CARING TOGETHER:

Strengthening Children and Families through Community-Connected Residential Treatment

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CONTINUUM PRACTICE PROFILE

DEPARTMENT OF CHILDREN AND FAMILIES
DEPARTMENT OF MENTAL HEALTH

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EXECUTIVE SUMMARY

Caring Together Vision

The Department of Mental Health and the Department of Children and Families (the Agencies) developed a shared vision for all Caring Together services: one in which families are the center of the design, development, and delivery of services and supports they need. The Executive Office of Health and Human Services and the Agencies envision a system where Massachusetts children and families have timely access to an integrated network of out-of-home and in-home treatment services and supports that reflects their voice, is responsive to their needs, and strengthens their ability to live successfully at home and in their local communities.

Achieve better and more sustainable positive outcomes for children and families who come to the attention of either DCF or DMH.
Promote the successful functioning of youth through the development of daily living skills and social, emotional, academic, and pre-vocational competencies.
Prepare families to support their children successfully at home.
Full family engagement during the course of the residential service in all aspects of a child's care and treatment (unless there are safety concerns that require alternative planning).
Promote families' capacity to sustain their child's and the family's wellbeing.
Promote innovation and creativity among service providers.
Increase family and youth satisfaction with these services.
Transform the residential treatment system from a primarily placement-oriented service to one that is primarily community-treatment -oriented.
Maximize the Commonwealths' fiscal resources by eliminating redundancy in administration and management.
Prevent or reduce the length of time a youth spends in out-of-home treatment services
CARING TOGETHER GOALS

Purpose of Continuum

The Continuum is a community-based service intended to support the vision of Caring Together and align with the best intentions and expectations of the Agencies' jointly redesigned residential service delivery system. The central purpose of the Continuum is 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. Like all Caring Together services, the Continuum is intended to address obstacles that prevent youth from successfully living with their families and in their communities by:

- Strengthening youth and family member's skills to live safely and more effectively together in their home and in their community;
- Strengthening lifelong relationships between youth and their family members;
- Bridging youth and family linkage and connection to community-based services/resources; and
- Supporting youth and family in identifying, building, strengthening, and utilizing their natural supports.

The Continuum collaborates with youth, family, and the referring agency to support youth and family in cultivating and strengthening permanency or enduring consistent parental and familial relationships that are safe and lifelong; offer legal rights and social status of full family membership; provide for physical, emotional social, cognitive and spiritual wellbeing; and assure lifelong connections to birth and extended family, siblings and other significant adults, family history and traditions, race and ethnic heritage, culture, religion, and language[1].

The Continuum supports youth and family in cultivating and strengthening enduring consistent parental and familial connections that celebrate with the youth in good times, comfort them through difficult times, and provide them with emotional support and family membership that last well beyond the age of 18. The Continuum adjusts its interventions in-line and in collaboration with the referring agency's relational, physical, and legal permanency plans for youth and family.

[1] Cited in, *Call to Action: An Integrated Approach to Youth Permanency and Preparation for Adulthood*. Casey Family Services in collaboration with California Permanency for Youth Project, Casey Family Programs and Jim Casey Youth Opportunities Initiative. 2005. http://www.aecf.org/m/resourcedoc/AECF-AnIntegratedApproachtoYouthPermanency-2005.pdf

CARING TOGETHER GUIDING PRINCIPLES

Continuum Service Description

The Continuum service is provided by a Core Team (clinician, outreach staff, and youth peer mentor) in consultation with the Continuum occupational therapy and psychiatry consultants. The Continuum coordinates and provides a robust array of clinical and therapeutic interventions individualized to meet the unique needs of each youth and family in a manner that is culturally relevant, family-driven, youth-guided, trauma-informed, and strength-based.

The Continuum facilitates the development of a Family Team in partnership with the youth/family and holds Family Team meetings where collaborative treatment planning and care coordination occur with the youth, family, and their formal and informal supports.

Practice Profile Process

At the request of the Agencies, the Children's Behavioral Health Knowledge Center (Knowledge Center) held focus groups with family members, Continuum staff, and state agency staff to learn more about the strengths and challenges with implementing the Continuum service. These focus groups suggested wide variability in understanding of Continuum service practice expectations. The Agencies and the Knowledge Center determined that Continuum services could be more clearly and consistently operationalized if guided by a well-specified practice profile.

The Knowledge Center, in collaboration with the Agencies, engaged in an extensive effort to develop a practice profile for the Caring Together Continuum service. A practice profile, as defined by the National Implementation Research Network (NIRN), is a tool for operationalizing the Core Elements of a service or practice. It breaks down large concepts, such as, "engagement" into discrete skills and activities that can be taught, learned, and observed.

The Practice Profile breaks down large concepts, such as, "engagement" into discrete skills and activities that can be taught, learned, and observed.

In October 2016, the Knowledge Center convened a kick-off meeting with a group of stakeholders from across the Commonwealth to orient them to the work of developing a practice profile. A series of twelve additional working sessions attended by Continuum practice leaders, family members, and the Agencies' staff from across the state were convened and facilitated by the Knowledge Center to develop and refine the practice profile.

Continuum Practice Profile Core Elements

The Continuum practice profile describes eleven Core Elements that reflect the practice-level work of the clinician and the outreach worker on the Core Team (i.e., what they are saying and doing when delivering Continuum services).

The work of the Youth Peer Mentor on the Core Team is guided by a separate practice profile called the Massachusetts Young Adult Peer Mentoring (YAPM) Practice Profile. YAPM is a specialty expertise based on sharing one's lived experience of mental health challenges with the purpose and intent to inspire hope and motivation in a young adult who is struggling with similar concerns. For more information about the YAPM Practice Profile, visit: http://www.cbhknowledge.center/young-adult-peer-mentoring-overview/.

Abbreviated definitions of the eleven Core Elements are listed below and are nonlinear.

PRACTICING CULTURAL RELEVANCE

The Core Team engages in the lifelong process of (1) acquiring an understanding of how values, beliefs, attitudes, and traditions of an individual's multiple cultural identities (such as racial, ethnic, religious, sexual orientation, gender identity, economic, social, educational status, and other affiliate groups) contribute to one's own and others' culture; (2) learning about personal circumstances, conditions, and experiences that influence one's own and other people's thinking, behaviors, and roles in their community; (3) acknowledging the power and privilege differences and similarities between and among groups of people; and (4) using this knowledge to work effectively with all people.

ENGAGING YOUTH AND FAMILY

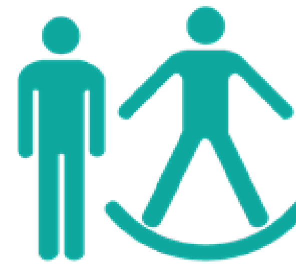
The Core Team engages in an ongoing process of relationship building with the youth and their family members to collaborate on shared goals for treatment. Engagement is conducted through respectful curiosity about individual and family strengths, needs, and culture.

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.

COLLABORATIVE TREATMENT PLANNING AND CARE COORDINATION

The Core Team engages in a structured collaborative care coordination approach that promotes continuity in treatment planning and results in the ongoing collaborative development, implementation, and amendment of the youth and family's Individualized Action Plan (IAP)/treatment plan.



INCORPORATING PSYCHIATRY AND OCCUPATIONAL THERAPY CONSULTATION

As part of the assessment process, the Core Team engages the occupational therapy consultant (OT) in a consultative screening and together they develop a plan for the OT's involvement going forward. The Core Team engages in an ongoing assessment of the need for psychiatric consultation with the Core Team and the Family Team.

ASSESSING RISK, SAFETY PLANNING, AND SUPPORTING FAMILIES THROUGH CRISIS

The Core Team engages in ongoing identification and anticipation of risks to a youth's and family's safety, permanency, and wellbeing and develops an evolving, shared understanding of what precipitates, drives, and helps to mitigate risk and crisis for the youth and family.

PROVIDING THERAPEUTIC INTERVENTIONS

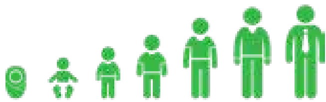
The Core Team engages youth and their family members in culturally-informed therapeutic interventions (strategies, activities, and actions) that build autonomy and self-efficacy as well as strengthen permanency of relationships with caregiver(s)/parent(s), siblings, and other family members and important people in the youth's life (including "chosen family").

CONTINUITY WITH HIGHER LEVELS OF CARE

The Core Team collaborates and coordinates with all relevant Family Team members and collaterals to support continuity of treatment and supportive approaches with the youth/family while the youth is in an out-of-home treatment intervention.

BRIDGING COMMUNITY INTEGRATION

The Core Team engages in an ongoing process of exploring, discovering, and strengthening interests, relationships, connections, and supports in the youth and family's environment who can celebrate with the youth/family in good times, comfort them through difficult times, contribute to a sense of belonging, remain unconditionally committed, and may also provide tangible assistance.



SUPPORTING LIFE TRANSITIONS

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

STRENGTHENING WELLBEING THROUGH RESPITE

The Core Team supports the idea that everyone needs periodic respite breaks that reduce youth, family, and caregiver fatigue and restore energy. The Core Team orients the family, youth, and Family Team to the impact that regular planned respite can have on promoting safety and strengthening permanency, wellbeing, resiliency, and recovery from the effects of trauma, mental illness, and physical illness.

Caring Together Vision

The Department of Mental Health and the Department of Children and Families (the Agencies) developed a shared vision for all Caring Together services: one in which families are the center of the design, development, and delivery of the services and supports they need. The Executive Office of Health and Human Services and the Agencies envision a system where Massachusetts children and families have timely access to an integrated network of out-of-home and in-home treatment services and supports that reflects their voice, is responsive to their needs, and strengthens their ability to live successfully at home and in their local communities.

Purpose of Continuum

The Continuum is a community-based service intended to support the vision of Caring Together and align with the best intentions and expectations of the Agencies' jointly redesigned residential service delivery system. The central purpose of the Continuum is to support youth and families in a manner that helps youth remain in and/or return home in a safe and timely manner and function successfully at home, school, and in their community. Like all Caring Together services, the Continuum is intended to address obstacles that prevent youth from successfully living with their families and in their communities by:

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- Strengthening lifelong relationships between youth and their family members;
- Bridging youth and family linkage and connection to community-based services/resources; and
- Supporting youth and family in identifying, building, strengthening, and utilizing their natural supports.

The Continuum collaborates with youth, family, and the referring agency to support youth and family in cultivating and strengthening permanency or enduring consistent parental and familial relationships that are safe and lifelong; offer legal rights and social status of full family membership; provide for physical, emotional social, cognitive, and spiritual wellbeing; and assure lifelong connections to birth and extended family, siblings and other significant adults, family history and traditions, race and ethnic heritage, culture, religion, and language[1].

This may include the involvement of "chosen family"[2] to provide a safe, stable lifelong relationship. "Chosen family" refers to those individual(s) who are emotionally close to the youth and who mutually and deliberately choose one another to play significant roles in each other's lives and consider one another as 'family' even though they are not biologically or legally related.

The Continuum advocates for and adjusts its interventions in line with the most clinically-sound permanency plan in collaboration with the referring agency's permanency plans for youth and family.

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[1] Gates, T. (2017). Chosen families. In J. Carlson & S. Dermer (Eds.), *The sage encyclopedia of marriage, family, and couples counseling* (Vol. 1, pp. 240-242). Thousand Oaks, CA: SAGE Publications Ltd.

[2] Fry, Lauren, et al. (2005). *Call to Action: An Integrated Approach to Youth Permanency and Preparation for Adulthood.* Casey Family Services in collaboration with California Permanency for Youth Project, Casey Family Programs and Jim Casey Youth Opportunities Initiative. New Haven, CT: Casey Family Services.

CARING TOGETHER GOALS

Continuum Service Description

The Continuum service is delivered by a Core Team (clinician, outreach staff, and youth peer mentor) in consultation with the Continuum occupational therapy and psychiatry consultants. The Continuum coordinates and provides a robust array of clinical and therapeutic interventions individualized to meet the unique needs of each youth and family in a manner that is culturally relevant, family-driven, youth-guided, trauma-informed, strength-based, and outcome-oriented.

