	JUVENILE JUSTICE SERVICES Classification and Programs	**Effective Date: 6/15/10**
		Issue Date: 6/15/10
	Title: Classification	
	Procedure #:P.21.9, 10, 12, 13 and 14	

1. **ISSUING AGENCY:** **Children, Youth and Families Department (CYFD)**

2. **SCOPE:** **Juvenile Justice Services (JJS)**

3. **STATUTORY AUTHORITY:** **8 NMAC 14.5.14**

4. **FORMS:** **Reserved**

5. **APPLICABLE POLICY**

8.14.21: Classification. JJS will ensure that there is a systematic and rational approach to classifying clients within facilities.

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7. **DEFINITIONS:**

5.1 **"**ADA**"** is the Americans with Disabilities Act. [Page 3]

5.2 "Administrative MDT" is a special MDT utilized only to resolve complicated or contentious MDT issues. It is made up of the facility superintendent or designee, the Facility Behavioral Health Director/designee, the Health Services Administrator or designee, the Diagnostics lead psychologist or designee, the education associate superintendent or superintendent designee, the client's Transition Coordinator, and the

lead Psychiatrist as needed. [Page 18]

5.3 "Central Intake" (CI) means a process within the facility designated by CYFD to receive clients committed to custody. [Page 3]

5.4 "CIU" is the Central Intake Unit. [Page 5]

5.5 "Classification officer" refers to the staff that provides direct case management and client advocacy throughout the client's commitment. The Classification Officer provides assessment of the client's risk, needs and strengths by which the Multi-Disciplinary Team will assign appropriate placement. [Page 5]

5.6 "Diagnostics & Disposition" (D&D) means the process where a client's medical, educational, behavioral, legal, safety and special needs are recorded and the initial treatment strategy is developed. [Page 10]

5.7 "Endorsed court order" means an order of the Court, signed by the Judge or stamped for signature of the Judge and filed with the clerk of the Court and bearing the stamp of the clerk of the Court as a filed document.[Page 3]

5.8 "Facility Release Panel" or "Panel" is the departmental Secretary-designated releasing authority that considers juveniles for supervised release. [Page 7]

5.9 Facility Transition Coordinator or Classification Officer (FTC/CO).

5.10 "Home study" means the assessment of the living environment where the juvenile offender may reside during the term of supervised release; the assessment is conducted by the department; specific strengths and weaknesses of the living environment are identified through the home study process.

5.11 "Initial Multi-Disciplinary Team" (IMDT) refers to the team that meets within 28 days of the client's arrival at the Central Intake Unit and develops the plans for placement and services. The team includes the client and family member(s), and behavioral health, education, medical, and security representatives, the juvenile probation officer, the Central Intake TPPO/Classification Officer and a transition coordinator if assigned. [Page 5]

5.12 "Intake, Diagnostics and Disposition" (ID&D) is an initial consensus meeting chaired by the attending Psychiatrist, with the Health Service Administrator/designee, Diagnostic Supervisor/designee and Education Diagnostician as members to form a consensus on diagnosis, treatment strategy and special accommodations.[Page 10]

5.13 Juvenile Probation Officer (JPO)

5.14 "Juvenile Public Safety Advisory Board" or JPSAB will advise the department on release decisions and make recommendations regarding programs and facilities. [Page 14]

5.15 "Plan of Care" (POC) refers to the plan developed at the first multidisciplinary team (MDT) meeting following placement at the facility and reviewed and updated at each subsequent MDT. The plan included goals and objectives in all disciplines and is broadly available to all staff with client contact. [Page 3]

5.16 "Pre-Dispositional diagnostic evaluation" means a court ordered examination of an adjudicated juvenile conducted in the community or at a designated CYFD facility while either in custody or on conditional release for the purpose of diagnosis and evaluation of the juvenile to be presented at the disposition hearing.[Page 14]

5.17 "Primary Review Date" (PRD) refers to the date by which a regularly scheduled MDT meeting must be designated as the PRD MDT meeting, where a determination of whether a client is on a supervised release track or an extension track must be made. [Page 16]

5.18 Regional Transition Coordinator (RTC)-

5.19 "Structured Decision Making" (SDM) is a risk and needs assessment and reassessment tool designed for use in the case management of all clients. [Page 2]

5.20 "Supervised Release" refers to the release of a juvenile, whose term of commitment has

not expired, from a facility for the care and rehabilitation of adjudicated delinquent children, with specified conditions to protect public safety and promote successful transition and reintegration into the community. A juvenile on supervised release is subject to monitoring by the department until the term of commitment has expired, and may be returned to custody for violating conditions of release. [Page 6]

5.21 "Temporary Supervised Release" refers to a short term, temporary supervised release of a juvenile into the community with specified conditions to protect public safety and promote successful transition and reintegration into the community. [Page 16]

5.22 "Treatment Plans" are the plans created by medical and behavioral health specialists to address client needs as per diagnostic assessments, testing, collateral information, committing offenses, legal mandates and professional judgment as it pertains to their specific discipline. The plans outline measurable goals and guide treatment.[Page 5]

5.23 "Unit Multi-Disciplinary Team" (UMDT) refers to the team that meets subsequent to the Initial MDT at the facility to develop, monitor, and revise client plans for placement and services. The team includes the client and family member(s), and behavioral health, education, medical, and security representatives, the Juvenile Probation Officer, the Central Intake TPPO/Classification Officer and a transition coordinator if assigned. [Page 6]

6. REFERRAL PROCESS

6.1 Referrals are received and processed to maintain the client in the least restrictive environment as determined by the multidisciplinary treatment team, facility and program descriptions and structured decision making.

6.2 New Commitments- Submission of Documentation.

6.2.1 The Juvenile Probation Office provides Central Intake with the name, date of birth, social security number and the probable date and time of transport of the client. Central Intake is informed of any immediate needs of the client regarding the client's well-being or threat to other clients such as gang membership, prescription medicine needs and health issues. (This notification of needs includes clients who may be transferred.)

6.2.2 Central Intake receives endorsed copies of the client's committing petition and the court's judgment and disposition as soon as the court files the judgment and disposition.

