# CONDUCTING A COMPREHENSIVE COLLABORATIVE ASSESSMENT

The Core Team conducts a comprehensive collaborative assessment that involves the ongoing process of gathering necessary accurate historic and current information about the needs, strengths, and culture of a youth and their family. The Core Team evaluates the relevance of that information and also develops a comprehensive life history, a psychosocial narrative of the youth and family in the context of their environment, experiences, culture, and present situation.

Clinical understanding is informed by (but not limited to) initial consultation with the youth, family, Continuum occupational therapist, consulting Continuum psychiatrist (when clinically warranted), and the referring agency. The assessment process results in an interpretive summary and clinical formulation that can be understood and supported by family members, professional helpers, and natural supports on the Family Team. The assessment process helps the Family Team (inclusive of the youth/parent/caregiver/legal authorized representative [LAR]) identify focal needs and prioritize treatment goals. The clinical formulation prioritizes the psychological safety and wellbeing risks for youth placed out-of-home and promotes urgency to resolve barriers to safely remaining home or transitioning home. Assessment and clinical understanding change over time as new information arises and the family situation changes.

Please see the following matrices for additional information related to conducting a comprehensive collaborative assessment:

- Engaging Youth and Family
- Continuity with Higher Levels of Care
- Incorporating Psychiatry and Occupational Therapy Consultation
- Assessing Risk, Safety Planning, and Supporting Families through Crisis
- Practicing Cultural Relevance

| IDEAL PRACTICE | DEVELOPMENTAL PRACTICE | UNSATISFACTORY PRACTICE |
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| **FURTHER DEVELOPING THERAPEUTIC ALLIANCE** | | |
| » Fully explains the assessment process and purpose to the youth and family. Asks for and clarifies questions.<br>» Explores with the family who they expect and hope will participate in assessment conversations, family therapy sessions, and Family Team meetings and how they envision Continuum services being delivered.<br>» Specifically explores whether the parent/caregiver wants their Family Partner (if they have one) or other supports to be part of the assessment meetings and includes them accordingly. | » Describes purpose and process but doesn't confirm understanding. Discusses with some, but not all key family members.<br>» Uses clinical language the family is not familiar with.<br>» Explores and identifies who the family wants to include in assessment but fails to explore how youth/family wants to include them and/or fails to support their participation.<br>» Slants discussion toward providers' view of who could support family during assessment. | » Restricts explanation of assessment process to only to include parent/caregiver and not youth.<br>» Does not explore with the family regarding who they would like to be involved in assessment conversations.<br>» Omits exploration of parent/caregiver's family partner involvement in assessment process. |
| » Takes time to get to know the youth and family. Demonstrates curiosity about their experiences. Exhibits respectful persistence when response is slow and paces the gathering of information when family is overwhelmed.<br>» Listens carefully to the family's narrative, and summarizes verbally what each family member has said to make sure it's understood. | » Ties process and pacing to systemic, contractual, and deadline pressures without consideration of family needs and circumstances.<br>» Upon becoming aware that something is affecting the family's level of participation, fails to explore it or to adjust timing of assessment accordingly.<br>» Relies heavily on assessment form to conduct assessment rather than engaging in a conversation with the family.<br>» Only pays attention to what some family members say. Summarizes one family member's perspective as representing that of the whole family.<br>» Conducts the assessment, but avoids uncomfortable topics. | » Fails to demonstrate curiosity about family. Gathers information based solely on timelines required.<br>» Pushes for action or attempts to fix/resolve issues without spending enough time exploring family experience.<br>» Ignores family cues about not wanting to talk about something or pushes family to resolve issues when they refuse.<br>» Labels family members as resistant.<br>» Talks more than the youth and family.<br>» Ignores what the family says. Appears distracted (looking at phone, clock, TV, etc.) while someone is speaking. |