The Continuum facilitates the development of a Family Team in partnership with the youth/family and holds Family Team meetings where collaborative treatment planning and care coordination occur with the youth, family, and their formal and informal supports. Members of the Family Team may include, but are not limited to, the youth and their family, referring agency, family partner, the youth's out-of-home treatment provider, Continuum staff, and the youth's and family's other formal and informal supports.

The Continuum works in partnership with the youth, parent/caregiver, and their Family Team to establish youth- and family-specific goals and implement an integrated intensive array of home-based and out-of-home interventions and formal and informal supports that address obstacles and strengthen the opportunity for the youth and family to live well together.

The Core Team engages in eleven core practice elements (listed below) that support youth and family wellbeing within their home and community. The Continuum provides services to youth who meet all the following criteria/conditions:

1. The youth is at risk for out-of-home placement due to safety concerns related to:
    - Mental illness or
    - Severe emotional disturbance or
    - Severe behavioral disturbance
2. The youth and family can benefit from intensive, community-based interventions with a clinician, outreach staff, and peer mentor (who have access to occupational therapy and psychiatry consultation) to help them develop or strengthen the skills needed to transition to or remain at home and live safely together within their community.
3. The youth may or may not require a Caring Together group home intervention that supports targeted youth and family skill development to live safely and successfully together.
4. The person(s) with authority to consent to treatment for the youth voluntarily agree(s) to participate in Continuum. In the event that this person is not the youth's parent/caregiver, then the youth's viable parent/caregiver also voluntarily agrees to participate in Continuum.

The Continuum is not designed to meet the needs of youth meeting any one of the following criteria:

- The person(s) with authority to consent to medical treatment for the youth does not voluntarily consent to participate in Continuum services.
- The youth's viable parent/caregiver does not voluntarily agree to participate in Continuum.
- Youth is in a (group living) treatment facility with no plan to return to a home living environment.

Practice Profile Process

At the request of the Agencies, the Children's Behavioral Health Knowledge Center (Knowledge Center) held focus groups with family members, Continuum staff, and state agency staff to learn more about the strengths and challenges with implementing the Continuum service. These focus groups suggested wide variability in understanding of Continuum service practice expectations. The Agencies and the Knowledge Center determined that Continuum services could be more clearly and consistently operationalized if guided by a well-specified practice profile.

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In October 2016, the Knowledge Center convened a kick-off meeting with a group of stakeholders from across the state to orient them to the work of developing a practice profile. A series of twelve additional working sessions attended by Continuum practice leaders, family members, and the Agencies staff from across the state were convened and facilitated by the Knowledge Center to develop and refine the practice profile.

CARING TOGETHER GUIDING PRINCIPLES

Continuum Practice Profile Core Elements

This document describes eleven Core Elements that reflect the practice-level work of the clinician and the outreach worker on the Core Team (i.e., what they are saying and doing when delivering Continuum services). The eleven Core Elements are listed below. They are not sequential and may overlap or occur simultaneously.

The work of the Young Adult Peer Mentor (YAPM) on the Core Team is guided by a separate practice profile called the Young Adult Peer Mentoring Practice Profile. YAPM is a specialty expertise based on sharing one's lived experience of mental health challenges with the purpose and intent to inspire hope and motivation in a young adult who is struggling with similar concerns. YAPMs use their lived experience as an active ingredient in a therapeutic process. YAPMs can make traditional behavioral health services more accessible and appealing to young adults as they manage their transition to adulthood and the underlying mental health conditions that can complicate their progress toward increased autonomy, reasonability, and potential periods of independence from and dependence on family members. For more information about the YAPM Practice Profile, visit: http://www.cbhknowledge.center/young-adult-peer-mentoring-overview/.

PRACTICING CULTURAL RELEVANCE

The Core Team engages in the lifelong process of (1) acquiring an understanding of how values, beliefs, attitudes, and traditions of an individual's multiple cultural identities (such as racial, ethnic, religious, sexual orientation, gender identity, economic, social, educational status, and other affiliate groups) contribute to one's own and others' culture; (2) learning about personal circumstances, conditions, and experiences that influence one's own and other people's thinking, behaviors, and roles in their community; (3) acknowledging the power and privilege differences and similarities between and among groups of people; and (4) using this knowledge to work effectively with all people.

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 individual youth and family readiness for change and meets them where they are.

CONDUCTING A COMPREHENSIVE COLLABORATIVE ASSESSMENT

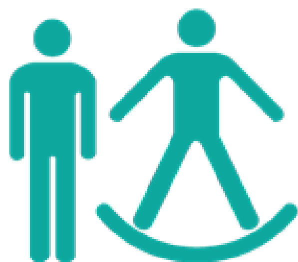
The Core Team conducts a comprehensive collaborative assessment that involves the ongoing process of gathering necessary, accurate historic and current information about the needs, strengths, and culture of a youth and their family. The Core Team evaluates the relevance of that information and also develops 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) 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.

COLLABORATIVE TREATMENT PLANNING AND CARE COORDINATION

The Core Team engages in a structured collaborative care coordination approach that promotes continuity in treatment planning and results in the ongoing collaborative development, implementation, and amendment of the youth and family's Individualized Action Plan (IAP)/treatment plan. It involves an ongoing process of engaging, coordinating, and collaborating with family members, the referring agency, out-of-home treatment providers, Continuum OT and psychiatry consultants, other treatment providers and services, community resources, and natural supports as a cohesive group (Family Team). It entails the Family Team coming together around the youth's and family's prioritized needs, setting measurable goals and objectives, identifying interventions that are most likely to succeed in transitioning youth home or remaining at home and living safely together within their community, and specifying who is responsible for each piece of the work. The process is family-driven and youth-guided, strengths-based, collaborative, outcome-oriented, and tailored for the needs of the individual youth/family. This ongoing process takes into account the family's circumstances, culture, and readiness to participate. The Core Team takes the lead role in facilitating collaborative treatment planning and service coordination whether the youth is living at home or in an out-of-home treatment intervention (group home).

ASSESSING RISK, SAFETY PLANNING, AND SUPPORTING FAMILIES THROUGH CRISIS

The Core Team engages in ongoing identification and anticipation of risks to a youth and family's safety, permanency, and wellbeing and develops evolving shared understanding of what precipitates, drives, and helps to mitigate risk and crisis for youth and family. It involves engaging the family to help them establish a family-driven individualized plan for how they can use their current skills and strengths to increase protective factors, build safety networks, and resolve potential dangers. Safety networks include a youth's and family's protective relationships that are critical to the success of a safety plan, in a crisis and ongoing. Input from all relevant supportive persons results in a coordinated comprehensive plan that is realistic for the youth/family to implement and addresses the assessed risks. Safety planning promotes effective collaboration and continuity in urgent situations across settings (i.e., school, home, group home). Safety plans offer a range of crisis supports to intervene when preventative measures cannot avert a crisis. Crisis support is provided and involves an urgent response that helps youth/family use their strengths and skills and network of relationships to diminish and/or manage acute risk.



INCORPORATING PSYCHIATRY AND OCCUPATIONAL THERAPY CONSULTATION

As part of the assessment process, the Core Team engages the occupational therapy consultant (OT) in a consultative screening and together they develop a plan for the OT's involvement going forward. This may include, but is not limited to, the OT providing a consultative assessment; recommendations to the family, Core Team, and Family Team; and/or coaching to the family. As agreed upon with the OT, the Core Team engages the OT to assist with assessing and addressing youth and family processing patterns and environmental factors that contribute to presenting concerns as well as developing individualized interventions that focus on establishing pro-social habits, such as healthy attachment, parenting skills, and routines, using occupations of the family and of childhood to enhance and promote self-regulation and relaxation, and developing strategies for managing symptoms (e.g., stress, anger, anxiety) that are associated with the presence of problematic behaviors. The Core Team may also coordinate with the OT to provide training/coaching to the Family Team to support their implementation of the occupational therapy recommendations. The Core team engages in an ongoing assessment of the need for psychiatric consultation with the Core Team and the Family Team. The Core Team consults with the psychiatry consultant as needed to assist with diagnosis, clinical formulation, and intervention planning, especially when addressing clinical complexities or when improvements have plateaued or high-risk behaviors are present.

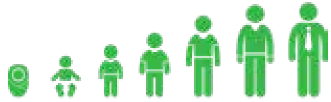
CONTINUITY WITH HIGHER LEVELS OF CARE

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 a group home, hospital, or 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 the youth and family have had success with. The Core Team supports continuity of treatment by continuing to provide seamless initiation of 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 a 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 a 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 the youth's and family's skills that promote flourishing together at home.

PROVIDING THERAPEUTIC INTERVENTIONS

The Core Team engages youth and their family members in culturally informed therapeutic interventions (strategies, activities, and actions) that build autonomy and self-efficacy as well as strengthen permanency of relationships with caregiver(s)/parent(s), siblings and other family members, and important people in the youth's life (including "chosen family"). Therapeutic interventions also build connection and relationship with peers and natural supports. Therapeutic interventions assist families in resolving conflicts, building and strengthening relationships, promoting healing, supporting lasting change, and enhancing and sustaining functioning in the community and home.

In-session actions and strategies and between-session activities (interventions and follow-up via phone, etc.) have a specific plan and purpose related to the goals in the established action/ treatment plan. Intensity, frequency, and duration of interventions are flexible, individualized, and build on youth/family strengths in real and tangible ways that help them address their needs toward the goal of transitioning youth home or remaining at home and in their community. Youth's and family's report of both improvements and challenges inform next steps as do Family Team member/ collateral perspectives (including, but not limited, to occupational therapy (OT) and psychiatry consultation as clinically indicated and agreed upon by the consultants) and direct observation by the Core Team. Therapeutic intervention is an active and ongoing process of discovering what works with a youth and family in this context and builds on their strengths. The Core Team effectively uses elements of evidence-based practice as well as practice-based evidence in developing interventions. The youth's peer mentor, parent/caregiver's family partner, and natural supports are included in interventions with the youth and parent/caregiver as agreed upon with the youth and parent/caregiver. The Core Team engages in ongoing coordination with OT and others around the interventions they are providing. Nontraditional and innovative interventions may be used.



SUPPORTING LIFE TRANSITIONS

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

BRIDGING COMMUNITY INTEGRATION

The Core Team engages in an ongoing process of exploring, discovering, and strengthening interests, relationships, connections, and supports in the youth and family's environment who can celebrate with the youth/family in good times, comfort them through difficult times, contribute to a sense of belonging, remain unconditionally committed, and may also provide tangible assistance. They may be extended family, friends, faith community, neighbors, people from school or work, or acquaintances and other natural supports who play a positive role in the youth's/family's life. They may also be places where the youth/family can volunteer, play, learn, worship, socialize, and build resiliency. They involve naturally-occurring community resources and supportive people that align with the youth's/family's interests, support the youth's/family's goals, and carry them beyond the reach of formal services. The Core Team thoughtfully uses flex funds to support and build family and youth's interests and resources. The Core Team helps family members consider ways to involve natural supports and include them in Family Team meetings and interventions (as agreed upon with the youth/family). The Core Team collaborates with the youth and family to help them connect to and sustain connections with naturally-occurring relationships, resources, and supports.

STRENGTHENING WELLBEING THROUGH RESPITE

The Core Team supports the idea that everyone needs periodic respite breaks that reduce youth, family, and caregiver fatigue and restore energy. The Core Team orients the family, youth, and Family Team to the impact that regular, planned respite can have on promoting safety and strengthening permanency, wellbeing, resiliency, and recovery from the effects of trauma, mental illness, and physical illness. The Core Team explores parent/caregiver and youth's access to and need for respite time and resources that reenergize, soothe, and provide relief from the day-to-day stress and exceptional demands of living with and parenting a child with emotional, behavioral, and/or mental health needs. The Core Team supports the parent/caregiver, youth, natural supports, Family Team members, and others (as appropriate) to develop and make decisions about respite plans. These plans coordinate resources that ensure the parent/caregiver, family and youth have regular reenergizing respite breaks. The respite plan supports parent/child attachment and prioritizes the use of a family member or natural support's home for respite care whenever possible. Respite care may also include the use and provision of in-home/ community-based respite provided by the Continuum as well as out-of-home respite care via the use of a respite bed in a facility.

