Residential Transitions Workgroup Report

December 2007

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Development of the Residential Transitions Planning Process Components was a collaboration between the University of Southern Maine's Muskie School of Public Service and the Maine Department of Health and Human Services, Office of Child and Family Services.

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Acknowledgements

Many individuals and member organizations contributed their time, perspectives and expertise to the development of the *Planning Process Components for Transitions from Residential Facilities.* Workgroup members represented parent advocacy agencies; contracted service providers and member associations; OCFS regional office staff representing Children's Behavioral Health and Child Welfare; staff from the OCFS Central Office, and staff from the Muskie School of Public Service/University of Southern Maine.

The *Planning Process Components* and accompanying checklist reflect the workgroup's efforts at identifying and synthesizing "best practice" guidelines for all transitions from residential care to community settings. To accomplish the charge set forth, a series of large workgroup meetings were held and a smaller workgroup was established to draft the language that eventually made up the four process components. The process involved numerous lengthy discussions related to current practices, evolving changes and ideal activities. The final product reflects the consensus reached by workgroup members through this very engaged process.

Workgroup Membership

Neil Colan	Goodwill Hinckley	Maine Association of Mental Health Services
Steve Dawson	WCPA	Maine Association of Mental Health Services
Sharon Gagne	Providence Service Corp	65 M/N Intensive Community Based Services
Dave McCluskey	Community Care	Maine Association Group Care Providers
Heather Stephenson	Casey Family Services	Community Provider
Roger Wentworth	Sweetser	Wraparound Maine Agency Provider
Carol Tiernan	GEAR	Parent Organization
Ann Long	ME Parent Federation	Parent Organization
Dean Bailey	Residential Program Manager	OCFS Central Office
Ellen Beerits	Child Welfare Program Admin	OCFS District 4
Teresa Barrows	Children's Behavioral Health	Region 3
Ericka Deering	Children's Behavioral Health	Utilization Review Region 2
Renna Hegg	Department of Corrections	Juvenile Services
Roxy Hennings	Department of Corrections	Juvenile Services
Barbara Dee	Department of Education	MADSEC
Nancy Connolly	Department of Education	DOE Central Office
Dean Crocker	Maine Children's Alliance	Ombudsman
Sarah Minzey	Home Counselors Inc	Family Reunification Provider
Kate Corbett	Muskie School Public Service	Youth Leadership Advisory Team
Leslie Rozeff	Muskie School Public Service	IPSI Social Service Programs

<u>Co-Chairs</u>

Lindsey Tweed	Children's Behavioral Health	OCFS Central Office
Frances Ryan	Special Projects	OCFS Central Office

Background

In the winter of 2007, residential provider community members raised concerns regarding how discharge decisions were being made by child welfare caseworkers. These concerns led to a formal request, from Maine's Department of Health and Human Services (DHHS), for technical assistance from the National Resource Center (NRC) for Child Protective Services. This resulted in an on-site review and comprehensive report with a set of recommendations from which the Office of Child and Family Services (OCFS) drafted an action plan. Concurrently, LD 487 (related to clinical assessment prior to discharge) was introduced by provider community members and was considered by the 123rd Legislature, Joint Standing Committee on Health and Human Services. The Committee voted *ought not to pass*. During the work session however, they reviewed the NRC report and the OCFS action plan. They supported the plan and requested that DHHS actively involve stakeholders in the development of relevant sections and report back regarding progress.

