SUPPORTING LIFE TRANSITIONS

The Core Team supports youth and their family in the ongoing process of anticipating, preparing for, and navigating through life transitions, including, but not limited to, family moves/relocation, changing grades or schools, loss of a supportive person in youth's/family's life, increased autonomy, and other adjustments to young adulthood. The Core Team also plans and prepares the youth, family, and Family Team for the youth/family's transition out of Continuum services.

Please see the following matrices for additional information regarding life transitions and bridging to and from professional service providers and supports:

- Collaborative Treatment Planning and Care Coordination
- Continuity with Higher Levels of Care
- Practicing Cultural Relevancy

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ANTICIPATING AND PLANNING FOR LIFE TRANSITIONS		
» Anticipates life transitions (such as changes in school/class/grade, school vacation, sibling or friend moving, parental change in work schedule, anniversaries, etc.). » Navigates anticipated and unexpected life transitions. Discusses anticipated transitions in ongoing Family Team meetings. Holds ad-hoc, face-to-face meetings with Family Team to address unplanned transitional needs. This could include, but is not limited to, anticipated or unanticipated need for alternate parent/caregiver/family for youth in the event that parent/caregiver is no longer able or willing to work towards the youth's return home or continue in an active, unconditionally committed parenting role. » Explores need to change the intensity and/or type of services and interventions to support youth/family through transition. Brainstorms strategies with Family Team to meet youth/family need for support through these transitions. » Develops a transition support plan with strategies to support youth/family through the life event and address the potential impacts on other aspects of life (e.g., impact of change in parent's work schedule on youth's morning routine and transportation to school). » Collaborates with youth/family/Family Team to determine ways to sustain necessary routines during time of transition.	» Ignores influence of youth's developmental stage on transition. » Focuses more heavily on the negative or positive potential impacts that the transition may have rather than considering both. » Fails to consider the potential impact of transitions on other aspects of life or other family members. » Inflexible during times of transition; keeps to the schedule of visits. Doesn't offer to increase face-to-face meetings or add phone check-ins as needed. » Doesn't take into account or validate the unique impact and experience this youth/family might have with the transition. Tries to give youth hope by saying things like "I made it to high school, you can too" without considering differences in resources, supports, learning needs, etc. the youth may experience.	» Belittles/minimizes importance of life transitions. » Develops a transition support plan without the youth's/family's participation. » Recognizes that a transition will be happening but doesn't engage family/Family Team in proactive planning. » Focuses discussion on understanding problems and/or barriers related to the transition without creating a plan with the family to address them.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ANTICIPATING AND PLANNING FOR LIFE TRANSITIONS		
Explores with the youth/family which individuals (teachers, Family Team members, natural supports, etc.) need to be proactively notified of life transition. As agreed upon, shares potential techniques to support youth/family navigating through the transition.	» Discusses with the family which individuals need to be notified but doesn't flesh out the details (e.g., the viability and role of supports) with them. » Establishes a plan with the family regarding who to notify but fails to determine who will provide the notification. » Outreaches proactively as agreed upon and shares vague, unclear descriptions of supportive techniques.	» Notifies providers without first exploring with family whom to notify. Notifies other providers of what the Core Team considers potential supports without first exploring supportive techniques with family. » Waits until a transition is occurring and then explores potential supports in a reactive manner rather than a proactive manner.