IDEAL, DEVELOPMENTAL, AND UNACCEPTABLE PRACTICES

The activities described in the following Core Elements are nonlinear, and many practices repeat across Core Elements. Each Core Element describes the ideal, developmental, and unacceptable practices as defined below.

- **Ideal**—Includes activities that exemplify practitioners who are able to generalize required skills and abilities to a wide range of settings and context, use these skills consistently and independently, and sustain these skills over time while continuing to grow and improve in their position.

- **Developmental**—Includes activities that exemplify practitioners who are able to implement required skills and abilities but in a more limited range of contexts and settings, use these skills inconsistently or need supervisor/coaching to complete or successfully apply skills, and would benefit from a coaching agenda that targets particular skills for improvement in order to move practitioners into the "expected/proficient" category.

- **Unacceptable**—Includes activities that exemplify practitioners who are not yet able to implement required skills or abilities in any context. Often times, if practitioners' work is falling into the unacceptable category, there may be challenges related to the overall implementation infrastructure.

PRACTICING CULTURAL RELEVANCE

The Core Team engages in the lifelong process of:

1. Acquiring an understanding of how values, beliefs, attitudes, and traditions of an individual's multiple cultural identities (such as racial, ethnic, religious, sexual orientation, gender identity, economic, social, educational status, and other affiliate groups) contribute to one's own and others' culture;

2. Learning about personal circumstances, conditions, and experiences that influence one's own and other people's thinking, behaviors, and roles in their community;

3. Acknowledging the power and privilege differences and similarities between and among groups of people; and

4. Using this knowledge to work effectively with all people.

Please see the following matrices for additional information related to practicing cultural relevance:

- Engaging Youth and Family
- Conducting a Comprehensive Collaborative Assessment
- Collaborative Treatment Planning and Care Coordination
- Assessing Risk, Safety Planning, and Supporting Families through Crisis
- Incorporating Psychiatry and Occupational Therapy Consultation
- Providing Therapeutic Interventions
- Continuity with Higher Levels of Care
- Supporting Life Transitions
- Bridging Community Integration
- Strengthening Wellbeing through Respite

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
CONDUCTING CULTURAL SELF-ASSESSMENT IN THE CONTEXT OF CONTINUUM WORK		
» Prior to working with each youth and family, takes an inventory of one's own values, beliefs, attitudes, biases, knowledge, and awareness relative to the youth and family being served. » Routinely conducts a self-assessment of one's own privilege status (and its potential impact) in relation to the family and youth's status in multiple dimensions (such as gender, race, ethnicity, economic status, and social status). This includes reflection on one's personal family history, experiences and circumstances and how these might affect biases or judgments about the family and youth's family situation, relationships, or preferred permanency outcome. » Takes responsibility for one's own continued growth in their education and comprehension of multiple cultural identities with whom one works. » Explores cultural differences among Continuum team members (Continuum clinician, outreach worker, peer mentor, supervisor). Engages in ongoing dialogue with one another and in supervision regarding one's own values, beliefs, attitudes, biases and potential implicit biases, and their impact on work with youth/family.	» Engages in this step at start of services but not on an ongoing basis. » Adheres to a limited or simplistic definition of culture. » Touches on obvious differences and similarities but not all dimensions. » Inventories own culture but without growth; not sure what to do and doesn't seek help. » Acknowledges some biases but does not recognize one's implicit bias. » Brings up cultural biases and other concerns but doesn't recognize transference or counter transference in supervision. » Relies on existing knowledge of culture, ethnicity, and other diverse groups but doesn't further explore or extend knowledge.	» Doesn't engage in self-assessment or inventory. » Makes no effort to grow in the area of cultural competence. » Denies privileged status. » Ignores or denies cultural differences/similarities among team members. » Assumes family is responsible for explaining cultural considerations. » Assumes that if family doesn't mention any issues related to culture, then there aren't any. » Imposes one's own beliefs, assumptions, and expectations of how team members or others should express their gender, race, ethnicity, or socio-economic status. Assumes gender, race, socioeconomic status, etc., based on appearances.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
	DISCOVERING YOUTH'S/FAMILY'S CULTURE	
» Creates "safe space" and pacing in which to explore. Explains that exploring and discovering youth's/family's culture can help the Core Team avoid engaging in a way that doesn't consider their culture. » In order to ensure culturally-relevant interventions and to respect family boundaries, engages in ongoing discussion with youth/family members about their unique values, beliefs, attitudes, assumptions, and life experiences within the larger racial, ethnic, religious, sexual orientation, gender identity, socio-economic, immigrant/refugee, or other groups with which they identify or feel an affiliation. Explores individual family culture as another layer of diversity and honors the wide variance of parenting that is safe and supportive to youth well-being. » Explores with curiosity what youth's and family's affiliations/identities mean to the youth and family.	» Acknowledges youth's self-identification of gender but doesn't recognize the fluidity of gender identity. » Gathers information but is not always attuned to the youth's/family's comfort level in sharing this type of information. » Gathers information in a planful manner but does not take advantage of information about the youth's/family's culture that arises spontaneously. » Engages in discussion at intake but with limited or no follow-up. » Superficial or limited exploration of impact of culture. » Asks pointed questions rather than exploring or inviting information.	» Persists in gathering information without considering the family's boundaries or their emotional responses when discussing issues of cultural identity. » Ask questions about family members' culture that bear no relevance to treatment but instead is based on own personal curiosity. » Assumes without discussion. » Attempts to homogenize family culture without acknowledging individual differences. » Assumes family is "just like me" based on shared generic categories (e.g., same race, socioeconomic status, etc.) » Assumes experiences of culture are the same for all family members.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
	DISCOVERING YOUTH'S/FAMILY'S CULTURE	
» Engages in ongoing discussion with youth and individual family members to discover differences and similarities among family members and between generations. Explores roles and privilege differentials within family (e.g., sons allowed to stay out later then daughters, fathers are disciplinarians, mothers cooks for everyone). Acknowledges youth's values/beliefs that are different from or conflicting with their families. » Acknowledges the wide range of safe and "good enough" parenting strengths, styles, techniques, and strategies as well as a similarly wide range of youth responses to, acceptance of, and benefits from his/her parenting.	» Discusses only with youth or parent/caregiver without bringing views together with whole family. » Gathers general cultural information (race, language) without exploring what is unique to this family (values, attitudes) or has limited views of what culture can be. » Engages in conversation but does not incorporate into treatment. » Only acknowledges or considers a rigidly restricted set of parenting styles to be "good enough." » Only acknowledges or considers a rigidly restricted set of youth responses to be acceptable.	» Takes sides in treatment based on generational or other differences. » Assumes race, ethnicity, religion, or other identity based on superficial data without discussion. » Assumes family has "no culture" and/or culture has no role in Continuum work without explanation. » Places burden on family to bring up and share cultural considerations. » Imposes own family's parenting and youth response styles as the expectation for youth/family.
During initial and ongoing discussion, explores youth/family member beliefs regarding physical health, mental health, behavioral and emotional responses, substance use, and treatment.	» Engages in limited or superficial discussions about youth's and family's beliefs regarding physical health, mental health, behavioral and emotional responses, substance use, and treatment. » Explores beliefs but only as problems or points of contention, not as strengths.	» Makes assumptions about youth's/family's beliefs without discussion. » Disregards beliefs, imposes own cultural values, or tries to convince family to comply with presumed standards without regard to their culture.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
	DISCOVERING YOUTH'S/FAMILY'S CULTURE	
» Explores the resilience and vulnerabilities that emerge from the youth/family members' culture and experiences. » Engages in initial and ongoing discussion specifically about strengths—including individual, family, and community strengths —related to youth and family culture. » Helps youth/family to recognize and explore strengths; shares/reflects on youth's/family's potential strengths even when youth/family are not initially aware of them.	» Engages in discussion at intake but with limited or no follow-up. » Engages in superficial discussion of strengths (e.g., lists activities/generalizations about strengths). » Bases ideas of strengths on a narrow definition of culture or what is acceptable as a strength (e.g., mother should speak up; father should help with child care). » Explores with only youth or only parent/caregiver. » Over-identifies with one member's role in the family. » Mistakes strengths (e.g., family roles, beliefs about mental health) for concerns.	» Emphasizes own perspective over the family's perspective. » Does not consider the emotional weight and impact that a discussion about vulnerability and resilience may have on the family. » Discusses problems only, with minimal or no discussion of strengths. » Assumes strengths based on stereotypes (e.g., "all Black people go to church," so church community is a strength). » No conversation linking strengths to culture; interpreting strengths based on own culture. » Disrespects others' cultural practices.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
DISCOVERING THE CULTURE OF YOUTH'S/FAMILY'S COMMUNITY		
» Acknowledges and explores, initially and on an ongoing basis, the neighborhood/community environment of the youth and family. Explores how family identifies/doesn't identify with the culture of the community in which they live. » Explores available resources, community crime rates, socio-economic conditions, and racial tensions at school and the impact they have on behavior, symptoms, and diagnoses. » Explores the impact and specific needs of youth who have experienced immigration-related and/or other separations from community or family (such as homelessness, kinship, foster home and long term residential placements, and adoption).	» Considers only some family members' safety. » Limits exploration to geographical community and does not explore other communities that the youth or family belong to. » Engages in discussion at intake but limited or no follow-up. » Superficial or partial discussion of the impact of community factors or immigration-related disruption on attachment. » Confuses practitioner's sense of discomfort in a neighborhood with youth/family being unsafe. » Minimizes the positive or negative impact of community/neighborhood.	» Does not explore community resources beyond those that are already known to the family or provider. Omits natural supports from discussion about community resources. » Does not consider youth's and family's positive connections to the community, even when others consider it unsafe. » Gives no consideration to community context. » Pathologizes behavior (as "oppositional" or "conduct disordered") without considering the impact of community factors. » Talks about community with stereotypical or negative descriptions (e.g., "bad neighborhood," "ghetto," "soccer-mom lifestyle").

