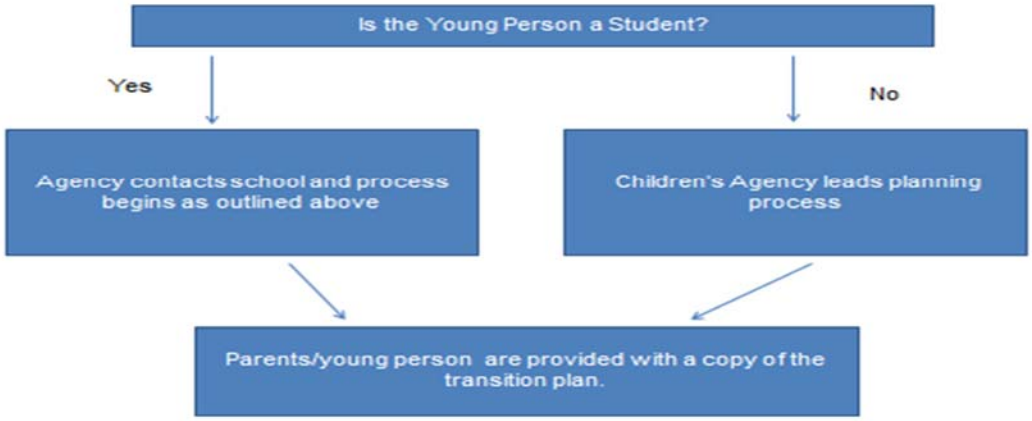
The following is diagram shows key aspects of the protocol pathways for Transitional Planning.



When a school initiates transition planning through the Individual Education Plan (IEP) process, the following steps will occur:



When a children's lead agency is contacted first by a young person or parent, the following steps will occur:



3. IDENTIFY THE YOUNG PERSON WHO WILL BE TRANSITIONING

3.1 Identifying the Young Person

Integrated transition planning is for young people (age 14 and older) who meet the definition of having a developmental disability under any of the EDU, MCSS and MCYS legislation frameworks or agency criteria. The single integrated transition plan is expected to be a long-range, evolving plan developed at age 14 and reviewed and updated regularly as part of the Individual Education Plan (IEP) planning process.

The goal is to identify youth at age 14 to the local Contact agency, or as early as possible before the age of 18. The youth/family/guardian, school board, children's aid society, ministry funded agencies and cross sector agencies may all identify the youth to their local Contact agency for the Transition Planning process. It is anticipated that many youth requesting/requiring Transition Planning will already be known to the local Contact agency within the context of their role as Single Point of Access. To ensure that all youth who may require Transition Planning are identified as early as possible:

- Each Contact agency will monitor those youth turning 14 who may require Transition Planning;
- Each Contact agency will work with the local School Boards to identify any youth who may not already be known to the local Contact agency;
- Children's Aid Societies will notify their local Contact agency of any youth with a developmental disability who becomes a Crown Ward;
- All Children's Service Providers will ensure that, when they are working with a youth with a developmental disability, they have checked with their local Contact agency to ensure that the youth is registered for Transition Planning.

Through integrated transition planning processes, young people with developmental disabilities will have a single integrated transition plan that will inform educational planning and help the young person transition from secondary school and child-centred services to adulthood and help to prepare parents or guardians and other family members for change.

Children's aid societies are expected to participate in and contribute to the development of transition plans for young people with developmental disabilities in care. CAS staff will be expected to work with community agencies, service providers and others to plan and prepare individualized transition plans on behalf of young people in care.

In the case of a person with a developmental disability who is a former Crown ward and receiving funding or other assistance under section 71.1 of the *Child and Family Services Act*, the CAS may provide transition planning assistance if requested by the young person, or the young person's substitute decision maker.

Everyone engaged in the process will share responsibility for providing information about the Transitional Planning process to eligible young person and their families, and exchanging plan information with appropriate consent.

3.2 Contact Agencies

The Contact agencies in the Hamilton/Niagara Region already play a primary role in the following:

- providing information to young person, families, service systems and the general public about available services and supports;
- assessing service needs of youth 14 to 18 through the intake process
- making referrals for these youth when required to children's mental health and developmental services and tracking service provision;
- reassessing service needs over time when requested or required;
- facilitating service coordination when required;
- providing case resolution as required.