6.2.3 Central Intake Bureau Chief receives the endorsed copy of the adjudication and disposition, clinical reports, SDM Risk and Needs assessment and reassessment(s), chronological history, predisposition study and report and any other material information on the client prior to or no later than the arrival of the client at Central Intake. The Central Intake Bureau Chief checks the information for completeness and accuracy and immediately contacts the referring District Chief of any missing or data requiring correction. These clinical reports are immediately made available to diagnostics and other staff.

6.3 COLLATERAL PACKET.

6.3.1 The collateral packet from the field Juvenile Probation Officer (JPO) must accompany the client at the time of intake and should update information that includes the following:

6.3.2 Community/Family

6.3. 2.1 Client/Family Baseline Assessment

6.3.2.2 Current Family Supports

6.3.2.3 Americans with Disabilities Act (ADA) Issues

6.3.3 Legal/Security

6.3.3.1 Court Orders (PS also if applicable
6.3.3.1.1 Diagnostic Evaluation(s)
6.3.3.1.2 Judgment(s)
6.3.3.1.3 Disposition(s)
6.3.3.1.4 Retake Warrant(s)
6.3.3.1.5 Statement Authorizing the Sharing of Information
6.3.3.2 Petitions Supporting Court Orders
6.3.3.3 Current Chronological Offense History (FACTS)
6.3.3.4 Current SDM Risk and Needs Assessment (FACTS)
6.3.3.5 Police Reports and Statements
6.3.3.6 Plan of Care (FACTS)
6.3.3.7 ADA Issues

6.3.4 Education
6.3.4.1 Attendance Records
6.3.4.2 Academic Information - e.g., Grades
6.3.4.3 Behavioral Information - e.g., Suspensions
6.3.4.4 Credits Report
6.3.4.5 Special Education Assessments and Records
6.3.4.6 GED or Diploma (if applicable)
6.3.4.7 Family Educational Rights and Privacy Act (FERPA) (FERPA release form or court order for release of educational records)
6.3.4.8 ADA Issues

6.3.5 Behavioral Health
6.3.5.1 Psychological Evaluations & Assessments (all available.
6.3.5.2 Treatment Summaries from Behavioral Health Facilities or Community-Based Services (within the past 12 months)
6.3.5.3 Functional Assessments (within the past 12 months)
6.3.5.4 ADA Issues
6.3.5.5 Protective Service documents as appropriate
6.3.5.6 Latest Community Behavioral Health Collaborative Care (Triage) Form
6.3.5.7 Latest Clinical Oversight Report

6.36 Medical
6.3.6.1 Immunization Records.
6.3.6.2 Private Insurance Information
6.3.6.3 ADA Issues
6.3.6.4 Medication Summary
6.3.6.5 Medications
6.3.6.6 Treatment Needs

6.3.7 Other
6.3.7.1 Birth Certificate (or Birth Certificate Form stating verification of original Certificate)
6.3.7.2 Social Security Card
6.3.7.4 Immigration and Naturalization Service (INS) Status
6.3.7.4 Tribal Notification from Field
6.3.7.5 ADA Issues

6.4 VERIFICATION OF CASE RECORD AND COLLATERAL PACKET

6.4.1 Information on the case record sheets is verified by Central Intake Bureau Chief or designee, including inquiring as to CYFD Protective Services involvement. When documents are insufficient or lacking, the Central Intake Bureau Chief

requests the required information from the Chief JPO in the district field office. The requested information will be provided to Central Intake as soon as possible.

6.4.2 Staff indicates the most serious recent adjudicated delinquent offense when Court orders indicate a violation of probation charge.

6.4.3 The verified case record sheet is copied; the original is placed in the client's master file. Copies are disseminated to all disciplines.

7 INITIAL CLASSIFICATION AND ASSESSMENT AT CENTRAL INTAKE

7.1 Central Intake Admissions

7.1.1 Intakes are scheduled to take place Monday thru Friday, 8:00am to 3:00pm, holidays excluded. Exceptions are made only in emergency situations at the discretion of the Superintendent of the facility.

7.1.2 Clients are provided an interpreter or accommodation to assist them to understand and to participate fully with the intake process as soon as possible.

7.1.3 First 24 Hours –Client arrives and Central Intake Youth Care Specialist security staff immediately does the following:

7.1.3.1 Admitting Officer e-mails notice of arrival to the Central Intake Bureau Chief or designee, the Health Services Administrator or designee the Foothill Principal or designee and to the Diagnostics & Disposition Unit).

7.1.3.2 The Bureau Chief or designee reviews all Court Orders.

7.1.3.3 Reviews Retake Warrants.

7.1.3.4 Transport Officer ensures completion and reviews Transport Officer Questionnaire.

7.1.3.5 If an emergent psychological/psychiatric need is detected, immediately notifies Diagnostics staff or if after hours, the Behavioral Health staff on call. If unable to reach that person then the Behavioral Health Director is called, if the Behavioral Health Director is unavailable then the Diagnostics supervisor should be called.

7.1.3.6 If designated to do so, administers a screening interview to the client and if the screening so indicates, calls the Diagnostics Supervisor for guidance.

7.1.3.7 Forwards field documentation to Central Intake Bureau Chief or designee for review.

7.1.3.8 Central Intake Bureau Chief or designee completes Demographics Face Sheet. (Prints from FACTS).

7.1.3.9 Central Intake Bureau Chief or designee completes Escape Form. (PRINTS Client Information Sheet from FACTS).

7.1.3.10 Central Intake Bureau Chief or designee reviews Case Assignment Placement Records.

7.1.3.11 Central Intake Bureau Chief or designee supervises Urine Collection.

7.1.3.12 Central Intake Bureau Chief or designee gives client the client handbook and explains the need to review the handbook and complete the client acknowledgement form. The client's Classification Officer/designee is responsible for ensuring that the acknowledgement form is signed by the client and placed in the client's file.

7.1.3.13 Central Intake Bureau Chief or designee mails Family Questionnaire and Parent Handbook to parent/guardian. The client's Classification Officer/designee is responsible for ensuring that the acknowledgement of receipt form is signed by the parent and placed in the client's file.

7.1.3.14 If applicable, the Central Intake Bureau Chief must contact Protective Services staff to notify them of the PS client's intake at JJS and obtain any PS information that was not included in the collateral packet, including any court orders, assessments, home studies, etc.