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
PREVENTING AND RESOLVING CULTURAL BARRIERS/MISUNDERSTANDING BETWEEN YOUTH/FAMILY AND CORE TEAM		
» Asks about youth and family members' preferred language for spoken, sign, and/or written communication at intake. Offers options for ensuring effective communication across language/literacy differences. » Considers Core Team's cultural fit with family preferences for fit. » Recognizes and acts on any practical concerns about meeting times and locations that relate to culture (holy days, family privacy boundaries, concern about stigma).	» Assumes language and/or literacy needs without discussion. » Adapts to youth/family needs but communicates that the flexibility is a burden. » Uses interpreter for sessions, meetings, and phone conversations but doesn't troubleshoot providing family with documents in their preferred language.	» Explains available options for working in preferred language but does not follow through. » Fails to offer options or explore ways to address language/communication needs. » Uses youth or family member as interpreter. » Disregards needs and concerns that are based on culture. » Minimizes/disregards family's cultural/religious practices when scheduling meetings.
Inquires with youth/family about experiences with how formal and informal supports and others have interacted with, understood, and/or misunderstood their cultural identity.	» Engages in discussion at intake with limited or no follow up discussions. Discusses with only a subset of family. » Discusses superficially or limits discussion to one-dimension (e.g., only discusses religion). » Tries to discuss but stops if topics are uncomfortable.	» Focuses on ways youth/family have misunderstood other's culture not on how they have been misunderstood. » Labels family as resistant to discussing past culture misunderstandings. Does not consider possibility that family members may be limiting what they share due to confusion, conflict, shame, embarrassment, etc.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
PREVENTING AND RESOLVING CULTURAL BARRIERS/MISUNDERSTANDING BETWEEN YOUTH/FAMILY AND CORE TEAM		
» Routinely checks in with family/youth around relevance of Core Team's approach to youth's/family's cultural identity needs and concerns. Encourages youth and family to inform Core Team of their experiences of cultural bias or misunderstanding by the Core Team. Promptly acknowledges, apologizes for, and corrects one's own actions and engages in repair work. » Assesses whether one's own cultural self disclosure meets youth/family clinical needs and only self discloses based on those needs. » Acknowledges and opens discussion of differences and similarities in culture and in power and privilege. Reflects actively with youth/family on how these affect dynamics of working with individuals/families. » Uses therapeutic alliance and adjusts practice approaches to bridge gap between culturally influenced perspectives of youth/family and Core Team. » Identifies the need for and obtains culturally relevant consultation and supervision around counter transference.	» Opens discussion without establishing a safe environment. » Engages in limited or superficial discussions. Discusses at intake but not throughout. » Explores beliefs but only as problems or points of contention, not as strengths. » Discusses family beliefs without sharing practitioner's own beliefs (when appropriate) and/or finding common ground. » Acknowledges one's own mistakes late. » Acknowledges mistakes but doesn't know what to do next; fails to ask for family's input around what Core Team could do differently to avoid similar mistakes in the future. » Makes/expresses overgeneralizations that one can relate to family based on similarities with the youth/family.	» Disregards beliefs, imposes own cultural values, and/or tries to convince family to comply with "shoulds" and "shouldn'ts" without regard to their culture. » Insists that a family must address team's mistakes even when the family does not want to. » Sees problems but says nothing. » Joins in negativity expressed by team members. » Blames someone else, e.g., "I'm sorry but my supervisor made me do it" or "You're too sensitive." » Assumes the need to check in with youth/family from some races/backgrounds and not others. » Overly apologetic such that family feels sorry for practitioner. » Apologetic without acknowledging ownership. (e.g., "I'm sorry you feel that way.")

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
SUPPORTING RESOLUTION OF CULTURAL MISUNDERSTANDING WITH FAMILY TEAM AND OTHER SUPPORTS/ENTITIES		
» Invites and supports family to discuss and address behaviors by team members that result from misunderstanding of culture. Supports family in addressing teamwork concerns. » Offers options for facilitating discussion between youth/family members and other external team members regarding youth- and family-preferred cultural considerations that may impact teamwork and decisions about culturally-specific interventions. Facilitates joint conversations between team members and youth/family in order to clarify any misinformation or misunderstandings related to the youth's/family's unique permanency strengths or situation. Acts as an advocate in helping team members understand the youth's/family's unique permanency strengths or situation. » Addresses directly and respectfully with other team members and youth/family when observing actions that appear insensitive to youth/family culture or experience.	» Engages in partial or superficial discussion with team. » Brings up discussion with team without preparing family. Does not explore range of options for family communicating with team. » Fails to prepare youth/family for how misunderstandings will be addressed. » Suggests that family speak up about concerning behaviors but without offering effective support or coaching in how to do it. » Addresses behaviors indirectly or in "sugar-coated" or hostile manner. » Addresses behaviors with some team members but avoids confronting others. » Processes with youth/family observed misunderstandings after youth/family have indicated they don't want to talk about it.	» Assumes without discussion. » Addresses "family culture" with team without including family. » Creates conflict in team due to manner of addressing problem, or by ignoring problem. » Replaces Core Team staff member without first facilitating discussion/process of repair work with youth/family. » Observes or is made aware of misunderstandings but doesn't address them. » Dismisses misunderstandings. » Blames another party/person for the need to address misunderstandings.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
SUPPORTING RESOLUTION OF CULTURAL MISUNDERSTANDING WITH FAMILY TEAM AND OTHER SUPPORTS/ENTITIES		
» Recognizes that institutionalized and systemic cultural and linguistic barriers exist and may be experienced by youth/family. Supports empowerment, educates and models ways they can advocate for their needs (e.g., requesting a translator, family partner, etc.). » Collaborates/coordinates around ways to educate Family Team and/or other supports regarding institutionalized and systemic cultural circumstances that continue to impact the youth/family.	» Acknowledges barriers but doesn't take action to address barriers. » Follows dominant societal cultural norms without questioning how youth and family experience these. » Makes assumptions that people who speak the same language share the same beliefs. » Acknowledges barriers but lacks initiative to educate self or relies on youth/family to educate. » Only focuses on programmatic factors and not larger societal issues.	» Ignores societal institutionalized linguistic cultural barriers and "isms." » Uses stereotypical language. » Assumes that prevailing norms and practices are the right and respectful way for all. » Ignores the possibility that institutions trying to help youth/family maybe inadvertently creating barriers based in prevailing cultural biases. » Upholds/maintains Family Team biases that are dismissive of youth/family cultural preferences.
» Respectfully informs/educates family on how cultural norms (e.g., discipline of children, expectations of women, etc.) may be in conflict with state laws and prevailing customs and how this could be problematic in some domains. » Explores family's current strategies and options (such as replacement behavior/ actions) to prevent/resolve potential conflict with U.S. laws and/or customs that could be problematic for the youth/ family.	» Discusses only the most obvious concerns or only in relation to DCF. » Over- or underemphasizes the impact of different practices. » Assumes family knows laws. » Files 51A without speaking with family first.	» Takes an authoritarian stance. Communicates that youth/family should adopt US customs regardless of own identity/customs. » Waits too long to talk with family. » Asks questions with a biased stereotypical or assuming slant. Asks question of some groups but not others. » Misinterprets laws/cultural norms.

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.

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
	FURTHER DEVELOPING THERAPEUTIC ALLIANCE	
» Fully explains the assessment process and purpose to the youth and family. Asks for and clarifies questions. » 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. » 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. » Uses clinical language the family is not familiar with. » 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. » 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. » Does not explore with the family regarding who they would like to be involved in assessment conversations. » 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. » 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. » Upon becoming aware that something is affecting the family's level of participation, fails to explore it or to adjust timing of assessment accordingly. » Relies heavily on assessment form to conduct assessment rather than engaging in a conversation with the family. » Only pays attention to what some family members say. Summarizes one family member's perspective as representing that of the whole family. » Conducts the assessment, but avoids uncomfortable topics.	» Fails to demonstrate curiosity about family. Gathers information based solely on timelines required. » Pushes for action or attempts to fix/resolve issues without spending enough time exploring family experience. » Ignores family cues about not wanting to talk about something or pushes family to resolve issues when they refuse. » Labels family members as resistant. » Talks more than the youth and family. » Ignores what the family says. Appears distracted (looking at phone, clock, TV, etc.) while someone is speaking.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
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. » 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. » Struggles to reframe/refocus discussion on strengths when needed.	» Strengths are not explored. » Focuses on identifying shortfalls of youth and family, and uses deficit based language. » 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. » Specifically inquires about concerns related to risk for sexual exploitation, substance use, bulling, gang involvement, and other risky situations. » 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. » 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. » Expresses knowledge of concerns and jumps to validate concerns without first fully soliciting them from each family member. » Explores concerns but fails to ask what family and youth think contributes to or exacerbates them. » Provides suggestions to help reduce risks without first exploring family member's viewpoint on what has worked to reduce, increase, or exacerbate risk. » Explores the past or present but not both. » 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. » Doesn't explore youth's/family's concerns. » Exaggerates or minimizes challenges that family is experiencing. » Imposes own view of contributing factors; does not balance with family view. » Asks about what keeps the issues of concern going or makes them worse but not what relieves them. » Ignores connection between medical/physical wellbeing and mental/behavioral wellbeing.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
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. » Doesn't listen for, observe, and explore family beliefs and culture around substances. » 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. » 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. » 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. » 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." » Explores professional supports but not natural supports. » 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. » Inquires only about youth's supports and fails to explore supports to parent/caregiver and others in the home. » Only obtains information from prescriber or family but not both. Obtains list of current medications but not history. » 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. » Fails to validate comments family makes about when things weren't going well or how hard it can be to remember a better time. » Expresses judgment—doesn't hold a neutral position. Dismisses or downplays family's experience. » Uses unprofessional language or is discourteous toward providers or services family didn't find effective. » Does not inquire about medication name, dosage, target symptoms, and side effects. » 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. » Only asks about relationship with prescriber and/or use of medication once, not on an ongoing basis.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
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. » 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. » 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. » 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. » Explores vision but lacks exploration of what it might look like when it's time to transition out of Continuum services. » Documents family's vision statement but not in their own words or includes things family agrees to half-heartedly. » Does not assist youth/family in seeing the commonalities and unifying themes when they present differing visions.	» Doesn't explore family's vision. » Imposes own vision for the family. » 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. » 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). » Asks about past family history of trauma, losses, and other adverse experiences as well as family history of substance use/abuse. » Explores protective and risk factors in the community environment and their impact on the youth/family.	» Explores in part but not all. » Limits exploration of home structure to home routines without inquiring about limit setting/discipline. » Fails to revisit (at later date) items youth and family didn't want to initially discus. » 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. » Lacks consideration of which items to explore with youth/family together and separate. » 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
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. » 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. » Mismatches timing of exploration with youth and family readiness to discuss permanency needs. Does not explain need to explore permanency. » Opens conversation but struggles to explore all possible obstacles. Only explores obstacles from one point of view (e.g., youth's or collateral's). » 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). » During conflict/disagreement, aligns strongly with one party over other(s). » Doesn't consider legal custody and restrictions when exploring youth relationships with parents and family. » Aligns/joins with obstacles. » Relies on out-of-home treatment provider or other collaterals to explore obstacles to permanency/community tenure. » Doesn't inquire about youth having lifelong support form a secure parenting relationship. » Doesn't inquire about DCF permanency plan (when DCF involved).

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
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. » 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. » Supports family members when something unsettling is disclosed. » Adjusts questions to the specific family, especially when working with transitional-aged youth.	» Asks about family configuration but omits exploration of "chosen family." » Does not consider the need to inquire with each family member individually or in small dyads versus a large family group. » When conversation involves multiple people, lacks follow up with each family member to inquire if they heard something new or surprising. » Allows negative discussion to go on to the exclusion of anything positive. » Does not determine timing and readiness to explore future vision for relationship. » 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. » Ignores when ground rules for discussion are broken and does not intervene to support the family in following ground rules. » Doesn't follow up with family members when something potentially unsettling is disclosed in family group setting.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
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. » Offers youth the option to have a peer mentor or other supports during this conversation. » Assesses readiness and invites youth to describe their hopes, wishes, or vision for their desired relationship with these individuals. » 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. » Does not offer youth the option to have peer mentor or other supports present during conversation. » 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. » Focuses only on negative experiences. Doesn't look for exceptions (occasions when the negative experiences didn't occur). » 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. » Pushes youth to continue to discuss topic even though youth is visibly distraught; doesn't offer youth a break. » Asks questions once and doesn't revisit. » Shuts down discussion of potential supports. Dismisses possibility that a potential connection could be a support.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
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. » Explores what maintains these obstacles, what makes them worse, and what makes them better. » 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. » Solicits some but not all family members' input in permanency planning. » Acknowledges safety needs but doesn't proactively address them. Acknowledges parent/caregiver's fears without exploration of what drives them. » Suggests what is/isn't a safety concern without exploring with family members what does/ doesn't feel safe to them. » 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. » Minimizes connection between youth and family relational conflicts and barriers to permanency. » Minimizes or actively ignores youth and family concerns. Avoids confronting family's anxiety and fear regarding youth's return home. » 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.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
	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. » Integrates information from multiple sources without fully assessing its relevance, significance, and/or validity. » 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. » Discounts youth and family perspective regarding collateral's information. » Discounts youth and family as experts of their own experiences. » 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. » 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. » 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. » Views behavior from only one lens (e.g., only sensory processing or only risk, etc.). » Asks general, open-ended questions about skill areas that need to be developed but fails to consider developmental stage and age. » 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. » Makes overgeneralization about meaning of behavior. » 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. » Only speaks to young adult's parent/caregiver rather than exploring independent living skill needs with youth as well. » Ignores developmental stages of transition to adulthood.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
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. » Does not clearly explain why or how specialized assessment will or will not be helpful.	» Doesn't explain potential contraindications to parent/caregiver. » 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. » 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. » 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. » Does not engage occupational therapist, psychiatrist, or peer mentor when needed.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
FILLING IN CONTEXTUAL UNDERSTANDING WITH STAKEHOLDERS		
» Consent permitting, obtains relevant information via written documents and conversations with Family Team members and other relevant collaterals. » 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. » Asks about medical/dental history of youth and documentation of any physical health concerns and current wellness status. » 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. » Doesn't revisit family's refusal to share information. » 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.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
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). » 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). » Explains the implication, relevance, or support of the current assessment of documents referred to in written assessment report. » 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. » 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. » Refers to other documents but doesn't clearly explain their implication, relevance, or support of the current assessment. » Written assessment only focuses on needs and deficits, not strengths. » 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. » Omits youth/family vision.	» Doesn't complete written assessment. » Documents information without evidence or documents information as fact when it is substantiated by some and unsubstantiated by others. » 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. » Excludes youth and family voices or disregards youth's or parent/caregiver's request not to include their specific wording as written.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
	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. » 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. » Includes prioritized clinical needs to be addressed, deferred, referred, out or declined. » 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. » Clinical formulation fails to support recommendations and/or link to reason for referral. » Some diagnostic clarification exists but rationale/ evidence for diagnosis is not explicit. » Proposes recommendations but rationale/ evidence supporting it is missing. » 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. » Needs, treatment recommendations, and/ or clinical formulation are not supported by information obtained in the assessment. » Fails to update clinical formulation when youth's level of care changes.