Consistent with these functions, the local Contact agency will:

- act as the central registration point in each community for young people requesting/requiring transition planning;
- track the need for transition planning by those already registered with the local Contact agency through the regular Access and intake process;
- receive information from young person, families, school boards, service providers, etc. who identify a youth who may require transition planning and who may or may not already be known to the Contact agency;
- identify priority populations, including individuals over the age of 18 in residential services funded by MCYS; and young person under the age of 18 in residential services.

When a Contact agency receives a referral they will register the young person for transition planning and will assist with identifying potential planning team members, inclusive of cross sector membership and based on the young person's preference, current involvement and anticipated future needs.

For young people not connected with a service provider agency, the local Contact agency will initiate communication with the youth/family/guardian for the purpose of reviewing the Transition Planning process and identifying support, referral needs, and community resource needs.

When necessary, Contact agencies will initiate, through local processes, the assignment of a Lead Responsible agency. This will include fulfilling the role of Lead Agency in the interim, when no other person is initially identified, until such time as this can occur. Lead agency assignment will consider the young person/family/guardian personal preference, current service provider connections, geographic location, expertise, cultural match, commonality of support needs and/or required expertise.

3.3 School Boards

School Boards will begin integrated transition planning at age 14 as part of the IEP process. The school IEP lead is designated by the principal. School Boards will establish a process for the school IEP lead to contact / link with designated community agency staff persons to begin the integrated transition planning process, if appropriate.

3.4 Children's Aid Societies

Children's Aid Societies will be responsible for identifying the wardship status of youth with a developmental disability to their local Contact agency as early as age 14 or at any time before the age of 18 when a youth becomes a Crown Ward. Children's Aid Societies, working with their local Contact agency, and as part of the Transition Planning Process, are responsible for ensuring that documentation of a developmental disability (specific to Crown Ward youth) is consistent with the requirements of the DSO for the confirmation of eligibility for adult services.

Children's Aid Societies are jointly responsible for ensuring youth placed outside of their home community who will need Transition Planning are identified to their local Contact agency.

3.5 Children's Services agencies, including School Boards

All children's service agencies, including school boards, play a role in ensuring that youth who may require adult developmental services are identified to their local Contact agency. All children's services agencies, including School Boards, share responsibility (as part of the Transition Planning process) for aligning assessment information with DSO eligibility determination requirements.

This protocol recognizes the legislated protections to individuals with a developmental disability, who have the same protection in law as other Ontario citizens.

4. IDENTIFY THE TRANSITION PLANNING TEAM

4.1 Identify the Transition Planning Team

Integrated transition planning involves school board officials, principals, teachers, students and their families and others who support the young person with a developmental disability such as community agency staff and health care providers. Schools will ensure that the proper consents are received from the young person with a developmental disability and his/her parent/guardian to initiate the integrated transition planning process.

Everyone should know who is on the team and what they bring to it. The team should include people who are important to the young person. The young person should be represented by people who are able and willing to work in the youth's best interest. The planning process must be carried out in a manner that respects and is in compliance with the young person's legal rights.

Transition Planning is an active and ongoing process, and changes when the youth's interests, situation or conditions change. In order to be truly Person Centered the youth must be respectfully and fully involved in Transition Planning.

Rights of consent and protection of privacy are paramount and must be a part of all the overall planning process. Everyone who is involved in integrated transition planning will follow the laws of Ontario when handling information or records.

Planning team members may include youth/family/ guardian, natural and community support people, current and potential service providers, the local Contact agency, school, child welfare, health care, mental health sector, and any other funded or non-funded services and supports involved with the youth, and whom the youth wishes to have involved in the Transition Planning process. With written permission from the young person / parent, the children's lead agency and the IEP lead are responsible for working together to start the integrated transition planning process in accordance with this regional protocol.

Individuals and families will have the opportunity to participate and will be supported to participate but this is not a condition for receiving a transition plan. In circumstances where the young person's parent or legal guardian or substitute decision maker does not actively participate in or contribute to the transition planning, the Planning Team will support the individual to be an active participant.

4.2 Youth

Young peoples' participation in decisions that affect them is valuable and has a range of positive outcomes for young people and those who engage with them. Consistent with Person Centered Planning principles, the youth would ultimately decide who is a part of the planning team. The youth is responsible to express their preferences and opinions related to their needs, goals, interests and desires, and following through with action steps as assigned to them.

