DEPARTMENT OF CORRECTIONS

Policy Number:	**203.011**
Title:	**Juvenile Resident Case Management ~~– Juveniles~~**
Effective Date:	**5/11/26~~TBD~~**

PURPOSE: To provide case management services for residents~~juvenile offenders committed to the commissioner of corrections or placed as a condition of probation.~~ that includes an orientation and assessment period to determine the resident's unique needs and strengths, the creation of a comprehensive individualized treatment plan to address the resident's high risk behaviors, and to plan for every aspect of the resident's community reentry.

APPLICABILITY: Minnesota Correctional Facility – Red Wing (MCF-RW), juvenile resident program ~~hearings and release unit (HRU)~~

DEFINITIONS:

Administrative separation – when residents are separated from peers because of the seriousness of their behavior or because their behavior "…presents an ongoing threat to the safety of the resident, other residents, or facility staff; and cannot be addressed by placing them in safety-stabilization period (Minnesota Rule 2960.0740, subpart 1)." ~~(Minnesota Rule 2960.0740, subpart 1)~~

Case plan – as defined in Minnesota Rule Chapter 2960.0020, Subp. 9.

Community service providers - agencies and persons who provide services to help the resident in their return to the community. Culturally competent agencies and persons are recruited to help in the transition program.

Community reentry plan - a report of the resident's transition plans in the areas including but not limited to community placement, employment, educational and vocational plans, after-care programming, leisure and recreational plans, budget plan, transportation, health and personal safety needs, and community support system.

~~**Community reentry plan – report specifying conditions relating to transition from the facility to the community.**~~

Comprehensive needs assessment summary – a~~n assessment~~ report that summarizes the results of assessments in the areas of ~~conducted prior to the development of the individual treatment plan, containing~~ mental health~~psychological~~, academic~~educational~~, health services, substance use~~chemical health~~, transition~~s~~, ~~and~~ recreation/leisure time, and Youth Level of Service/Case Management Inventory high risk domains. ~~evaluations.~~

Individual treatment plan – an individualized plan ~~consisting~~ of the resident's goal(s), intended outcome, and assignments and tasks to complete to achieve the goal(s). ~~programming needs, program goals and means of goal achievement which are developed based on the resident's Youth Level of~~

~~Service/Case Management Inventory 2.0 (YLS/CMI 2.0) assessment high-risk domains, and recommendations from the treatment team.~~

~~Program progress report – quarterly report of progress toward the goals established in the resident's individual treatment plan.~~

Resident manual – an overview of the facility's programs, services, rules, and policies through which residents gain information concerning rules governing conduct, visiting, correspondence, bathing, laundry and clothing and bedding exchange, and procedures for obtaining personal hygiene and canteen items.

Residents – as defined in Minnesota Rule Chapter 2960.0020, Subp. 59 that includes extended jurisdiction juveniles as defined in Minnesota Rule Chapter 2960.0020, Subp. 35.

Restrictive procedures – procedures used to limit a resident's movement, including mechanical restraint, physical escort, physical holding, and safety-based separation (Minnesota Rule 2960.0020, subpart 63).

Safety-based separation ~~–~~ – when residents are separated from peers and on-going programming in a locked or unlocked area from which they are not free to leave for the amount of time necessary to ensure the safety of residents, staff, and facility operations. Includes administrative separation, medical separation, and safety-stabilization period~~.~~ (Minnesota Rule 2960.0020, subpart 63a).

Transition treatment team meeting - to review and discuss the resident's history, facility adjustment, assets, barriers to community re-entry, and aftercare plan recommendations. Attendees typically include the resident, transition corrections security caseworker (CSC)/designee, probation officer (PO), family, community service provider(s), education staff, mental health staff, and program corrections security caseworker (CSC).

Treatment team – living unit corrections officers and program~~group of~~ staff that work with the resident on a daily basis.~~consisting of~~ Team members include the resident's corrections security case worker (CSC) and staff from ~~caseworkers, therapeutic~~ recreation~~ staff~~, education~~teachers~~, ~~individual education plan (IEP) case managers,~~ behavioral~~mental~~ health~~ staff~~, health services,~~ staff,~~ and transition~~and correctional officers who have regular contact with residents~~.