» Explores any conflicting perspectives regarding best interventions to support youth/family through transition. When the Family Team is unable to reach consensus and resolve conflicting perspectives, the Core Team makes an interim, concurrent plan with the Family Team. » Monitors the plan with specific measures and timeframes that can help the Family Team learn more about the success, challenges, and progress of the plan. The Core Team revisits the plan with the Family Team within the agreed upon time frame.	» Takes sides with one entity rather than engaging in a more neutral/mediating manner with the conflicted parties. » Avoids conflict by changing the subject. » Establishes a plan that lacks specificity and detail. Establishes vague measures and timeframes. » Adheres to timeframes rigidly (without adaptive flexibility). » Waits too long and follows up outside of the agreed-upon timeframe.	» Passively or actively participates in disagreement. Doesn't mediate to address conflicting perspectives. » Explores conflicting perspectives but doesn't follow through on the planning process. » Ignores the need to monitor and/or to revisit the plan.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
SUPPORTING YOUTH/FAMILY THROUGH LIFE TRANSITIONS		
Considers the need for and engages in collaboration with family, youth, and school to ensure maintenance of successful school routines throughout any life transition.	» Only considers one aspect of school routines. » Always goes along with the LEA/school district's goals and/or progress toward goals without facilitating a collaborative discussion with the school, Family Team, youth, and family about youth's needs and options to meet needs. » Places responsibility of engaging LEA solely on parent/caregiver rather than asking and discussing with the parent/caregiver whether they need and want support from the Core Team and/or Family Team members.	» Fails to consider the potential impact any/all of the youth's life transitions may have on school. » Doesn't review or use the youth's 405 Plan or IEP to inform the youth' potential life transitions.
» Validates and normalizes youth/family feelings, fears, hopes, and worries associated with life transitions. Processes youth/family loss and grief associated with life transitions. Helps the youth/family identify hopes and celebrates successes. » Makes adjustments to Continuum service approach and interventions in order to provide targeted support and skill-building coaching to the youth/family during times of life transition. » Explores need for and encourages connections with natural supports during transition period.	» Validates one family member's experience over another's. » Only focuses on negative transitions, such as losses, and doesn't acknowledge positive ones. » Focuses only on fears and worries without any expression of hope or discussion of the potentially-positive experiences and opportunities that can come with change. » Adjusts approaches but doesn't check in to see how they are working for youth/family.	» Doesn't talk about or address life transitions. » Invalidates and/or pathologizes youth/family experiences. » Fails to consider how transitions could be a loss for the family. » Provides minimal, unattainable, and/or biased options to adjust service approach/interventions.
» Provides continuous encouragement to both youth and family in using plans to support youth through transition. Celebrates successes. » Explores with youth, family, and Family Team aspects of the transition support plan that are/aren't successful. Updates plan with all relevant parties to increase success.	» Explores with only one family member and excludes others. » Explores but doesn't take any actions (e.g., planning, updating plan, providing encouragement, or sharing plan with family team). » Co-creates plan with youth/family but doesn't support family and/or Family Team in implementing plan. » Writes a plan without a breakdown of tangible steps.	» Continues with the same plan even though Family Team members report a lack of success. » Lacks consideration for or anticipation of the need to explore feasibility of plan with the youth/family.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
SUPPORTING YOUTH IN TRANSITION TO YOUNG ADULTHOOD		
» Consults with OT around potential strengths and challenges of youth's transition to young adulthood. Considers the use of various tools (e.g., Youth Readiness Tool) to assess youth's strengths and needs in preparing for young adulthood within the context of ongoing parent/caregiver/family relationships. » Partners with the youth/family to anticipate and identify strengths and challenges in preparedness for adulthood (especially for those leaving foster care or group home or any youth who will be living independently after discharge). » Considers the lack of safe and permanent parent/caregiver/family at the time of transition to be an acute need (emergency) that must be immediately addresses and remediated by the youth's Family Team. Underscores with youth and Family Team the risks for youth who transition from placements within child welfare or mental health systems without safe and permanent family relationships.	» Unilaterally addresses independent living strengths and needs but doesn't access consultations or tools in an effort to develop a more comprehensive approach. » Focuses on identifying strengths or challenges, but not both. » Lacks urgency in bringing the team together to address lack of safe and permanent parent/caregiver/family. » Discusses risks with youth or team but not both.	» Waits until youth is about to turn 18 to consult with OT and/or have discussions with youth/family. » Doesn't explore and address clinical, developmental, and/or other barriers to prioritizing and attending to independent living strengths and challenges. » Underscores risk to youth and team but doesn't explore or identify which are most pertinent to this individual youth.
