ENGAGING YOUTH AND FAMILY

The Core Team engages in an ongoing process of relationship building with the youth and their family members to collaborate on shared goals for treatment. Engagement is conducted through respectful curiosity about individual and family strengths, needs, and culture.

It involves empathy, careful listening, sensitivity, humor, and compassion and establishes an expectation of shared decision making in which the youth and families' voice, experiences, and opinions are prioritized and are persistently sought and validated. It demonstrates mutual engagement: that you are where you want to be—with this family at this time—and ready to give full attention. Engagement is a critical aspect across the Core Team's essential functions, not just at a point in time, and takes into account youth and family readiness for change and meets them where they're at.

Please see the following matrices for additional information related to engaging youth and family:

- Practicing Cultural Relevance
- Conducting a Comprehensive Collaborative Assessment
- Assessing Risk, Safety Planning, and Supporting Families Through Crisis
- Continuity with Higher Levels of Care
- Incorporating Psychiatry and Occupational Therapy Consultation
- Collaborative Treatment Planning and Care Coordination

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
RESPONDING TO REFERRAL		
» Within three days or receipt of the referral, calls the referring agency and collaborates to establish a plan for the Continuum's initial contact with the family. » Determines whether the initial contact meeting will occur via phone or in person, who will schedule and facilitate the meeting, and what the Continuum's role will be in the meeting. » Determines who will contact the parent/caregiver ahead of the meeting in order to ask the parent/caregiver and youth (as developmentally appropriate) who they would like to have attend the initial meeting. » When the Continuum contacts the parent/caregiver ahead of the initial meeting, the following possible attendees are explored: parent/caregiver (and youth as applicable) other family members, natural supports, Family Partner (when in place), DCF/DMH staff, Continuum staff, and other applicable collaterals. Determines together who will invite the selected individuals. » Explores parent/caregiver's expectations about the meeting including what they feel is important to discuss. Considers options to engage the youth in the initial contact meeting (e.g., attend part of the meeting, plan to discuss with youth in a follow-up meeting, etc.). Considers how to prepare youth to participate based on age, developmental level, and individual needs as well as which team member is best to prepare the youth.	» Prepares only partially for meeting with the referral agency. Develops an incomplete plan for initial contact with the family. » Discusses preparations for the initial meeting with youth/family but doesn't explore who else should or will be invited or attend the meeting. Tells the youth/family about the initial meeting but does not help them to anticipate what to expect or does not ask what they feel should be discussed. » Doesn't open up discussion to help determine which Continuum staff person (e.g., Clinical Director, Program Director, or Core Team to be assigned) is the best one to attend the initial meeting with this family.	» Responds to referral agency after four or more days after receipt of referral. » Ends call with referent without determining a plan for initial contact with family. » Doesn't inquire about who should or will be invited or in attendance. Contacts the youth/family but doesn't explore their expectations for the meeting. » Doesn't specifically inquire about whether there is a Family Partner. Doesn't advocate for a Family Partner to attend or explore why the Family Partner is not attending (when there is one in place). » Doesn't obtain clarity on Continuum's role in this meeting.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
FACILITATING INITIAL (PRE-INTAKE) MEETING WITH YOUTH/FAMILY		
» Facilitates or attends an in-person pre-intake meeting with the youth, their family, DMH/DCF referent or designee, Family Partner (if one is in place), natural supports, and other collaterals (consent permitting) as agreed upon with the family and referring agency. » Explains who made the referral, if not stated by other participants in the meeting. » Clearly states the central purpose of Continuum services (to support youth and families in a manner that helps youth remain in and/or return to their home in a safe and timely manner and function successfully at home, school, and in their community).	» Facilitates the meeting but doesn't address all the priority items on the agenda. » States the central purpose of Continuum services (safe and timely transition of youth home or successfully remaining at home and in their community) but not clearly or continuously throughout meeting. » Explains some, but not all, aspects of the Continuum. » Provides an unclear description of Continuum or doesn't clarify confusion regarding services. » Doesn't solicit questions about the Continuum service.	» Doesn't follow previously agreed-upon meeting facilitation plan. » Misses meeting and fails to notify facilitator ahead of time. » Facilitates/attends the pre-intake meeting without the family. » Is unclear about the central purpose of Continuum services (safe and timely transition of youth home or successfully remaining at home and in their community).