| IDEAL PRACTICE | DEVELOPMENTAL PRACTICE | UNSATISFACTORY PRACTICE |
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| **EXPLORING NEEDS, VISION, STRENGTHS, AND HISTORY OF HELP** | | |
| Engages youth and family members to identify and describe skills, abilities, knowledge, interests, and strengths of the youth, individual family members, and family as a whole. | » Only elicits the strengths of one family member.<br>» When family struggles to identify their strengths, keeps going rather than creatively eliciting additional strengths. Suggests generic, non-individualized strengths specific to this youth and family.<br>» Struggles to reframe/refocus discussion on strengths when needed. | » Strengths are not explored.<br>» Focuses on identifying shortfalls of youth and family, and uses deficit based language.<br>» Suggests a strength the family identifies for themselves is not a strength rather than exploring it further and acknowledging the strength in the suggestion. |
| » Elicits each individual family member's impression of primary concerns.<br>» Specifically inquires about concerns related to risk for sexual exploitation, substance use, bulling, gang involvement, and other risky situations.<br>» Explores youth and family members' perspectives on what contributes to primary concerns. Inquires about what keeps the concerns going, what stressors make them worse, and what helps relieve them.<br>» Explores the impact that medical/physical wellbeing has had on youth's and family's mental and behavioral wellbeing and vice versa. Explores family's preventative care practices such as immunizations, wellness check-up, disease prevention, and dental services. Identifies and collaborates with family and providers around care coordination needs in these areas. | » Only elicits some family members' concerns.<br>» Expresses knowledge of concerns and jumps to validate concerns without first fully soliciting them from each family member.<br>» Explores concerns but fails to ask what family and youth think contributes to or exacerbates them.<br>» Provides suggestions to help reduce risks without first exploring family member's viewpoint on what has worked to reduce, increase, or exacerbate risk.<br>» Explores the past or present but not both.<br>» Explores impact of medical/physical health concerns on mental/behavioral health but not vice versa. | » Only focuses on history of concerns without soliciting family's perspective on current concerns and risk factors.<br>» Doesn't explore youth's/family's concerns.<br>» Exaggerates or minimizes challenges that family is experiencing.<br>» Imposes own view of contributing factors; does not balance with family view.<br>» Asks about what keeps the issues of concern going or makes them worse but not what relieves them.<br>» Ignores connection between medical/physical wellbeing and mental/behavioral wellbeing. |

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| **EXPLORING NEEDS, VISION, STRENGTHS, AND HISTORY OF HELP** | | |
| The clinician conducts a youth and family screening for past and current substance use/abuse within thirty (30) days from intake. This may be conducted as part of an ongoing risk assessment, CANS, or a standardized assessment tool. | » Avoids assessment/screening of someone even when there is information to suggest they may be using or abusing substances.<br>» Doesn't listen for, observe, and explore family beliefs and culture around substances.<br>» Assessment is limited to exploration of use or abuse of one substance but not all. | » Neglects to screen for both past and current substance use/abuse.<br>» Doesn't explore risk of future substance abuse. |
| » Engages youth and family members in describing times in the past when needs were more or less acute and explores what was different.<br>» Asks about the types of supports that have helped manage needs in the past and at present. Asks about formal help (such as state agency involvement, out-of-home treatment, community services, prescribers, alternative healing approaches, etc.) and natural supports (such as friends, coworkers, neighbors, clergy, etc.). Explores what youth/family experienced as most/least effective and validates their experience.<br>» Explores medication usage, target symptoms, and possible side effects with family and prescriber. Explores beliefs about medications, access to and resources to fill prescriptions, and how they are taken (e.g., according to directions or not) on an ongoing basis. | » When family struggles to describe a time when things were better, fails to ask when things were "just a little better."<br>» Explores professional supports but not natural supports.<br>» Uses the term "natural supports" with youth/family rather than using common language such as "friends," "supportive family members," "people from" (the neighborhood, church, work), etc.<br>» Inquires only about youth's supports and fails to explore supports to parent/caregiver and others in the home.<br>» Only obtains information from prescriber or family but not both. Obtains list of current medications but not history.<br>» Asks whether the youth is complying with medication instead of asking how medications are taken. | » Doesn't explore/ask what was helpful in past and present.<br>» Fails to validate comments family makes about when things weren't going well or how hard it can be to remember a better time.<br>» Expresses judgment—doesn't hold a neutral position. Dismisses or downplays family's experience.<br>» Uses unprofessional language or is discourteous toward providers or services family didn't find effective.<br>» Does not inquire about medication name, dosage, target symptoms, and side effects.<br>» Biased toward provider view of medications and doesn't explore youth and family beliefs about medications. Insists medications must be taken (shuts down exploration) when youth/family opens up about not wanting to take medication or using alternative medicines.<br>» Only asks about relationship with prescriber and/or use of medication once, not on an ongoing basis. |