» Collaborates with youth, school and family, OT Consultant around opportunities that will help youth achieve educational success and skill attainment for post-secondary educational advancement and/or gainful employment, and other preparations for independent living. » Educates youth on and helps them identify and develop skills to navigate the transition from school to work. » Provides and/or links youth to needed assistance with employment, college, and/or financial aid applications.	» Fails to fully explore clinically and developmentally appropriate options available to youth as part of transition out of high school. » Prioritizes parent/caregiver/LAR opinions, expectations, requests and vision over the youth's.	» Only consider post-secondary educational options. Neglects consideration of employment. » Doesn't help youth family identify current or needed skills to support post-secondary goals. » Asks only the parent/caregiver/LAR about post- secondary school planning. Excludes the youth from exploration of their specific opinions, expectations and vision for their future.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
SUPPORTING YOUTH IN TRANSITION TO YOUNG ADULTHOOD		
» Explores with youth and parent/caregiver/LAR the needs that youth has that could result in the use of adult services/benefits. » Shares and/or links youth and parent/caregiver/LAR to others with expertise in resources and services available to adults and ways to navigate the adult service system. » Encourages, coaches, and empowers youth in securing documentation (i.e., social security card, birth certificate, Mass ID, etc.) as well as applying for and accessing adult services and benefits (e.g., Mass Rehab, Job Corp, vocational training). Involves youth's family and natural supports in securing these items and services together with the youth whenever possible, promoting this as another tool to strengthen relationships, work positively together, and enhance self-advocacy skills as well as decreasing ongoing reliance on professionals and systems.	» Limits the scope of exploration of youth's needs. » Shares some information with the youth and parent/caregiver/LAR but fails to link them to those who have greater knowledge on the topic. » Lacks any information on adult services/benefit systems but looks for the information. » Offers support based on clinician's impression of need without exploring with the youth what type of support the youth needs.	» Waits until the youth is within 3 months of turning 18 to explore adult services/benefits. » Links youth to services without asking/exploring youth's preferences with them. » Doesn't discuss, explore, or link youth to any services/benefits. » Lacks awareness of adult services system and/or benefits and does not seek information.
» Normalizes and prioritizes youth's need for supportive relationships as they transition into adulthood. » Explores, with youth and parents, how they are navigating their transitioning relationship as it relates to shifting responsibilities, custody status, decision making, etc. » Discusses with youth and parent/caregiver/LAR each person's vision for how they will/will not stay involved in each other's lives as the youth moves into adulthood.	» Acknowledges the life-stage transition with youth/family but doesn't open up discussion about resulting changes in the parent-child relationship or doesn't explore ways to navigate the changes in responsibility, decision making, etc. » Explores youth's shifting relationship with parents but not shifting relationships with siblings and other family members, or vice versa.	» Discusses the parent/child relational shift and changes in roles/responsibilities with DCF/DMH but doesn't discuss it directly with youth and parent. » Addresses current/acute issues without spending time to consider youth's/family's future vision for youth's adulthood. » Fails to review obtaining re-consent for services at age 18.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
SUPPORTING YOUTH IN TRANSITION TO YOUNG ADULTHOOD		
» Explores with youth and parent/caregiver which relatives and other caring adults will provide the youth with support as they move into adulthood. Facilitates purposeful joint conversation between youth and family/natural supports about what, specifically, the youth can expect from each adult relationship and what each adult can expect from the youth.		
