CONTINUITY WITH HIGHER LEVELS OF CARE

The Core Team collaborates and coordinates with all relevant Family Team members (especially parents, family, and youth's and family's natural supports) and collaterals (such as providers, school personnel, professional and natural supports, group home, hospital, and Community Based Acute Treatment staff) to support continuity of treatment and supportive approaches with the youth/family while the youth is in an out-of-home treatment intervention (such as group home, hospital, and Community Based Acute Treatment).

The Core Team coordinates the use of consistent effective strategies and approaches with youth and family across all of these entities and settings. The Core Team shares successful approaches with the other levels of care (as agreed upon with youth/family) and also utilizes other's approaches that youth and family has had success with. The Core Team supports continuity of treatment by continuing to provide seamless initiation or continuation of the same intensity of family treatment, ongoing family engagement, youth and parent skill building, peer mentoring, care coordination, and linkage to the community when a youth is participating in an out-of-home treatment intervention. They continue to promote and build connections between youth/family and natural network of supports as well as professional long-term, community-based supports while the youth is in an out-of-home setting. When clinically indicated and authorized, the Continuum utilizes group home as a short-term, flexible treatment intervention that is integrated with the Continuum treatment plan and incorporates clinical and therapeutic interventions necessary to strengthen youth's and family's skills that promote flourishing together at home.

Please see the following matrices for additional information related to continuity with higher levels of care:

- Engaging Youth and Family
- Incorporating Psychiatry and Occupational Therapy Consultation
- Assessing Risk, Safety Planning, and Supporting Families through Crisis
- Practicing Cultural Relevance
- Collaborative Treatment Planning and Care Coordination
- Supporting Life Transitions
- Strengthening Wellbeing through Respite
- Conducting a Comprehensive Collaborative Assessment
- Providing Therapeutic Interventions

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENSURING CONTINUITY DURING ENCOUNTERS WITH EMERGENCY PSYCHIATRIC SERVICES (ESP)/MOBILE CRISIS INTERVENTION (MCI)		
» Anticipates crisis intervention needs. Proactively provides Continuum on-call staff and MCI/ESP with needed alert information, consent permitting. » Offers to be an in-person supportive presence to youth and family during MCI/ESP encounter. Explores with youth/family the natural support persons best suited to provide in-person support and presence during a crisis. » Exchanges and updates information with MCI/ESP daily through the duration of the MCI/ESP encounter, consent permitting.	» Waits to share alert information. » Suggests or assumes youth and family don't need Continuum presence during MCI encounter, rather than asking them directly. » Engages during crisis intervention but only communicates with MCI/ESP and lacks communication directly with youth/family, or vice versa. » Waits to update or inconsistently updates/exchanges information with MCI/ESP throughout the encounter. » Offers to be an in-person supportive presence but doesn't explore natural supports who can also be a supportive presence during MCI/ESP encounter.	» Ignores cues that youth/family may be approaching a crisis point. » Refuses to have any Continuum staff present during MCI/ESP encounter. » Disregards need to collaborate with youth/family and Family Team during MCI/ESP encounter. » No Continuum staff is available during MCI/ESP encounter.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
SUPPORTING YOUTH/FAMILY ORIENTATION TO OUT-OF-HOME INTERVENTION (HOSPITAL, CBAT, DETOX, GROUP HOME, ETC.)		