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
FACILITATING INITIAL (PRE-INTAKE) MEETING WITH YOUTH/FAMILY		
» Describes Continuum services and how they might be helpful to the youth and family, including: » Core Team approach to home-based work and in-home and out-of-home interventions. » Roles of the clinician, outreach worker, and youth peer mentor. » Family therapy, skill building/coaching, care coordination activities, and functions of the Continuum. » Family Team Meeting process, with encouragement of family to begin considering possible team members. » How the Core Team bridges with other service providers (CBHI/CT Family Partner Service, DCF/DMH agencies and services, etc.). » Criteria for participation in Continuum services (youth's clinical needs and youth and family's voluntary agreement). » Confines of service such as mandated reporting and confidentiality. » Answers questions and provides any additional information needed to ensure family has sufficient information to make informed consent for services.	» Fails to anticipate what participants might want to know and to provide that specific information. » Explains services in a rote manner that doesn't represent how the Continuum can potentially help with the unique needs of this youth/family. » Doesn't inform family about who made the referral. » Uses jargon and acronyms (without explaining them).	» Misrepresents Continuum services or doesn't explain Continuum services. » Only talks to professionals before, during, or after the meeting and doesn't speak directly to the family. » Describes service as low-intensity and/or required/involuntary. » Gives misinformation.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
FACILITATING INITIAL (PRE-INTAKE) MEETING WITH YOUTH/FAMILY		
» Explores who youth/family and legal authorized representative (LAR) identify as "family" using a broad definition of family that is not restricted by blood or legal relationships. Uses youth/family engagement tools (e.g., Scaling Question, Timeline, Three Houses, Bulls Eye Family Safety Circle, I want to Say Something, etc.) to facilitate this discussion as appropriate. » Inquires how family members prefer to be addressed and addresses them in that manner.	» Explores who is in the family with youth or with family, but not with both, or uses a narrow or traditional definition of family. Asks closed-ended questions. Doesn't ask questions or doesn't use tools like ecomap to help generate a full understanding of relatives and others that youth/family consider family. Doesn't use or doesn't know how to use youth/family engagement tools to effectively facilitate this discussion. » Calls family members by given names on referral form without inquiring how they'd like to be addressed. » Inquires, but then inconsistently addresses family members in the manner they requested (e.g., inconsistently uses pronouns/names requested or uses "mom" or "dad" instead of names).	» Uses previous records and/or conversation with collaterals to explore family constellation, but doesn't explore it with family. Isn't aware of youth/family engagement tools or refuses to use them in facilitating this discussion. » Constantly calls youth/family by a name they requested not be used. » Persistently misuses pronoun/name (especially in regard to gender identity).
» Explores youth/family and other participants' hopes, worries, needs (including safety and risk) and goals for the youth/family as well as family's strengths and progress on activities/goals thus far. Uses youth/family engagement tools to effectively facilitate this discussion as appropriate. » Asks about past experiences (what did and didn't help) with service providers and natural supports.	» Asks about some hopes, worries, needs, goals, or strengths, but not all, or asks about all with minimal exploration of each item. Doesn't use or know how to use youth/family engagement tools to effectively facilitate this discussion as appropriate. » Asks broad question about past experiences rather than asking specifically what works and didn't in particular services. » Only asks about what was helpful with providers or natural supports, but not with both.	» Doesn't inquire about past experiences. » Isn't aware of youth/family engagement tools or refuses to use them in effectively facilitating this discussion. » Dismisses any participants' expressed hopes, worries, needs, goals and/or progress.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
FACILITATING INITIAL (PRE-INTAKE) MEETING WITH YOUTH/FAMILY		