PROCEDURES:

A. The use of restrictive procedures~~physical escort, physical holding, mechanical restraints, and safety-based separation~~ are~~are~~ permitted in accordance with ~~used only as permitted in, and consistent with,~~ the resident's i~~I~~nitial s~~S~~ervices p~~P~~lan ~~(ISP)~~ (attached) and individual treatment plan~~Individual Treatment Plan (ITP)~~ (attached) per Policy 301.079, "Juvenile Response to Resistance and Restrictive Procedures."

B. Residents with reading or comprehension difficulties have written materials read to them and explained~~and explained to them~~.~~ Language translation services are provided to residents who have difficulty reading or speaking English.

C. C~~The c~~orrections security case workers (CSC) must not share~~cannot share~~ information with the parent or ~~/~~legal guardian of a resident that is 18 years of age or older without the resident's consent. ~~-~~Residents who are 18 years of age or older~~of that age~~ sign a release of information if they approve the CSC to share information with their parent or ~~/~~legal guardian.

D. Volunteer services staff coordinate opportunities for residents to interact with culturally similar adults and to participate in cultural groups.

E. Supervision of treatment – the corrections program director (CPD):

1. Supervises the development of each resident's service and treatment plans;

2. Engages in the treatment planning process;

3. Signs ~~the~~ service and treatment plans; and

4. Supervises the implementation of the service and treatment plans, as well as ~~and the~~ ongoing documentation and evaluation of each resident's progress.

F. Case plan ~~– as set out in Minn. R. 2960.0020 subp. 9.~~

~~1. Intake lieutenants ask the probation officer (PO) to send the resident's case plan before they arrive at the facility.~~

~~2. CSCs:~~

~~a) Requests the placing agency's case plan if not already received;~~

~~b) Works with the resident, parent/legal guardian, PO, and treatment team to implement the case plan;~~

~~c) Coordinates the facility's plan for services with those in the case plan;~~

~~d) Works with the PO to identify the resident's projected length of stay;~~

~~e) Consults with the PO to:~~

~~(1) Identify conditions under which the family will be reunited; and~~

~~(2) Specify the alternative permanency plan if the family will not be reunited;~~

~~f) Communicates with the PO what the facility will do to help carry out the living arrangements plan; and~~

~~g) Recommends case plan changes to the PO.~~1. Intake lieutenants request that the probation officer (PO) provide the resident's case plan prior to the resident's arrival at the facility.

2. The resident's CSC works with the resident, parent or legal guardian, PO, and treatment team to implement the placing agency's case plan for the resident. The CSC:

a) Requests the placing agency's case plan if it has not already been received;

b) Coordinates the facility's plan for services to the resident with the placing agency's case plan for the resident and;

(1) Works with the PO to identify the resident's projected length of stay; and

(2) Consults with the PO to:

(a) Identify conditions under which the family will be reunited;

(b) Specify the alternative permanency plan if the family will not be reunited; and

(c) Communicates to the PO what the facility will do to help carry out the living arrangements plan; and

c) Recommends case plan changes to the PO.

3. Throughout the residents' stay at the facility, the ~~In accordance with the case plan,~~ CSCs:~~;~~

a) Identify and share information about the resident's treatment and goals with persons directly involved in the resident's individual treatment plan; ~~Identify and share information about the resident's treatment and goals with persons directly involved in the resident's treatment plan;~~

b) Communicate, as necessary, with the resident's previous school and the facility's school personnel;

c) Report the resident's behaviors, special accomplishments, ~~and~~ progress, and other important information to the PO and others as indicated;

d) List procedures and program plans to facilitate the involvement of the resident's family or other concerned adult~~s~~~~(s)~~ in the resident's treatment or program activities, if family involvement is a goal.

e) Upon request, unless prohibited by law, share information with:

(1) The PO;

(2) Agencies providing services to the resident, such as, ~~(~~therapists, physicians, or other professionals~~)~~; and

(3) Agencies that must provide services to the resident upon release.~~-~~ This information may pertain to the resident, the resident's family, and the facility's plans and strategies to resolve the resident's identified problems.