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

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENGAGING IN ONGOING ASSESSMENT		
» In collaboration with youth and family, clinician reviews and updates the assessment as needed and annually at minimum. » Incorporates new information and amends assessment as needed. » Considers diagnostic accuracy in light of new information. » 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. » Considers and updates some information.	» Doesn't complete an annual update. » Never reconsiders diagnosis. » Updates document without reviewing and discussing changes with family and Family Team.

COLLABORATIVE TREATMENT PLANNING AND CARE COORDINATION

The Core Team engages in a structured collaborative care coordination approach that promotes continuity in treatment planning and results in the ongoing collaborative development, implementation, and amendment of the youth and family's Individualized Action Plan (IAP)/treatment plan. It involves an ongoing process of engaging, coordinating, and collaborating with family members, referring agency, out-of-home treatment providers, Continuum OT and psychiatry consultants, other treatment providers and services, community resources, and natural supports as a cohesive group (Family Team). It entails the Family Team coming together around the youth's and family's prioritized needs; setting measurable goals and objectives; specifying who is responsible for each piece of the work; and identifying interventions that are most likely to succeed in supporting youth and family in helping the youth remain in and/or return home in a safe and timely manner and function successfully at home, school, and in the community.

The process is family-driven and youth-guided, strengths-based, collaborative, outcome-oriented, and tailored for the needs of the individual youth/family. This ongoing process takes into account the family's circumstances, culture, and readiness to participate. The Core Team takes the lead role in facilitating collaborative treatment planning and service coordination whether the youth is living at home or in an out-of-home treatment intervention (group home).

Please see the following matrices for additional information related to collaborative treatment planning and care coordination:

- 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
- Supporting Life Transitions
- Strengthening Wellbeing through Respite
- Bridging Community Integration
- Conducting a Comprehensive Collaborative Assessment