» Explores youth/family experience with the specific level of care (group home, hospital, CBAT, detox, etc.) and the particular facility youth will or may be admitted to. » Empowers family as experts on their youth/family. Explores and validates youth and family concerns about using this level of service/facility and provides psychoeducation on what to expect when youth is admitted. » Reviews roles and responsibilities of Core Team members relative to group home, hospital, CBAT, and detox staff.	» Explores some, but not all, experiences with levels of care or facilities with family. Explores initially, but doesn't revisit. Explores but doesn't ask specific questions aimed at a more thorough understanding of the youth's and the family's experiences and feelings about interpersonal relationships with individuals providing services. » Obtains insufficient information to determine whether/how to reengage (or avoid) using this same treatment provider. » Listens to youth's/family's experience, but doesn't recognize opportunities to validate and empower them as experts on themselves.	» Dismisses or minimizes family/youth's experiences or feelings about collaterals. » Defends provider when youth/family shares a negative experience. Insists that they must use this provider again. » Colludes with negative perspective on provider. Shares own list of own negative experiences with them. » Fails to explore ways youth/family can address concerns with collateral directly. Fails to explore how Continuum can be a support in reengaging or continuing to use provider with whom youth/family has had a negative experience.
» Explores youth's and family's expectations around frequency and type of contact they hope to have with youth once admitted. Encourages daily contact. » Assists parent/caregiver/LAR and out-of-home facility in exploring options for daily contact between youth and family members (such as phone, email, in person, etc.). » Plans for, anticipates, and addresses barriers to maintaining daily contact between youth and family members.	» Is aware that contact is occurring but doesn't explore sufficiency of contact and any need for reconsideration of options to strengthen contact between youth/family. » Discusses barriers to daily contact but doesn't explore and troubleshoot ways to overcome them. Suggests narrow range of options for contact and what parent/caregiver can do for/with youth in group home. » Doesn't orient family to the possibility for youth and family to experience a variety of intense emotions during admission. Ignores the need to offer support to the family around self-care and other strategies to manage these emotions in order to be empathically present during daily contact with youth.	» Ignores family's expectation of minimal contact. Provides no education on the importance of using this time to maintain, strengthen, and/or rebuild a connection or relationship with the youth. » Insists on daily contact and disregards family request to have a "cooling-off" period. » Ignores the need for support around establishing or maintaining regular contact between youth/family—leaves it to them to figure out.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENSURING CONTINUITY DURING OUT-OF-HOME ACUTE TREATMENT INTERVENTION (HOSPITAL, CBAT, DETOX, ETC.)		
» Offers to be present during acute treatment admission (psychiatric hospitalization, medical hospitalization, detoxification, etc.) and remains with the youth during the admission process. » As agreed upon with youth/family, assists with contacting/engaging natural support persons best suited to provide physical support and presence to youth/family during a crisis. » Provides needed information to acute facility during the admission process, consent permitting.	» Communicates with acute facility but doesn't offer to be physically present. » Communicates with youth/family during admission but not with acute facility, or vice versa. » Discusses with parent/caregiver the natural supports who can be supportive during admission but doesn't offer to assist with contacting them.	» Doesn't offer to be present and doesn't communicate with acute facility or family during admission. » Ignores the supportive role that natural supports may be able to provide during admission.
Serves as a resource to aid acute facility in their assessment. Consent permitting, provides current Continuum assessment, individualized action plan/ treatment plan, and safety plan in writing to the acute treatment provider as soon as possible but no longer than one business day after the admission.	» Provides all paperwork but not in specified timeframe. » Provides some, but not all, paperwork.	» Shares documents/information without consent. » Ignores need to share documentation with acute provider. » Shares historical information only. Omits documentation of updated treatment goals, safety plan, medications, etc.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENSURING CONTINUITY DURING OUT-OF-HOME ACUTE TREATMENT INTERVENTION (HOSPITAL, CBAT, DETOX, ETC.)		