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| **EXPLORING NEEDS, VISION, STRENGTHS, AND HISTORY OF HELP** | | |
| » Explores youth's and family's future-oriented vision. Invites youth and family members to envision and describe a time in the future when their family is able to manage challenges more effectively. Uses tools such as miracle question to help the family generate ideas.<br>» Supports the youth/family in developing a written vision statement that will help guide the Core Team and the Family Team's work with the family.<br>» Explores how the youth/family and the Core Team will know when it's time to transition out of Continuum services. | » Vision is not obtained from all family members.<br>» Doesn't ask the type of curious question that helps address/express a hope for how things will be some day. Simply asks the family "what's your vision" without using miracle question or some other tool to help the family consider it.<br>» Explores vision but lacks exploration of what it might look like when it's time to transition out of Continuum services.<br>» Documents family's vision statement but not in their own words or includes things family agrees to half-heartedly.<br>» Does not assist youth/family in seeing the commonalities and unifying themes when they present differing visions. | » Doesn't explore family's vision.<br>» Imposes own vision for the family.<br>» Uses youth/family goals as their vision statement rather than exploring vision as a distinct thing. Ignores or simply acknowledges youth/family differences on their individual visions and moves on with the process.<br>» Misinterprets the family's vision. Documents team's vision for the family. |
| » Explores home routines, structure, limit-setting and discipline practices as well as parent/caregiver needs (mental health, life skills, and basic needs).<br>» Asks about past family history of trauma, losses, and other adverse experiences as well as family history of substance use/abuse.<br>» Explores protective and risk factors in the community environment and their impact on the youth/family. | » Explores in part but not all.<br>» Limits exploration of home structure to home routines without inquiring about limit setting/discipline.<br>» Fails to revisit (at later date) items youth and family didn't want to initially discus.<br>» Focuses conversation on deficit based items and doesn't ask about protective factors, nurturing relationships, etc. | » Ignores when youth and family aren't ready to discuss and pushes for discussion.<br>» Lacks consideration of which items to explore with youth/family together and separate.<br>» Fails to explore whether the environment feels safe to youth/family to discuss or fails to correct for environment (e.g., opens discussion with other people in the room). |

| IDEAL PRACTICE | DEVELOPMENTAL PRACTICE | UNSATISFACTORY PRACTICE |
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| **EXPLORING PERMANENCY, STRENGTHS, NEEDS, AND BARRIERS** | | |
| » Specifically assesses for the presence and sustainability of youth's relationship with at least one committed adult who provides a safe, stable, and secure parenting relationship, love, unconditional commitment, and lifelong support. Engages in initial and ongoing exploration (with youth, family, and relevant collaterals) of strengths, needs, and obstacles for youth and family in maintaining, strengthening and/or achieving such a relationship.<br>» Considers family's readiness when timing the exploration of the topic. | » Explores permanency initially, but not on an ongoing basis, or gathers some information but is not thorough.<br>» Mismatches timing of exploration with youth and family readiness to discuss permanency needs. Does not explain need to explore permanency.<br>» Opens conversation but struggles to explore all possible obstacles. Only explores obstacles from one point of view (e.g., youth's or collateral's).<br>» Explores permanency with family, collaterals, or youth, but not all. | » Initiates work without first learning about the legal custody status and caregiver sustainability (lifelong nature).<br>» During conflict/disagreement, aligns strongly with one party over other(s).<br>» Doesn't consider legal custody and restrictions when exploring youth relationships with parents and family.<br>» Aligns/joins with obstacles.<br>» Relies on out-of-home treatment provider or other collaterals to explore obstacles to permanency/community tenure.<br>» Doesn't inquire about youth having lifelong support form a secure parenting relationship.<br>» Doesn't inquire about DCF permanency plan (when DCF involved). |

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| **EXPLORING PERMANENCY, STRENGTHS, NEEDS, AND BARRIERS** | | |
| » Explores and gathers understanding of the full family configuration (including "chosen family," custodial parents, marital status, foster parents, and siblings). On an ongoing basis, explores whom the youth and family consider to be family members. Explores the roles those family members have within the family.<br>» Explores family's interpersonal relationships with the youth. Assesses readiness and invites family members to describe their past and current relationships with the youth, including frequency of contact and quality of contact. Invites family members to describe their hopes, wishes, or vision for the relationship they want to have with the youth.<br>» Supports family members when something unsettling is disclosed.<br>» Adjusts questions to the specific family, especially when working with transitional-aged youth. | » Asks about family configuration but omits exploration of "chosen family."<br>» Does not consider the need to inquire with each family member individually or in small dyads versus a large family group.<br>» When conversation involves multiple people, lacks follow up with each family member to inquire if they heard something new or surprising.<br>» Allows negative discussion to go on to the exclusion of anything positive.<br>» Does not determine timing and readiness to explore future vision for relationship.<br>» Doesn't adjust questions to the specific needs of transitional-aged youth (e.g., doesn't assess for or inquire about guardianship needs). | » Does not create a safe space (e.g., solicit ground rules) for family members to share, discuss, and describe relationships.<br>» Ignores when ground rules for discussion are broken and does not intervene to support the family in following ground rules.<br>» Doesn't follow up with family members when something potentially unsettling is disclosed in family group setting. |