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
	ESTABLISHING A FAMILY TEAM	
Reviews the purpose and role of the Family Team with the family, including how it may be different/similar to other types of team meetings. Ensures that youth and family know that Family Team membership can change over time as youth/family needs change.	Gives a broad explanation of Family Team that fails to clarify how it may be different/similar to past team meetings the youth/family may have experienced.	» Gives confusing or inaccurate description of the Family Team's purpose and role. » Solely describes how providers and professionals have a critical role on the team and negates the critical role and participation of youth, parent/caregiver, and their informal supports.
» Explores and identifies, with youth/family and referring agency, the individuals they wish to include on the Family Team. Considers whether there are important missing Team members (such as natural supports, Family Partner, group home staff, medication prescriber, school personnel, peer mentor, DMH case manager/DCF social worker, non-custodial parent, caregiver, therapist, etc.). Uses diligence and persistence in reaching out to engage family and natural supports. » Fully explores and periodically revisits with family and referring agency the decision to leave out a particular stakeholder, including possible outcome of that decision.	» Explores Family Team membership once without regularly exploring any new supportive people in the youth's/family's life that they would like to invite to join the Family Team. » Fails to recognize potential key stakeholders or asks limiting questions that aren't broad enough to help solicit potential team members. » Only explores professional/formal supports as potential Family Team members to the exclusion of natural/informal support or vice versa. » Addresses key stakeholder that youth/family doesn't mention but fails to explore why or what it would take to feel comfortable with them on the team. » Doesn't revisit discussion.	» Makes individual determination and tells family who Family Team members will or should be. » Uses coercive approach to get parent/caregiver agreement on Family Team member participants. » Dismisses possible participants, makes assumptions about individuals' availability. » Proceeds to schedule and hold meetings without ever asking youth/family if the process of establishing Family Team membership works/makes sense for them.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ESTABLISHING A FAMILY TEAM		
» Schedules face-to-face Family Team meetings with youth (as developmentally appropriate), family, and Family Team members at a time and location feasible for the youth/family. » Explores possible virtual attendance of Team members not able to attend in person. » Includes youth in meetings to every extent possible. » Plans for and schedules any needed special arrangements or accommodations, such as professional interpreters.	» Schedules meeting solely based on what works for some, but not all, Family Team members needed for discussion of particular agenda items. » Schedules meeting without explaining team member scheduling conflict to parent/caregiver; excludes parent/caregiver from troubleshooting ways to avoid leaving a key person out of the meeting. » Does not provide the option of some members attending virtually.	» Doesn't hold Family Team meetings. » Holds meetings without family present. » Holds meetings, but almost never in person. » Comes to agreement on virtual attendance for some members but neglects to follow through on setting it up. » Doesn't explore options to include youth in meetings. » Ignores the need for special arrangements such as a professional interpreter. Makes plan with family to have family member or support person translate.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
PREPARING FAMILY/YOUTH FOR FAMILY TEAM MEETINGS		
» Engages parent/caregiver (and youth to every extent possible) in face-to-face preparation for Family Team meetings. » Ensures that youth and their parent(s)/caregiver understand that they have a driving voice in the Family Team process and that their involvement is vital. Discusses options for how the parent/caregiver and youth can participate and what support they may need. Asks youth/family to identify agenda items. » Determines meeting structure together (such as youth and family participation, seating, and ways to take a break if one is needed). Prioritizes Family Team meeting agenda items together. Explores youth and parent/caregiver expectations, concerns, and apprehension regarding meeting and agenda items. Explores and discusses ahead of time any sensitive information youth and parent/caregiver anticipate may be brought up and develops strategies to respond to it.	» Only aligns with the family or provider(s) agenda items, doesn't fully integrate both for prioritization with youth/family. » Limits description of what to expect in Family Team meetings; omits that meetings can be an opportunity to find a path forward when team members hold differing perspectives and hopes for the youth/family. » Assures the youth/family that their perspective is vital but doesn't fully explain that the shared decision-making process includes weighing others' perspectives as well. Gives parent/caregiver the impression that team members will go along with whatever they request/say. » Asks about youth's/family's anticipated need for support during meetings but doesn't explain or give examples of what is meant by support.	» Prioritizes agenda items without parent/caregiver and youth. » Does not adhere to agreed-upon plan for sharing Family Team member's sensitive information with parent/caregiver. » Fails to explore with youth/family whether and how they want to be supported during the meeting. » Remains focused on the plan for the day (prepping for the meeting) despite the fact that the family is experiencing a crisis situation. Ignores imminent risk/safety concerns. » Only focuses on crisis situation without consideration of how to include crisis as a priority item in the agenda being prepared.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
PREPARING FAMILY/YOUTH FOR FAMILY TEAM MEETINGS		
» Role plays/practices team meetings, as needed. » Explains that Family Team members may disagree and this is to be expected at times. Explains that there may be team decisions (and occasional external decisions by the state agency) that they disagree with or will be disappointed by and explores options for how to respond. » Prepares youth and parent/caregiver to meet any team members whom they have not previously met in person. » Plans for post-meeting debrief and support.	» Initiates holding meetings in youth/family home assuming it is easier for them, without exploring family cultural perspectives on having meetings in the home (e.g., number of people in the house, worries about what the neighbors will think, expectation that people take their shoes off at the door, etc.). » Doesn't ask parent/caregiver if they want to have their existing Family Partner in the preparation meetings.	» Intentionally leaves out parent/caregiver's Family Partner from the preparatory conversation with family. » Uses disrespectful or condescending language or tells the family what will be helpful and supportive to them during the Family Team meeting. » Discusses preparation for high-conflict discussions without preparing for and considering ways to diffuse conflict with youth/family.
» Engages youth and peer mentor (or other Family Team member of youth's choosing) in exploration of ways to support youth's involvement in Family Team meetings. Explores ways of having youth's voice in the meeting even if they can't attend in person. » Uses youth engagement tools as appropriate to bring youth voice into team meetings (such as, "Three Houses– Dreams/Wishes, Worries, Good Things and "I Want to Say Something" tools).	Discusses the need for youth voice in the meeting but without exploration of creative alternative ways (e.g., writing a letter, asking Family Team members to speak for them, etc.) to involve the youth when they don't feel ready to express themselves at the Family Team meeting in person	» Assigns an individual that the Core Team believes to be the "right" person to support youth's voice in the meeting without discussing it with youth. » Prepares youth in a general, vague, or superficial way that isn't specific to their needs or developmental stage.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
PREPARING TEAM MEMBERS FOR FAMILY TEAM MEETINGS		
» Underscores the central importance of and advocates with the parent/caregiver/LAR for full inclusion of safe, caring, and committed parent/family relationships as primary in youth's treatment, healing, and trauma recovery. » Outreaches new potential Family Team members identified/agreed upon by the youth, parent/caregiver/LAR (together with family members if they choose) prior to the Family Team meeting. » Describes the Continuum service and the Family Team structure, process, and purpose. » Describes roles of Family Team members and how they partner with one another and family members. Explores and clarifies the role/responsibilities of the particular team member. » Invites individuals to the Family Team meeting and asks about their needs and preferences for meeting.	» Provides insufficient information or detail to help potential Family Team members understand the purpose of the Family Team, the purpose of their attending the meeting, and the role of the youth/family in the meeting. » Minimally explores participant's relationship to youth/family in order to understand their potential role and value they add to the Family Team meeting. » Describes new team member's role for them rather than exploring how they might help support the youth and family within the meeting structure and process described.	» Fails to reach out to any potential team members or lacks persistence in attempted outreach to potential team members. » Reaches out to individuals listed in records/documents that were never discussed with parent/caregiver. » Determines a potential conflict of interest in adding a new team member to the Family Team and invites that person anyway without consulting with supervisor and, potentially, revisiting with youth and parent/caregiver/LAR.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
PREPARING TEAM MEMBERS FOR FAMILY TEAM MEETINGS		
» Reaches out to and prepares old and new Family Team members prior to every Family Team meeting. » Reviews evolving hopes, worries, strengths, needs, goals, and progress that the youth/ family holds for themselves and those that each Family Team member holds for the youth and family. » Reviews format and topics to be discussed and solicits agenda items. Reminds team members that the agenda will include various participants' agenda items that these are prioritized by youth/parent/caregiver/LAR.	» Assumes sole responsibility for outreach to all team members without considering how parent/ caregiver might want to participate in the process. » Engages in general inquiry about Family Team member's perspective on the youth's/ family's progress without explicitly exploring the worries, strengths, needs, and hopes/ goals they have for the youth and family. » Asks about hopes, worries, etc. Family Team members have for the youth but not the family, or vice versa. » Prepares some sub groups of Family Team members but not all.	» Insists Core Team members are always the best equipped to call and prep Family Team members. » Refutes youth/family request for outreach to some potential participants without exploring this option. » Shares family's hopes, worries, strengths, and needs with a judgmental or shaming tone/language. » Expresses youth's/family's hopes, worries, strengths, and needs from provider's view, not the youth's/family's perspective. » Shares information without consent. » Reaches out and prepares Family Team member once but not on an ongoing basis.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
PREPARING TEAM MEMBERS FOR FAMILY TEAM MEETINGS		
» Explores any reluctance from Family Team members to participate in a Family Team meeting and/or to support youth's/family's goals and vision. Explores options to move forward. » Explores and anticipates with team member any sensitive or difficult information that they or the youth, parent/caregiver, or other Family Team members may bring up. Explores options for responding to and framing sensitive information and determining whether the Family Team meeting is the best place to discuss it. » Develops strategies with Family Team members to discuss difficult information with the family in a manner that is individualized to youth/family (e.g., takes into account who, where, when, and how to discuss it).	» Asks Family Team members about barriers to engaging, etc., without also opening discussion about how to establish a path forward/next steps. » Downplays barriers that Family Team members identify. » Discusses sensitive information without exploring with family whether to share it and possible strategies to do so. » Develops strategy to share difficult information without considering all aspects of who, where, when, and how this youth/family will be most able to hear the information.	» Avoids exploring Family Team member's reluctance to engage or support youth/family in their goals. » Omits to plan for and strategize how to discuss difficult information. » Acts in a silo. Creates a strategy for addressing difficulties (with youth/family) without the Family Team member that brought up the difficulty. » Disregards agreed-upon strategy and shares difficult information with family in a different manner. » Avoids discussing difficult information. » Only prepares Continuum staff, not other Family Team members.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
	CONVENING FAMILY TEAM MEETINGS	
» Convenes and facilitates face-to-face Family Team meetings within 30 calendar days, 90 days of intake, and at 90-day intervals thereafter (at minimum) and at greater frequency when needed to address the intensive needs of the youth/family. » Reschedules meeting if youth or parent/caregiver/LAR is unable to attend.	» Holds meetings but not within timelines. » Waits too long to meet with Family Team. Misses opportunities to bring Family Team members together to discuss concerns/progress together. Doesn't explore the need to convene additional team meetings when family circumstances change. » Relies primarily on phone or email. Holds minimal face-to-face meetings.	» Only holds Family Team meetings as scheduled and not ad hoc in response to significant changes (such as when intervention is "stuck," youth is hospitalized or has ESP/MCI encounter, or when Family Team members, Continuum Core Team members or other providers/support persons change). » Holds meeting when family is absent.
» Creates a welcoming atmosphere and assists in building relationships among Family Team members. Facilitates agreement on and commitment to a set of ground rules for Family Team meetings. » Expresses value for each Family Team Member and honors everyone's input and perspectives. Brings team members together in exploring ideas, uniting, planning, and moving the planning process forward.	» Makes inconsistent use of facilitation skills (too rigid, too lenient, off-topic, not everyone is heard). » Encourages the sharing of information and opinions with a slant toward a particular outcome. » Weighs one team member's perspective heavier than others. Looks to one team member for guidance/direction. Elicits participation and input from only a subset of the team.	» Lacks intentional facilitation, leaves it to others, or doesn't facilitate at all. » Facilitates meetings without first establishing ground rules that support respectful participation. » Doesn't hold participants to established ground rules.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
	CONVENING FAMILY TEAM MEETINGS	
» Helps all Family Team members engage in a process of shared decision making. Makes sure that youth and family have the time and encouragement needed to participate fully in discussions at meetings. Facilitates Family Team discussions that leverage team member's best clinical judgment combined with youth's and family's expertise in order to collaboratively identify and address the needs/goals in the youth's Treatment Plan/Individualized Action Plan. » Assures discussion of permanency status and progress at every Family Team meeting including next steps, tasks, and timeframes toward a permanency outcome. » Helps team members address and resolve conflicts in processes, perspectives, roles, and strategies both in the moment and with any needed follow-up. » Invites the Peer Mentor or other Family Team member selected by the youth to speak on behalf of the youth when agreed upon by youth. Invites the Family Team member or natural support to assist parent/caregiver in voicing their opinions, experiences, etc. as agreed upon with parent/caregiver.	» Continues discussion that is off agenda without refocusing on youth/family's agreed-upon prioritized agenda items. » Recognizes conflict on team but does not seek ways to resolve it. » Sets ground rules in a silo, doesn't involve participants in establishing them. » Inconsistently holds participants to ground rules they helped to establish.	» Actively or passively excludes participation among Family Team members. (e.g., leaves members to speak off topic and/or out of turn and does not attempt to invite input from all members at each step). » Doesn't carve out specific time for youth and family to speak. » Ignores the need to check in during meeting to ensure that all Family Team members (especially family members) are clear and agreeable to what is being discussed.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
	CONVENING FAMILY TEAM MEETINGS	
» Ends Family Team meeting with a recap of action items and timelines for activities between meetings and clearly identifies who will work on what. Encourages Team members (who youth/family believe or agree are best fit for each task) to volunteer for tasks/action items that need to occur between meetings. » Develops/confirms a plan (frequency and medium) for Family Team members to communicate updates between meetings.	» Asks for volunteers to complete tasks without first considering which items the family would prefer to be responsible for and/or which individuals are a best fit for the task. » Doesn't check in with family (and other team members) on their understanding of action items to be completed. » Ends meeting without a time frame for future meetings.	» Ends meeting without team members understanding or agreeing on next steps and activities that will be worked on between meetings. » Dictates a how team members will communicate updates between meetings without discussion and agreement. » Dictates task assignments rather than asking specific individuals to take on a task or soliciting volunteers.
» As youth approaches transition out of Continuum services, holds Family Team meetings to plan and decide collaboratively with family members on next steps (attempts to meet youth/family at least virtually to support transition and discuss next steps even if family terminates abruptly). » Progressively engages, encourages and expects youth, family, and natural supports in taking on – to the best of their ability – supportive roles previously played by professionals.	» Begins transition planning too late. Arranges meetings with insufficient time to bridge work to new provider. » Offers community resources/services to family rather than holding a meeting to review, plan, and decide on next steps collaboratively.	» Neglects to engage youth and family in any planning for transition. » Ignores or minimizes the need to support youth in planning for events and experiences unique to transitional-age youth. » Invites new service providers to meetings without consent.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
FOCUSING FAMILY TEAM ON MAINTAINING, STRENGTHENING, OR ACHIEVING PERMANENCY		
» For youth who live with their family or are planning to returning to live with their families, uses the Family Team meeting process (pre-meetings and Family Team meetings) to establish action plan and agreement around how the Family Team will help maintain or strengthen emotionally secure family relationships and physical and legal permanency. » Brainstorms individualized strategies and interventions to help the youth build emotionally secure and lifelong relationships with parents, siblings, relatives, and other important people in their life and help the parent/family provide safe, supportive, and unconditionally committed, lifelong and/or legal family relationships for the youth. » Facilitates Family Team identification of youth-related, parent/family-related, and system-related needs and barriers. » Facilitates exploration of and collaboration on goals, objectives, interventions, and strategies to address needs and barriers to youth and family returning to or continuing to reside together.	» Discusses permanency with family but lacks consideration for possible multiple understandings of permanency. » Works with youth/family without engaging Family Team. Reaches out to DCF/DMH without involving family. Identifies/solicits needs from DCF/DMH but not youth/family. » Maintains Family Team plans without revisiting and adjusting to emerging permanency related needs. » Explores but doesn't take steps to resolve or mediate differences between youth and parent/caregiver and/or Family Team. » Launches into individualized strategies and interventions to help the youth build relationships and connections with parents, siblings, relatives, and other important people in their life without ever brainstorming options with Family Team.	» Guides Family Team away from a focus on maintaining/strengthening permanency. Dismisses the importance of maintaining or strengthening permanency in cohesive families. » Develops a provider-driven support plan for maintaining/strengthening permanency without youth/family input. » Rejects Family Team member's input or offers of support. » Develops action items that are unrealistic/not feasible for the youth/family. » Focuses on parent-child relationship without regard for options to strengthen relationships with siblings and extended family members. » Seeks out-of-home treatment intervention prior to attempting to stabilize living situation.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
FOCUSING FAMILY TEAM ON MAINTAINING, STRENGTHENING, OR ACHIEVING PERMANENCY		
