


MISSISSIPPI DEPARTMENT OF HUMAN SERVICES	
DIVISION OF YOUTH SERVICES	
JUVENILE INSTITUTIONS	
Subject: Transition	Policy Number: 19
Number of Pages: 6	Section: XIII
Attachments	Related Standards & References
A. Transition Checklist B. Transition Planning Checklist	TRANSITION TOOLKIT 2.0: MEETING THE EDUCATIONAL NEEDS OF YOUTH EXPOSED TO THE JUVENILE JUSTICE SYSTEM South Carolina Department of Juvenile Justice Colorado Reference Guide Maricopa County Sheriff's Office
Effective Date: May 7, 2009 Revised: January 12, 2011	Approved:  Kathy Pittman, Director

I. POLICY:

It is the policy of the Mississippi Department of Human Services, Division of Youth Services (DYS) that a successful transition plan development for a committed youth is critical and consistent with the rehabilitative ethic embodied in the state's juvenile justice code. It is an opportunity to redirect the lives of young people toward productivity, self-sufficiency, a continuity of care, and law-abiding behavior to their own benefit while at the same time making our communities a safer place to live.

II. DEFINITIONS

As used in this policy and procedure, the following definitions apply:

- A. **Transition Process** – An individualized planning process for the youth that follows a series of steps, designed within an outcome-oriented, strength-based and team-driven course of action, which promotes successful movement from the community to a juvenile justice setting, and to community reintegration.
- B. **Transition Plan** - It contains all information related to the youth's strengths and needs—behavioral screening results, academic and vocational assessment results, education records (including past IEPs), credit earned at the community school, all medical and mental health records - where appropriate, and other relevant information.
- C. **Treatment Team** – (As outlined in Treatment Team Policy XIII.4.), partners working together to develop, implement, and evaluate a comprehensive and thorough transition plan that will be incorporated into the youth's service plan. This team is comprised of individuals best suited to create and implement a plan that meets the individualized needs the youth should concentrate on during and after commitment. The community services counselor will communicate with the institutional counselor by phone regarding issues or concerns he may have with the youth's transition plan. The team shall include an institutional counselor who is the chairperson of the treatment team, transition coordinator/counselor, a

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mental health counselor or advocate, psychiatrist as appropriate, educational representatives, direct care staff from housing unit, and members of other community based support resources. This team also includes the youth and his or her family or an adult advocate or mentor who can act on the family's behalf.

- D. **Transition Coordinator** –Individual responsible for the direction, coordination and organization of the transition process. The Coordinator will meet with treatment team partners at the different stages of treatment to effectively support community reintegration and ensure the involvement of each partner from the various departments and community.
- E. **Mentor** - Individual giving of their time to act as a big brother/sister to a youth committed to training school.
- F. **A-Team** – Team coordinated by the community counselor and other agency partners collaborating to discuss resource and placement alternatives for youth with mental illness and or substance use disorder.
- G. **Community Transition Phase** – The period of time that a youth is under the supervision of the community counselor, which is also known as parole.
- H. **Service Plan** – (Service Plans Policy XII.5) Is the overall plan developed by the treatment team for the youth and is also known as the Transition Plan by incorporating the services required to successfully release the youth back into the community.

III. **PROCEDURE**

Transition services are designed to operate in four phases. The process will begin with the “end in mind” that is, preparing the juvenile and their family for the juvenile's return to the community and to reduce recidivism. The phases include coordination and delivery of services that involve working with Community Staff, Social Workers, Educational Services, Mental Health Services, Medicaid, and other community service agencies as partners with Youth Services.

Community Phase I: Pre -Commitment Process

- A. Community counselor will explain and/or provide literature to family members and their youth about the commitment process and system, their rights and their youth's rights, the goals of commitment, and other pertinent information. Community staff is to help the family members overcome any initial hesitation about involvement, and communicate to family members that the institution/facility is where the child is held accountable for his/her actions and will receive rehabilitation services.
- B. Referrals for the family, i.e., for parenting education with the Family Resource Centers, mental health or substance abuse treatment services or other appropriate family groups, are to be made by community staff.

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- C. Community counselor will provide a social history to include a plan with post parole school re-enrollment information, service needs of the youth, to include special providers covered under insurance, and resource information given to the family.

Institution Phase II: Intake Screening/Assessment/Rehabilitation Process

- A. Upon entry to the institution, institution staff will be screen the youth for mental, emotional, and behavioral conditions. (See Youth Screening and Assessment Policy XIII.3). Institution staff will interview the youth to learn about his or her basic goals, interests, preferences, and self-identified needs. The assessment unit will continue to conduct assessments throughout the youth's stay, if warranted.
- B. The institution staff will contact the community staff within three working days to verify youth's family history and determine if there are any issues that would cause problems with his placement by into community.
- C. Information from the initial medical/mental health screenings (Medical Policy XI.15, 16, 17, 19, 20, and 21), intake interviews, educational assessments indicating for pre-existing eligibility for special education (SPED), and school records will be discussed with the treatment team to establish the needs of the youth.
- D. Enter all information on each youth into CMS for tracking and monitoring of the youth's progress during and after commitment.
- E. Juveniles that have a length of stay classification score of a 1, 2, or 3 (Length of Stay Policy XIII.15) will receive an assessment by institution staff within 10 days of admission to the institution to determine treatment options upon return to community.
- F. Place within the initial Service Plan (Service Plans Policy XIII.5) transitional information to meet the following requirements:
 - i. Education: determine the course of study the youth will pursue (e.g., GED, diploma, certificate, etc.) and what needs to occur in order for the youth to either meet this goal while at Oakley or how he or she will pursue them once released (e.g., youth needs 21 additional credits and will need to re-enroll in XX High School upon release).
 - ii. Mental Health: determine the key areas of need (e.g., substance abuse treatment; family counseling; parenting) and discuss how services provided at Oakley will be continued in the community, if necessary.
 - iii. Medical: determine the youth's chronic health issues and how they will be addressed in the community.