The Residential Transitions Workgroup was formed in July of 2007 to address the action steps specific to residential transitions. The specific charge was to:

> ***Develop a format for individualized transition planning for children and youth leaving residential care and to prepare recommendations for policy inclusion and implementation.***

The workgroup was comprised of representatives from: Maine Association of Group Care Providers, Maine Association of Mental Health Services, Contracted Community Service Providers (Wraparound Maine, Family Reunification Services, 65M&N), Foster Family Treatment Association, Central and Regional Child Welfare and Children's Behavioral Health staff, Maine Parent Federation, GEAR, Department of Corrections, Department of Education, MADSEC, and staff from USM, Muskie School of Public Service. The workgroup met monthly from July through November 2007, with a subcommittee convening for document preparation. The Committee used a variety of resources to guide our work including consultation from John VanDenBerg- a national consultant currently engaged to support Maine's implementation of High Fidelity Wraparound. Dr. VanDenBerg has extensive experience in transitioning youth from residential care and systems of care development.

While the workgroup was initially focused on concerns related to the child welfare system, we determined early on, the need to attend to a broader group. Therefore, the components herein address "best practice" guidelines for all transitions from residential care to community settings. The committee structured the guidelines into four main components focusing on activities that are:

- Team led,
- Family-Centered and Youth Guided,
- Individualized and
- Collaborative and meaningfully coordinated.

Introduction

OCFS believes that when a child is placed in a residential setting, family-centered collaborative team planning and decision-making must remain the essential components in an inclusive process for children and families. Children, youth and families can make substantial gains in the context of high quality residential treatment. The challenge becomes helping the child/youth and family maintain their gains and continue to grow and develop as the child/youth transitions to a family-based setting. A bridge must be built between the child/youth and family's residential treatment experience and their life in the community. A successful transition back into community life can be greatly facilitated by a planning process that is thoughtful, comprehensive, and inclusive.

This document was written to provide practice guidance to the child and family team, case workers and case managers as they work in partnership with children/youth, their families, community-based and residential care providers to support successful transitions from Children's Residential Facilities to community settings (biological family, relatives, foster home, adoptive home etc.).

This document contains two sections. The first section includes the *Planning Process Components for Transitions from Residential Facilities* which are grouped into four broad categories. The workgroup recommends that these best practice components be utilized by all parties engaged in discharge and transitioning planning activities. The second section includes a checklist intended for use by those engaged in transition planning in a lead case management role (either through employment or through contract with DHHS or Department of Corrections) to ensure that key transition and discharge planning activities have been accomplished. Based on the practice principles included herein, an OCFS policy will also be developed that will specifically address the role of child welfare caseworkers and practice expectations related to discharge and transition planning processes for children and youth as they move from a residential facility to home or a community-based setting.

The work of the Residential Transitions Committee dovetails with that of the Residential Standards Workgroup. The *Program Standards for Residential Treatment* are written for Residential Care Providers. The product of the Residential Transitions Workgroup, *Planning Process Components for Transitions from Residential Facilities* is specific to the area of discharge planning and is written for DHHS caseworkers but is encouraged for use by all case managers and others engaged in discharge planning activities. In line with the *Program Standards*, the product of the Residential Transitions Workgroup supports residential care being utilized as a targeted, intensive short-term treatment intervention that actively includes the child and family as integral members of the team.

Definitions

The following is a brief list of commonly used terms that are used in multiple ways depending on the setting. We have included these working definitions as those that the committee came to define as our common language:

Child and Family Team: a defined group of people that includes, at a minimum, the child and his/her family and any individuals important in the child's life who are identified and invited to participate by the child and family. This may include, for example, teachers, extended family members, friends, family support partners, healthcare providers, coaches, community resource providers, behavioral health providers, representatives from churches, synagogues or mosques, agents from other service systems like juvenile corrections, education, behavioral health and child welfare. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child and which individuals are needed to develop an effective service plan. The team can therefore expand and contract as necessary to be successful on behalf of the child.

Family: the primary care-giving unit, inclusive of the wide diversity of primary care-giving units in our culture. Family therefore is a biological, adoptive or self-created unit of people residing together and consisting of adult(s) and children, with adult(s) performing duties of parenthood for the children. Persons within this unit share bonds, culture, practices and significant relationships. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family.