» During the youth's acute treatment intervention, maintains a therapeutic relationship with youth and family. » Reaches out to youth and/or family daily by phone or in person (unless otherwise agreed upon). Checks in with youth/family regarding necessary ongoing frequency of this contact. » Explores frequency of visits family has with youth and needed support to help visits occur. » Provides ongoing treatment interventions, assessment, and safety planning. » Continues to bridge youth/family relationships with Family Team members and supports relationship development with acute facility team members. » Provides the acute facility team members with contextual information re: permanency situation to prevent disruption or disconnection of relationships, promote continuity for youth, and reinforce primary role of parents/family in treatment, healing, and trauma recovery process.	» Reaches out to family but not at the frequency agreed upon with the youth/family. » Reaches out to family minimally per their request and doesn't revisit the question of frequency to see if it's meeting everyone's needs. Doesn't explore the need to return to active engagement and/or treatment after giving family a brief break/respite when requested. » Checks in with youth/family but lacks intentionality, focus, or purpose. » Has contact regularly with youth or family but not both. » Overlooks the need to support youth and family in building and practicing skills that will help them have successful visits together. » Provides some permanency information but doesn't discuss ways that the acute team may help prevent disruption or disconnection of relationships, promote continuity for youth, and reinforce primary role of parents/family in treatment, healing, and trauma recovery process. » Provides some permanency information but doesn't keep acute provider updated on any changes.	» Takes a passive stance: disengages in active communication and/or coordination with youth, family, and collaterals while youth is in acute setting. Suspends treatment and/or Family Team meetings. » Dismisses the need to reach out to youth and family regularly while admitted. » Dismisses/discounts youth's ability to develop the skills to be successful outside of the hospital setting. » Doesn't follow agreed-upon plan of contact. Doesn't communicate with family or team when crisis arises. » Makes unilateral decision to stop all treatment interventions rather than considering, with family and facility, what can and should continue. » Overlooks the need to provide acute facility with permanency information.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENSURING CONTINUITY DURING OUT-OF-HOME ACUTE TREATMENT INTERVENTION (HOSPITAL, CBAT, DETOX, ETC.)		
» Reaches out to acute provider daily to exchange progress updates and build a shared understanding of clinical formulation, strengths, treatment goals, and discharge plan. » Coordinates and collaborates around LGBTQ, cultural, and dietary considerations for integration into the acute setting, group home, school, and home and/or community settings. » Collaborates and coordinates with youth, family, and acute treatment team on integrating treatment approaches, interventions, recommendations, and medication changes. Incorporates them, as agreed upon with youth/family, into the existing Continuum treatment plan. » Prior to discharge, explores step-down options, new supports, and interventions needed. Comes to agreement around any action items and begins developing/ integrating new approaches at home, group home, community, school, etc.	» Makes sporadic contact with acute provider. » Unilaterally decides which goals and recommendations to update/incorporate into treatment plan. » Automatically defers to treatment goals of acute setting. Considers the hospital's recommendations as superior and doesn't explore goodness of fit for this particular youth/family.	» Lacks coordination with acute provider around treatment approach, goals, and medication changes. » Ignores acute provider's recommendations. » Doesn't explore or consider the need to adjust treatment approach or update treatment plan and safety plan. » Fails to begin exploring ways to integrate changes in Continuum's treatment approach and safety/ crisis support prior to youth's discharge.
» Continues to facilitate Family Team meetings. Incorporates acute facility into Family Team meetings, consent permitting. Coordinates with Family Team Members and other relevant supports (school, collaterals, etc.) around the integration of new approaches to treatment, medication administration, etc. » Asks about and attends all acute facility-based meetings as requested by family and acute treatment provider.	» Doesn't notify DCF/DMH of admission to Hospital/CBAT. » Doesn't coordinate with and bridge the work of the acute facility and the Family Team. » Keep some, but not all, relevant collaterals/ Family Team members updated. » Fails to offer to call into a meeting when unable to attend in person.	» Acts independently. Stops holding Family Team meetings. » Refuses to attend or participate in meetings at the acute setting even when requested by the family.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENSURING CONTINUITY DURING OUT-OF-HOME ACUTE TREATMENT INTERVENTION (HOSPITAL, CBAT, DETOX, ETC.)		