» Assesses and strategizes with the youth, parent/caregiver/LAR and Family Team around the unique physical, relational (and potential legal) permanency needs of transition-age youth, especially those leaving foster care or a group home who will be living independently. » Provides information and/or linkages to resources including those relevant to guardianship needs as indicated.	» Doesn't explore, address, or advocate for youth/family permanency needs when funding source ends services without time for transition. » Considers and incorporates permanency-related needs but not the needs specific to transitional-age youth. » Doesn't solicit input from all Family Team members.	» Doesn't solicit youth's hopes, wishes, and opinions when strategizing. » Fails to anticipate barriers to permanency planning when youth needs to leave foster care or a group home (i.e., has yet to locate a feasible place to live or Family Team members are not in agreement about where the youth should live). » Offers supportive services without collaborating with funding source. Doesn't obtain information from funding source regarding transitional-age supportive services.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
BRIDGING YOUTH'S TRANSITION OUT OF CONTINUUM		
» Explains at intake and throughout service delivery, to youth/family and Family Team, that continuation of Continuum services depends on family choice and DCF/DMH determination of clinical need. » Begins discharge planning (including the youth's vision for themselves as a young adult) at intake and throughout the service with youth/family and Family Team. Increasingly over time, creates opportunities for parent/caregiver and family/natural supports to adopt roles and responsibilities together with the youth, rather than the professionals/system. » Builds consensus among youth/family and Family Team members regarding how they will know when it's time to end Continuum services and how they will measure progress toward that end. » Addresses different perceptions to reach consensus on readiness to end Continuum intervention.	» Delays raising the topic of transition/waits for a favorable moment to do so. » Initiates discharge planning based on an arbitrary timeline. » At the beginning of service, builds consensus on how to recognize when Continuum service should end but doesn't revisit this and continue to build consensus throughout the service. » Overlooks the need to reassess the frequency of Family Team meetings. Decreases meeting frequency part of the phase-out routine when an increase in meetings may be warranted.	» Allots insufficient time (waits until services are ending) to discuss transition. Engages in abrupt and rushed transition discussions. » Avoids discussing or explaining that transition means making progress toward goals, not that everything is perfect. » Ignores lack of consensus around transition indicators.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
BRIDGING YOUTH'S TRANSITION OUT OF CONTINUUM		
» Reviews readiness for transition out of services on a quarterly basis, at minimum, with the Family Team (and more frequent as needed and agreed upon especially during active transition). » Continually monitors youth/family, Family Team members, and other relevant formal and informal supports' perspectives on challenges and progress toward increasing readiness to transition out of Continuum services. Builds ongoing, congruent understanding of strengths, treatment goals, strategies, and interventions needed to progress toward transitioning out of Continuum services. » Uses data on measurable goals (# of school days attended, # of times successfully used coping skills) to reflect progress and readiness for exiting services. Validates the youth's and family's progress, readiness, and apprehension. » Explores the drivers that move progress/readiness forward and the challenges that restrict progress/ readiness for transition out of Continuum. » Brainstorms and prioritizes options to overcome challenges and strengthen drivers of success and readiness.	» Explores progress but avoids discussion of how progress on goals helps determine readiness for discharge. » Acknowledges conflicting perspectives regarding what will support progress and readiness for discharge but doesn't explore ways to move forward. » Explores minimally, doesn't open detailed discussion around what drives and restricts progress. » Uses non-strengths-based data to measure progress. » Overlooks consideration for and need to address how youth, family, and Family Team members might be nervous or fearful about the transition.	» Clinician arbitrarily chooses discharge criteria without the family's input. » Sets unrealistic goals. » Fails to develop target dates/criteria for discharge. » Doesn't explore youth's and family's perspective on progress toward or readiness for discharge.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
BRIDGING YOUTH'S TRANSITION OUT OF CONTINUUM		
» Prepares with youth/family for planned transition out of Continuum. » Gradually engages the youth/family in less frequent sessions/interventions. Discuss loss of Continuum support and any other changes in youth/family support network. » Discusses success, reviews internalized skills, and ensures that family members can coordinate care. Plans with youth/family for a final Family Team celebration of successes. Helps youth/family prepare reflections they may want to express during the meeting. » Prior to discharge, uses challenges and moments of crisis as opportunities to learn and plan for a future with less intensive supports.	» Doesn't make a plan for gradually decreasing frequency of sessions/interventions with youth/family. Abruptly goes from frequent to infrequent. » Doesn't acknowledge or explore ways the family is capable of managing crises or future challenges. » Steps in to address crises rather than providing coaching or "behind the scenes" support. Misses opportunities to support the Family Team in helping the family through crises. » View crises or challenges merely as setbacks and not opportunities for learning. » Doesn't acknowledge and explore that graduation can mean something different to families and providers.	» Tells family/youth they aren't capable working of without Continuum support. » Tells family/youth they are ready for Continuum service to end without validating their ambivalence and helping them recognize the skills they have to manage their fears and worries. » Doesn't recognize, acknowledge, and validate feelings of loss associated with transition out of Continuum. » Only celebrates transition out Continuum when youth/family is stepping down in level of care. » Doesn't allow time or opportunities for youth/family to practice skills independently.
