DSO
Developmental Services Ontario
Your access point for adult developmental services
Toronto Region

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

Pathway from Health to Developmental Services

If a Developmental Disability is suspected but unconfirmed

If a Developmental Disability is confirmed but developmental service providers are unknown

If developmental sector service providers (e.g. case manager/service coordinator) are known

Contact Developmental Services Ontario (DSO)-Toronto Region Community Liaison Navigator:

Melanie Randall
melanie.randall@surreyplace.on.ca
416.925.5141 ext. 2421

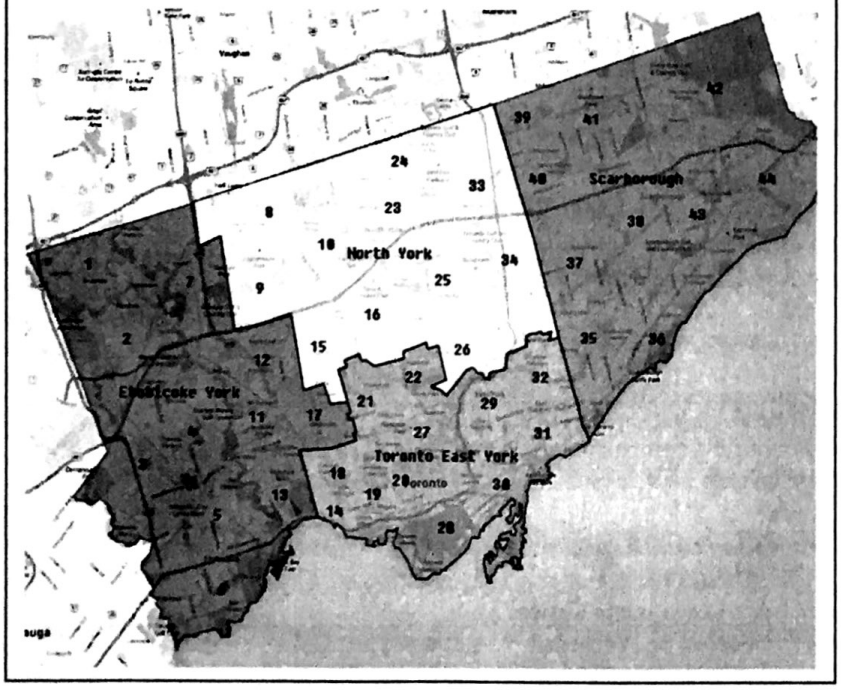
Begin collaborative care planning with the developmental sector service providers as early as possible

If collaborative care planning is complex/challenging or the person is in hospital, contact Toronto Network of Specialized Care

TNSC Coordinator:
Jennifer Altosaar
Jennifer.altosaar@surreyplace.on.ca
416.925.5141 ext. 3115

And/or Health Care Facilitator (APN):
Angie Gonzales
angie.gonzales@surreyplace.on.ca
416.433.1639