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- G. The institution counselors will contact the community counselor to collaborate community reintegration based on the local communities' available resources assessed during the commitment. A comprehensive spectrum of mental health, academic, vocational, and other support service resources organized into a coordinated network that is family centered to meet the needs of the youth shall be provided.
- H. The Transition Coordinator will meet the changing needs of the youth and the family developed by institutional staff. This will be accomplished by the following actions.
 - i. The Transition Coordinator will hold individual sessions with the student.
 - ii. The Transition Coordinator will verify availability of required services in the community.
 - iii. The Transition Coordinator will ensure that medications are provided to students with mental health problems. The Transition Coordinator will also ensure that medications are provided to students on other medicines.
 - iv. The Transition Coordinator will ensure that education provides needed information to the student's home school.

Phase III: Pre-Release

- A. Institution counselor and the Transition Coordinator shall continue activities initiated at entry. The institution counselor will discuss with the community counselor the expectations of the youth upon being paroled to see if he/she can meet them.
- B. Provide transition counseling, supplied by the institution counselor, to establish appropriate goals and objectives for rehabilitation.
- C. The following action steps are to be handled by the treatment team, transitional coordinator, and the institution counselor:
 - i. Complete the final Service Plan which becomes the Transition Plan, including Parole Report, educational documentation, medical reports, etc.
 - ii. Medical clinic staff shall make medical/dental/mental health appointment(s). Complete the medical release summary outlined in Medical Policy XI.9 to include necessary contact information. Appointment information should be forwarded to the Transition Coordinator.

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- iii. Transition Coordinator shall refer to the A-Team youth who are on medication for a mental illness (serious emotional disturbance - SED) and or have co-occurring disorders of substance use disorder and SED, if appropriate.
 - iv. The Transition Coordinator will link services between the institution and the community to ensure a seamless transition of services upon the youth's return to the community.
 - v. The Transition Coordinator will receive treatment summaries or recommendations of services from each Department Head of each unit (Medical, Education, Mental Health) and contact the appropriate community counselor.
 - vi. The Transition Coordinator will complete a Transition Summary by day of parole and submit to the community counselor.
 - vii. The Transition Coordinator will verify with the community counselor that all documents related to the release of the juvenile have been received the next working day.
- D. Institution counselor and community counselor will jointly prepare the juvenile, and family for the juvenile's return to the community.
 - E. The community counselor will work with the family to begin the Medicaid application process prior to release, if applicable.
 - F. The community counselor will contact organizations providing mentoring services as appropriate prior to the youth's release.
 - G. The community counselor will provide the parent/custodian a list of state and local resources for employment, education, medical, and mental health services and procedures for access to these services.

Phase IV: Parole/Continuing Care Phase

- A. **Parole (Community Transition Phase)** – This phase begins the day of the juvenile's return to the community. The following objectives will be accomplished during this phase by the community counselor:
 - i. Youth requiring medication (MOA IV A.21) are provided Medication up to 45 days upon release by Medical. The Medical Release Summary will be provided to the parents and forwarded to the transition coordinator on the date of parole. The transition coordinator/counselor will forward this summary to the community counselor on the day of parole.

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- ii. The community counselor will follow up with the transition coordinator to verify that juveniles and their families receive the services, support and supervision as outlined on the Transition Plan.
- iii. The Transition Coordinator will follow up and verify with the community counselor after the first monthly community counseling session to review the transition plan and to access if the plan is helping the youth to achieve his/her goals.
- iv. The community counselor shall maintain ongoing monitoring of needs and student progress (e.g., academic, social, behavioral, vocational) based on the youth's service plan incorporated into the parole agreement. Ensure the juvenile's successful adjustment and reintegration into the community.

B. Evaluation of Transition Programs – The transition process will be reviewed monthly when the community counselor submits the Parole Tracking Form to the community services director. He will then submit a report to the Institution Director to review with the transition team members. The following shall be tracked to ensure that the effectiveness of the transition program may be measured and modifications and improvement can be made when appropriate:

- i. % of youth who leave facility with 30-day supply of psychotropic medication
- ii. % of youth who leave facility already enrolled in subsequent school placement
- iii. % of youth who actually start going to school upon release
- iv. % of youth who leave facility with employment or promise of employment.
- v. % of youth who leave facility already enrolled in Medicaid program
- vi. % of youth who actually keep Mental Health appointments upon release
- vii. % of recidivism of youth in the system for Oakley