G. Communication with family and social supports

1. Staff document contact with the resident's social supports on the s~~S~~ocial s~~S~~upports c~~C~~ontact l~~L~~og (attached). ~~-~~This includes both staff-initiated contact and contacts initiated by the resident's social support person.

2. CSCs use this log to document meetings held about the resident's treatment to include:

a) The date of meetings;

b) The type of meetings, for example, ~~(i.e.,~~ staffing, treatment team, special education staffing~~)~~;

c) Persons that participated; and

d) A brief description of the reason for the meeting and its outcome.

H. Treatment team meetings

1. Residents participate in:
   a) An initial treatment team meeting within the first 30 days to review the results of their assessments.- Residents have an opportunity to ask questions about program expectations and participate in identifying their treatment goals; and

   b) Their transition treatment team meeting.

2. Treatment team meetings are held throughout the treatment planning process and the resident's stay to share:
   a) Evaluative data; and

   b) Current information and insight about the resident's assessment results, program progress, behaviors, and upcoming treatment needs.

3. Administrative treatment team meetings may be held to address resident living unit moves and other cottage living concerns. -Parents or /legal guardians are contacted and given updates followingafter these meetings.

4. Results of the initial treatment team meeting are available to all staff throughvia the completed cComprehensive nNeeds aAssessment sSummary (attached) (CNAS) and individual treatment planITP.

5. To the extent possible, treatment team meetings are scheduled to accommodate the schedule of parents or /legal guardians, POs, and other community or /professional representatives.

I. The treatment planning process:
   a) Begins at admission with the completion of intake screenings;

   b) Continues throughout the:
      (1) Initiation of the orientation process and initial services plan; and
      (2) Completion of the assessment process; and

   c) Concludes with the creation of the comprehensive needs assessment summary, which serves as the foundation for the individual treatment plan.

JI. Orientation and initial service plan
1. Initial intake and orientation tasks are completed by intake staff Dayton staff upon admission.

2. The goals of the orientation program are for residents to:
   a) Learn about MCF-RW programming and expectations;

   b) Participate appropriately iAppropriately participate in programming; and

   c) Complete the iIntroduction to pProgramming course.

3. Orientation begins within two days of admission and is designed to be ~~fully~~ completed in approximately five weeks.
   a) Successful completion of orientation is based on the resident achieving the ~~n accomplishing~~ goals, expectations, assignments, and skill development and is documented on ~~their~~a resident's ~~i~~initial ~~s~~services p~~p~~lan ~~(ISP)~~.

   b) ~~Residents~~A resident may need to further review goals, expectations, and skill development beyond the five-week period.

4. Residents participate in program activities, such as, ~~(i.e.~~ school, and recreation~~)~~.

5. Within 72 hours of intake, the orientation corrections security caseworker (CSC):
   a) Arranges for the resident to view the Prison Rape Elimination Act (PREA) video/review and discussion;

   b) Provides the resident overviews of:
      (1) Kites and grievances;
      (2) Treatment t~~T~~eam m~~M~~eetings;
      (3) Safety-based separation and loss of privileges (LOP);
      (4) Group process, ~~/~~meetings, and expectations;
      (5) Casework review, treatment plan, and resident treatment input;
      (6) Level system and staff roles;
      (7) Counts and movement;
      (8) J-Pay, telephone, and mail;
      (9) Orientation treatment packets; and
      (10) Resident rights ~~review~~.

   c) Completes screenings with the resident as follows:
      (1) C~~C~~ultural & g~~G~~ender r~~R~~esponsivity s~~S~~creening; and
      (2) Vulnerability s~~S~~creening.