DSO Toronto Boundaries



ED Developmental Disabilities Contact Sheet

	GATEWAY TO ADULT SERVICES	CRISIS & TRANSITIONAL SERVICES / RESPITE SUPPORTS	DUAL DIAGNOSIS
Agencies	**Developmental Services Ontario (DSO-TR)**	**Griffin (Crisis & Transitional) Respiteservices.com**	**CAMH: Adult Neurodevelopmental Services**
Contact Info	www.dsotoronto.ca 1-855-DS-ADULT or (1-855-372-3858) dsotr@surreyplace.on.ca	http://www.griffin-centre.org/ contact@griffincentre.org 416-222-1153 (M-F, 9-6pm: Griffin) 416-929-5200 (After hours: Gerstein CC) www.respiteservices.com info@respiteservices.com 416-322-6317 x1 (intake & info; 9-5)	http://www.camh.ca/en/hospital/care_program_and_services/dual_diagnosis_program/Pages/default.aspx 416-535-8501 ext. 37803 Fax completed referral form to Access CAMH 416-979-6815
Hours	- M-F, 9-5pm - phone calls will be returned within 1- 3 business days -211can assist after hours	**Griffin:** M-F, 9-6pm (intake will return messages within same day) **Respiteervices.com:** M-F, 9-5pm **Gerstein Crisis Centre:** After hours	-M-F, 9-5pm - phone calls will be returned within 1 business day
Service Criteria (age, diagnosis)	- 16+ years (services at 18) - Developmental disability diagnosis (significant limitations in cognitive and adaptive functioning); or no formal diagnosis on file, but seeking an assessment to confirm diagnosis	**Griffin:** 16+ years - Developmental disability or dual diagnosis (developmental disability + mental health issues). Documentation of diagnosis is generally not required. **Respite:** Lifespan service. Families must be registered, children & adults with DD living in family home. If 18+ years confirmed eligible by DSO required	- 16+ years - Diagnosed with intellectual disability and/or autism spectrum disorder presenting with mental health concerns or severe challenging behaviour problems - History of unclear assessment & diagnosis -History of ED use -Have a community physician
Geographic Criteria	Toronto, Scarborough, North York, Etobicoke	**Griffin:** Toronto **Respiteservices.com:** Toronto	**Toronto.** For Peel Region contact Dual Diagnosis Consultation Service 416-535-8501- ext77713
Services Offered	• Information about available supports and services (both funded and non-funded) • Confirmation of eligibility to receive Ministry funded adult developmental services and supports, • Assistance completing Application Package to assess individual service and support needs • Creation of support plan and Connection with available supports and services including specialized clinical services • *Can quickly verify with ED if patient registered with DS agency*	**Griffin (Crisis & Transitional):** • All Services are in collaboration with community partners with time limited supports including: • short term safe beds or day programs, • staffing supports, • interim case management, • crisis planning and consultation, access to specialized assessments **Respiteservices.com** • Central resource for caregivers & professionals wishing to access respite supports & services in City of Toronto • Contact online or by phone	• Psychiatric Consultation Clinic- *assessment and recommendations to referring physicians* • Medication Consultation Clinic- *medication only consultation* • High Functioning Autism Pathway- *diagnostic assessment and limited group treatment for anxiety and mood disorders.* • Inter-professional Assessment and Treatment Pathway- *provides assessment and time limited treatment* • Intensive Intervention Pathway- *provides assessment and treatment* • Brief Intervention Unit- *Inpatient Pathway- planned 4-8 week admissions through outpatient services. Inter-professional assessment and treatment.*
Wait Times	DSO can connect you to services and determine eligibility, but there may be wait times (e.g., psychological assessment for diagnostic purposes may be 3 mos). DSO does prioritize based on the urgency of the case.	**Griffin:** if patient is in ED, will endeavor to send someone out to assess and consult, but this can take up to 72 hours. **Respiteservices.com:** Respite is a short, *planned* break. Not an emergency or crisis response service.	Wait times vary. Please contact service directly to inquire.
Service Limitations	**Cannot** provide crisis response, but can refer to crisis services.	**Cannot** provide medical or mental health emergency services that require an immediate mobile crisis response.	**Cannot** provide crisis response, can offer assistance or direction over phone during business hours.

Developmental Services Ontario:

What you and your patients need to know

What is DSO?

- DSO helps adults with developmental disabilities and their caregivers connect with services and supports
- There are nine DSO agencies in Ontario
- Completes an application package and needs assessment
- Makes referral to adult developmental services and programs on your behalf

Developmental Services and Supports Accessed and Organized through DSO

- Community participation supports (e.g., work, recreation, passport funding)
- Residential supports (e.g., group homes, supported independent living)
- Caregiver respite services (in home and out of home)
- Person-directed planning supports (help adults with developmental disability develop their own vision and goals for their future)
- Specialized supports (e.g., service coordination, clinical services, case management)

These supports can be delivered one-on-one or in groups. More information may be found at http://www.dsontario.ca/ (under "Developmental Services in Ontario")

What will happen when your patient or their caregiver calls DSO?

- The call will be answered by a DSO worker who will talk about the supports and services needed. The DSO worker will:
  - Ask about the person with a developmental disability and their current situation
  - Provide information about services that might be of interest
  - Explain the process to go through that is required to be eligible for services funded by the Ministry

Who is eligible for DSO?

- Age **18+ years** to receive services, but *can apply between 16-18 years*
- Documentation confirming age (e.g., government issued ID like a health card, passport, birth certificate)
- Resident of Ontario
- Documentation confirming residency in Ontario (e.g., government issued ID like a health card, passport, birth certificate)
- Have a developmental disability
  - Documentation by a psychologist confirming adult eligibility criteria. Typically, this is the most recent psychological assessment you have available (e.g., psychological assessment completed during school years).

How does my patient apply for DSO?