» Explores family's expectations of the Continuum service, clarifies any confusion regarding what the service can offer and explores family's level of interest and readiness to participate. » Inquires whether the family is ready to consent to receive Continuum services and, if so, arranges the first meeting at the family's convenience. If consent is not given, arranges a time check back in on their decision. Asks youth/family what would assist them in being ready to consent. Uses a scaling question effectively in this discussion as appropriate.	» Overlooks incongruence between family's hopes, needs, and goals and those the referring agency holds for them. » Discusses the need for consent for services, but doesn't specifically ask if family is ready to consent at that time. Suggests they will follow up (when family is not yet ready to consent) but doesn't give a date when they will get back in touch with family to check in. Doesn't ask youth/family what would assist them in being ready to consent. Is unsure of how to use a scaling question effectively in this discussion.	» Doesn't explore family's understanding of and interest in the service. » Tells the family they must consent. » Arranges meetings at a time convenient for staff but does not consider the family's schedule. Doesn't understand how to empower the family by asking them what it would take for them to be ready to consent. Isn't aware of what a scaling question is or how to use it. » Considers youth or family readiness for treatment, but not both. » Doesn't follow up with families who are not ready to consent at the initial meeting.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
FACILITATING INITIAL (PRE-INTAKE) MEETING WITH YOUTH/FAMILY		
» Explores and identifies any special considerations affecting Core Team Staff assignment. » Asks family members about: » Preferred modes of communication, » Learning styles » Cultural practices » Preference for staff's cultural/linguistic background and assigns staff who fit this preference, whenever possible. When linguistic fit is not possible, uses interpreters to support ongoing engagement in all aspects of service (assessment, treatment, skill development, therapy, crisis/safety planning and response, etc.). » Discusses most convenient times and locations for the family to participate in meetings and activities, such as evening hours, weekend(s), at family's home/community, or other accessible locations. Schedules and holds meetings and interventions at these times and places. » Asks youth/family how they prefer to be prepared for meetings in advance, including opportunities to give input to agenda items. » Shares with family intention to communicate schedule and engage with family according to their stated preferences. » Explains conditions under which staff will have to use non-preferred modes of communication (due to electronic access, HIPAA, etc.).	» Limits inquiry or shifts discussion of family's expression of special considerations and/ or preferred cultural and linguistic fit. » Asks about preferred modes of communication, learning styles, and cultural practices but doesn't explore need areas for each item. » Does not overtly state commitment to use family's stated preferred modes of communication. Doesn't explain conditions under which staff will have to use non-preferred mode of communication (due to electronic access, HIPAA, etc.) until after the fact. » Limits scheduling options without considering family's preferences for location or date. Tells family they can't meet outside the home even when family prefers that. Schedules meeting on family's observed holiday but promptly changes it, once discovered. » Schedules meetings with family but does not consider including relevant non-regular attendees, such as grandparents, adult siblings, etc. » Does not ask youth/family how they prefer to be prepared in advance for meetings, including opportunities to give input to agenda items.	» Doesn't inquire about family members' preferred modes of communication, learning styles and cultural practices. » Engages family in a manner that is inconsistent with family's stated preferences and/or disrespectful of their cultural practices. » Ignores mismatch of staff to youth/family cultural/ linguistic preferences or makes staff choices based on assumed preferences. (e.g., African American clinician automatically assigned to black family without any inquiry about preferences). » Doesn't provide needed interpreter or brings interpreter without family's permission or uses youth or siblings for interpreting. » Doesn't solicit input from family/youth about convenient times/locations for meetings. » Schedules time and place that is convenient for providers or for Continuum staff but not for the family. » Does not prepare youth/family in advance or provide opportunities to give input into meeting agendas. » Lacks flexibility, doesn't consider alternative meeting locations (e.g., declines to meet with family because the home environment is "too chaotic").