» Coordinates with acute provider to ensure a discharge meeting is held. Participates in or co-facilitates discharge meeting with acute provider prior to discharge. » Develops/updates the safety and crisis prevention plan with the youth, family, and acute treatment team as part of acute-treatment discharge process, making sure to include the identified roles of youth's/family's safe and protective relationships/natural supports. » Coordinates with the acute treatment provider in support of their discharge paperwork, follow-up appointments, and other pertinent information and materials (e.g., prescription, prior authorizations, personal belongings, etc.) being provided to the appropriate entities (family, Core Team, group home, school, prescriber, and outpatient and other treatment providers, etc.).	» Doesn't address the need for a discharge meeting or requests one without sufficient time to involve all relevant parties. » Updates the safety plan and/or treatment plan without youth/family input or leaves out roles of youth's/family's safe and protective relationships/natural supports.	» Maintains the same crisis plan that was in place prior to admission. Doesn't modify it or the treatment plan. » Doesn't coordinate to integrate treatment changes that will need to be implemented in the next setting (such as medication changes at group home). » Insists that youth will be discharged home without sufficient preparation. » Doesn't explore with the family whether the discharge plan is feasible for them. » Doesn't collaborate with the school to support a smooth transition back to school.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENSURING CONTINUITY DURING GROUP-HOME TREATMENT INTERVENTION		
» Coordinates, co-facilitates, and participates in a pre-intake meeting with group home staff, youth, and family. Prioritizes participation of youth and parent/caregiver/LAR in exploration, selection, and decision about group home. » Attends intake meeting with group home staff, family, and DCF/DMH and is present at admission to group home. » Establishes roles and responsibilities of group home, Core Team, and Family Team. Discusses process for coordinating care and integrating treatment planning and safety planning with the group home. » Co-creates initial goals of group home treatment. » Facilitates agreement on initial plans for youth to have continued contact with family by phone and in person at the group home. Begins to develop an initial plan for time spent at home as well.	» Doesn't invite all key collaterals to the meeting. » Describes roles/responsibilities of group home and Core Team but doesn't explain the Family Team. Gives vague description of roles/ responsibilities of group home and Core Team. » Facilitates development of group home goals, family time, or initial safety planning, but not all three. » Begins discussion of goals and plan to support continued youth and family contact but does not determine any actionable items. » Provides family with a vague or unclear explanation of programmatic restrictions on family contact that are rooted in "daily life" at the group home. Lacks exploration of how to work with/ around them to ensure youth has ongoing regular contact with family at the program.	» Doesn't invite youth and parent/caregiver/ LAR to pre-intake meeting. » Doesn't include youth and parent/ caregiver/LAR in exploration, selection, and decision about group home. » Has meeting without parent/caregiver/ LAR. Doesn't hold a meeting or leaves the meeting without a plan. » Leaves conflicts unresolved or takes no next steps aimed at resolving conflicts that came up during the meeting. » Does not describe Continuum and group home relation to one another in service to this youth/family. » Leaves meeting without any discussion of co-creation of goals or initial plan for continued support youth and family. » Doesn't recognize and/or address operational barriers to increasing youth time with family.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENSURING CONTINUITY DURING GROUP-HOME TREATMENT INTERVENTION		
» Coordinates with the family, LAR, and the group home provider to ensure that youth and family have in-person contact at the family's home and community as often as possible during a time of day that is reasonable, practical, and convenient for them, including evenings and weekends (lack of emanate risk permitting). » Coordinates a plan with group home, youth, and family/LAR that helps youth/family structure home/community time. Considers and plans for multiple factors (such as length of time at home, who will be present, how time will be spent, level of structure needed, how crisis will be anticipated and dealt with, etc.). » Safety plans with youth, family, and group home. Updates/amends the safety plan document. » Plans for and provides 24/7 face-to-face crisis response and support to youth and family while youth is in the home and community.	