~~6. Within 72 hours of intake, the PREA lieutenant/designee completes the PREA lieutenant follow up review and notifies the orientation CSC when it's complete.~~

6~~7~~. The orientation ~~(~~CSC ~~)~~and education staff conduct i~~I~~ntroduction to p~~P~~rogramming classes on the following topics:
   a) Steps to c~~C~~hange (four sessions);
   b) Resident manual and safety orientation;
   c) Canteen, property, restitution, and uniforms;
   d) Incentives;
   e) Visiting, rules, dress code, and application process;
   f) Strengths for s~~S~~uccess;
   g) Behavioral health and health services;
   h) School, c~~C~~elebration of e~~E~~xcellence, and p~~P~~ositive b~~B~~ehavior i~~I~~nterventions and s~~S~~upports (PBIS);
   i) Transition services;
   j) Volunteer services and spiritual care;
   k) Recreation activities;

l) Identifying pProblems or /nNeeds in tTreatment;
m) Review "Giving and Receiving Feedback";
n) Review "Are You Snitching or Helping";
o) Career sScope;
p) Strong Interest Inventory; and
q) Introduction to Aggression Replacement Training ® (ART®), cCarey gGuides, additional programming classes offered, and relapse prevention plan.

76. The treatment program CSC begins treatment planning activities.

8. Initial services plan
a) The orientation CSC:
(1) Creates an initial services plan within three business days of the resident beginning the orientation program;
(2) Reviews the plan with the resident;
(3) Has the resident signs the plan. If the resident refuses to sign the plan, staff document the refusal and sign it;
(4) Signs the plan; and
(5) Scans the signed plan and saves it to the resident's electronic file.

b) Records office staff distributes the plan to the (PO), the PO's supervisor, and the assigned judge.

c) When the initial service plan is complete, the orientation CSC:
(1) Marks orientation completion on the initial service plan;
(2) Signs the plan;
(3) Has the resident sign the completed plan;
(4) Scans the signed plan and saves it to the orientation supervisory file; and
(5) Emails notification of the completed plan to the treatment program CSC.

d) The corrections program director (CPD) signs completed plan.

e) Records office staff distribute the plan to the PO, the PO's supervisor, and assigned judge.

f) The orientation CSC gives a copy of the completed and signed plan to the resident.

~~J. Initial services plan (ISP)~~
~~1. The orientation CSC:~~
~~a) Creates an initial services plan (attached) within three business days of the resident beginning the orientation program;~~
~~b) Reviews the plan with the resident;~~
~~c) Gains the residents signature on the plan;~~
~~d) Signs the plan; and~~
~~e) Scans the signed plan and saves it to the resident's e-file.~~

~~2. Records office staff distributes the plan to the probation officer (PO), PO's supervisor, and assigned judge.~~

3. When the ISP is complete the orientation CSC:
   a) Notes orientation completion on the ISP;
   b) Signs the plan;
   c) Gains the resident's signature on the completed plan;
   d) Scans the signed plan and saves it to the orientation supervisory file; and
   e) Emails notification of the completed plan to the treatment program CSC.

4. The corrections program director (CPD) signs completed plan.

5. Records office staff distribute the plan to the probation officer (PO), PO's supervisor, and assigned judge.

6. The orientation CSC gives a copy of the completed and signed plan to the resident.

K. Assessment process
1. The program CSC:
   a) Completes a comprehensive needs assessment summary ~~comprehensive needs assessment summary (CNAS) (attached)~~ within 30 business days of admission;

   b) Completes the y~~Y~~outh l~~L~~evel of s~~S~~ervice/c~~C~~ase m~~M~~anagement i~~I~~nventory (YLS/CMI) if one has not been completed in the last six months;

   c) Completes a YLS/CMI results review, file review, and interviews ~~with~~ the resident's parent or ~~/~~guardian and ~~probation officer (~~PO~~)~~ to identify risk levels. ~~in the following domains~~areas:
      ~~(1) Offense;~~
      ~~(2) Family;~~
      ~~(3) Education;~~
      ~~(4) Peers;~~
      ~~(5) Substance abuse;~~
      ~~(6) Leisure;~~
      ~~(7) Personality/Behavior;~~
      ~~(8) Attitude;~~
      ~~(9) Trauma history; and~~
      ~~(10) Special needs and methods of accommodation.~~
   d) Documents their attempts to contact the resident's parent or legal ~~/~~guardian and, if available, the extent to which they wish to be involved during the resident's stay, along with ~~and~~ other related information about the resident; and

   e) Documents other related information by working with the PO, the resident, the resident's family, and concerned persons in the resident's life.