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| **EXPLORING PERMANENCY, STRENGTHS, NEEDS, AND BARRIERS** | | |
| » Considering the youth's readiness for this exploration, asks them to name and describe their past and present relationships, including frequency of contact, quality, and nature of contact (e.g., asks about memories, things they liked to do together, etc.), with important people in their lives to whom they feel connected, such as family members and "chosen family," whether living near or far.<br>» Offers youth the option to have a peer mentor or other supports during this conversation.<br>» Assesses readiness and invites youth to describe their hopes, wishes, or vision for their desired relationship with these individuals.<br>» Explores with LAR, family, and collaterals to identify past and present familial and non-familial connections and important people in the youth's life. Asks about their perceptions of the nature of the youth's and family's relationship with these individuals and those the youth identified. Explores opportunities to strengthen youth's connections and relationships with them. | » Asks about relationships with the family but not separately with the youth.<br>» Does not offer youth the option to have peer mentor or other supports present during conversation.<br>» Explores past or current relationships but not both. Inquires only about family but not about other significant relationships and connections. Neglects to inquire specifically about people who live far away.<br>» Focuses only on negative experiences. Doesn't look for exceptions (occasions when the negative experiences didn't occur).<br>» Neglects to determine the timing and youth's readiness to explore future vision for relationships. | » Simply acknowledges that youth "has no one" (when they report this) and doesn't reframe or ask additional questions to gather more understanding.<br>» Pushes youth to continue to discuss topic even though youth is visibly distraught; doesn't offer youth a break.<br>» Asks questions once and doesn't revisit.<br>» Shuts down discussion of potential supports. Dismisses possibility that a potential connection could be a support. |

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| **EXPLORING PERMANENCY, STRENGTHS, NEEDS, AND BARRIERS** | | |
| » Explores (with youth, family, and collaterals) all potential obstacles to youth returning or continuing to reside with family (such as complex clinical/trauma needs, family isolation, youth/ family violence, youth/ family readiness) on an ongoing basis.<br>» Explores what maintains these obstacles, what makes them worse, and what makes them better.<br>» Explores complex safety needs, including what each person needs in order to have an optimal degree of physical safety and emotional security within the context of the family relationship and home environment. | » Solicits some but not all possible obstacles to youth residing at home.<br>» Solicits some but not all family members' input in permanency planning.<br>» Acknowledges safety needs but doesn't proactively address them. Acknowledges parent/caregiver's fears without exploration of what drives them.<br>» Suggests what is/isn't a safety concern without exploring with family members what does/ doesn't feel safe to them.<br>» Prioritizes one family member's needs and safety concerns over another's. | » Neglects to explore potential barriers to relationship building and permanency or fails to consider ways to strengthen these, including when permanency and attachment appear strong.<br>» Minimizes connection between youth and family relational conflicts and barriers to permanency.<br>» Minimizes or actively ignores youth and family concerns. Avoids confronting family's anxiety and fear regarding youth's return home.<br>» Limits exploration of individual safety needs. Neglects to solicit different family member's definitions and experience of safety or lack thereof. |
| Uses a genogram, ecomap and/or other tools to help youth/family visualize different relationships in the youth's life. | Completes genogram, ecomap and/or other tools but doesn't use them with youth/family to help them visualize relationships/connections in their life or to discuss their significance. | Uses tools to suggest or reinforce a narrow view of family's relationship and connectedness to others. |