» For youth who's parent/caregiver becomes unable or unwilling to continue in the role of safe, unconditionally committed, lifelong legal parent or for youth with permanency plans that have become unclear, fragile, or lack sufficient progress toward a permanency outcome, uses the Family Team meeting process (pre-meetings and Family Team meetings) to develop an action plan and establish agreement around how and when the Family Team will help achieve or solidify permanency, including legal, physical, and lifelong, emotionally secure relationships. » Coordinates with the youth, family, and Family Team members to identify the need for and engage in integrated concurrent permanency planning. Uses best-practice tools and approaches to facilitate concurrent planning discussions with youth, parents, and family (such as "My Forever House" and "Three Types of Parents" tools). » Collaborates with DCF/LAR on individualized strategies (such as Family Find, Family Group Conferencing, permanency planning activities, concurrent planning, specialized family recruitment, etc.) to identify and connect youth with family members with whom a lifelong kinship relationship can be developed.	» When permanency plan changes or additional concurrent planning is needed, straddles old and new plan in a confusing, conflicting, or incongruent manner. » Doesn't identify the need for and/or help youth consider the long-term benefits of establishing and maintaining familial relationships that lasts well beyond the age of 18. » Asks the peer mentor to share youth's perspective at the Family Team meeting without allowing time for the peer mentor to explore with the youth what to share.	» Maintains adherence to previous permanency plan when an updated one has been developed. » Doesn't explore permanency resources with the DCF/DMH. » Ignores DCF/DMH guidance regarding connecting to new family members. » Acts in a silo without offering to support DCF/DMH in pursuing permanency for youth/family. » Neglects to give youth an opportunity (in person or by proxy) to express ideas about their legal, physical, or emotional permanency needs and wants. » Ignores or disregards differing ideas for achieving permanency expressed by, youth, parent/caregiver, and/or Family Team members.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
FOCUSING FAMILY TEAM ON MAINTAINING, STRENGTHENING, OR ACHIEVING PERMANENCY		
» Provides assistance (as needed and agreed upon with LAR) in the identification, location, and assessment of potential lifelong relationships as well as connecting the youth with relatives and other important persons from near and far locations. » As developmentally appropriate, gives youth the opportunity to express their own ideas to Family Team members about how and with whom they want to achieve permanency, including legal, physical, and emotionally secure family relationships.		
Explores and identifies the need for and coordinates and obtains specialized consultations, such as a permanency consultation, with experts in the field to mitigate barriers (e.g., complex parent/caregiver/family medical concerns) to achieving permanency. Integrates permanency consultation (and other specialty consultation) recommendations into strategies with youth, family, and Family Team members.	» Pursues specialty consult but doesn't collaborate/coordinate with DCF/DMH. » Only provides limited information for specialty consult. » Integrates specialty consult recommendations into work with family but doesn't share recommendations with other Family Team members.	» Ignores physical/mental health challenges of family members in the home that may affect achieving permanency. » Obtains specialized consultation but omits integrating recommendations into Family Team process and/or interventions and interactions with youth/family. » Ignores any need to consider, explore, or coordinate logistics, such as payment for consult.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
FOCUSING FAMILY TEAM ON MAINTAINING, STRENGTHENING, OR ACHIEVING ACADEMIC SUCCESS		
» Explores (and revisits) supports and advocacy needed to assist youth in accessing educational services. Brainstorms ways to help family access educational and supportive forums that assist family in supporting and advocating for their child. Connects family with resources to help them obtain information regarding educational laws, statutes, and regulations. » Specifically communicates, coordinates, and collaborates with family, youth, OT consult, out-of-home provider, and school around youth's educational needs. » Obtains and reviews youth's current IEP (if one exists) and participates in IEP meetings. » Regularly discuss educational concerns. Proactively share successful behavioral support techniques with teachers/school personnel as appropriate. Asks about establishing a school support person ("champion") for the youth as needed. » Collaborates as needed to establish/ maintain a school routine that promotes regular, prompt attendance and supports participation in extracurricular activities. » Collaborates and brainstorms around options to support preparations for upcoming activities (tests, performances, athletic events, homework concerns, etc.). » Facilitates agreement on school enrollment prior to group-home admission.	» Ignores school domain when youth is doing well in school instead of considering how team could build on these strengths with youth. » Engages in minimal exploration around school needs and/or minimal care coordination to address school needs. » Uses "Do for, do with, cheer on" approach in manner that is misaligned with youth or parent/caregiver needs (e.g., "does for" - calls to make a referral when parent/caregiver could do this successfully with some coaching and/or a supportive presence from staff). » Creates a plan without considering/planning for ancillary needs such as transportation.	» Lacks coordination with OT or other specialty service from the beginning especially when there's an identified need to do so. » Lacks persistence when following up with school on planning and addressing needs. » Makes recommendations for school plans either without expertise to do so or against youth/family wishes, thoughts, and needs. » Fails to consider talking with the parent/caregiver about inviting the school (as an important stakeholder in the youth's life) to all Family Team meetings or some Family Team meetings that will have a school specific agenda.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
FACILITATING FAMILY TEAM INDIVIDUALIZED ACTION (TREATMENT) PLANNING		
» Encourages Family Team discussion of strengths of youth and family members as individuals and as a family system. Elicits specific, notable aspects of strengths and where each strength appears. » Encourages the Family Team to consider how strengths can be used and built upon to meet goals.	» Elicits strengths but doesn't help team members consider how youth/family might use them to meet goals. » Does not consider with the Family Team how individual strengths can help youth/family enhance their connection/relationship with one and help them live well together.	» Allows conversation about strengths to remain derailed without reorienting back to discussion of strengths. » Neglects to reframe back-handed compliments or other insults disguised as, or accompanied by, a compliment.
» At the initial Family Team meeting and throughout services, develops and reviews specific, measurable, achievable, realistic, time-targeted goals that are based on youth's/family's priority needs. Assists the family in prioritizing goals with the Family Team to ensure there aren't too many simultaneous goals overwhelming family or team members. » Anticipates and discusses how strengths and priority needs may change and impact goals over time. Makes specific efforts to continuously anticipate and discuss shifting priority needs, goals, and strengths of youth from the point of intake. For youth approaching their 18th birthday, uses the Family Team as the primary vehicle to plan interventions to address any urgent risk to the lack of permanency.	» Focuses team only on current needs without connecting them to youth's/family's future vision. » Doesn't prioritize needs/goals or prioritizes them but doesn't address them in prioritized order. » Communicates observed needs but doesn't » Invite Family Team members in the process of exploring, expressing, and prioritizing Youth/Family needs.	» Allows only professionals to express priority needs and set priority goals. » Doesn't solicit multiple perspectives when one or two individuals insist on which goals to prioritize. Negates what youth/family have indicated are priority goals for themselves. » Neglects to focus Family Team on anticipating family/youth life transitions and considering options/ interventions to meet related needs.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
FACILITATING FAMILY TEAM INDIVIDUALIZED ACTION (TREATMENT) PLANNING		
» Engages the Family Team in a process of brainstorming formal and informal options (interventions, services, creative strategies, etc.) to meet the youth's/family's prioritized needs/goals. » Establishes shared understanding of which options are most likely to succeed and promotes agreement on which ones to try first. » Explores with Family Team members how they will know if chosen option is effective. Reaches consensus on clear, observable measures of change as well as indicators of readiness to transition out of service.	» Focuses brainstorming on things other than strengths, needs, and creative interventions. Doesn't inspire team members to continue focusing on problem solving. » Acknowledges lack of agreement but avoids exploring what options/interventions might be most likely to succeed. » Limits brainstorming and exploration of what team members think should be tried first. » Only relies on discharge criteria from referring agencies rather than also facilitating Family Team discussion of how all will know when it's time for transition out of Continuum services. » Adds goals without considering indicators of readiness for discharge.	» Restricts brainstorming to formal/professional supports rather than also helping the Family Team members consider natural and informal resources as potential options to meet the youth and family needs. » Only reviews readiness for discharge when discharge seems imminent. Fails to facilitate discussion of discharge at the onset of services and periodically throughout.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
FACILITATING FAMILY TEAM INDIVIDUALIZED ACTION (TREATMENT) PLANNING		
» Engages Family Team members to share progress, successes, and challenges with chosen options (interventions, services, creative strategies, etc.) attempted since the last meeting as well as the measurable impact of these on goals and readiness to transition out of service. Helps team members express and celebrate successes. » Explores the specifics of what worked, what didn't, and what might help make the chosen options more effective. » Explores ongoing and new needs (especially including those related to upcoming life transitions and safety/risk). » Involves the entire Family Team in making decisions about ending or modifying services, treatment approaches, and safety interventions and brainstorms new options to meet new/ongoing needs.	» Is aware of successes but doesn't help team members express and celebrate them. Doesn't elicit or value each team member's view of success. » Shares Core Team updates as agreed upon with the family (during pre-meeting preparation) but doesn't encourage other Family Team members to do so as well. » Uses and/or allows Core Team members to use rehabilitation or clinical language family is unfamiliar with, without explaining it. » Facilitates discussion of progress but neglects to facilitate discussion of goals and interventions to be modified. » Discusses need to modify goals but doesn't facilitate brainstorming of new options to meet modified goals.	» Ignores what the family is working on, including their developing strengths. Doesn't elicit exploration of what has worked. » Only focuses on challenges or failures or fails to help team shift from only focusing on these things. » Relies only on clinician's (and/or other formal supports') judgment of progress and doesn't elicit other perspectives—especially informal supports and youth/family themselves. » Ignores the need to facilitate discussion of progress during Family Team meeting. » Listens to one or two but not all team members' perspectives on what is useful/effective. Gives greater weight to what other's feel is effective rather than what the youth/parent/caregiver says is effective. » Excludes occupational therapist or psychiatrist consult updates and impact on progress.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
FACILITATING FAMILY TEAM INDIVIDUALIZED ACTION (TREATMENT) PLANNING		
» Promotes continuity of approaches across Family Team members. Reviews Family Team member's goals for, expectations of, and work with the youth/family. » Acknowledges similarities and differences among approaches and facilitates discussions to make use of meaningful tensions among perspectives.	» Explores goals Family Team members are working on with youth/family but doesn't consider differences and similarities among them. Misses opportunities to coordinate efforts with and promote continuity of approaches across Family Team members. » Acknowledges differences but lacks planning for next steps to work through differences. » Discrepancy between youth and parent/caregiver goals or between family and Family Team member's goals are not acknowledged or explored.	» Omits exploration of Family Team member's expectations and goals for the family. » Ignores incongruence of Family Team member's goals for family or acknowledges incongruence but neglects to explore opportunities for integration. » Ignores disagreement that youth and family expresses about Family Team member's goals for them.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
FACILITATING FAMILY TEAM INDIVIDUALIZED ACTION (TREATMENT) PLANNING		
» Based on goals agreed upon in Family Team meeting, documents goals (in youth/family agreed-upon language) in youth's treatment plan/ individualized action plan within 30 calendar days, 90 days of intake, and at 90-day intervals thereafter at minimum (greater frequency when needed to address the intensive needs of the youth/family). » Shares draft treatment plan/individualized action plan with youth and family, in youth's and family's preferred language(s), and ensures that it is agreed upon and understood by all. Invites feedback and revises as agreed to with youth and parent/ caregiver/LAR and then obtains youth and parent/ caregiver/LAR and other required signatures and provides Family Team members with copies of plan.	» Waits to update treatment plan/individualized action plan at scheduled intervals, doesn't reconvene Family Team to update plan when needs of youth/family change. » Focuses on goals for youth or parent/ caregiver but not both. » Inconsistently shares written treatment plan/ individualized action plan with team members. » Shares treatment plan/individualized action plan with youth/family but excludes Family Team members. » Uses clinical language the family is unfamiliar with without explanation.	» Develops or revises Treatment Plan/Individualized Action Plan without input and agreement from youth, parent/caregiver and Family Team members. » Asks family to sign Treatment Plan/Individualized Action Plan without reviewing it with them and asking them if they agree with it. » Treatment Plan/Individualized Action Plan slanted toward provider bias not the prioritized goals and objectives agreed upon in the Family Team meeting. » Omits treatment planning/individualized action planning from Family Team agenda. Ignores the need to prioritize this agenda item in collaboration with parent/caregiver when goals are due for review or family circumstances change. » Neglects to invite and revise treatment plan/ individualized action plan with feedback from parent/caregiver and youth.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
COORDINATING CARE IN BETWEEN FAMILY TEAM MEETINGS		
» Establishes and maintains weekly communication with Family Team members (or other frequency based on youth/family and referring agency need). » Checks in with each Family Team member to learn about their progress on agreed-upon tasks. Explores tasks measurable impact on goal(s). Troubleshoots, problem solves, and empowers team to complete tasks and helps plan for next steps especially when encountering challenges/barriers to task completion. » Helps youth/family and the Family Team recognize and celebrate "micro" successes week to week, as they occur. » Actively addresses conflicting perspectives among youth, family, and Family Team members and revisits differences periodically. » Gathers information on Continuum effectiveness in order to improve Continuum services to youth/family.	» Has a general check-in with team members that lacks focus on progress related to the task they agreed to work on in the Family Team meeting. » Empowers Family Team member(s) to complete a task that they need help troubleshooting, or visa versa. » Talks with referring agency about concerns but doesn't collaborate on and/or help coordinate a strategy for discussing their concerns with the youth/family. » Listens to team members' conflict but doesn't help mediate it. » Neglects to specifically inquire and collaborate around successes and challenges with achieving/maintaining community tenure/permanency.	» Neglects to follow up with team members in between meetings. Waits for weekly update rather then communicating in real time when it is needed. » Expresses judgment of Family Team members for not accomplishing tasks. » Agrees with negative comments Family Team member(s) make, colluding with negativity and bolstering conflict. » Ignores conflicts and barriers.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
COORDINATING CARE IN BETWEEN FAMILY TEAM MEETINGS		
» Attempts persistently to include prescribing practitioner in care coordination. Makes diligent outreach efforts (secure email, telephone, in person) to contact prescribing practitioner during initial assessment and intervention planning in order to include their perspective in written documents and to provide them with information relevant to the role of medication in context of Continuum interventions (includes parent/ caregiver in these outreach efforts as agreed upon with them). » Establishes a written, two-way communication plan with prescriber to monitor medication (benefits, compliance, side effects, and changes). Gathers input from prescribing practitioner at minimum before each Family Team meeting and treatment plan update. » Consent permitting, shares information regarding youth/family permanency plan and status with the prescriber to maximize full understanding and ongoing support of the youth's/family's situation. » Invites prescribing practitioner to Family Team meetings as agreed upon with parent/caregiver/LAR. » Explores the need for support around and attends prescribing practitioner meeting with youth/family as requested and/or helps youth/family prepare for meetings (considering information to share, questions to ask, etc.).	» Gathers information about medications as a rote task without taking the time to understand implications of that information. » Agrees to attend prescribing practitioner meeting with youth/family but cancels when one staff can't go, rather than negotiating to determine who else can attend and how parent/caregiver wants to handle the absence. » Makes minimal, non-persistent attempts to include prescribing practitioner in care coordination and two-way communications that address youth progress and any concerns or symptoms. » Shares pieces of the permanency plan but not to the fullest extent possible or shares initially but doesn't keep the prescriber updated.	» Does not consider using psychiatrist consult to better understand youth's medications and what they mean. » Declines attending prescribing practitioner meeting even when parent/caregiver requests that of support from Continuum services. » Makes no attempts to communicate with, obtain information from, share information with, or otherwise involve prescribing practitioner.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
BRIDGING WITH ALL ENTERING AND EXITING PROVIDERS/SUPPORTS		
» Helps family navigate the service system and links youth/family with needed services including but not limited to Continuum specialty consultations (OT & psychiatry); clinical services; social, educational, and vocational services; and formal and informal community resources. » Coordinates with family and Family Team members to arrange or provide transportation as needed.	» Links to service and follows up to be sure youth/family are connected but neglects to explore youth's/family's experience of new service. » Fails to arrange or provide transportation as needed.	» Links to services without any follow-up to ensure connection. » Ignores parent/caregivers' failed attempts at outreach to a provider/support. Offers no assistance. » Unsure where to access resources and does not seek assistance or figure out how. » Doesn't obtain consent to speak, coordinate, or collaborate with new supports/services.
Coordinates with youth/family as well as sending and receiving providers to ensure direct communication and continuity among them when necessary (e.g., coordinating psychiatrist-to-psychiatrist direct communication when there is a change in psychiatrist).	» Coordinates between sending and receiving providers without including the family. Jumps into "do for" without first considering if that's the best approach for the family. » Initiates collaborating/connecting providers but doesn't follow through or follow up to ensure it occurs. » When family indicates that they will coordinate the connection between providers, doesn't offer the family an opportunity to think through potential options for strategies they can use to connect providers.	» Disregards the need for coordination between providers. » Discusses/coordinates with providers without consent.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
BRIDGING WITH ALL ENTERING AND EXITING PROVIDERS/SUPPORTS		
» Creates a bridge to services, schools and programs by creating opportunities for in-person transition meetings with staff, family, and youth that are designed to assist the youth and family in establishing a comfort level with new services. Invites (consent permitting) new providers to Family Team meetings and intervention sessions. Engages in "warm" hand-offs (directly introduces the youth/family to a new service provider during which all three parties are present in person during a visit, meeting, or conference call as part of the process for supporting youth/family transition to a new service). » Meets in person with the youth/family and any entering/exiting provider/supports (regardless of whether they are on the Family Team) to transfer information and practices to help sustain treatment gains and continuation of effective therapeutic/ behavioral interventions, safety plan approaches, skill-building activities, and care coordination. Ensures particular attention is paid to youth/ family voice, including specific interventions, skill development activities, and crisis prevention tactics that the youth/family reports to be helpful. » Establishes an agreed-upon transition time frame that is viable and specific to the individual needs of the youth/family. » Exchanges necessary documentation (CANS, safety plan, discharge summary, etc.)	» Has transitional phone conversations (rather than face-to-face meetings). » Under-shares or over-shares documentation (e.g., has consent to share all of it and doesn't consider which pieces are most relevant—shares the whole document). » Shares information and practices without checking in with youth/family on their effectiveness or without exploring with youth/ family which ones are most important to share. » Fails to prepare youth/family for meeting (e.g., doesn't discuss who will attend or help youth/family consider what to share).	» Fails to focus transition-oriented meeting on transfer of information and helpful practices. » Shares documentation without consent. » Orients new provider to family via phone without any family involvement in the process. » Uses shaming/blaming language when sharing information about youth/family with the provider. » Focuses on failures rather than approaches to consider avoiding/using based on family's actual experience with them as unhelpful/most helpful. » Neglects to revisit Family Team membership and explore with youth/family whether and how to include these new supports on their Family Team (e.g., full membership or attend a specific meeting).