Contact the local DSO to confirm if they are eligible for DSO services or encourage them to contact DSO as part of follow-up.

Region	Email	Phone	Fax
Central East	dsocentraleast@yssn.ca	905-953-0796 1-855-277-2121	905-952-2077
Central West	dso@dsocwr.com	1-888-941-1121 **Dufferin:** 519-821-5716 **Halton:** 905-876-1373 **Peel:** 905-453-2747 **Waterloo:** 519-741-1121	**Dufferin:** 519-821-4422 **Halton:** 905-876-2740 **Peel:** 905-272-0702 **Waterloo:** 519-743-4730
East	admin@dsoer.ca	1-855-376-3737	1-855-858-3737
Hamilton-Niagara	info@dsohnr.ca	1-877-376-4674	
North East	dso@handstfhn.ca	1-855-376-6376	705-495-1373
Northern	info@lccctbay.org	1-855-376-6673	1-807-346-8713
South East	esteele@dsoser.com	1-855-237-6737 1-613-354-7977	
South West	maryregan@dsoswr.ca	1-855-437-6797	519-673-1509
Toronto	DSOTR@surreyplace.on.ca www.dsotoronto.com	1-855-372-3858	

We would like to acknowledge the DSO website (http://www.dsontario.ca/), DSO Central West Region, and DSO Central East Region for providing information on this handout.

MD Tip Sheet

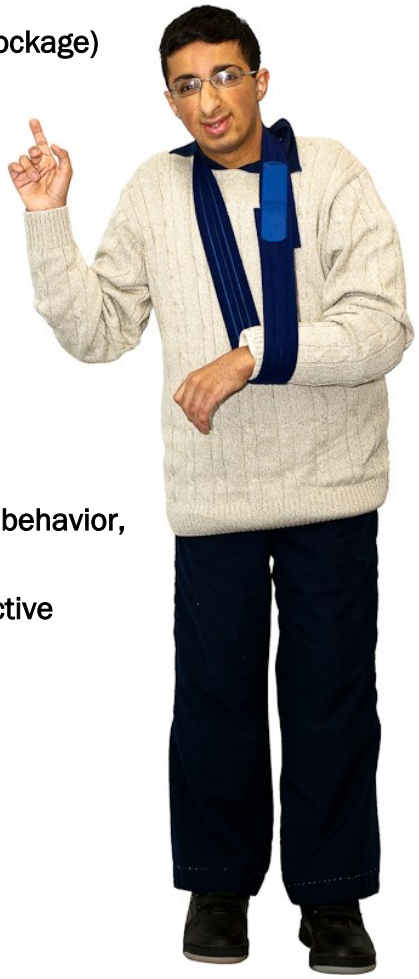
Developmental Disabilities in the ED

- For some patients with DD, their MEDS LIST is available from ODSP ***even if they are under 65.***
- Ask "how is their current behavior compared to baseline"?
- PAIN often presents as CHANGE IN BEHAVIOUR.
  - Think **"ABC"**:

All Behaviour is Communication

- Commonly missed diagnosis/physical findings:
  - Bowel obstruction
  - Constipation
  - Abdominal Sepsis
  - Cerumen impaction
  - Dental sores, caries, abscesses
- Sensory hypersensitivity is common:
  - Lights, noises, smell, touch, may lead to behavioural change.
- Hearing and vision are often impaired. Ask GEM RN for a **"Communikit"** (communication aids).
- Body language is critical! Slow down, lower your voice, and adjust your approach - it will improve the visit.
- Most people with DD will have experienced trauma/abuse in their past.

Commonly Missed Diagnoses: Head-to-Toe Assessment



H Headache and other pain, or Hydrocephalus related issue (ex. Shunt blockage)

E Epilepsy

A Aspiration pneumonia or dysphagia

D Drugs! Patients are at high risk for adverse effects or polypharmacy.

Have a follow up plan if prescribing psychotropics!

T Teeth! Dental abscesses or impacted teeth can cause pain, aggressive behavior, food refusal

O Ocular or Otolaryngology issue – Vision problem, Hearing issue, Obstructive Sleep Apnea (up to 80%)

T Tummy – GERD, Constipation, Bowel obstruction and volvulus

O Osteoporosis and atypical fractures, pressure sores

E Etiology or cause of IDD - is it known? – some genetic syndromes have important acute presentations (ex. Calcium disturbance in William's Syndrome)

S Serious illness can present atypically – ask caregivers how this patient expresses pain. Is there a subtle sign that they are very ill?