If a youth declines to participate in planning, the agency most involved with the youth will facilitate offering the young person new opportunities to be involved at regular intervals unless this would not be in the best interest of the youth because of the young person's condition or circumstances. At a minimum, written information about the process and resources will be shared with the youth in an accessible format.

The most involved agency (IEP lead and/or children's lead agency) will offer the young person the opportunity to select a support person or people who are willing to help and to

act in his or her best interest for planning. If the young person selects a representative to engage in the planning on his/her behalf, the Lead Agency will request that the representative debrief with the young person about the plan and seek agreement or revisions from them regarding the plan and share the outcome with team members.

4.3 Family/Guardian

In the event that the family/guardian decline to participate, but the youth agrees to participate, planning will continue with the youth. Agencies involved with the family/guardian will provide new opportunities for them to get involved in the planning process. At a minimum, written information about the process and resources will be shared with the family/guardian.

4.4 Contact Agencies

When necessary, Contact agencies will facilitate the establishment of the planning team, provide guidance on the composition of the team and/or identification of a Lead Agency, and/or act as a team member.

Contact agencies will be responsible for completing any children's referrals that are identified as appropriate through the Transition Planning process, and storing a copy of the Transition Plan. Contact agencies will also be responsible for completing a referral to the DSO at the appropriate time, ideally just prior to the 16th birthday.

4.5 Lead Agency

The Lead Agency will be identified in consultation with the youth/family and may or may not be involved in providing direct service. The Lead Agency may be a school, children's service, Children's Aid Society, Contact agency or any other community agency or service. Throughout the Transition Planning process, the Lead Agency will facilitate opportunities for the youth/family/guardian to fully participate in the planning process inclusive of team membership selection, meeting location, documentation of discussions and action plans.

When the school initiates transition planning through the IEP process, the young person and/or parent will be asked if they would like to have children's services agencies involved in transition planning. If so, the IEP lead (with written permission from the young person/parent) contacts the children's lead agency. When a children's lead agency is contacted first by a young person / parent, the children's lead agency (with written permission from the young person/parent) contacts the school IEP lead. The children's lead agency and the IEP lead are responsible for working together to start the integrated transition planning process in accordance with the regional protocol.

The Lead Agency will facilitate initial and subsequent planning meetings as necessary and will attempt to utilize existing planning meetings such as individual education plan (IEP) to develop the transition plan. The Lead Agency will also initiate calling the planning team

together to address significant change variables regarding the support needs of the young person or family that impact on the overall direction of the plan.

The Lead Agency, with support from the planning team where applicable, will be responsible for identifying circumstances that require the participation of people with specialized expertise and knowledge (health care, mental health, etc) to develop an appropriate transition plan and/or provide specialized information, advice or guidance that contributes to the best transition plan; and facilitate inviting them to participate in developing the plan. Where required, the Lead Agency can always consult with the local Contact agency for advice.

It is important to recognize that the Lead Agency may change throughout the Transition Planning process as the needs of the youth change. Those involved in the planning process as part of the Transition Planning Team may also change over time as the youth gets older and/or service needs change.

4.6 The Developmental Services Ontario

The Developmental Services Ontario Hamilton-Niagara Region will provide the young person, his or her parents or guardians, and other relevant transition team members with information about eligibility criteria, the application process and relevant community-based services for adults with a developmental disability. This information shall be clear, transparent and up-to-date. 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.

Qualified assessors may also administer the Application Package [consisting of the Application for Developmental Services and Supports (ADSS) and the Supports Intensity Scale (SIS)], with applicants from the age of sixteen who, with the exception of the age requirement, meet the criteria for Ministry-funded adult developmental services and supports in accordance with the Act. In addition, the DSO and adult developmental service agencies will provide information to individuals and families about the range of adult services that may be available in a particular community.

The DSO may not facilitate referrals for these applicants for Ministry-funded adult developmental services and supports until they are eighteen years of age.

4.7 Adult Service Providers

The MCSS developmental adult service providers will act as a resource to the Transition Planning Team and may be involved as members of the Transition Planning Team as the youth approaches the age of 18. It is anticipated that Lead Agency responsibilities will transition from children's service providers to adult service providers once eligibility for adult developmental services is confirmed and as the youth gets older.

Adult service providers outside of the developmental sector, such as health, adult education, mental health and community services, may also become involved in the Transition Planning process over time.