» Identifies and bridges to ongoing and new connections to formal and informal resources and clinical services likely to sustain healthy functioning after Continuum Services end. » Establishes an agreed-upon transition time frame that accounts for youth's/family's specific individual needs, waitlists, potential barriers, delays to transition, and the time needed for bridging overlap with other providers/supports.	» Solicits family's input, preferences, and post-discharge service needs but doesn't take action or follow through on what is discussed. » Makes all referrals on behalf of family without coaching them on how to do so. » Establishes a plan for overlapping with receiving provider but with too short a time frame and doesn't advocate for more time with clinical rationale.	» Waits until the last minute to make referrals. » Ignores family's preferences, culture, needs, transportation limitations, language, etc. when making referrals. » Ignores a specialized need for treatment (e.g., need for a psychiatrist that specializes in psychotic disorders).

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
BRIDGING YOUTH'S TRANSITION OUT OF CONTINUUM		
» Collaborates with youth/family in determining who will refer them to needed services (i.e., self-referral vs. provider referral). Assists in addressing access barriers by discussing wait lists with family, advocating for priority access with new providers when appropriate, and partnering with youth/family on follow-up actions.		» Makes no consideration of or request for overlapping Continuum service with new providers/supports prior to discharge.
» Anticipates challenges that may arise after transition. Plans with the youth/family and remaining/ongoing team members around potential challenges to sustaining functioning after Continuum services end. » Develops a post-transition crisis plan with youth/family that addresses potential risks, coping skills for reducing risk, behaviors that precede crisis, and specific steps for youth/family members to respond effectively to risks (avert or manage crisis). Reinforces family/natural supports and includes the specific relationships that are most protective and easily accessible to the youth in a time of crisis.	» Develops a safety plan that is exclusively youth-focused and doesn't include family system/family members living at the home. » Develops a plan that relies heavily on professional supports and omits natural supports. » Focuses a plan on extreme crises events (such as those that lead to calling 911 or MCI/ESP) and doesn't include addressing less extreme crises or anticipating/preventing crises. » Overlooks the need to check in with family to ensure plan is feasible and that they have confidence and comfort with using it.	» Develops a plan without youth/family input. » Doesn't develop a post-transition safety plan. » Lists items in the plan that will not be available, are unsustainable, or are unlikely to be used post-discharge. » Creates a superficial, generic, "cookie cutter" plan (e.g., call 911, take medications, etc.) that isn't individualized to youth/family. » Gives family the existing safety plan without updating it to reflect needed support from someone other than Continuum staff.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
RESPONDING TO UNPLANNED SERVICE ENDINGS		
When youth/family show signs of risk for unplanned ending of Continuum or other service, the Core Team makes respectfully persistent efforts to contact and reengage the family/youth in the service. Discusses/ offers changes in approach that might work better for youth/family. Explores the family's interest in meeting with Core Team and/or Continuum leadership to explore options for strengthening the work of the Core Team with the youth/family.	» Reaches out to ask about unplanned ending, but closes down conversation or doesn't ask questions to understand rationale for the unplanned ending. » Offers to change approach and promptly makes suggestions without first asking the youth/family what would help. » Informs some but not all Family Team members.	» Recognizes youth's/family's disengagement as a risk for unplanned discharge but doesn't make extra efforts to reach out to them. » Uses blaming/shaming language when discussing why services are ending. Expresses negative judgment of family's decision and/or uses coercive tactics, such as persistent cajoling, stating that they will regret ending the services, etc. » Doesn't inform Family Team members or informs them with conflicting and inconsistent information.