S Screen for abuse

All Behaviour is Communication!

♦Listen to Caregivers ♦Ensure access (reduce noise, fluorescent light) ♦Link – ask about community supports ♦Look for a Care Plan ♦Wallet sized Health Passport

Do you suspect a patient you are seeing has developmental disability but has not been identified? Refer to Developmental Services Ontario.

(Do you think your patient might benefit from a Coordinated Care Plan because of their complex health needs? Refer to "Health Links".)

Grier, L. 2015

Communication Tips for patients with Developmental Disabilities

General Strategies:

- Familiarity helps: seek out someone who the patient knows, and is comfortable with. Do inquire about caregiver stress/burnout.
- Ask for strategies and tips - what do they find helpful? Should I write things down? Use technology?
- Encourage the use of 'comforters' - items or activities they find soothing (favourite item, music, phone, doll, food/snack, etc.)
- Try to find a quiet spot without too many distractions (isolation room?) (vision and hearing deficits)
- Use simple words, and speak slowly. Give pauses and allow extra time for processing. Do not shout.
- Use a ***Tell***, then ***Show***, then ***Do*** approach - pausing in between each step to help build readiness.
- Be extra mindful of your non-verbals and body language. Many people with DD have experiences of trauma - they could be very afraid of the hospital, so extra sensitivity can help.
- Use visuals - gestures, or drawings, when possible.
- Give ongoing positive praise and encouragement, after even the smallest of steps.

Behavioural Concerns?

- What is the behavior trying to tell us? (Pain? Unmet need? Attention? Sensory loss? Avoidance?)
- How is today's presentation (*behavior) different from baseline? How long has this been going on for? What has helped in the past? What are you currently trying?
    - Pain: How do we know when the person is in pain?
    - Commonly missed medical causes:
        - Dental Pain;
        - Constipation/obstruction;
        - Infection;
        - Cerumen impaction;
        - Abdominal sepsis
    - Environment: Have there been any changes to supports? Occupational issues?
    - Emotional needs: Recent life changes/losses? Bullying? Vulnerabilities? Triggering anniversary?
    - Is there a known psychiatric disorder?

Maximizing Comprehension, Optimizing Discharge

- Ask the patient to rephrase in their own words to assess their understanding
- Give simple written information, with concrete next steps to help summarize and improve follow-up

Environmental Adaptations

The emergency department is a fast-paced, loud, and overstimulating environment. This will be overwhelming for most of us—especially so for people with DD. How can your environment be adapted to better support people with disabilities?

- Quiet space: Can the patient (and caregivers) be offered a quiet/adapted space? In some settings, there may be a space already dedicated for such a purpose, but if not, the following are considerations:
    - An isolation or infection control room (remembering you will be using this just temporarily)
    - A mental health interviewing room
    - A corner room
    - If no rooms are available, a bed that is further from hallways or nursing station may provide a slight reduction in stimuli.
- Turn off any non-essential monitoring equipment
- Fluorescent lighting can be distracting or irritating. Is it possible to dim the lights in the patient's area? Or turn off? If not, a pair of sunglasses may be beneficial.
- Limit the number of different team members going in and out of the patient's space. Consistency is always best if this this possible.
- Encourage caregivers to remain present for testing and imaging. Ask them about what has helped (or not helped) in the past.
- Sit at eye level.
- Use a show-tell-do approach. Show the patient the instrument or procedure you will use, allowing the to touch/explore it; describe the steps involved, and what can be expected; then proceed.
- Consider a Sensory Box that is offered to patients. This can include very simple items that may go a long way in soothing, calming or distracting a patient while they are waiting, and during care/assessment:
    - Squishy balls
    - Fidgets
    - Noise reducing headphones
    - Sunglasses
    - Brush
    - Weighted lap pad/blanket
- Have coloring books, playing cards on hand.