4.8 Planning Team Members

Planning team members are responsible for coming to meetings prepared to contribute to the plan development, which may include sharing and discussing existing plans, prior relevant history including assessment, and/or service history, health support needs, important relationships and community involvement.
In their participation, each team member will be guided by the principles of Person Centered Planning while participating in the planning process.

Planning team members will have a role in:

- plan implementation
- monitoring the plan for necessary revisions
- providing updates to the Lead planning agency
- reviews, at least yearly

It is acknowledged that the planning team may have an ebb and flow of membership, based on the extent of involvement, natural transitions from one resource to another, or the young person's preferences, etc.

5. COLLECT INFORMATION TO SUPPORT PLANNING – Coordinate Cross Sector Planning

Everyone who is involved in Transition Planning will follow the laws of Ontario when handling information or records. In Ontario, there are several pieces of legislation that set out the requirements governing the collection, use and disclosure of different types of information of a personal or confidential nature. These include:

- Municipal Freedom of Information and Protection of Personal Privacy Act, R.S.O. 1990, CH. M. 56
- Freedom of Information and Protection of Privacy Act, R.S.O. 1990, CH. F. 31
- Personal Health Information Protection Act, 2004, S.O., 2004
- Child & Family Services Act, RSO 1990
- Youth Criminal Justice Act, 2002

Generally, consent from the individual to which the information relates is required before collecting, using or disclosing information.

All parties involved in Transition Planning will comply with the applicable legislation when collecting, using or disclosing information, including those listed above and any other applicable legislation governing access to or privacy of records. Individuals or organizations

should seek their own legal advice should they have questions or concerns about the application of or adherence to any privacy legislation.

This Transition Planning process is coordinated with the transition plan that is part of the IEP process of the school boards. The process will support a move towards integrated planning with local school boards and with other sectors. This will include adult health services where appropriate, as well as any other supports that the individual may need as an adult.

6. DEVELOP THE PLAN

The development of a young person's transition plan will be consistent with the principles of this protocol and the transition planning Framework, which are rooted in the philosophy of Person Centred Planning as found on page 8 of this document, including consideration for engaging in local community processes that support a person's cultural and linguistic needs.

Plans will reflect good practices in planning for a young person's developmental needs and support his or her progression to adulthood and greater independence and social inclusion (Appendix C - A Guide to Person-Directed Planning).

Transition plans will identify the services and expertise needed to help the young person build skills, competence and confidence prior to the age of 18. Transition planning is an opportunity for building the skills that the young person needs to transition successfully. The young person's planning team facilitates options including current and future arrangements for work, education, social supports, health care and community involvement into adulthood. Young people with developmental disabilities will be engaged to explore all appropriate potential community activities that meet their needs and aspirations and transition plans will include strategies for accessing these activities.

Plan development will recognize the requirements of the French Language Services Act and reflect ethno-cultural diversity and language with processes that support the needs and preferences of First Nations and other Aboriginal people, and ethno-cultural minorities.

The Lead Agency will ensure responsibilities are assigned for coordinating, scheduling and managing meetings; gathering information and recording decisions; and safeguarding transitions documents. The Lead agency will also facilitate the development of a written transition plan using the Transition Plan Template. The plan will incorporate any pre-existing plans; will document decisions; will identify roles, responsibilities and action plans; will anticipate potential issues and develop contingency plans for significant delays in receiving requested services.

At a minimum, the written plan includes:

- Names of the Planning Team members and identification of the Lead Agency

- Consideration of the information contained in the young persons Individual Education Plan (IEP), Plan of Care (if appropriate) and any other existing plan
- Details on how cross member communication will be managed
- Youth articulated goals and support needs
- Community resources engaged with the young person (family, faith, employment, volunteer, education)
- Actions required, responsibilities and time lines
- Instructions for handing off from one Lead agency to another, as necessary
- Plans for the youth to apply for income and employment supports (ODSP), as desired
- Plans for the youth to initiate the application process with Developmental Services Ontario through the local Contact agency, as desired
- Consideration of the results from the Developmental Services Ontario Application, as available
- Details for handing off the planning process from children's sector to adult sector
- Identification of the time frame for review
- Strategies to help prepare for the move from children's to adult services

The Lead Responsible agency will facilitate the process for ensuring that a copy of the planning document is provided to the youth/family/guardian and updated documents are forwarded to the local Contact, with consent, at least annually.