2. Treatment team members conduct assessments specified in the comprehensive needs assessment summary. ~~in the following areas:~~
   ~~a) Academic/vocational abilities and special needs;~~
   ~~b) Substance use;~~
   ~~c) Recreation/leisure pursuits;~~
   ~~d) Religious and spiritual preferences;~~

e) Cultural identity;
f) Physical and dental health;
g) Mental health;
h) Trauma history;
i) Peer associations;
j) Personality and behavior; and
k) Attitude.

3. Treatment team members observe the resident's interaction and participation with peers and staff.

4. The treatment team meets within 21 days of the resident's admission to review assessment results. -At the conclusion of the meeting, the program CSC:
   a) Identifies special needs;

   b) Arranges for further assessments or specialized care, -if warranted;

   c) Follows processes outlined in Operating Guideline 106.111RW, "Releases" if assessment results indicate the resident's needsthe needs of the resident cannot be met by the facility;

   d) Reviews the results of assessments with the resident and the resident's parent or /guardian;

   e) Completes the comprehensive needs assessment summary CNAS within 30 days of admission and forwards it to the CPD; and

   f) Uses the assessment results to create the resident's first- individual treatment planITP.

5. The CPD reviews and approves the comprehensive needs assessment summary CNAS.

6. Records office staff:
   a) Distributes the comprehensive needs assessment summary CNASas listed on the report; and

   b) Uploads the comprehensive needs assessment summary CNAS to the resident's electronic file.

L. Individual ttreatment pplan (ITP)
1. The treatment planning process:
a) Begins at admission with the completion of screenings and initiation of the Initial Services Plan;
b) Carries over into the assessment process; and
c) Ends with the CNAS which serves as the foundation for the ITP.

12. Residents, parents or /legal guardians, the PO, and treatment team members participate in the creation of the individual treatment plan ITP and reviews individual treatment plan ITP progress.

23. When developing the resident's individual treatment plan~~ITP~~, the program CSC:
   a) Refers to the comprehensive needs assessment summary~~CNAS~~;

   b) Obtains information from the resident's parent or ~~/~~legal guardian, PO, treatment team, and other concerned adults in the resident's life in regard to treatment planning;

   c) Assists the resident to prioritize goals and objectives for the course of treatment;

   d) Works with the resident to develop goals and outcomes;

   e) Documents modifications to the use of restrictive procedures to accommodate the resident's needs, medical or mental health considerations, and assigned treatment services; ~~Documents restrictive procedures accommodations, medical/mental health considerations, and assigned treatment services;~~

   f) Reviews the plan with the resident; and

   g) Routes the plan to the CPD for review and approval.

34. After the individual treatment plan ~~ITP~~ is signed by the resident, program CSC, and CPD, records office staff:
   a) Scan and distribute the plan as listed; and

   b) Files the original in the resident's electronic file.

45. Individual treatment plans ~~ITPs~~ may be re-written or deviate from the comprehensive needs assessment summary ~~CNAS~~ if new:
   a) Information is received; or
   b) Behaviors emerge that necessitate a change in goals.

56. Individual treatment plan~~ITP~~s are reviewed once a month or more often, if necessary.
   a) Individual treatment plan~~ITP~~s may be reviewed during a treatment team meeting based on the resident's attitude, behavior, and motivation towards their goals.

   b) In the review section of the ~~-~~individual treatment plan ~~ITP~~, the program CSC notes:
      (1) Motivation for change; and
      (2) Skill development and goal progress.
      ~~(4) Treatment Team Meetings and Social Support Contacts.~~

67. If the individual treatment plan~~ITP~~ is changed or updated, it is signed and distributed as noted in procedure L.4.

78. When one individual treatment plan ~~ITP~~ is completed, ~~then~~ a new individual treatment plan is developed. This process ~~nother is written. This~~ continues~~s done~~ until all areas identified in the comprehensive needs assessment summary ~~CNAS~~ have been addressed.