Griffin Community Support Network (GCSN)	CAIR (Planned Intervention)	CAIR - Alternate Level of Care (Planned Transition)
Short-term/transitional, generally up to 90 days.	Medium-term/time-limited, based on clinical plan, up to maximum 180 days.	Longer term, up to two years.
Immediate response to crisis, urgent and/or intensive needs, which may or may not be 'clinical'.	Planned response to assessed clinical needs and based on a sound 'clinical resource plan'.	Planned response to assessed clinical needs and based on a sound 'clinical resource plan'.
DS 'Eligibility' and diagnosis not required.	'Eligibility' for DS sector services required.	'Eligibility' for DS sector services required. Transitioning from Hospital or Treatment Bed.
Individual may be 'new' to sector.	Individual will be known to specialized providers, will likely have been assessed.	Individual will be known to specialized providers, will likely have been assessed.
Individual may not have an assessment/plan.	Individual may not have an assessment/plan.	Individual may not have assessment/plan.
For persons aged 16+.	For persons aged 18+.	For persons aged 16+.

camh
Centre for Addiction and Mental Health

griffin centre
EVERYBODY COUNTS

COMMUNITY NETWORKS OF SPECIALIZED CARE
TORONTO REGION

CAIR

Information Package for CAIR/ALC applicants

Background Information

Collaborative and Individualized Resource (CAIR) program is a time limited intervention and clinical support for adults with a developmental disability and complex needs who require flexible, innovative, and individualized response to be maintained in the Toronto community. Funded by the Ministry of Community and Social Services and Toronto Network of Specialized Care initiative, CAIR's services are provided through a partnership with Griffin Centre and the Centre for Addiction and Mental Health (CAMH) – Adult Neurodevelopmental Service. The Alternative Level of Care (ALC) program is a part of CAIR and is funded by Ministry of Health and Long-term Care.

Eligibly Criteria

CAIR is for adults 18 years of age or older who have a developmental disability and:

- Are eligible for Developmental Service Ontario (DSO) in Toronto
- Are struggling with mental health and behavioural challenges
- Require clinical planning and/or short-term resources to support the implementation of the clinical plan
- Will benefit from time-limited transitional assistance (up to 6 months with CAIR/ up to 2 years with the ALC program)

Initial Referral

Intake and referral to the CAIR/ALC program is initiated by contacting Griffin Centre (CAIR Resource Supervisor) to include information regarding the individual, assessment and planning activities to that point in time, consents and reports available to contribute to the clinical planning and resourcing process. A case manager (social worker, facilitator etc.) or an individual wiling to act in this capacity **must** be involved in order to access CAIR's services. To access the Alternative Level of Care (ALC) program, the individual needs to be deemed ALC within a hospital context or within a DSO treatment bed, however, the intake/referral process remains the same as above.

The CAIR process

Once the client is deemed eligible and the completed referral is submitted to the CAIR Resource Supervisor, the CAIR Clinical Facilitator will follow up with the referring agency/ case manager (social worker, facilitator etc.) to plan an initial CAIR meeting. The case manager and Clinical Facilitator will determine who should be present for the initial CAIR meeting.

At the initial CAIR meeting, the Clinical Facilitator will provide a draft clinical plan (based on past assessments and reports) for review and collaborative development by the inter-professional service team supporting the client and family. The Clinical Facilitator will also involve the CAIR/ALC Behaviour

Therapist based on the referral package. **The CAIR clinical plan is an integral part of the planning and determination of appropriate resource allocation of our service.** The client's case manager will be responsible for timely updates and dissemination of the CAIR clinical plan to the service team. The Clinical Facilitator will be available for consultation and facilitation of the on-going CAIR meetings. CAIR will remain involved for up to six months and will discharge once the plan is in place and goals are met. **Resource allocation will be determined on a case by case basis, based on agreed upon goals, in consultation with the CAIR service team and management.**

Responsibilities

CAIR Service:

- Provide a draft clinical plan to client service team for review and development
- Participant in the comprehensive development of the CAIR clinical plan with client case manager and service team
- Schedule and facilitate ongoing CAIR meetings with client case manager and service team
- Where eligible- will provide Alternative Level of Care behavioural and transitional support to client, case manager and service team up to 2 years based on relevant goal attainment
- Where approved- will allocate resources to be reassessed on an ongoing basis
- Assist with education and training and overall, community capacity building
- Provide relevant updates to the Clinical Conference table

Client Service Team:

- Referring agency/ case manager will provide past reports/ assessment to CAIR service
- Case manager/ service team will participate in the development of the CAIR clinical plan
- Case manager/ service team will available for ongoing CAIR meetings and update the clinical plan as needed
- Work towards completing tasks highlighted within the clinical plan and report on progress to the team as needed

Collaboration is a key value in the CAIR service model and we welcome the opportunity to work with your team and organization.

Sincerely,

CAIR/ALC TEAM