When there is an urgent need for a children's or adult developmental service that is not available or access is delayed, a back up plan will be developed by the Planning Team and will include established community practices such as Single Point of Access through the local Contact agency, and the local Children's and/or Adult Case Resolution process. Historical or current support needs may have a bearing on the need to develop a back up plan proactively.

Contact agencies will act as the single point of identification and referral to the DSO for these youth, for the purpose of eligibility determination for adult services. The local Contact agency will work with the DSO and the family/youth and local service providers to facilitate the transfer of information that the DSO may require to determine eligibility, and the DSO will notify the local Contact agency when eligibility has been determined. The Contact agencies will work with the DSO to engage adult services in the planning process when appropriate. Information from the ADSS and SIS will be used in the planning process once it is available, when a young person wishes to apply for adult developmental services and supports. The availability of adult developmental services will be considered, as well as alternate possibilities that take into account the preferences of the individual, and include community services other than or in addition to developmental services.

All compliments/suggestions/feedback/complaints/concerns about the Transition Plan and process will be brought to the attention of the Lead Agency representative. Any individual, parent, guardian or transition team member can initiate a complaint process by speaking directly to the Lead Agency staff person who is a member of the Transition Team. If the complaint or concern is about a specific agency staff or service delivery, the complainant will

be directed to that agency's existing complaints process. If the complaint or concern is about the Transition Plan or process, the Lead Agency will be responsible for leading the problem solving process, and will develop a strategy for addressing the concern with the complainant. This may include bringing the concern to the Planning Team as a whole, to individual members of the Planning Team, and/or to others who may be able to assist by becoming Planning Team members. If necessary, the Lead Agency and/or Planning Team can request the assistance of the local Contact agency for facilitating problem-solving discussions.

The Lead Agency representative will ensure that, where appropriate, the information is shared with the local Contact agency in order for the feedback to be used in the evaluation of the process and the protocol.

7. REVIEW AND UPDATE THE PLAN

At a minimum, the Lead Agency/Planning Team will ensure that there is an ongoing review of the person's support needs and progress at least annually, and more frequently if warranted by a young person's condition or significant changes in individual or family circumstances. The review will include discussion with the young person and/or his or her family or guardian, a meeting of the Planning Team when necessary and written updates to all relevant sections of the Plan. The Plan and all updates will be dated. The timelines and lead responsibility for reviewing the plan will be written into the plan itself.

A copy of the Plan and all annual updates will be sent by the Lead Agency to the local Contact organization. The local Contact organization, as lead agencies to the protocol, will monitor that Plans and updates are completed. A copy of the single integrated transition plan, which includes the IEP, and all updates, will be provided to the parents (and the student if 16 and older) and a copy will be included in the individual's Ontario Student Record (OSR).

8. IMPLEMENT THE PLAN

Each young person's plan will clearly outline a coordinated approach for communication, implementation of the plan, assigned responsibilities, time lines and sharing of outcomes. The written plan will specify actions to be taken to initiate and carry out the plan, identify the people responsible for taking action and specific timelines for action. The identified Lead Agency will have primary responsibility for monitoring implementation and receiving updates from those identified as responsible for specific actions, as the implementation steps identified in the Plan occur. The Planning Team will support the young person, his or her family or guardian, and the Lead Agency in implementation, as it is expected that individual members of the Planning Team will have action steps to implement. The youth/

family/guardian will be fully involved in all elements of plan implementation, which may or may not result in access to services/supports and may include waiting list variables.

9. EVALUATION

Review of the protocol will be completed annually by local Contact agencies. The review will be conducted by a representative group of signatory agency and provider organizations and will include participation by youth and their parents/guardians. The review will assess:

- the implementation of the protocol
- the success of the protocol from the perspective of young people, their families and friends and service providers and agencies
- young people's experience of Transition Planning
- areas for improvement

Evaluation results will provide insight into the effectiveness of the protocol, inform the development of best Transition Planning practices through the evaluation of data collected, and may lead to changes in the protocol itself.

Evaluation results will be shared with local communities, ministry offices and service providers.

Contact agencies will provide high level statistics to:

- the Hamilton-Niagara Developmental Services Ontario (DSO) organization about the number of potential youth age 16+ who may be eligible for adult services;
- the local Children's Planning Tables and/or the local Children's Case Resolution Table (as appropriate), for the purposes of evaluating the process and system planning.