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
FACILITATING YOUTH/FAMILY INTAKE		
» Meets in person with the youth and family to provide any needed (re)orientation to the service and orientation to agency, reviews intake paperwork and obtains consent for treatment, if it has not yet been obtained. » Reminds family of the central purpose of all Continuum interventions and activities as well as the Core Team approach described during the pre-intake meeting. Asks for and clarifies any questions. Orients youth and/or others who were not part of the initial meeting (regarding Continuum services, mandated reporting, and confidentiality). Asks all participants if there's anything else they want to review from the initial contact conversation/pre-intake meeting and reviews that information as requested/needed. » Informs the family in writing about their right to withdraw consent as well as other rights and responsibilities of the youth and family and responsibilities of the provider. Informs the youth/family of the process and contact information for expressing concerns and complaints about the Continuum service as well as the organization's formal grievance process. » Provides written contact information (office location, answering service, etc.) and explains to family and youth, when developmentally appropriate, the process for contacting the Continuum during regular interactions and emergency situations.	» Does not reiterate the central purpose of all Continuum interventions and activities. Reviews intake paperwork and obtains consent but doesn't orient youth/family to the larger organization that houses the Continuum. » Explains concern/complaint and formal grievance process but does not provide explanation in writing. » Written information is given without explanation and/or the opportunity to ask questions. » Mentions the pre-intake meeting but doesn't ask for or clarify questions from that meeting. » Answers questions with facts but doesn't explore the concerns that may underlie the questions. Overlooks the opportunity to validate that this may be a confusing time for the family and that it is typical to have questions. Doesn't check whether the information is clear. Doesn't solicit questions throughout or at the end of the meeting. » Provides family with Continuum on-call contact info, but not the youth, even when it's developmentally appropriate to do so.	» Jumps into obtaining consent without reviewing paperwork, reminding family of Core Team approach or inviting questions and providing clarification. » Does not understand or cannot clearly explain the Continuum's central purpose (safe and timely transition of youth home or successfully remaining at home and in their community). » Doesn't discuss family's readiness to consent or doesn't obtain consent. Obtains consent only from the non-custodial parent. » Does not explain the concern/complaint and formal grievance process verbally or in writing. » Written information is given in a language the family doesn't read. » Provides incomplete or incorrect information, guesses at answers rather than planning to follow up with the correct information at a later time. » Tells family the emergency contact information, but doesn't provide it in writing. » Provides youth/family with local MCI team or emergency room contact information only rather than including Continuum on call contact information, or vice versa.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
FACILITATING YOUTH/FAMILY INTAKE		
» Describes the importance of gathering and sharing relevant information to/from other sources important to youth/family. » Requests permission to gather/share information to/from other providers, agencies, and schools involved with youth and family and clearly explains why and how it will be used to assist them in achieving their goals. » Explores any reluctance to obtaining/sharing information and presents options for providing only information that the family feels comfortable sharing. » Gathers/shares information to/from other sources as consented to by family.	» Gives the youth/family no explanation of the importance of being able to talk with other supports/providers in youth's/family's life. Gives a vague explanation of why and how this information will be used or doesn't connect the information to the youth's/family's goals. » Explores reluctance for consent, but doesn't open dialogue about options for a path forward (options such as: limiting consent content, limiting consent to a few days, offering to have parent/caregiver/LAR present when calling the individual). » Doesn't find resolution to parent/caregiver/LAR's reluctance to exchanging information with others. Overlooks the need to revisit the discussion again.	» Gives family a blank Release of Information (ROI) to sign and/or doesn't explain reason for ROI. Does not explain why and how information that is gathered will be used. » Tells parent/caregiver/LAR that an ROI is needed without fully explaining why. Uses coercive language, tells parent/caregiver/LAR they "need to" sign consent due to a particular reason rather than asking or explaining that the consent will allow Core Team members to speak to an individual. » Withholds information from sources family consented to even when sharing that information is not clinically contraindicated. » Uses derogatory, blaming or shaming language when sharing information about youth/family with other sources.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
FACILITATING YOUTH/FAMILY INTAKE		