M. Administrative sSeparation (AS) sSuccessful lLiving pPlan (SLP)

1. All requirements of using administrative separation are followed per Policy 301.078, "Safety-based Separation of Juveniles and Strength-based Behavioral Interventions."

2~~1~~. Residents may be placed on an administrative separation ~~AS~~ successful living plan ~~SLP~~ when:

a) Their time on AS exceeds 48 awake hours; and/or

b) They need more time, based on their behavior, to reintegrate to their living unit.

3~~2~~. An administrative separation successful living plan ~~AS SLPs~~ is~~are~~ not punitive in nature. The plan is:

a) An amendment to the individual treatment plan ~~ITP~~; and

b) A focused intervention that addresses specific unsafe behaviors through skill development and demonstration.

4~~3~~. Administrative separation successful living plan ~~AS SLPs~~ are reviewed daily. ~~-~~The resident is reintegrated as soon as they demonstrate they are able to safely function in t~~hat settin~~he open program~~g~~.

5~~4~~. The CSC initiates an administrative separation successful living plan ~~AS SLP~~ by conferring with the CPD and living unit lieutenant.~~-~~ The CSC may initiate a treatment team meeting for more complicated cases.

6~~5~~. Residents may be allowed to attend other programming (i.e. mixed group activities, facility-wide assemblies, etc.) outside the separation unit ~~Dayton~~ to demonstrate their ability to be safe in the open program.

7~~6~~. The treatment team participates in the creation, review, and discontinuation of an administrative separation successful living plan.~~AS SLPs.~~

~~7. All requirements of using AS are followed per Policy 301.078, "Safety-based Separation of Juveniles and Strength-based Behavioral Interventions."~~

N. Individual t~~T~~treatment p~~P~~plan s~~S~~summary

1. The i~~I~~ndividual t~~T~~reatment p~~P~~lan s~~S~~ummary is completed when a resident:

a) Is removed from or leaves the program prior to successful completion; or

b) Successfully completes the program and is preparing to move to the transition phase of the program.

2. The program CSC completes the summary within ten business days of a resident's treatment completion or program release and notes:

a) Reason for discharge;

b) Status at discharge (including the extent to which services provided assisted the resident in achieving their individual treatment plan~~ITP~~ goals, services that were not provided as indicated in the individual treatment plan~~ITP~~, and why the services were not provided);~~.~~

c) Aftercare, community reentry plan (attached), and recommendations;

d) Potential risk factors;

e) Protective factors;

f) Mental health status, diagnosis, medications; and

g) Continued care recommendations.

3. The program CSC:
   a) Reviews the summary with the resident (if available); and

   b) Routes the summary to the CPD for review and approval.

4. After the i~~I~~ndividual t~~T~~reatment p~~P~~lan s~~S~~ummary is signed by the resident (if available), program CSC, and CPD, records office staff:
   a) Scans the summary;

   b) Distributes it as listed on the plan; and

   c) Uploads it to the resident's electronic file.

O. Community reentry planning
1. Transition planning:
   a) Begins when a resident is admitted; and

   b) Intensifies as they progress through the program and complete their individual treatment plan~~ITP~~.

2. Family involvement is strongly encouraged and promoted throughout the resident's transition preparations.

3. Residents' unique transition needs are assessed in the following areas:
   a) Family and Other Supportive People;
   b) Living Arrangements/Home and Family Life;
   c) Education;
   d) Employment;
   e) Chemical Health;
   f) Health/Mental Health and Medication;
   g) Recreation and Leisure;
   h) Personal Needs;
   i) Spirituality/Religion;

j) Identification Documents;
k) Transportation;
l) Expenses;
m) Community Services and Referrals;
n) High Risk Areas Self-Care; and
o) Strengths/Assets.

4. Initial interview - the transition CSC/designee:
   a) Meets with a resident within their first 30 days to provide a brief description of the transition program and talk with them about their community reentry needs and plans;

   b) Refers the resident to community service provider(s) based on their unique needs and interests; and

   c) Processes birth certificate, social security card, and state identification applications as needed.

