

Coordinated Services Team Initiative Handbook for Working with Children & Families

Module 5

5.1 The Team Transition Process

- Transition Phase Tasks
- Transition Phase Products
- Planning for Transitions
- Moving from Formal to Informal/Natural Supports
- Reasons for Team Transition/Closure

Tools

- Family Closure Survey
- Team Member Closure Survey
- Youth Closure Survey
- Child Portfolio – Sample Table of Contents

5.1 Team Transition Process

Transition Phase Tasks

Service Coordinator

- Continue to hold CFT meetings as needed
 - Solicit all team members sense of progress
 - Chart sense of met need
 - Help team discuss what life will be like after the process ends
- Review underlying context/conditions that brought family to the system in the first place to determine if situation has changed
- Help team identify who else should be involved
- Facilitate inclusion of “post-process” support & resource people
- Create or assign rehearsals or drills with a “what if” approach
- Formalize structured follow-up if needed
- Creates a commencement ritual appropriate to family & team

The following items should be covered in preparation for transition out of enrollment in CST (ideally 60-90 days before completion):

A. Family:

- 1. Thorough evaluation of family’s perceptions regarding their ownership of the plan and process.
- 2. Review of how and in what form they would like the team process to be continued
- 3. Review of plan: how will Needs continue to be met? How will necessary services be continued?
- 4. Plan a celebration/transition event or time

B. Team:

- 1. Review of team process continuation: roles, time frames, form of team, communication
- 2. Review of plan, especially continuation of necessary team members and services
- 3. Final evaluation of progress and process

Other Team Members

- Help child and family visualize post-team era
- Continue to insure balanced participation and accurate communication
- Provide informal check-ins as frequency of meetings decreases

Transition Phase Products

- Updated Plan of Care (Transition Plan) to address ongoing needs for support
- Updated Crisis Response Plan(s)
- Plan for future Child and Family Team Meetings and/or contact

Planning for Transitions

There are several types of transitions that a team may need to plan around including: *transitions to different settings* (e.g. different grade in school, new school, or move to a new community); *transitions to different living environments* (e.g. foster home, hospital, or residential care center); *transition to adulthood and the adult system of care*; and *transition out of the team process* (i.e. team closure).

Regardless of the type of transition, there are several issues that should be considered by teams including: when to begin planning; how to plan for the transition; and who should be involved in the planning process. Teams should start planning well in advance of the planned transition date. For example, the guideline for beginning transition planning for a child's transition to adulthood is by age 14. Transition planning follows that same collaborative, creative approach as followed in the initial Plan of Care. When deciding who should be involved in addition to current family team members, teams should consider who will be involved with the child and family once the transition has occurred and invite them to be a part of the planning.

As the team is preparing for closure, the focus should be on long-term planning. Consider what services and transitions the family and child will encounter in the future and develop a plan around these needs. The team should also review the Crisis Response Plans to ensure they are up-to-date in case they need to be referenced in the future.

Moving from Formal to Informal Supports

Child/Family Need	Current Service Provided	Informal Support Possibilities

Reasons for Team Transition/Closure

From the beginning of the team process, it should be recognized that any family that has a child with special needs will need support at times. The intent of the team is not to solve every problem that the family or service providers have, but rather to develop the skills, gain the knowledge, and identify and access the resources necessary to meet the greatest needs. Once this process is working and doesn't necessitate the support of a team, the formal team process should end. This doesn't mean that services aren't necessary or that individual or organizational supports aren't needed. It simply means that:

- Families feel confident that they have a **voice** in decisions that are made regarding their children
- Families have **access** to needed services
- Families know how to plan for the future (**ownership** of plans concerning their child/family)

State Statute 46.56 for Integrated Services Projects identifies five ways that closure can occur (with no time limit identified):

- By agreement of all participants that the goals of the service plan have been met
- By withdrawal of the family
- By recommendation of the project coordinator and the treatment team
- Because the child no longer meets the eligibility criteria for the program
- By order of the court, if services are being provided under court order

In the ongoing process of working toward the goal of team closure, the team process should:

- Emphasize the identification of informal/natural supports
- Include regular review of the goals outlined in the Plan of Care
- Include team discussion of progress toward goals
- Utilize the Family Team Meeting Review form (found in this *Module 4*) as a guide to keep the team on track

When closure does occur, the Team Member and Family Member Closure Surveys (found in "*Tools*") should be used to gather information that might be helpful for future family teams.

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