» Conducts a current risk assessment including risk of harm to self and others, and risk of harm by others, medical problems, fire safety, problematic sexual behavior substance use, domestic violence, and run-away risk at minimum. » Includes an assessment of risks to psychological safety as well as physical safety – specifically how to sustain attachments and other protective relationships, prevent separation, loss, loneliness, and disconnection whether the youth is living at home or in an out-of-home intervention. » Develops an initial safety plan with the youth and the family to address physical and psychological safety concerns identified with strategies agreeable to the family.	» Focuses heavily on youth's past risk as an indicator of current risk without assessing for current resiliency factors, sustained success/progress, and mastery of coping skills that have since reduced risk. » Creates a safety plan with the youth and family that is not individualized to include strategies they will actually use (e.g., plan states "call 911" when family is adamant that they will never call 911 due to fears of police racial profiling). » Focuses only on physical safety and does not address risks to youth's psychological safety.	» Doesn't engage in risk assessment and/or safety planning. Does not understand difference between physical and psychological safety. » Develops a risk assessment and/or safety plan without the youth/family. » Files a 51A without explaining and giving parent/caregiver the opportunity to be part of the reporting process.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
FACILITATING YOUTH/FAMILY INTAKE		
» In collaboration with the youth, parent/caregiver/LAR, Family Partner, providers, and agency staff, develops initial treatment plan based on shared treatment goals to address youth's behavioral and emotional needs that interfere with the youth's successfully transitioning to or living at home and engaging/participating in their community. » Also includes in the treatment plan the parent/caregiver/family strategies, skills, or resources that will effectively support the youth successfully transitioning to or living/engaging/participating in home and community. Identifies treatment plan tasks for youth, family, and professionals. » Initiates a plan for strengthening/maintaining educational access in the youth's home community school and for supporting educational attainment (once later finalized, includes educational plan in the Treatment Plan). » Develops an initial discharge plan including a projected discharge date.	» Focuses treatment plan solely on youth behavioral and emotional needs and inadequately considers the essential parent/caregiver/family strategies, skills, and resources needed to support the youth transitioning or successfully remaining in home and community. » Identifies primarily youth treatment plan tasks with few parent/caregiver/family tasks and/or no tasks for professionals. » Ask youth/family what assistance/support is needed for educational attainment, but doesn't explore barriers or a plan to address them. » When exploring community attainment, only focuses on professional supports and does not include natural supports or community resources such as church, community center, etc. » Brings up the need to consider discharge but doesn't explore how youth/family and team will know when it's time to end services.	» Develops an initial treatment plan without input from the youth/family. Does not attend to the parent/caregiver/family role in youth successfully living at home or transitioning back home. » Identifies only treatment plan tasks for the youth. » Develops a treatment plan that doesn't include some focus on community engagement and school attainment. » Omits any discussion of discharge.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ONGOING FOSTERING OF FAMILY-DRIVEN THERAPEUTIC ALLIANCE		
» Identifies, encourages, and reinforces parent/caregiver and sibling's patience, persistence, and perseverance in raising a child with mental, emotional, and/or behavioral health needs. » Acknowledges youth and family strengths and successes in residing together.	» Ignores or minimizes impact of secondary trauma on some family members (e.g., recognizes for parent/caregiver but not sibling). » Rushes to name strengths for youth and family without eliciting from them directly. » Identifies strengths but doesn't help the youth and family see times when they have used those strengths to live well together. » Stays focused on family description of difficult times without helping them move toward considering what it would look like if the living situation improved.	» Disregards the emotional weight (e.g., shame, guilt, frustration, etc.) and implications of parenting struggles. » Ignores or minimizes the parent/caregiver or other family member's mental, emotional, behavioral health needs, secondary trauma (from child's needs), and how secondary trauma impacts that person's mental, emotional, and behavioral presentation and ability to engage and/or complete tasks at hand. » Ignores aspects or times when youth and family do feel a strong connection or close relationship with one another or a sense of success living together.
» Uses a range of specific engagement skills (active listening, open-ended questions, appreciative inquiry, strengths-based language, etc.). » Adapts to differences in home setting (distractions, locus of control, boundaries, etc.) and individualizes approach to the various stages of readiness for change experienced by each family member. » Uses language that is respectful of the parent/caregiver, youth, and family's culture.	» Doesn't persistently attempt to engage or adjust engagement approach to family members who are hard to reach. Starts a new intervention without enough exploration of youth/family member's readiness for change. Moves ahead before youth/family is ready to. » Uses the same few engagement strategies, but does not try new ones. Asks mostly closed-ended questions. Speaks more than youth/family members. Doesn't probe for greater understanding when needed. » Aligns ineffectively with family members but recognizes and corrects it.	» Acts on own/other's perspectives about youth and family readiness without first exploring it with them. » Is too flexible with engagement strategies and doesn't maintain boundaries. » Doesn't allow parent/caregiver to bring natural support(s) to meetings to help understand/express themselves. » Looks at clock throughout session/intervention and/or ends abruptly. » Uses derogatory terms, expression of stereotypes, or discriminatory language.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ONGOING FOSTERING OF FAMILY-DRIVEN THERAPEUTIC ALLIANCE		