7.1.3.15 If applicable, Central Intake Bureau Chief or designee sends Tribal Notification from Facility and sends a copy to the Native American Liaison.

7.1.3.16 If applicable, Central Intake Bureau Chief or designee administers the Determination of Mexican Nationality questionnaire and sends Consulate Notification Letter and informs the Deputy Secretary or a designee. A copy of the Determination of Mexican Nationality should be sent to the Behavioral Health secretary or a designee.

7.1.4 Days 2 Through 21 - Central Intake security/admitting staff completes the following:

7.1.4.1 Intake Form.

7.1.4.2 Initial Facility Classification Tool and add findings to the report.

7.1.5 The Diagnostics Unit procedure can be found in Client Care and Treatment 8.14.4.12:

7.2 MEDICAL INTAKE & DIAGNOSTICS

7.2.1 First 24 Hours - Medical staff completes the following:

7.2.1.1 Medical Intake Screen

7.2.1.1.1 Medical Intake Screen notes time and date of review, and whether client was cleared or referred for follow-up.

7.2.1.1.2 Medical staff will visually inspect the client's hair for lice; only upon visual confirmation will a medically approved solution be applied. Medical personnel will take into account pregnancy and any other medical condition or previous delousing.

7.2.1.2 Profile Five Drug Screen.

7.2.1.3 Pregnancy testing.

7.2.1.4 STD testing.

7.2.1.5 Review of current medication(s).

7.2.1.6 Vision and hearing screening.

7.2.1.7 Tuberculosis screen initiated (PPD is planted).

7.2.1.8 Orientation on how to access medical care.

7.2.1.9 ADA assessment.

7.2.2 If No Emergent Need Exists

7.2.2.1 Youth is referred to intake living unit.

7.2.2.2 Orientation File goes to placement with client (later, original Orientation File goes to Master File; copy remains in unit).

7.2.2.3 Unit supervisor assigns caseworker.

7.2.2.4 Assigned caseworker gives client orientation to the facility, living unit, and programming.

7.2.3 Emergent Need Exists

7.2.3.1 Youth stays in Medical.

7.2.3.2 On-site nurse assesses and orders immediate care.
7.2.3.3 Nurse pages psychiatrist, physician, or Behavioral Health staff for follow-up.
7.2.3.4 Treatment steps are documented in the Medical file.
7.2.3.5 Based on the emergent needs, follow-up, or accommodations needed, youth is referred to appropriate living unit. Special instructions are communicated through the "*Notification of Special Diet or Medical Needs*" form.

7.2.4 Days 2 Through 21- Medical staff completes the following:
7.2.4.1 Client history and physical.
7.2.4.2 Notification of special diet or medical needs.
7.2.4.3 Reviews immunization records and updates vaccines, if applicable.
7.2.4.4 Psychiatric referral, if applicable.
7.2.4.5 Initiation of chronic clinic visits as applicable.

7.3 INTAKE AND DIAGNOSTICS

7.3.1 First 24 to 48 Hours – Diagnostics staff completes the following:
7.3.1.1 Reviews emergent screens from Medical, etc.
7.3.1.2 Completes the Initial Behavioral Health Screen form.
7.3.1.3 Develops the Initial Plan of Care (remains in place until client's arrival at long-term placement).
7.3.1.4 Administers and reviews MAYSI (if not done previously).
7.3.1.4.1 If emergent needs are apparent takes immediate action consistent with client's condition.
7.3.1.4.2 Informs the Behavioral Health Director or designee if, after examination, they believe that the client should be recommended for a reconsideration of placement by the court. At that point the Behavioral Health Director will decide whether to proceed.
7.3.1.4.2.1 The Behavioral Health Director wil contact the Office of General Counsel to initiate the reconsideration process.
7.3.1.5 Evaluates the need for behavioral health testing and initiates psychological testing if necessary. All admissions to CYFD are screened initially for emergent needs. However, supervised release revocations, transfers, re-commitments or brief stay visitors transiting to another CYFD facility will be given a behavioral health evaluation at the discretion of the Diagnostics Supervisor or if directed to by the Behavioral Health Director.

7.3.2 Days 2 Through 21 - Completes comprehensive assessment, unless there are factors preventing the client from completing the assessment. In that circumstance the Diagnostics Supervisor, Health Services Administrator, Behavioral Health Director, Education Superintendent and the Facility Superintendent will meet to decide the type and extent of any assessments:
7.3.2.1 Substance abuse screening.
Diagnostic interview.
Functional assessment (including ADA issues).
Other assessments as indicated.

7.3.3 Convenes an ID & D meeting to discuss client prior to MDT. Decisions and recommendations arising from the ID&D meeting are preliminary and may be modified after discussion with client and family at the MDT meeting. The ID&D meeting ensures the physical presence from each discipline and:

7.3.3.1 Reach diagnostic consensus.
7.3.3.2 Make Behavioral Health treatment level recommendations.
7.3.3.3 Make placement recommendations.
7.3.3.4 Reach consensus on target symptoms.
7.3.3.5 Identification of behavioral health Target Population.
7.3.3.6 Identification of the target population in the facility is accomplished by:
Initial screens (MAYSI, etc.).
7.3.3.6.1 Application of standardized instruments to diagnose.
7.3.3.6.2 ID&D reaches a consensus diagnostic agreement between Psychiatry and Behavioral Health and includes input from education and medical into the diagnosis.
Re-assessment is considered at the Unit MDT on a routine basis.

7.3.4 Convenes Initial MDT

7.4 EDUCATION INTAKE AND DIAGNOSTICS

7.4.1 First 24 Hours – Education staff completes the following:
7.4.1.1 Student is interviewed about previous educational experiences.
7.4.1.2 School and Positive Behavior Support expectations are explained.
7.4.1.3 Student class schedule is generated and student is expected to attend classes daily.