» Develops a plan but doesn't revisit and adjust it if it's not working. » Overlooks transportation needs, use of natural supports, creative approaches, or other factors that will set youth/family up for successful time together. » Doesn't explore additional options when LAR overrides parent's needs/preferences. Doesn't facilitate discussion of concerns with DCF/DMH that will lead to a successful plan. » Ignores group home planning; prepares for youth/family time in silo and doesn't reach out to coordinate youth/family. » Lacks detailed exploration of, planning for, and structuring time and involvement with other agreed-upon family members (siblings, grandparents, divorced/separated parents living outside youth's primary home, etc.) while planning home/community time.	» Imposes a specific method to resolve conflict rather than brainstorming options and listening to family preferences. Ignores the need to educate group home on family's needs/preferences. » Ignores aspects of the plan that are not working or recognizes it but doesn't reconvene and adjust the plan. » Restricts family contact due to youth not "earning" it or for other punitive reason. Suggests contact will be restricted as an incentive to manage youth's behavior. » Doesn't update the safety plan when youth is in group home. » Doesn't plan for and provide in-home crisis response when youth is spending time in home/community. » Leaves it to group home to plan for and respond to youth crisis during home time rather then coordinating with group home around Continuum providing in-home crisis response.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENSURING CONTINUITY DURING GROUP-HOME TREATMENT INTERVENTION		
» Meets—quarterly at minimum—face-to-face with out-of-home treatment provider, youth, family, and Family Team Members to revise the youth's treatment plan. » Coordinates with the group home to ensure that the goals, objectives, and interventions of the group home are aligned with and integrated with the Continuum treatment plan. Co-creates, reviews, develops, and integrates goals of the group-home treatment intervention into the treatment plan. Considers how to integrate activities of the family partner and peer mentor with the group home.	» Meets/updates treatment plan less than quarterly. Verbally updates/discuses treatment plan changes but without documentation. Has a written plan but doesn't put it into practice. » Unclear regarding ways family partner and peer mentor can contribute to group home and Continuum work with youth/family on goals.	» Creates treatment plan independent of group home, peer mentor, and/or family partner. Maintains original treatment plan without integrating it with group home's. » Doesn't clarify when group home goals that are unclear or incongruent with Continuum goals. » Dictates goals without exploring group home's recommendations and observations regarding youth/family needs and group home progress to date with family.
» Coordinates with group home, family, school, and community programs to support continuity of youth connection with, engagement, in and participation in school and community activities to every extent possible while in group home. » Explores the need to identify a new school placement.	» Leaves it to group home to coordinate with school and community program around ways to help youth stay connected while in group home. » Without discussion, leaves it to group home to coordinate school placement. » Talks with school about return but doesn't share concrete interventions/ coping strategies that work for youth. » Does not explore school-related needs.	» Ignores or dismisses youth's school-related needs all together. » Coordinates with group home and school but excludes parent/caregiver and youth from the process.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENSURING CONTINUITY DURING GROUP-HOME TREATMENT INTERVENTION		
» Provides family treatment, parent/caregiver support, outreach, and peer mentoring in the home, community, and/or at the group home. » Identifies the need for and engages youth/family in any skill building and coaching needed to support youth and family spending the maximum amount of time together at home and community as well as their participation in school and community activities.	» Plans for and practices skills used during home time that aren't reflective of how life will be in the home once living there full time. » Focuses skill building on one individual rather than on all family members, caretakers, and co-parents in and out of the primary home. » Informs group home of skill building being worked on with youth/family but lacks collaboration with group home around ways group home and Continuum staff can integrate and establish continuity of approaches across settings. » Continues providing same interventions but with less frequently rather than reevaluating and adjusting the type and frequency of interventions based on new clinical needs. » Hesitant to address negative interactions of parent/caregiver or youth when they cease contact. » Initiates skill building without exploring youth, family, and group home perspectives on the skill-building needs. » Considers the group home's recommendations as superior and doesn't explore goodness of fit for the particular youth/family.	» Dismisses/discounts youth's ability to develop the skills to be successful outside of the group home setting. » Disengages from active communication, coordination with youth, family, and collaterals while youth is in group home setting. » Suspends Continuum treatment interventions, skill building activities, and/or Family Team meetings. » Doesn't incorporate or teach/coach family members successful interventions/strategies used at the group home that can also be used in the home, community, or school setting. » Works exclusively with youth/family without any discussion/collaboration with group home treatment provider. Ignores the need to exchange treatment and skill-building progress updates with group home frequently. » Teaches/coaches skills used in the group home that aren't feasible at home.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENSURING CONTINUITY DURING GROUP-HOME TREATMENT INTERVENTION		