Family-driven care: families have a primary decision-making role in the care of their own children. This includes: choosing supports, services, and providers; setting goals; designing and implementing programs; monitoring outcomes; and partnering in funding decisions. The definition delineates principles and characteristics of family-driven care, most notable of which is that "administration and staff share power, resources, authority, responsibility, and control" with families and youth.

Case Worker: individuals employed by the Department of Health and Human Services Office of Child and Family Services as human services caseworkers working in child protection, children's services, and adoption

Case Manager: individuals who serve a case management function with children and families through contract with Maine's Department of Health and Human Services, Office of Child and Family Services - Children's Behavioral Health Services or Maine Department of Corrections- Juvenile Corrections.

Planning Process Components for Transitions from Residential Facilities

1. The Transition Planning Process is Team Based

a) Each child must have a child and family team. This team is comprised of a group of people that may change depending on the needs of the child and family. When DHHS is the guardian, the team shall include at a minimum: Parents, child/youth, informal familial supports, DHHS caseworker, representatives of the placing agency, residential providers, community case manager (if one is involved) and educational staff. When guardianship resides with the family, the team is selected by the family and includes natural and community supports and any public or private child serving agencies that are or may need to be involved

b) Transition plans must include the family members' input regarding the types of services and supports that will be most helpful to them. These should be realistic, achievable and not burdensome to the family. Children and their families should be provided with the supports (i.e., logistical, emotional, personal) necessary to allow their full participation in the transition planning process. To this end, it is inherent on the transition team to assess the child and family's support needs and make arrangements to meet these needs.

c) When team members are not able to participate in planning processes, their input needs to be actively solicited and included

d) While most children entering out-of-home placements will have a team in place at the time of admission, caseworkers, case managers and out-of-home providers will need to work with the family, community providers and referral sources to initiate the development of a team when children are admitted without one.

e) As the dynamic child and family team expands to incorporate members from the out-of-home provider, its' members will communicate about what has worked in previous planning for the child and family and about integration of significant family strengths and culture into day-to-day treatment of the child

f) It is expected that the team composition may change as the transition nears to include current members and those from the receiving community/placement such as educators and outpatient providers. Involvement of receiving providers is vital as it supports continuity of care and a smoother transition process

g) Team members will continually assess how they are functioning as a team with the following overarching principles: have a shared understanding of the goals, a commitment to the process, clear expectations, clarification of roles and functions, coordination of efforts, clear decision-making process and ongoing reflection – giving and receiving feedback and negotiation

2. Families must be meaningfully involved in all aspects of care from day one

a) Planning must operate within a family centered practice framework, valuing the importance of the family and demonstrating a strong respect for the inherent strength and capabilities of family members in all phases including the assessment process, setting and prioritization of treatment goals, ongoing care and discharge planning
b) Families should be drivers of the plan and youth should have the opportunity to guide the plan
c) Families should be provided with clear, concise information, including their rights, so they can make well-informed decisions regarding clinical considerations and recommendations. The team must ensure that this information is provided in a manner that meets the child and family's learning style and capacity to understand.
d) Plans should include and honor the child's and family's wishes whenever possible
e) Caseworkers and providers should continually pursue an effective level of engagement and re-engagement as some families might be reluctant to participate in their child's care. To effectively engage families, functional aspects of a particular family's life must be identified, sanctioned, and expanded to those areas that do not work as well. In addition, it is important to reach out to additional relatives, friends and supportive individuals beyond the immediate family.
f) Transitions should be contingent upon the child/youth and family's having had sufficient practice to feel confident about meeting the challenges at home and on the availability of community based supports (formal and informal) that can adequately address their needs, including any familial and community safety needs
g) Transitions will include visits to help the child/youth reintegrate back into their home, community, school, social network and recreational activities. Visits will include strategies to assist the child and family as they move from a structured environment to one that is less structured. Strategies should include ways to support sibling interactions as family dynamics may have shifted during the out-of-home placement
h) Team members must each take responsibility to ensure that youth who may not have an identified family to return to are actively assisted in developing ties to a supportive community, including extended family members and non-family resources upon which they can depend for assistance. These ties should include connections with caregivers that can meet their relationship needs. This process should be guided by the child/youth
i) In situations where youth may not be able to return to their birth family, ongoing connections and relationships with their birth family should continue to be encouraged and supported when safety is not a concern