7.4.2 Days 2 Through 21 - Education staff completes the following:
7.4.2.1 Public Education Department's (PED) Student Teacher Accountability Reporting System (STARS) number is accessed.
7.4.2.2 Permanent educational file is created with STARS number and DOB affixed to file.
7.4.2.3 Request is sent to CYFD's Information Technology (IT) department for computer access.
7.4.2.4 Student is registered in the Northwest Evaluation Assessment (NWEA), Measures of Academic Progress (MAPS) short-cycle testing system.
7.4.2.5 Record is requested from previous school district(s), including:
7.4.2.5.1 Transcripts.
7.4.2.5.2 Special education evaluations and Individual Education Plans (IEP).
7.4.2.5.3 Attendance records.
7.4.2.5.4 Immunization records.
7.4.2.6 Basic hearing test is completed and forwarded to Medical.
7.4.2.7 MAPS test is administered.
7.4.2.8 Career Assessment Inventory is administered.
7.4.2.9 Student Language Survey is completed, and if needed, English as a Second Language (ESL) testing is completed.
7.4.2.10 Weekly review by Student Educational Review Team (SERT) occurs.
7.4.2.11 If student is classified as a Special Education student:
7.4.2.11.1 Evaluations and IEP are reviewed.
7.4.2.11.2 Additional testing is completed if needed.
7.4.2.11.3 Special education file is created.
7.4.2.12 Report and summary section is typed and submitted to CIU at MDT meeting.

7.5 ADMISSIONS-INITIAL MULTIDISCIPLINARY TEAM MEETING

7.5.1 Initial Multi-Disciplinary Team (MDT) meeting is conducted.
- 7.5.1.1 Informs client and guardian of treatment and Plan of Care.
- 7.5.1.2 Affirm symptoms and treatment and discuss symptoms with client and guardians.
- 7.5.1.3 Confirm treatment level recommendations.
- 7.5.1.4 Confirm placement recommendations.
- 7.5.1.5 The Diagnostic team convenes and holds an Initial MDT to develop a POC to reduce problem behaviors, assign a treatment level, and determine treatment.

7.5.2 Days 21 to 28 Convene Initial MDT:

7.5.3 The Initial MDT is convened by Diagnostics.

7.5.4 The following are required to attend the Initial MDT:
- 7.5.4.1 Youth and family member(s) or Guardians.
- 7.5.4.2 Classification Officer.
- 7.5.4.3 Youth Care Specialist Manager
- 7.5.4.4 Education Representative.
- 7.5.4.5 Medical – Community Outreach Nurse.
- 7.5.4.6 JPO.
- 7.5.4.7 Case Worker.
- 7.5.4.8 Youth Care Specialist.
- 7.5.4.9 Facility Transition Coordinator.
  - 7.5.4.9.1 If applicable the following may also attend:
    - 7.5.4.9.1.1 Regional Transition Coordinator.
    - 7.5.4.9.1.2 Tribal Court/Tribe representative.
    - 7.5.4.9.1.3 Consulate Representative.
    - 7.5.4.9.1.4 Psychiatrist.
    - 7.5.4.9.1.5 Family Advocate.
    - 7.5.4.9.1.6 Representative from Protective Services

7.5.5 The Initial MDT recommends placements based on a client's risk/needs, facility safety tool, geographical location, and facility programming options including consideration of any recommended specific education needs and/or ADA accommodations.

7.5.6 Placement and services are based upon availability. If there is no vacancy at the primary facility determined as the best placement (considering security, programs and services) by the team, the team shall determine an appropriate next choice. The Initial MDT will determine what client needs can be met at both facilities and so designate in the Plan of Care. The Initial MDT will determine whether the client should be transferred at a future date to the facility of first choice, if any, and include that determination in the POC.

7.5.7 The Initial MDT identifies and documents the needs of a client using assessments and reassessments obtained from the JPO to determine the specific needs of a client including consideration of the recommendation of the committing Court.

7.5.8 If the Initial MDT determines there are factors not considered in the initial assessment tool that significantly affect risk, a discretionary override may be applied by the Initial MDT group. Via memo the reason for the override is indicated and immediately sent to the superintendent. The superintendent may appeal that decision to the Director of Facilities. The initial MDT is permitted to raise or lower the risk to any level. However, the facility superintendent must approve any amount beyond one level.

7.5.9 If there is dual PS case involvement, the client's FTC/CO is responsible for

inviting the PS Social Worker to all MDTs, and keeping the PS worker informed of the client's JJS progress and inquiring as to court dates/orders, assessments, home studies, etc. from the PS worker.

7.6 The Initial MDT will discuss the following:

7.6.1 Development of a Plan of Care.

7.6.1.1 If necessary a treatment plan.

7.6.2 Recommendation for best placement to receive treatment.

7.6.2.1 The Youth Care Specialist Manager will advise Diagnostics on the changing environments within the units and to advocate for realistic placements based on these realities.

7.6.2.2 The only exception is at Camino Nuevo Youth Center where unit identity is established by the special service needs of the client.

7.6.3 Release planning: A representative of the Facility Release Panel shall attend the Initial MDT and unless documented extraordinary circumstances prevent, the members of the initial MDT shall determine a tentative release date and discuss potential release placement.

7.6.3.1 The MDT shall provide the juvenile with a Notice of Tentative Release Date and Placement at the conclusion of the Initial MDT.

7.6.4 Aftercare Placement options will be discussed at the Initial MDT so that family interventions may be employed and goals set so as to strengthen marginal home placements.

7.6.4.1 The most recent Client & Family Baseline Assessment should be referenced.

7.6.4.2 A Home Study should be ordered and periodically updated as needed to monitor changes in the proposed home placement.

7.6.5 Client, Parents and guardian provide input into planning, problem solving, and decision making relating to participation in the POC and the release plan. The MDT makes a reasonable effort to involve all parties in developing and implementing the POC. This effort will be coordinated by the assigned Diagnostic staff and documented in the client's chart.

7.6.6 If the MDT is unable to reach a facility or unit placement recommendation consensus due to case difficultly or the complexity of the client's programming needs, then the staff may request an Administrative MDT.

7.7 At the conclusion of the period of classification and assessment at Central Intake the Classification Supervisor/designee presents the MDT's placement recommendation to the appropriate facility superintendents to arrange for transfer of the client to the assigned facility.

7.7.1 If there is no available bed at the recommended facility, then the Classification Supervisor will put the client on a waiting list.

7.7.2 The Diagnostic Supervisor will notify the Initial MDT of the anticipated wait time. The MDT may make a second choice alternative placement recommendation.

7.7.3 While waiting for permanent placement (temporarily placed at YDDC) the client's POC is reviewed every thirty days via an MDT meeting, documented and signed by the client and MDT. A client signs an acknowledgment of participation and may request from a classification officer a review of his/her progress and program status at any time.