Values the family's knowledge of what works for their family by exploring and listening for strategies of problem-solving and solution- seeking they've tried (including what's worked and what hasn't) and utilizing that information to customize helping approaches and to fit the youth's/family's uniqueness, personality, culture, and interest. Uses tools such as solution-based or exception questions.	» Doesn't ask family/youth what they have tried already. » Uses solution-based or exception questions ineffectively (e.g., in a non-conversational manner, closed-ended, rushed, with judgmental tone, etc.). » Attempts but is inconsistent in individualizing approach to each family member or doesn't shift approach as needed to fit family. Relies on certain skills or strategies that aren't working for family. » Moves too quickly into "change making" or implementing a solution.	» Doesn't create space for youth/family to express their expertise on themselves/family. » Doesn't consider or use solution-based or exception questions. » Only attributes expertise to professionals, not youth and family. Engages in problem solving discussions with professional only, not youth/family. » Disregards family's culture.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ONGOING FOSTERING OF FAMILY-DRIVEN THERAPEUTIC ALLIANCE		
» Has regular, in-person discussions with the youth/family to hear about their evolving perspectives on their hopes and worries, strengths, needs, short-term goals and long-term vision as well as to learn about their involvement with natural and formal supports. » Provides nonjudgmental, unconditional, positive regard to the youth and family and validates their expressed experiences, feelings, struggles, and hopes. » Reinforces central purpose of Continuum service (to help facilitate timely transition of youth home or successfully remaining at home and in their community) and references specific treatment goals during each session. Concludes each session with agreed-upon next steps in advancing progress toward goals.	» Has regular, in-person discussions with youth or parent/caregiver but not both. » Struggles to hold delicate balance of alignment with parent/caregiver and youth concurrently, resulting in parent/caregiver or youth feeling staff are "siding" with the other. » Explores youth and family's perspectives on their hopes and worries, strengths, needs, and goals initially but not on an ongoing basis. » Listens to but doesn't validate youth's/family's expressed experience, feelings, struggles, and hopes. » Does not purposefully discuss the central purpose of Continuum services and/or specific treatment goals during each session. Does not discuss what each person is agreeing to do prior to the next session to advance progress toward goals.	» Has most discussions with youth and family by phone, rarely engages in person. » Does not connect the reason for each youth/family discussion to advancing progress toward specific treatment goals and/or the timely transition of youth home or successfully remaining at home and in their community. » Ignores or does not seek youth and family perspectives, needs, hopes, etc. » Identifies and updates short term goals based on factors other than family needs. » Speaks as the expert on youth's/family's experience, feelings, struggles, and hopes rather than expressing youth's/family's expertise in this area. » Is disingenuous or inauthentic. Uses shaming, blaming, or infantilizing language. Fakes encouragement or cheerleading. » Compares work with one family to another in a judgmental tone. Expresses hopelessness about the youth/family to the family/ youth.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ONGOING FOSTERING OF FAMILY-DRIVEN THERAPEUTIC ALLIANCE		
» Checks in with youth and family members at beginning and end of each session to hear and validate their firsthand reports of progress, challenges, and changes. Summarizes what was covered and next steps at the end of each session. » Elicits questions and input (including what's helping and not helping) from all family members during all stages of intervention planning and implementation as service proceeds. Opens discussion about processes, perspectives, roles, interventions and strategies that conflict with youth's/family's expectations. » Explores satisfaction with the effectiveness of Core Team's engagement and partnership with the youth and family. Explores logistical and perceived barriers (trust, beliefs, quality of engagement, etc) to engagement and revisits this as service progresses. Explores practical barriers (work schedule, child care, physical health) and intangible barriers (distrust of mental health concepts, fear of violence in neighborhood, stigma).	» Only engages in check-in at 90-day progress review intervals. » Checks in and solicits questions/input inconsistently and without the structure needed for everyone to share and speak to all points. » Focuses on crises only or doesn't leave enough time and rushes through check in. » Notices that the intervention is not going well but doesn't acknowledge and open dialogue with family to find resolution. » Listens to youth/family express disappointment, incongruence, or conflict with Continuum but doesn't explore options for shifting approach or consider other options to resolve. » At times, doesn't recognize misalignment/ dominance of Core Team's agenda over youth's/family's agenda. » Shifts approach based on feedback from youth/family but doesn't revisit discussion to see if it's working better for them.	» Doesn't check in, solicit input or ask about family's experience of how Continuum services and/or Core Team's partnership are going. Consistently omits summary at end of session. » Invalidates or dismisses family's perspective, defends/argues reasons for processes, perspectives, roles, interventions and strategies. Takes expert stance on what strategies are best for the family. » Uses shaming/blaming language in discussing family's progress, setbacks, and changes. » Focuses on own agenda and is not responsive to the needs of the family to shift the agenda.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ONGOING FOSTERING OF FAMILY-DRIVEN THERAPEUTIC ALLIANCE		