5. Transition treatment team meeting
   a) To the extent possible, the date of the transition treatment team meeting accommodates the schedule of parents or ~~/~~guardians, the PO, and other community representatives.

   b) The transition CSC/designee:
      (1) Provides a summary of the resident's social history, program progress, academic level, and any other special needs or unusual circumstances;
      (2) Solicits information from the parent or ~~/~~guardian, PO, and community service provider regarding the resident's previous community adjustment and current transition needs; and
      (3) Documents information gathered during the meeting.

6. Community reentry plan
   a) The transition CSC/designee:
      (1) Works with residents to establish goals for their community reentry plan (attached) with input from the treatment team, family members, PO, and, if appropriate, the persons who will provide support services to the resident upon release; and,
      (2) Coordinates services with the appropriate staff to address the resident's educational, employment, community participation, recreation and leisure, and living arrangements.

   b) The CPD reviews the plan and forwards it to records staff.

   c) Records staff:
      (1) Scans the plan;
      (2) Distributes it; and
      (3) Uploads it to the resident's electronic file.

P. Relapse assessment and treatment plan

1. Residents that are committed to the commissioner of corrections ~~and~~ who have previously completed the program and their individual treatment plan ~~ITP~~ goals may be returned to the facility from:
   a) A community reintegration furlough due to unsafe behaviors in the community; or

   b) Parole through the Hearings and Release Unit (HRU) process.

2. A relapse assessment and treatment plan (attached) is created to address the specific behaviors that resulted in the resident's return to the facility.

3. A treatment team meeting is held within approximately 21 days of the resident being returned to the facility. ~~-~~The program CSC:
   a) Gathers information from the resident, parent or ~~/~~legal guardian, PO, transition CSC, HRU, and a representative from the placement if the resident was not placed at home;

   b) Assists the resident to create goals and outcomes to help their successful transition to the community;

   c) Documents modifications changes to the use of restrictive procedures to accommodate the resident's needs, medical or mental health considerations, and assigned treatment services;~~Documents restrictive procedure accommodations, medical/mental health considerations, and assigned treatment services;~~

   d) Reviews the plan with the resident; and

   e) Routes the plan to the CPD for review and approval.

4. After the relapse assessment and treatment plan ~~relapse treatment plan~~ is signed by the resident, program CSC, and CPD, records office staff:
   a) Scan~~s~~ the plan;

   b) Distribute~~s~~ the plan as listed; and

   c) Upload~~s~~ it to the resident's electronic file.

5. Relapse assessment and treatment plans are reviewed once a month or more often if necessary. ~~-~~The plan is reviewed, signed, and distributed following each review.

6. In the ~~relapse treatment~~ plan review section of the relapse assessment and treatment plan~~relapse plan~~, the program CSC notes:
   a) The date of review;

   b) Whether or not the plan is complete; and

   c) Comments or addendums.

7. When the resident successfully completes the goals in the relapse assessment and treatment plan~~relapse plan~~, the program CSC completes the ~~relapse treatment plan~~ completion section of the relapse assessment and treatment plan ~~relapse plan~~ noting:

a) The date the plan was completed;

b) If the most recent individual treatment plan ~~individual treatment plan summary~~ reflects the resident's current community re-entry needs; and

c) Updated community re-entry needs if applicable.

~~A. The caseworker supervisor assigns residents to a caseworker and a living unit. The resident's assigned caseworker is responsible for providing or coordinating case management activities, including case history reviews, need assessments, Individualized Treatment Plans, program progress evaluations, 30-day Treatment Plan reviews, transition/aftercare planning (transition caseworkers), and individual and group counseling.~~

~~B. The caseworker initiates and documents orientation and assessment activities for assigned residents, including preparing the Comprehensive Needs Assessment Summary (attached).~~

~~C. The caseworker schedules an initial treatment team meeting within 30 days of a resident's arrival. The treatment team reviews and approves program plans, goals, and progress. The resident, the resident's family/guardians, and the resident's parole agent are invited participants in the treatment team process.~~

~~D. The caseworker prepares a Juvenile Treatment Plan (attached) based on assessed needs on the Youth Level of Service/Case Management Inventory (YLS/CMI) assessment and treatment team recommendations.~~

~~E. The caseworker schedules 30-day treatment plan reviews as well as quarterly progress reports.~~