3. Individualized discharge planning begins at the time of admission and continues throughout treatment with an emphasis on planning for transitions.

a) Treatment plans will focus on reintegration through outreach efforts, skills strengthening, practicing and preparation
b) Throughout treatment, plans will be developed and revised that have clear, measurable objectives with projected timeframes. Plans will include strategies and techniques that can be used by parents when the child returns to the community
c) Plans will be reality-based and address needs in the most practical way possible, drawing upon existing resources available to the team. Discharge planning will be approached in a careful manner, providing ample time for the family to make adjustments to the impending discharge and sufficient planning for setting up the necessary services and /or supports in the home/receiving community. On those occasions when a placement opportunity necessitates a rapid planning process, the team should respond accordingly and demonstrate flexibility in developing supports for the child and family
d) When there is a disagreement amongst team members, all parties will work openly towards resolution. A protocol will be in place, with a structured process, so that parties have an avenue to address the issue. This should include a thoughtful dialogue, weighing all considerations, and may include consultation to assist the team in reaching consensus.
e) If a discharge happens quickly and supports are not in place at the time to discharge, the team should meet very soon after discharge and on a regular basis thereafter to insure that adequate supports are quickly put in place
f) Team members, including the out-of-home care provider, are expected to continue to work with all parties to ensure the child's and family's safety when faced with a precipitous or unplanned discharge
g) Planning takes into consideration all Life Domains of the child and family (see appendix A)

4. Community providers, out-of-home providers, and child serving agencies (including schools) must develop successful and well-defined protocols to ensure appropriate placements, collaborative service planning and meaningfully coordinated care that is individualized

a) The team will address family readiness and specific support needs to ensure placement stability and success
b) Children and youth will be actively engaged and included in the planning process. Information will be shared in age appropriate terms. Special consideration and sensitivity will be placed on preparing them for the transition and identifying ways to support and maintain connections that were made during their out-of-home placement with provider staff, peers, school personnel and other community members.

c) Community, educational and home-based services necessary to support the child and his/her family will be identified including strategies to assist the child and family as they move from a structured environment to a less structured environment.
d) Service plan reviews (as referred to in Licensing standards) will be conducted with all team members participating
e) The level of effort/frequency/duration of contact expected of the DHHS caseworker or community case manager, in order to ensure the safety and stability of the placement, will be clearly defined
f) Youth Crisis Plans and Preventative Safety Plans will be developed and will include predicable issues given the child's and caregiver's past experiences
g) Planned and emergency respite options (both informal and formal) will be actively explored and (when indicated) will be determined prior to discharge

Recommendations for Usage and Implementation

1. OCFS Child Welfare division will develop a policy incorporating the *Planning Process Components*. Child Welfare Services will facilitate dissemination of the policy and will hold discussions at the district level to allow for interpretation clarifications and practice implications.

2. Use of the checklist should be tracked and monitored at the district and central office level.

3. Child Welfare Services should develop a protocol for appropriately addressing situations in which there is disagreement between the guardian (child welfare caseworker) and other members of the treatment team.

4. Childrens' Behavioral Health Services should give serious consideration to adding the practices outlined in the *Planning Process Components* and the accompanying checklist to contracts with case management agencies.

5. CBHS should monitor the use of the checklist by their case managers.

6. Distribute this report and transition processes to Maine Administrators of Services for Children with Disabilities (MADSEC), Department of Education Special Services Division. OCFS should send a representative to a MADSEC to discuss the processes.

7. Distribute this report and transition processes to the Maine Group Care Association, Maine Association of Mental Health Services and the Foster Family Treatment Association.