» Supports youth's/family's engagement and rapport with other new formal and informal supports by providing information and answering questions about them. » Explores youth's/family's experience and relationships with current formal and informal supports (e.g., providers, school personnel, state agency staff, natural supports). Acknowledges and validates expressed discomfort and/or conflict; and asks what might help them youth/family feel more comfortable and/or manage conflict going forward. » Explores options for resolving conflict with providers and other support people; and assists youth/family in trying their chosen option through practice, role play, letter witting, etc. If the initial option doesn't work, helps them explore additional options. Offers to be a supportive presence when youth/family engage in chosen action steps to resolve conflict with other providers/supports. » Strategically facilitates conversations between youth/family and informal or formal supports to assist in building or strengthening relationships, reaching consensus, and resolving conflict. » Develops strategies with the family to discuss any difficult information obtained from collateral sources. Based on family's preferences, includes them in between-session communications with collaterals or updates them separately. Shares all relevant communication with the family in clear, family-friendly language.	» Makes attempts to strategize with youth/family ways to feel more comfortable/manage conflict with other supports going forward, but doesn't explore path forward when family declines. » Explores youth's/family's experience and relationships with current formal and informal supports but changes topic when youth/family mentions discomfort or conflict with a support person. » Explores aspects of and makes plan for who, where, when, how family wants to receive difficult information, but inconsistently uses this agreed-upon communication process. » Facilitates conversations between youth/family and informal or formal supports but not directed toward building and resolution. » Uses planned method of communication without any follow up to see if it's working for youth/family. » Uses acronyms or other language unfamiliar to youth/family when communicating with them.	» Lacks exploration with youth/family about new or current supports. » Doesn't share difficult information. » Shares difficult information with the family in a location or around people with whom the family prefers not to discuss it. » Doesn't explore preferred communication style. » Fails to facilitate conversations between youth/family and informal or formal supports regarding resolving conflict. » Leaves family out of communication updates in between sessions. » Doesn't share communication about family with them or does so using shaming/blaming language.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ONGOING FOSTERING OF FAMILY-DRIVEN THERAPEUTIC ALLIANCE		
Selectively shares aspects of one's own values, beliefs, attitudes, and life experiences only when deemed appropriate and clinically beneficial to the youth/family (e.g., in order to partner and engage in a treatment alliance with a reluctant, pre-contemplative, or difficult-to-engage youth or family member).	» Refuses to shares own values, beliefs, attitudes, and life experiences with youth/family under any circumstance. » Does not always know when it's appropriate to share so doesn't share any values, beliefs, attitudes, and/or life experiences.	» Shares personal information without consideration for how this information will help/hurt the therapeutic relationship or treatment intervention. » Shares specific information with clinical intent but continues on to share other non-relevant or inappropriate information about self or other clients.
» Promptly acknowledges mistakes and corrects own actions, if they have resulted in misunderstanding or other disruptions. Involves others (Core Team members, supervisor, Family Partner, etc.) who can help support resolution as needed. » Apologizes when youth/family express feeling minimized, ignored, or otherwise disenfranchised in past system interventions.	» Takes a long time to recognize, acknowledge, and/or correct one's own actions with youth/family. » Is quick to acknowledge how own actions resulted in misunderstanding or disruptions but doesn't sustain corrections in behavior. » Apologizes in abrupt, non-specific, or insincere way for youth/family past experiences with past system providers that resulted in feeling minimized, ignored, or otherwise disenfranchised (e.g., "yeah, sorry about that" and moves on quickly). » Doesn't always involve the right people to (Core Team members, supervisor, Family Partner, etc.) to help support resolution.	» Ignores or denies misunderstandings or one's own problematic actions. » Recognizes misunderstanding or other disruptions, but doesn't see that one's own actions should be corrected. » Ignores the need to apologize for the past disenfranchisement of youth/family since it was prior to personal involvement and "not my fault". » Excludes others (Core Team members, supervisor, Family Partner, etc.). who can help support resolution when it is needed.