DEPARTMENT OF CORRECTIONS

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

PURPOSE: To provide case management services for residents 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

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)."

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.

Comprehensive needs assessment summary – a report that summarizes the results of assessments in the areas of mental health, academic, health services, substance use, transition, recreation/leisure time, and Youth Level of Service/Case Management Inventory high risk domains.

Individual treatment plan – an individualized plan of the resident's goal(s), intended outcome, and assignments and tasks to complete to achieve the goal(s).

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 staff that work with the resident on a daily basis. Team members include the resident's corrections security case worker (CSC) and staff from recreation, education, behavioral health, health services, and transition.

PROCEDURES:

A. The use of restrictive procedures are permitted in accordance with the resident's initial services plan (attached) and individual treatment plan (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. Language translation services are provided to residents who have difficulty reading or speaking English.

C. Corrections security case workers (CSC) must not 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 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 service and treatment plans; and
   4. Supervises the implementation of the service and treatment plans, as well as ongoing documentation and evaluation of each resident's progress.

F. Case plan

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 CSCs:
   a) Identify and share information about the resident's treatment and goals with persons directly involved in the resident's individual 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, 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 adults 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 social supports contact log (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, 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 following these meetings.

4. Results of the initial treatment team meeting are available to all staff through the completed comprehensive needs assessment summary (attached) and individual treatment plan.

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.

J. Orientation and initial service plan

1. Initial intake and orientation tasks are completed by intake 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 in programming; and

   c) Complete the introduction to programming course.

3. Orientation begins within two days of admission and is designed to be completed in approximately five weeks.
   a) Successful completion of orientation is based on the resident achieving the goals, expectations, assignments, and skill development and is documented on a resident's initial services plan.

   b) 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, 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 team meetings;
      (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.

   c) Completes screenings with the resident as follows:
      (1) Cultural & gender responsivity screening; and
      (2) Vulnerability screening.

6. The orientation CSC and education staff conduct introduction to programming classes on the following topics:
   a) Steps to change (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 success;
g) Behavioral health and health services;
h) School, celebration of excellence, and positive behavior interventions and supports (PBIS);
i) Transition services;
j) Volunteer services and spiritual care;
k) Recreation activities;
l) Identifying problems or needs in treatment;
m) Review "Giving and Receiving Feedback";
n) Review "Are You Snitching or Helping";
o) Career scope;
p) Strong Interest Inventory; and
q) Introduction to Aggression Replacement Training ® (ART®), carey guides, additional programming classes offered, and relapse prevention plan.

7. 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.

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

b) Completes the youth level of service/case management inventory (YLS/CMI) if one has not been completed in the last six months;

c) Completes a YLS/CMI results review, file review, and interviews the resident's parent or guardian and PO to identify risk levels.

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 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.

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 needs 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 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 plan.

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

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

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

L. Individual treatment plan

1. Residents, parents or legal guardians, the PO, and treatment team members participate in the creation of the individual treatment plan and review individual treatment plan progress.

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

   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;

   f) Reviews the plan with the resident; and

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

3. After the individual treatment plan 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.

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

5. Individual treatment plans are reviewed once a month or more often, if necessary.
   a) Individual treatment plans 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 , the program CSC notes:
      (1) Motivation for change; and
      (2) Skill development and goal progress.

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

7. When one individual treatment plan is completed, a new individual treatment plan is developed. This process continues until all areas identified in the comprehensive needs assessment summary have been addressed.

M. Administrative separation successful living plan

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

2. Residents may be placed on an administrative separation successful living plan 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. An administrative separation successful living plan is not punitive in nature. The plan is:
   a) An amendment to the individual treatment plan; and

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

4. Administrative separation successful living plan are reviewed daily. The resident is reintegrated as soon as they demonstrate they are able to safely function in the open program.

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

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

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

N. Individual treatment plan summary

1. The individual treatment plan summary 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 goals, services that were not

provided as indicated in the individual treatment plan, 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 individual treatment plan summary 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.

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 who have previously completed the program and their individual treatment plan 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;

    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 is signed by the resident, program CSC, and CPD, records office staff:
    a) Scan the plan;

    b) Distribute the plan as listed; and

    c) Upload 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 plan review section of the relapse assessment and treatment 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, the program CSC completes the completion section of the relapse assessment and treatment plan noting:
   a) The date the plan was completed;

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

   c) Updated community re-entry needs if applicable.

STATE CORRECTIONAL FACILITY SECURITY AUDIT STANDARDS: None

INTERNAL CONTROLS:

A. All documentation, including the comprehensive needs assessment summary, individual treatment plan, 30-day treatment plan reviews, and community reentry plan are filed and retained in the resident's electronic file according to retention schedules.

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"

REPLACES:
Policy 203.011, "Case Management Process - Juveniles," 11/5/19.
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:
Comprehensive Needs Assessment Summary (203.011B)
Individual Treatment Plan (203.011C)
Community Reentry Plan (203.011E)
Individual Treatment Plan Summary (203.011F)
Relapse Assessment and Treatment Plan (203.011G)

Social Supports Contact Log (203.011H)
Initial Services Plan (203.011I)

APPROVALS:
Commissioner of Corrections