7.8 DIFFICULT TO PLACE CLIENTS

7.8.1 The Initial MDT shall identify difficult-to-place clients at the beginning of their treatment program in order to have community options available at the time of supervised release, although a client may be designated as difficult to place at any time during their commitment.

7.8.1.1 Once a client is identified as difficult to place, they shall have a goal

designed to address the circumstances that make them difficult to place inserted into their Plan of Care, which shall be reviewed at each subsequent Unit MDT.

7.8.2 Criteria: Criteria that define a juvenile as "difficult-to-place" include one or more of the following:

7.8.2.1 Home is not an option for future placement because:

7.8.2.1.1 Identified victims are living in the home;

7.8.2.1.2 Other criminal offenders reside at the home; or

7.8.2.1.3 Other circumstances, such as lack of services, geographical area, proximity to services needed, etc. cause home to not be a viable option.

7.8.2.2 The Behavioral Health Treatment Level, CAFAS score that indicates functional impairment or other special circumstances;

7.8.2.3 Prolonged history of being unsuccessful in out-of-home placements;

7.8.2.4 Prolonged history of aggressive/assaultive behavior;

7.8.2.5 There are no viable alternative placements to home;

7.8.2.6 Active or prior PS involvement; or

7.8.2.7 The client is low-functioning/lacking in cognitive skills.

7.8.3 Identification and Staffing Requirements:

7.8.3.1 The client's Initial MDT shall identify if a client may be difficult-to-place based on the above listed criteria;

7.8.3.2 If the client meets one or more of the criteria, the assigned case manager shall then schedule an Administrative MDT staffing.

7.8.3.2.1 An appropriate Transition Coordinator will be assigned.

7.8.4 At the staffing, the Administrative MDT shall review the Plan of Care to identify the following areas to be addressed prior to release:

7.8.4.1 Facility Placement

7.8.4.2 Programming

7.8.4.3 Treatment

7.8.4.4 Transition Plan

7.8.4.5 A preliminary alternative placement options are identified.

7.8.4.6 Assess viability of home placement and if needs are identified refer to JPO to recommend services to strengthen support system

7.8.4.7 Mandatory family inclusion in all MDTs.

7.8.4.7.1 Via video conferencing in necessary and/or

7.8.4.7.2 Alternative meeting times.

7.8.4.8 If the client's parents/guardian/custodian is unable to attend the Administrative MDT date or time, all efforts shall be made to include them, including but not limited to holding the MDT during days or times when the parent/guardian/custodian can attend or using video or teleconferencing capabilities.

7.9 Central Intake Bureau Chief compiles, verifies completeness and signs the overall report summarizing the client's initial MDT. The report is then provided to the facility where the client is recommended. The electronic report is available to the facility superintendent and the Facility Release Panel.

8 SUPERVISED RELEASE PLACEMENT AND PLAN OF CARE FOLLOW-UP

8.1 A minimum of 120 days prior to the client's expected tentative release date, the transition coordinator shall have a placement identified and, if possible, the approval and/or funding secured;

8.2 If the transition coordinator is unable to secure finding/approvals prior to 120 days of the

tentative release date, they shall request supervisory administrative assistance in obtaining funding and/or approvals as soon as possible to ensure a successful transition. If necessary, the transition coordinator shall request an Administrative MDT to discuss issues with placement approvals or funding.

8.2.1 The transition coordinator shall communicate with other affected entities to discuss cost sharing and transportation expenses;

8.2.2 The case manager/transition coordinator shall:

8.2.2.1 Ensure other requirements due by other entities, such as Interstate Compact for Juveniles (ICJ) and Interstate Compact for the Placement of Children (ICPC) packets and investigations, are completed;

8.2.2.2 Ensure that the placement is appropriate to provide intervention according to the juvenile's needs if the juvenile is released interstate to a placement or to a placement in state;

8.2.2.3 Ensure a complete Plan of Care:

8.2.2.3.1 Reflects placement objectives consistent with identified needs; and

8.2.2.3.2 Progress can be measured with specific target dates for completion of goals.

8.2.2.3.3 Contact the placement, legal guardian, and the juvenile telephonically every month while the juvenile is in placement.

8.2.2.4 The Facility Release Panel may order that the contact with the juvenile and with the placement to be face-to-face.

8.2.2.5 After the MDT staffing the juvenile probation officer shall discuss any problems encountered and review and update any progress made.

9 CLIENT TRANSPORT

9.1 Upon the Recommendation of the client's MDT the Sending Facility shall;

9.2 Transport the client's personal property and client master file to the receiving facility.

9.3 Send medical, behavioral health and educational records.

9.4 Send any medications the client is taking.

9.5 Transfer the client's money in accordance with the Administrative Service Division policies and procedures.

9.6 Notify the parent/guardian/custodian of the transfer and documents in client master file.

10 CLIENT ARRIVAL AT THE ASSIGNED FACILITY

10.1 When a client arrives at the assigned facility, staff reviews the paperwork identified in the Intake assignment and orientation. If any of the paperwork is missing or incomplete, the receiving facility contacts the ID&D Secretary.

10.2 Orientation To Assigned Facility

10.2.1 The orientation phase of the facility program allows the client to learn facility rules, program goals, facility emergency procedures, and client expectations and responsibilities. In no event are educational services delayed by the orientation process.

10.2.1.1 The client arrives at the facility via transport and is escorted to the intake area.

10.2.1.2 Provide a written receipt to transport staff acknowledging client has been received.

10.2.1.3 The records are delivered to the appropriate departments.

10.2.1.4 Secure client's personal belongings and inventory client's property.

10.2.1.5 Conduct a search as outlined in contraband control.

10.2.1.6 The client is issued the appropriate clothing, hygiene products and bedding.
10.2.1.7 Staff issues and explains to the client the orientation handbook and the facility expectations.
10.2.1.8 The client's information, including demographics, emergency contacts and contact list is obtained and verified.
10.2.1.9 The client is escorted to Medical for the medical intake.
10.2.1.10 Client is escorted to the assigned unit where Behavioral Health staff will conduct an intake.
10.2.1.11 Receive and review client master file, including a copy of the index card.
10.2.1.12 Allow client to place a phone call to his/her parent/guardian/custodian.
10.2.1.13 Distribute and copy paperwork to appropriate programs within the receiving facility.
10.2.1.14 Assign the client to living unit and issue property as identified.