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| **CONDUCTING CONTINUOUS EVALUATION** | | |
| Clinician, with youth and family, assesses the validity and relevance of information gathered and suspends conclusions until information is gathered from multiple sources, including from DCF, DMH, school, other providers, and collaterals. | » Gathers information from a limited number of sources.<br>» Integrates information from multiple sources without fully assessing its relevance, significance, and/or validity.<br>» Weighs information from some sources (e.g., hospitals) as the most credible in all situations. | » Takes gathered information at face value and doesn't assess its validity or relevance or consider the reliability of reporter, how well and for how long reporter has known the youth/family, and the nature of their relationship to youth/family.<br>» Discounts youth and family perspective regarding collateral's information.<br>» Discounts youth and family as experts of their own experiences.<br>» Weighs information from one source (e.g., hospitals) as the most credible in all situations regardless of level of understanding about this youth and family. |
| » Continuously observes, assesses, and explores changes in youth's behavior, interactions, and level of functioning with different caregivers, adults, siblings, school personnel and peers relative to impulse control, communication, cognitive abilities, sensory processing, social/emotional development, health and wellness, risk behaviors, overall mental status, strengths and interests, and other factors, in different settings and accounting for developmental stage. Also observes the behavior of others interacting with youth.<br>» For young adults, also observes and assesses level of functioning in employment, independent living skills, financial literacy, and activities of daily living. Completes youth readiness tool when indicated.<br>» Explores and assesses youth and parent/ caregiver need for skill development. | » Limits observation of changes in youth's behaviors to one setting or to interactions with a limited number of people. Doesn't observe/consider the behaviors of other people in their interactions with the youth.<br>» Views behavior from only one lens (e.g., only sensory processing or only risk, etc.).<br>» Asks general, open-ended questions about skill areas that need to be developed but fails to consider developmental stage and age.<br>» Limits exploration of need for skill development to either youth or parent/caregiver. | » Doesn't observe behaviors; relies only on information from collaterals and/or verbal expression by youth and family or found in records.<br>» Makes overgeneralization about meaning of behavior.<br>» Doesn't listen for, explore, or assess areas for skill development. Doesn't use readiness tool. Waits until youth is 18 to begin exploring skills needed to function independently.<br>» Only speaks to young adult's parent/caregiver rather than exploring independent living skill needs with youth as well.<br>» Ignores developmental stages of transition to adulthood. |

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| **CONDUCTING CONTINUOUS EVALUATION** | | |
| Clinician evaluates, with family, the benefits and contraindications of obtaining specialized assessments (e.g., fire-setting, neuro-psychological testing) and/or outside consultation. | » Discusses only the benefits or only the contraindications of obtaining specialized assessments.<br>» Does not clearly explain why or how specialized assessment will or will not be helpful. | » Doesn't explain potential contraindications to parent/caregiver.<br>» Refers for specialized assessment as a matter of standard practice rather than first considering potential benefit and contraindications. |
| » Clinician continuously evaluates need for and coordinates the addition of peer mentoring as well as consultations from the Continuum occupational therapist and psychiatrist.<br>» Uses input obtained from occupational therapist, psychiatrist, and peer mentor to inform ongoing assessment. | » Uses peer mentor, occupational therapist, or psychiatrist in a limited manner.<br>» Evaluates the need for these once but not on an ongoing basis. | » Ignores input from occupational therapist, psychiatrist, or peer mentor to inform ongoing assessment.<br>» Does not engage occupational therapist, psychiatrist, or peer mentor when needed. |

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| **FILLING IN CONTEXTUAL UNDERSTANDING WITH STAKEHOLDERS** | | |
| » Consent permitting, obtains relevant information via written documents and conversations with Family Team members and other relevant collaterals.<br>» Asks about and obtains state agency and other provider assessments, CANS, and other documentation relative to youth/family history, needs and strengths, and risk factors.<br>» Asks about medical/dental history of youth and documentation of any physical health concerns and current wellness status.<br>» Asks about school attendance, behavior, academic progress, and social/emotional functioning at school. Asks about bullying, being bullied, and any known school-related risk factors. Asks about/obtains school records (e.g., IEP, evaluations, report cards, etc.) | » Obtains some information but not all.<br>» Doesn't revisit family's refusal to share information.<br>» Lacks persistence it attempting to obtain information from collaterals (e.g., only requests once). | Reads records but doesn't talk with collaterals to learn more or obtain updated information. |
| Clinician reviews assessment with supervisor, outreach worker, peer mentor, occupational therapist, and psychiatrist for consultation as needed. | Reviews with some but not all. | Doesn't review with anyone. |

