HALTON
COORDINATED
SERVICE PLANNING

one family. one story. **one plan.**

Who is eligible for Coordinated Service Planning?

Children and youth who live in Halton under the age of 18, and young people between the ages of 18 and 21 who remain in school, are eligible for Coordinated Service Planning.

Accessing CSP: A Family's Journey to Coordinated Service Planning:

The following describes the phases that may occur as families access **Coordinated Service Planning**:

Phase 1: Referrals

Referrals to Coordinated Service Planning can be made at any point a child/youth's needs are recognized to be multiple and/or complex.

Any special needs service provider (such as healthy child development, healthcare and child care providers as well as educators) may recognize that a family might need Coordinated Service Planning. They will explain what Coordinated Service Planning is and why it may be beneficial to the family. If the family is interested, with consent, their information will be shared with the Coordinating Agency for intake. Families can also self-refer to Coordinated Service Planning.

Phase 2: Intake and Assessment

When a family is referred to Coordinated Service Planning, they will be assessed to determine whether they should receive Coordinated Service Planning. When making a determination about whether a family should receive Coordinated Service Planning, the family's appropriate level of intensity will be assessed at time of referral.

This could include:
- Brief supports - e.g. a Coordinated Service Plan developed and brief, time-limited supports from a Coordinated Service Planner.
- Intermittent support – e.g. more intensive level of support during transitions and less intensity at other times.
- Continuous supports.

Decisions regarding how frequently a Coordinated Service Planner is engaged and how frequently the Coordinated Service Plan is reviewed and updated will be made jointly by the Coordinated Service Planner, the family and the child/youth.

Phase 3: Family strengths and needs are identified

When a plan is initiated, the Coordinated Service Planner will gather key information about the child/youth through the following:
- discussion with the child/youth and family
- information shared by other service providers
- conducting a strengths and needs assessment

A strengths-based approach will be used in the development of the Coordinated Service Plan. These can be functional strengths such as behaviour and problem-solving skills; or family, cultural and community strengths, for example, the involvement of members of the extended family. A family's ties to a cultural community, such as a First Nations, Métis, Inuit and urban Indigenous community, will also be identified as part of the strengths assessment to inform the Coordinated Service Planning process.

A family strengths and needs will be monitored and updated at regular intervals. As the needs and strengths of the family change over time, the intensity at which Coordinated Service Planning is delivered may be adjusted.

Phase 4: Assigning a Coordinated Service Planner

When the family is ready to set goals, a Coordinated Service Planner will be formally assigned/identified and the following will be taken into account:

- family preferences
- existing relationships
- needs assessment (specific experience or expertise may be required)
- other factors (e.g. linguistic or cultural needs)

Families will be made aware of who their Coordinated Service Planner is, what their role is, and that they are the key contact for questions about the plan.

Phase 5: Family (and/or child/youth) goals are set and prioritized

The family's circumstances, preferences and goals will be the foundation of the planning. The child/youth's voice, preference and goals will be central to Coordinated Service Planning, particularly as they mature and begin to prepare for adulthood.

Goal setting will be based on what the family and/or child/youth sees as the most important. Goals can be related to specific activities, therapies, or other areas of development (e.g. feeding oneself, attending a birthday party). Goals can also be prioritized based on what is most urgent for the family.

Phase 6: Provider team is identified

Family members (parents/guardians), and child/youth are critical partners in Coordinated Service Planning and should be identified as equal members of the team. With family and/or child/youth consent, the team may include providers from outside the children's services sectors, e.g. from school, healthcare, child welfare.

Examples of service providers that may be included are:

- speech and language therapists
- behavioural therapists
- occupational therapists
- special education teachers or other educators
- social workers
- healthcare care coordinator

Families and/or the child/youth will determine which service providers should be invited to meetings.

Phase 7: Coordinated Service Plan is developed

The Coordinated Service Plan is a written document for the child/youth and his/her family, as well as all service providers involved in his or her care. They are living documents that grow and develop with the child/youth. The plan belongs to the family and the Coordinated Service Planner monitors and updates the plan on the family's behalf.

It is the responsibility of the Coordinated Service Planner to understand and document how services will support the family to achieve their goals. While Coordinated Service Planning will be focused on the needs of the child/youth with complex and/or multiple special needs, Coordinated Service Planners will also be aware of other needs the family has and will be able to make referrals to relevant services.

Phase 8: Plan is shared with family and providers

Once the Coordinated Service Plan has been documented, the plan will be shared with the family and child/youth. The final decision about who should see the plan, or specific parts of the plan, rests with the family and/or child/youth.

9. Services and goals are monitored

In addition to regular communication with families, service providers should inform families that they can contact their Coordinated Service Planner when they:

- have a question about the plan
- think the plan should be adjusted
- want to adjust goals
- require additional supports
- need a new service