11 PLAN OF CARE:

11.1 Provides focus to the client and staff on the issues that brought the client into the system and what tasks the client needs to complete to be successfully discharged from the system.

11.2 Encourages client, the parent/guardian/custodian and staff to understand the desired outcomes that have been set out in the Plan of Care.

11.3 Identifies goals whose objectives provide for specific interventions for the client, parent/guardian/custodian, staff, and interested parties.

11.4 Decreases the duplication of services by providers.

11.5 Provides precise, measurable objectives to evaluate CYFD interventions at all stages of process.

11.6 Includes specific plans, including measurable goals and objectives, for the client's transition from the facility to the community.

11.7 Components of a Plan of Care:

11.7.1 Medical Treatment Plan

11.7.1.1 Client is placed in psychiatric or medical chronic clinic as appropriate.
11.7.1.2 Client is seen at the frequency mandated by the chronic clinic guideline.
11.7.1.3 Vaccinations are given as appropriate.
11.7.1.4 Annually, every client receives a full physical exam and Snellen Eye check.
11.7.1.5 Medications are administered as ordered by a practitioner.

11.7.2 Behavioral Health Treatment Plan can be found in Client Care and Treatment 8.14.4.12.

11.7.3 Educational Treatment Plan

11.7.3.1 The Education Treatment Plan includes the Student STARs number, MAPS testing results, copy of IEP (if appropriate), Language Survey or New Mexico English Language Proficiency Assessment (NMELPA) if applicable and a career assessment inventory.

11.8 Development of Plan of Care

11.8.1 When developing the client's Plan of Care, the MDT addresses security

requirements and needs identified from the client's needs assessment. The MDT uses additional information and supporting documentation gathered during the central intake interview which is documented and forwarded to the client's assigned facility.

11.8.2 Within fourteen days of arrival at the assigned facility, MDT reviews client assessment and client's Plan of Care. MDT meetings are scheduled and chaired by the facility designee. The living unit case worker reports to the MDT a synopsis of the client's observed behavior on a monthly basis.

12 SUPERVISED RELEASE VIOLATORS

12.1 If the client has been out of a JJS facility for less than one year then the client is assessed through an abbreviated Central Intake process:

12.1.1 Medical will conduct a Medical Intake Screen.

12.1.2 Behavioral Health will conduct an Initial Behavioral Health Screen

12.1.3 Education will:

12.1.3.1 Interview the client to determine previous educational experiences.

12.1.3.2 Explain school and Positive Behavior Support expectations.

12.1.3.3 Generate student class schedule; student is expected to attend classes daily.

12.1.3.4 Additional evaluation and diagnostics may be completed if warranted.

12.2 When a client returns to a facility from supervised release due to a preliminary revocation:

12.2.1.1 If there is a bed in the unit they came from, they will return there after the BH and medical screen.

12.2.1.2 If there are no available beds in their last unit, they will go to the top of the list for the first bed. If their last unit was at the J. Paul Taylor Center and they have less than 2 weeks remaining in their commitment period, they will not return to JPTC.

12.2.1.3 If there are no available beds and there are not likely to be any within 2 weeks, an Administrative MDT will decide where the placement will be.

12.2.1.4 Regardless of what unit a returned client goes to, there will be an MDT held once they return. The initial MDT shall:

12.2.1.5 review the client's previous facility plan of care, the client's supervised release plan, and the reasons for revocation, and make a recommendation to the facility release panel chair for either a re-release on a new supervised release plan, or a final revocation hearing.

12.2.1.6 If a re-release cannot occur within 10 business days or prior to the next regularly-scheduled facility release panel meeting, whichever occurs last, the recommendation will be for a final revocation hearing.

13 CONCURRENT COMMITMENTS

13.1 Youth who receive a new commitment while in CYFD custody may at the recommendation of the MDT be transported to the CIU for additional diagnostic evaluation.

14 UNIT MDTs

14.1 A Unit MDT is conducted at least every 30 days.

14.2 The following are required to attend the Unit MDT:

14.2.1 Youth and family member(s) or Guardians.

14.2.1.1 If the client's parents/guardian/custodian is unable to attend the Unit MDT date or time, all efforts shall be made to include them, including but not limited to holding the Unit MDT during days or times when the parent/guardian/custodian can attend or using video or teleconferencing capabilities.

14.2.2 Classification Officer
14.2.3 Youth Care Specialist Manager
14.2.4 Education Representative
14.2.5 Medical – Community Outreach Nurse
14.2.6 JPO
14.2.7 Case Worker
14.2.8 Youth Care Specialist
14.2.9 Facility Transition Coordinator
14.2.10 Behavioral Health representative

14.3 If applicable the following may also attend:
14.3.1 Juvenile Public Safety Advisory Board Member.
14.3.2 Regional Transition Coordinator.
14.3.3 Tribal Court/Tribe representative.
14.3.4 Consulate Representative.
14.3.5 Psychiatrist.
14.3.6 Family Advocate.

14.4 ROLES OF THE UNIT MDT MEMBERS:
14.4.1 Classification Officer:
14.4.1.1 Leads the Unit MDT.
14.4.1.2 Responsible for scheduling all meetings.
14.4.1.3 Responsible for completion of paperwork and obtaining signatures.
14.4.1.4 Responsible for distribution of paperwork.
14.4.2 Behavioral Health Staff (as appropriate):
14.4.2.1 Prepares weekly progress notes on clients assigned.
14.4.2.2 Progress or lack of progress of behavioral health goals.
14.4.2.3 Treatment issues.
14.4.2.4 Mental health status.
14.4.3 Education Staff:
14.4.3.1 Write weekly progress notes on clients assigned.
14.4.3.2 Progress or lack of progress on educational goals.
14.4.3.3 Special Education vs. Regular Education.
14.4.3.4 Grades.
14.4.3.5 Peer Socialization.
14.4.3.6 Staff Socialization.
14.4.4 Security:
14.4.4.1 Write in weekly progress notes in FACTS.
14.4.4.2 Report on progress or lack of progress.
14.4.4.3 Adherence to rules and regulations.
14.4.4.4 Peer relations.
14.4.4.5 Staff relations.
14.4.4.6 Pro Social skills.
14.4.5 Client:
14.4.5.1 Strengths and weaknesses.
14.4.5.2 Progress or lack of progress in all areas.
14.4.5.3 Other relevant information.
14.4.6 Family:

14.4.6.1 Strengths and Weaknesses.
14.4.6.2 Relevant information.
14.4.7 Juvenile Probation Officer
14.4.7.1 Discharge Planning.
14.4.8 Transition Coordinator:
14.4.8.1 Transition Planning.