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| **COMPLETING THE WRITTEN ASSESSMENT** | | |
| » Within 30 days of intake, the clinician gathers available information (including family and professional input) into a written comprehensive assessment that describes a well-rounded understanding of youth and family in their words (as agreed upon with youth and family).<br>» Incorporates available information regarding youth's and family's needs, strengths, stressors, and risk factors including history and current mental health, social/emotional/financial wellbeing, medications and target symptoms, interpersonal relationships with family, peers, and natural supports, substance use, trauma, protective factors, court/criminal involvement, and developmental milestones (e.g., communication, vocation, education, etc. and related support), functioning (uses CANS to help document functioning).<br>» Explains the implication, relevance, or support of the current assessment of documents referred to in written assessment report.<br>» Describes youth's interests and aspirations as well as a family vision for their future. | » Completes written assessment, but not within 30 days of intake timeframe.<br>» Written assessment is incomplete, doesn't include important details that were explored, or has gaps in information and doesn't indicate whether the area was explored.<br>» Refers to other documents but doesn't clearly explain their implication, relevance, or support of the current assessment.<br>» Written assessment only focuses on needs and deficits, not strengths.<br>» Uses family member's words in the written assessment but doesn't check in with them to make sure they are agreeable to these specific words.<br>» Omits youth/family vision. | » Doesn't complete written assessment.<br>» Documents information without evidence or documents information as fact when it is substantiated by some and unsubstantiated by others.<br>» Misquotes youth and family in the document and/or uses their words without regard for impact they could have when document is shared with them.<br>» Excludes youth and family voices or disregards youth's or parent/caregiver's request not to include their specific wording as written. |

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| **COMPLETING THE WRITTEN ASSESSMENT** | | |
| » Clinician writes a clinical formulation that provides diagnostic clarification (explains rationale synthesizing available evidence for diagnosis), identifies and prioritizes focal treatment needs and articulates recommendations for how needs will be addressed by Continuum staff, group home staff (when involved), other formal and informal supports, family, and youth.<br>» When a youth's relationships with parents, family, caregivers, and other attachment figures are interrupted, removed, broken, or disconnected, the clinical formulation includes psychological safety and wellbeing risks.<br>» Includes prioritized clinical needs to be addressed, deferred, referred, out or declined.<br>» Focal needs include but are not limited to those related to permanency and community tenure. | » Focal need documentation is incomplete or complete but not prioritized.<br>» Clinical formulation fails to support recommendations and/or link to reason for referral.<br>» Some diagnostic clarification exists but rationale/ evidence for diagnosis is not explicit.<br>» Proposes recommendations but rationale/ evidence supporting it is missing.<br>» Lists needs without indicating which ones are priorities for Continuum to address first, which are referred out, and which are deferred or the family declines to work on at this time. | » Doesn't complete a clinical formulation.<br>» Needs, treatment recommendations, and/ or clinical formulation are not supported by information obtained in the assessment.<br>» Fails to update clinical formulation when youth's level of care changes. |

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| | **COMPLETING THE WRITTEN ASSESSMENT** | |
| » Clinician shares assessment with the parent/caregiver/LAR and engages in a collaborative conversation using language the family is familiar with (explains unfamiliar terminology).<br>» Reviews strengths and need as well as the specific diagnosis with family and explains basis for diagnosis.<br>» Comes to agreement on which needs and goals are prioritized to be addressed first, declined, deferred, or referred out.<br>» Considers impact of family culture when redacting written assessment report.<br>» Explores areas of disagreement and consensus and makes needed revisions/additions to the assessment before obtaining signatures. | » Assessment review is hurried.<br>» Review is only conducted with parent/caregiver and not youth (as developmentally appropriate).<br>» Uses a lot of clinical terminology with inconsistent or minimal effort to explain it to the family in more familiar language.<br>» Does not acknowledge or explore differences in family's perspective. | » Does not share assessment with parent/caregiver/LAR.<br>» Does not highlight strengths.<br>» Minimizes family's identified needs to be addressed.<br>» Uses clinical terminology without attempts to explain to family in more familiar language.<br>» Omits family feedback from revisions.<br>» Does not consider impact of culture in understanding family. |

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| | **ENGAGING IN ONGOING ASSESSMENT** | |
| » In collaboration with youth and family, clinician reviews and updates the assessment as needed and annually at minimum.<br>» Incorporates new information and amends assessment as needed.<br>» Considers diagnostic accuracy in light of new information.<br>» Reviews all changes to the assessment with family, explains reasoning, and discusses any impact that changes may have on diagnosis, treatment options, or expected transition out of Continuum services. | » Updates assessment annually but not when emerging needs arise; is unclear on threshold for when to update.<br>» Considers and updates some information. | » Doesn't complete an annual update.<br>» Never reconsiders diagnosis.<br>» Updates document without reviewing and discussing changes with family and Family Team. |