» When Continuum or other service ends in an unplanned manner, contacts family to understand reason for ending and discusses next steps. » Informs Family Team members of unplanned ending and works with DCF/DMH and relevant providers to determine if there is a way for the Family Team to offer youth/family support recommendations, say goodbye, and refer youth/ family to others who can meet their needs.	» Lacks clarity about DCF/DMH decision to end services, doesn't seek to understand it, and is vague and unclear in explaining it to youth/family. » Allows DCF/DMH decision to override Core Team's good clinical practice of contacting the family to mark the end of therapeutic relationship and services; results in service termination without saying goodbye and giving the youth/family opportunity for closure.	» Doesn't consider the youth's/family's need for closure. Does not reach out or offer resources, supports, a closing session, etc. when the family ends services in an unplanned manner. » Vents frustrations to youth/family regarding unplanned ending. » Uses blaming, shaming, or judgmental language when referencing the family to DCF/DMH.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
DEVELOPING A DISCHARGE PLAN		
» Clinician develops a discharge plan with the youth, parent/caregiver/LAR, and Family Team and shares it with youth, parent/caregiver/LAR, Family Team members and new providers to whom the youth is transitioned. » Completes and uses the discharge CANS for discharge planning purposes, outcome measurement, and baseline indication of the youth's and family functioning at discharge. » Attaches the post-transition safety plan to the discharge plan. » Shares discharge plan (with attached safety plan) with family and Family Team members and other relevant parties, consent permitting.	» Writes plan with clinical jargon, not everyday language that is familiar to the youth/family. » Shares plan with some but not all Family Team members.	» Develops discharge plan without youth or parent/caregiver/LAR input. » Develops a superficial, generic, "cookie cutter" plan or one that is rote and/or rushed. » Completes CANS based on clinician's perspective only. » Fails to include safety plan as part of or attachment to the discharge plan. » Hands the family the discharge plan and doesn't review it with them. » Doesn't share plan.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
DEVELOPING A DISCHARGE PLAN		
» Writes a discharge plan in everyday language that reflects hope, possibility, and explicitly states signs of resiliency. » Includes a summary which describes the youth/family culture and language preferences, vision, review of needs and strengths, progress toward goals, current medications, anticipated challenges, and next steps for sustaining gains. Elicits and describes youth's/family's input on their progress and experience of Continuum services. » Describes successful behavioral support strategies that can be followed in the future (includes crisis prevention and intervention strategies). » List future provider/collateral appointments with date, time, location, and contact information. Includes contact information for all formal and informal supports, resources, and community-based services to be used as part of the aftercare plan. » Describes actions/support plan to ensure continuity of all remaining/incoming treatment services, including psychopharmacology. » Describes actions/support plan relative to employment/education that has been worked out with the school or school district, where applicable. Includes provisions to ensure a seamless transition to a new school, if applicable.	» Leaves out youth/family perspective on experience of Continuum services. » Focuses discharge plan on history rather than current status and sustainability recommendations. » Includes some but not all pieces in the discharge plan. » Lists appointments, resources, or supports under the support persons and contact information section even though family has indicated they won't use some of them, rather than noting these as recommendations for when the youth/family are ready. » Doesn't explore feasibility of all action items on the plan with youth and family. » Omits recommendations for ways how remaining/incoming team members can bridge continuity.	» Uses shaming/blaming language. » Describes youth's/family's perspective on experience of Continuum services without asking them about it. » Doesn't review the summary section with the family and edit it as requested and agreed upon.