14.5 THE UNIT MDT WILL DISCUSS THE FOLLOWING:

14.5.1 Appropriateness of the current placement to meet the client's needs in the least restrictive environment.
14.5.1.1 All client movement must be approved by an MDT.
14.5.2 Risk and needs scores
14.5.3 Discuss the client's program and his/her strengths and weaknesses.
14.5.4 Review the progress toward client's goals and objectives during the month.
14.5.4.1 Adjust goals or objectives as necessary.
14.5.4.2 The client receives a written statement of progress or lack of progress.
14.5.5 The Plan of Care created at the Initial MDT will be reviewed. Changes will be made if necessary.
14.5.6 Client, parents and guardian provide input into planning, problem solving, and decision making relating to participation in the POC and the release plan. The MDT makes a reasonable effort to involve all parties in developing and implementing the POC. This effort will be coordinated by the assigned case manager and documented in the client's chart.
14.5.7 The POC is reviewed every thirty days, documented and signed by the client and MDT. A client signs an acknowledgment of participation and may request from a classification officer a review of his/her progress and program status at any time.
14.5.8 After the monthly progress report is completed by the Unit MDT, the MDT then discusses the following items every thirty days:
14.5.8.1 New projected tentative release date, if applicable.
14.5.8.2 Assigned Treatment Level and inclusion in Target Population if applicable.
14.5.8.3 Work release/school release, if applicable.
14.5.8.4 Referral to other facilities or programs.
14.5.8.5 Summary of major/serious rule infraction, disciplinary findings and sanctions if applicable.
14.5.8.6 Clients, parent/guardian/custodian and the Facility Release Panel are provided monthly progress reports from the classification officer.
14.5.9 ALTERNATIVE PROGRAMMING
14.5.9.1 When the client has physical, cognitive or emotional disabilities that prevent active understanding and participation in the standard program, then a modified program that meets the actual capacities of the client to respond and benefit should be considered and constructed by the treatment team.
14.5.9.2 Anytime a client is being considered for an alternative program, a MDT must be done.
14.5.9.3 Treatment team members must discuss client's special needs that warrants being placed on an alternative program.
14.5.9.4 Treatment Team must complete the documentation of the individual alternative program, including duration and review time frames.

15 PRD MDT MEETINGS

15.1 PRD's will be scheduled by the FTC/CO as follows:

15.1.1 Clients on a one-year commitment will have a PRD scheduled on or before his or her seventh (7^{th}) month of commitment;

15.1.2 Clients on a two-year commitment will have a PRD scheduled on or before his or her nineteenth (19^{th}) month of commitment;

15.1.3 Clients on an up to age twenty-one years of age [21] commitment will have a PRD scheduled on or before serving fifty percent [50%] of his or her commitment, and then reviewed each calendar year thereafter; and

15.1.4 Clients serving concurrent commitments will have the later commitment reviewed.

15.2 By the PRD, the individual MDT members will submit their reports and information to the FTC/CO, who will lead the MDT, and discuss the programmatic status of each client. Representatives of the Facility Release Panel, the client's releasing JPO, and the client's RTC (if assigned) will be notified of the PRD meeting and will be encouraged to attend in order to coordinate efforts.

15.3 The PRD MDT will:

15.3.1 present client service and treatment documentation in terms of measurable objectives and/or statements;

15.3.2 discuss the client's progress or lack of progress and prognosis in relation to treatment, educational and behavioral goals established during the clients initial treatment plan; and

15.3.3 Identify any obstacles to the client's continued progress and any additional services needed in order for the client to be eligible for services in a less restrictive environment and/or on supervised release.

15.4 At the PRD MDT, the following disciplines will be responsible for entering the following information in the client's monthly progress report in FACTS:

15.4.1 Behavioral Health Staff will present the client's target treatment goals that are set forth in the client's treatment plan. Staff will prepare and deliver a progress report to the MDT members regarding the client's obtainment of each goal identified.

15.4.2 Educational Staff or their designee will present the client's educational goals that are set forth in the client's educational plan. Staff will prepare and deliver a progress report to the MDT members regarding the client's obtainment of each goal identified. Statements regarding progress will be made in terms of percentage of completion of target goal.

15.4.3 Medical Staff or their designee will present the client's medical issues, including current diagnoses, medications, and current and future medical needs.

15.4.4 Living Unit Staff will submit a report that summarizes all Incident Reports, and give an assessment of the client's adherence to unit living rules, socialization with peers and adherence to reasonable directives by Unit Staff.

15.5 The MDT Members will encourage participation and/ or input from the client, family members, and any other person that may provide meaningful input into the client's review.

15.6 If the client is determined by the MDT to be on track for supervised release on the tentative release date, then the MDT members may discuss the appropriate use of Temporary Supervised Release.

15.6.1 Upon recommendation from an MDT, the facility release panel may consider a juvenile for temporary supervised release. A juvenile may also petition his or her MDT for temporary supervised release.

15.7 If the client is determined to need to have their commitment extended, their Classification Officer is responsible for immediately instituting the extension procedure.

16 RISK AND NEEDS REASSESSMENTS

16.1 The MDT, through the client's classification officer, conducts the Safety Assessment Tool every ninety days from the date of disposition when circumstances warrant a change in risk level, in addition to the monthly MDT meetings and reviews. The MDT reassessments include completion of the SDM risk and needs reassessment tools, and if the risk level has changed, a review of the commitment facility programming options.

16.2 The risk reassessment assesses behavior since the initial assessment or the last reassessment to assess changes in the case affecting facility placement decisions. A reduction in risk may permit transfer of a client to a less secure facility. An increase in risk level may warrant transfer to a more secure facility. If the MDT determines there are factors not considered in the reassessment tool that significantly affect risk, a discretionary override may be applied. The reason for the override is indicated and a Superintendent's signature is required. Criteria for override include violence at facility and behavior problems. Unlike the initial risk assessment, the MDT is permitted to raise or lower the risk one level.