~~F. Upon treatment plan completion, the caseworker must prepare a Juvenile Treatment Plan summary and a Community Reentry Plan (attached) and a pre-parole review report for the officer of the hearings and release unit (HRU). Once the resident has completed the treatment plan, the resident begins a 30-day furlough in the community with the support of the resident's transition caseworker and Community Reentry Plan. At the completion of the 30-day furlough, the transition caseworker summarizes the resident's fu~~
~~rlough experience and the completion of the MCF-RW program.~~

~~G. All documentation must be filed in the resident's case management file, and retained according to retention schedules. All supervisory reviews of the case management file must be noted in the file.~~

STATE CORRECTIONAL FACILITY SECURITY AUDIT STANDARDS: None

INTERNAL CONTROLS:

A. All documentation, including the cc~~e~~omprehensive nn~~e~~eeds aa~~s~~ssessment ss~~u~~ummary, ii~~n~~dividual tt~~r~~eatment pp~~l~~an, ~~progress reports,~~ 30-day treatment plan reviews, and cc~~o~~mmunity rr~~e~~entry

pplan are filed and retained in the resident's electronic ~~case management~~ file according to retention schedules.

~~B. All supervisory reviews of the case management file are noted in the file.~~

~~**ACA STANDARDS:** 4-JCF-5B-01, 4-JCF-5C-05, 4-JCF-5C-06~~

REFERENCES: Minn. Stat. § 241.01
Minn. R. 2960.0020, 2960.0080, 2960.0180, and 2960.0190

Policy 106.110, "Juvenile Adjustment Reviews"
Policy 106.111, "Juvenile Facility Reviews"
Policy 106.112, "Approval and Modification of Release Plans"
Policy 202.041, "Juvenile Facility Admissions"
Policy 202.050, "Offender/Resident Orientation"
Policy 203.015, "Offender/Resident Risk Assessments"
Policy 300.040, "Volunteer Services"
Policy 301.079, "Juvenile Response to Resistance and Restrictive Procedures"
Operating Guideline 202.051RW, "Resident Manual"
Operating Guideline 202.055RW "Resident Rights"
Operating Guideline 202.100RW "Program Placement"
Operating Guideline 303.020RW "Resident Dress, Hygiene, Hair Care"
Operating Guideline 303.025RW "Resident Housing, Conditions/Expectations"
~~Operating Guideline 203.011-7RW, "Levels of Achievement."~~
~~Operating Guideline 300.010-3RW, "Program Services."~~

REPLACES: Policy 203.011, "Case Management Process - Juveniles," 11/5/19~~11/3/15~~.
Operating Guideline 202.050RW, "Resident Orientation," 1/23/25.
Operating Guideline 203.011-1RW, "Assessment Process," 1/23/25.
Operating Guideline 203.011-2RW, "Treatment Planning and Reports," 1/24/25.
Operating Guideline 203.011-9RW, "Community Reentry Plan," 1/30/25.
All facility policies, memos, or other communications whether verbal, written, or transmitted by electronic means regarding this topic.

ATTACHMENTS: ~~The following forms are located in MCF-RW's shared forms folder:~~
~~Social Supports Contact Log (203.011A)~~
~~Initial Services Plan (203.011B)~~
Comprehensive Needs Assessment Summary (203.011B~~C~~)
Individual Treatment Plan (203.011C~~D~~)
~~Individual Treatment Plan Summary (203.011E)~~
Community Reentry Plan (203.011E~~F~~)
Individual Treatment Plan Summary (203.011F)
Relapse Assessment and Treatment Plan (203.011G)
Social Supports Contact Log (203.011H)

Initial Services Plan (203.011I)

~~Comprehensive Needs Assessment Summary (203.011B)~~
~~Juvenile Treatment Plan (203.011C)~~
~~Juvenile Treatment Progress Report (203.011D)~~
~~Community Reentry Plan (203.011E)~~
~~Discharge Summary (203.011F)~~

APPROVALS:

Commissioner of Corrections
~~Deputy Commissioner, Community Services~~
~~Deputy Commissioner, Facility Services~~