8. Distribute this report to all relevant parent organizations.

9. Review the report with YLAT and ask for their input on how teens can be informed about the expectations for transitions planning processes.

10. Present the report at the Youth Permanency Summit to elicit further ideas about implementation.

11. Workgroup should reconvene six months after implementation to review any needed changes to the recommendations or implementation process.

Appendix A

Life Domain Areas as used in Wraparound Planning

(adapted from Vroon VanDenBerg LLP, Wraparound Training 101)

Children and Youth who access Children's Residential Facilities benefit from support and interventions across settings and various life domains. The life domain framework used in Wraparound Planning is a tool that has multiple uses and is applicable to any collaborative, strength based team planning process. Inquiring about strengths and needs in each life domain helps ensure that all life areas are fully explored.

The following list is offered for consideration in planning for transitions from Children's Residential Facilities. These are *examples* and would need to be customized to each individual/family

Residence
Where does the family live? Do the living arrangements meet the family's needs?

Family
Who is in the family by their definition? Do all family members have appropriate access to each other? What do family members need to stay together or in touch with each other? Are there serious, unmet needs for any family members that impair the family's ability to participate in community, home, school or work life?

Social
Do family members have friends and access to their friends? Does this family have the opportunity to socialize with each other? As Individuals? Do they have any fun? Do they have any way to relax?

Behavioral/Emotional
Are any problems blocking a family member's chances of having a good life? Does referred individual have any unmet needs in this area? Other family members? Are there unresolved issues or behaviors that impede normal interactions within the family or community?

Educational/Vocational
What will it take to ensure a viable education for the child? Do older children have access to employment opportunities? For what sort of future are they being prepared?

Safety
Is everybody in the family safe? Are there dangers to individual family members? Is anyone potentially dangerous to themselves or the community?

Legal
Are any family members involved in the judicial system, on probation or parole? Do they have representation? Are there issues around custody?

Health
Are healthcare needs met? Does the family have access to any specialized medical services they may need?

Cultural
Is cultural uniqueness recognized and respected? Are there any unmet cultural needs?

Other possible areas: Spiritual, Financial, Pets, Recreation, or whatever suits the specific child/family

Appendix B

Checklist

It is recommended that the Child and Family Team review this checklist at each team meeting as means to ensure continuous attention to the transition plan. This checklist is then to be used for review and sign off by team members at the final meeting prior to discharge and will serve as a record of completion.

Child/Youth Name: _____ Date of Birth: _____

Residential Facility: _____ Date of Admission: _____

Placement at discharge: _____Date of Discharge: _____

_____ A Team Based planning process has occurred throughout treatment

_____ Family members have been meaningfully involved in all aspects of care

_____ The receiving school district has been involved in team meetings *prior to* discharge.

_____ Youth without family resources have been actively assisted in developing ties to a supportive community.

_____ Strengths and Needs across all relevant *Life Domains* * have been actively reviewed and applied to the plan.

_____ There is a clear plan for Case Worker/Case Manager involvement following discharge from residential care including frequency of contact expected.

_____ Community, educational and home-based services/supports have been identified and are set up prior to discharge

_____ Transition visits have occurred (home, school, community)

____ A Crisis/Safety Plan has been developed by the team prior to discharge.

* *Life Domains* is a term used to describe the many life areas that are relevant for any person and include areas such as Residence, Family, Social, Behavioral/ Emotional, Educational/Vocational/Safety, Legal, Health and Cultural.

The following Child and Family Team members have been involved in discharge planning and are in agreement with the plan:

Parent	Date
DHHS/Legal Guardian	Date
Natural/Informal Support (relationship)	Date
Natural/Informal Support (relationship)	Date
Residential Facility Representative	Date
Receiving School District Representative	Date
Community Provider	Date
Community Provider	Date
Other (relationship)	Date
Other (relationship)	Date

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