16.3 The needs reassessment assigns the client to a needs level of low, moderate, or high as well as identifying three priority needs and strengths and assessing any disabilities the client may have and subsequent need for accommodations. The needs reassessment is used to guide Plan of Care updates which reflect current needs. Like the risk reassessment, the needs reassessment assesses change since the most recent assessment. The MDT completes items related directly to the client; when the client is not eligible for supervised release, the MDT completes items related to the household based on the best available information. When the reassessment occurs after the client is eligible for a release consideration hearing, the MDT notifies the JPO and requests assistance in completing those items related to the household.

16.4 Risk and needs reassessments are used to review and update the Plan of Care as necessary. Discussions of progress towards meeting Plan of Care goals and reassessments occur every thirty days and SDM reassessments occur every 90 days and include the client and family whenever possible.

16.5 If the client's risk level changes, the MDT may consider a change in placement.

16.6 When a reassessment occurs after the minimum time period a youth is required to spend in a commitment facility, the youth is referred by the MDT to the Facility Release Panel for a hearing.

17 DOCUMENTATION

17.1 The designated MDT members document weekly the client's progress on the Plan of Care. Any incidents/accomplishments are noted on the activity notes.

17.2 Documented Behavior involving DIR/SIR in non-educational setting.

17.3 Documented Behavior involving DIR/SIR in educational setting.

17.4 Documented Attitude or negative behavior, regarding security/educational staff.

17.5 Documented Attitude or negative behavior regarding peers.

17.6 Special Conditions/Requirements:

- 17.6.1 Documented Restitution requirements as set by the courts system.
- 17.6.2 Community Service as set by the court system.
- 17.6.3 Clients involved in same crime and at the same facility.
- 17.6.4 Clients who have caused documented harm or crime to another client's family or friends.

17.7 Extracurricular Activities/Accomplishments:

- 17.7.1 Educational achievements (Diploma, Other)
- 17.7.2 Educational achievements; tutor, aide, aide, library assistant, etc.

17.7.3 Sports/Sporting event accomplishments (ribbons, trophy, etc.
17.7.4 Employment

17.8 Treatment Progress:
17.8.1 Documented treatment progress
17.8.2 Group participant/involvement
17.8.3 Treatment goals/progress

17.9 Education/Academic Progress:
17.9.1 GPA
17.9.2 Positive/ Negative educational status
17.9.3 Curricula
17.9.4 Social Skills

17.10 Vocational/Employment Progress:
17.10.1 Post Secondary
17.10.2 Trade school
17.10.3 Education other
17.10.4 Employment status\Career track

17.11 Family Involvement/Relationship:
17.11.1 Family status
17.11.2 Guardian status
17.11.3 Foster family status
17.11.4 Frequency of visitation

17.12 Other Activities

18 CLIENT MOVEMENT

18.1 No client movements between facilities or between specialty programs or between living units within facilities will take place unless approved by an MDT except in the case of an emergency.

18.2 An emergency transfer without an MDT approval must be initiated by the superintendent, requires the express written approval of the Director of JJS or the Deputy Director of Facilities and shall specify the reasons for the emergency transfer, and shall be recorded in the youth's file. An MDT shall occur within 48 hours after the emergency transfer, and in no case shall a youth be transferred to a placement that is unable to adequately meet his/her individual needs.

18.3 If the MDT is unable to reach a transfer placement recommendation consensus due to case difficultly or the complexity of the client's programming needs, then the staff may request an Administrative MDT.

19 ADMINISTRATIVE MDT

19.1 Staff may request an Administrative MDT to review difficult cases where consensus at the regular MDT cannot be reached or client programming needs are complex and/or demanding. Some of the primary reasons would be:
19.1.1 The client has been identified as difficult to place.
19.1.2 The time needed to discuss the case would exasperate the usual time allotted for Unit MDT due to complexities.
19.1.3 Consensus cannot be reached and/or client risk and needs are significant concerns of staff.
19.1.4 Special programming is required and/or staff feels that client's needs are not being met at the current level of programming or in the current unit from which they are receiving programming.

19.2 The request to convene an Administrative MDT is given to Unit Classification Officers:

19.2.1 The Classification Officer is responsible for gathering information from the client's Caseworker, scheduling the meeting and inviting the appropriate staff.

19.2.1.1 Notifications is given to Parents/Guardians, Superintendent, Psychiatry, Behavioral Health, Medical, Education, Clients Caseworker and Administration.

19.2.1.2 Any staff with pertinent input that will assist client advocacy. Interested parties, such as unit staff and clinicians, may be invited to the meeting for presentation of pertinent information that will assist client advocacy. Interested parties are not included in the final decision and may not delay the committees' decision.

19.2.1.3 This is not a venue for "blocking options" for clients.

19.3 The Unit Classification Officer and BH staff would co-facilitate the meetings:

19.3.1 The agenda will be time limited and goal focused to assist the clients with the needs the MDT have identified.

19.3.2 Staff will discuss and decide if the current level of care is appropriate and if not what services/programming needs are required to meet the needs/risk identified by the Unit MDT.

19.4 The Administrative MDT members will be tasked with resolving the identified issues so the client can either:

19.4.1 Move to a more appropriate space, or

19.4.2 Determine what is needed for them to remain at their current location with the appropriate wrap-around services.

19.5 Unless there are over riding Clinical and/or Security issues, the MDT consensus will determine the recommendations.

19.6 If decisions cannot be reached within the allotted time, the issues will be referred to JJS Administration for resolution.

20 CLASSIFICATION APPEALS

20.1 Clients may appeal any transfer decision through the approved grievance procedure.

21 CENTRAL INTAKE UNIT DIAGRAMS.

The most current Central Intake diagrams can be access on the CYFD intranet at: http://cyfweb/jjf/index.html , select the Programs and Services Tab, then select Central Intake Admissions, Intake and Diagnostics Flowchart.

22 AUTHORIZED SIGNATURE:

APPROVED: _____ 6/10/10_____

Dorian Dodson, Cabinet Secretary Date

Children, Youth and Families Department