» Has weekly contact with the out-of-home treatment team lead or liaison to exchange progress updates, coordinate care, and integrate treatment approaches, interventions, and goals. » Exchanges updates on progress in treatment as well as updates on youth's and family's strengths, challenges, and use of safety plan. » Coordinates support to families around planning for activities related to time spent at home and community. Explores progress with and ways group home and Continuum is attempting to maximize amount of time youth and family spend together at group home and at home and in their community. » Explores, coordinates, and revisits ways group home and Continuum are supporting caregiver/parents' continued or new engagement in parenting activities that are feasible for the particular parent (e.g., attending PCC appoint with youth, taking youth shopping, saying goodnight to youth each night, etc.) and that are congruent with their cultural practices.	» Has irregular or inconsistent contact with group home. Contact is driven by crises only, not proactive. » Exchanges treatment progress updates but doesn't discuss how to integrate group-home treatment and in-home treatment. » Has contact but doesn't discuss/explore in enough detail to coordinate and integrate work together. Doesn't facilitate agreement on next steps. » Collaborates around plan to maximize youth/family time together but doesn't follow up on expectations or check in with others on their tasks. » Coordinates time with youth and family but doesn't plan aspects that will set youth/family up for more effective time together (e.g., planning for siblings to have play time in addition to formal family time). » Engages in limited exploration or understanding of cultural practices and expectations when considering options for youth/family to spend time together.	» Shifts treatment approach and updates plan without collaborating with the out-of-home treatment provider and/or youth and family; collaborates but doesn't update the treatment plan. » Ignores crisis and maintains original plan. » Doesn't share with/solicit from group home notable situations, environmental changes, stressors, etc. as they arise for youth/family. » Fails to explore ways to maximize youth time at home. » Fails to explore what is working for the youth in the milieu. » Doesn't engage DCF as LAR around a persistent, incremental and transparent plan to maximize youth/family time when reunification is the plan but no action has been taken to support this. » Updates safety plan without including successful interventions/strategies used in group home.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENSURING CONTINUITY DURING GROUP-HOME TREATMENT INTERVENTION		
» Plans for Family Team meetings, discharge, care coordination activities, and any needed follow up with youth, family, DCF/DMH, and school around action items and next steps to integrate new approaches at group home, community, home, school, etc. » Anticipates and plans for challenges, transitions, and crisis prevention/safety planning. Coordinates safety planning, implementation and updates to the safety plan (including role of continuum). » Coordinates the sharing of documentation.	» Coordinates with group home but not family, or vice versa. Excludes Family Team and/ or other needed supports in coordination. » Addresses immediate crisis but doesn't plan for following up on other topics requiring to discussion.	
» Explores with the out-of-home treatment provider, youth, family, and other Family Team members which support services are needed to help youth and family return to living together in the community. » Provides interventions that support youth and family living together. Bridges them to any additional formal and informal supports that are needed to help them return to living together.	» Explores with some entities but not all. » Provides interventions but doesn't bridge to additional supports or vice versa. » Explores resources with family input but doesn't bridge them. Locates services for family without including them in decision. » Uses narrow, "cookie cutter"/one-size-fits-all/generic list of supports. » Explores natural supports but doesn't explore whether/how they will be able to provide support. » Anticipates needs but doesn't make plan for how to access them.	» Doesn't take an active role in planning for discharge/step-downs and bridging. » Doesn't focus work toward return to community. Doesn't provide interventions or link youth/family to additional supports that will support them in living together. » Leaves youth out of planning process.