ASSESSING RISK, SAFETY PLANNING, AND SUPPORTING FAMILIES THROUGH CRISIS

The Core Team engages in ongoing identification and anticipation of risks to a youth's and family's safety, permanency, and wellbeing and develops evolving, shared understanding of what precipitates, drives, and helps to mitigate risk and crisis for youth and family. It involves engaging the family to help them establish a family-driven individualized plan for how they can use their current skills and strengths to increase protective factors, build safety networks, and resolve potential dangers.

Safety networks include a youth's and family's protective relationships that are critical to the success of a safety plan, both in a crisis and on an ongoing basis. Input from all relevant supportive persons results in a coordinated comprehensive plan that is realistic for the youth/family to implement and addresses the assessed risks. Safety planning promotes effective collaboration and continuity in urgent situations across settings (e.g., school, home, group home). Safety plans offer a range of crisis supports to intervene when preventative measures cannot avert a crisis. Crisis support is provided and involves an urgent response that helps youth/family use their strengths and skills and network of relationships to diminish and/or manage acute risk.

Please see the following matrices for additional information related to risk/safety planning and support:

- Engaging Youth and Family
- Conducting a Comprehensive Collaborative Assessment
- Continuity with Higher Levels of Care
- Incorporating Psychiatry and Occupational Therapy Consultation
- Practicing Cultural Relevance
- Collaborative Treatment Planning and Care Coordination
- Supporting Life Transitions
- Strengthening Wellbeing through Respite

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
COMPLETING INITIAL RISK ASSESSMENT AND SAFETY PLANNING		
» At time of intake but no later than eight (8) hours after consent for services, conducts a risk assessment and develops an initial safety plan with the youth and family to address any safety concerns that are identified at that time. » Guided by available referral, intake, assessment, collateral information, and observation, invites each family member (as appropriate to situation) to describe any immediate safety concerns. » Explores youth's risk of harm to self and others as well as their risk of harm by others. Explores family and youth medical concerns, fire safety, problematic sexual behavior, sexual exploitation, substance use, domestic violence, and elopement. » Explores how the youth/family typically responds to crisis and who they reach out to, particularly natural supports and protective relationships, in moments of crisis, risk, and high stress. » Gathers history of experience using formal and informal crisis plans and supports, including natural supports and emergency psychiatric services. Inquires about history of psychiatric hospitalization. » Begins to develop a shared understanding with youth/family as to what they experience as moments of crisis, risk, and high stress. » Explores and/or observes conditions in home and community and assesses for risk and safety (child-proofing, weapons, pets).	» Doesn't include all parties/family members in development of the safety plan or completion of risk assessment. » Risk assessment and initial safety plan is developed with family but not documented in the record in timely manner for access by all staff. » Jumps into safety planning without exploring examples of what youth and family experience as crises. » Jumps into safety planning without exploring youth's/family's experience using formal and informal crisis plans and supports. » Inquires about what youth/family experience as moments of crisis, risk, and high stress but doesn't reflect back understanding of this to be sure it is accurately heard and understood. » Is only future-oriented, omits inquiry regarding past experiences of support from informal and formal supports during times of crisis and overwhelming stress. » Observes risky conditions, such as drugs being used in the park across from youth/family home, but doesn't explore how youth/family deal with or try to avoid those risks.	» Excludes youth from the assessment and safety planning process. » Expresses rigid belief about what a crisis is. Identifies for family what their safety concerns are. Invalidates or dismisses youth/family perspective of a crisis situation. » Bases understanding of family's experience of crisis solely on information from referral, intake, assessment, collateral conversations, and observation without asking the youth/family about their experience. » Is judgmental and uses a disingenuous tone when inviting each family member to describe their safety concerns.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
COMPLETING INITIAL RISK ASSESSMENT AND SAFETY PLANNING		
Provides contact information for Continuum on call/after-hours number and Mobile Crisis Intervention Team (provides hospital emergency department contact for youth with private Insurance, where indicated). Discusses when to contact each entity, especially youth's/family's natural supports and protective relationships, and typical crisis response(s) by each entity during imminent and non-imminent risk.	Plans to use only professional supports during crisis. Omits the use of informal/natural supports.	» Gives phone numbers to call when in crisis without assessing for level of risk and/or engaging in individualized safety planning that is feasible for the youth/family. » Engages in safety planning but excludes consideration of who, when, and what phone numbers youth/family can call for support when in crisis. » Tells family to call MCI when in crisis rather than opening discussion of options family can use and exploring whom they would be most comfortable contacting for various types of crises and support.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
CONDUCTING ONGOING EVALUATION OF THE FULL RANGE OF RISK AND SAFETY CONCERNS		
» Engages in ongoing individual exploration with the youth, parent/caregiver, household members, and collaterals regarding youth safety concerns. » Asks youth who they feel most safe with and when they feel most safe; uses youth/family engagement tools as appropriate to gather this information. » Explores safety in environments youth/family frequent such as home, school, neighborhood, social media, etc., as well as any risk and safety precautions in place in these settings. Explores risks to psychological safety related to loss, disconnection from or removal of attachment, and protective adult relationships. » Explores with each household member what they experience as cues/triggers to a crisis at home and in community locations and what they already do to safeguard youth and others in times of crisis (if any). Explores coping function of current safeguarding strategies and any unintended worsening of crisis it may cause as well as alternative options. » Explores cultural and community mores parents/caregivers ascribe to in order to keep their children safe (e.g., meet-and-greet with youth and local police so they can get to know one another). » Considers carefully the distinctions between self-harm and suicidality and provides family with psychoeducation on distinctions between these when needed. Explores intention, means, access to objects that may be used to cause harm to self/others.	» Explores risk and safety concerns with parent/caregiver only. Excludes youth, other household members, and/or collaterals. » Explores one area of risk or one setting youth frequents. » Jumps to providing a solution without fully exploring risk. » Engages in minimal exploration, making assumptions of when youth/family feel at risk.	» Omits exploration with each household member regarding their and the youth's experience of crisis cues/triggers in the home and neighborhood. » Misses or ignores the safety plan and/or strategies that the youth/family already has in place. » Ignores cues that suggest the need to have a separate conversation about risk with youth and each family member. » Expresses bias toward family's way of handling risky behavior that is within their cultural norms. » Rigidly insists that self-harm is or is not an indication of suicidal behavior/thoughts rather than exploring further and assessing for suicidal ideation, plan, means, and access.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ORIENTING YOUTH AND FAMILY TO THE SAFETY PLAN DEVELOPMENT PROCESS		
» Discusses with youth/family how written (or visual) plan(s) can prevent or deescalate a crisis as well as support their approach and manage provider, school, other collaterals, and support persons' participation in crisis situations. » Discusses the benefit of involving others (Family Team members, referring agency, OT/psychiatry consults, school, MCI, out-of-home provider, natural supports, police, family, etc.) in planning how they might help youth/family prevent risk and/or provide support in the moment of crisis. » Explores youth/family concerns when they are ambivalent about or decline to make a safety plan and/or decline to involve people who may be a support in the planning process. Revisits discussion as clinically indicated. Uses tools such as a scaling question to identify what would help them move one or two steps forward in involving safe and supportive adults.	» Misses opportunity to explore/explain specific ways that a safety plan can help this given youth/family. » Engages in safety planning in isolation. Takes sole responsible for risk and safety planning conversations without including Family Team members and other formal and informal supports. » Discusses the option of involving others in the safe planning process with youth/family on one occasion but doesn't revisit. » Validates ambivalence about safety planning and revisits discussion but does not explore what is driving the ambivalence or reluctance.	» Approaches safety planning as a task and form to complete and file away rather and an ongoing process. » Tells family that the safety plan is required rather than explaining how it can help. » Uses generic safety planning template without individualizing it to this youth/family. » Invites relevant parties to safety planning meeting without parent/caregiver/LAR consent. » Does not include potentially valuable informal and formal supports in youth/ families life in the safety planning process. » Does not build the therapeutic alliance and relationship needed to assist the family in developing a plan that will be usable for them.
Provides ongoing, needed education on Continuum's safety protocols, mandatory reporting, and Continuum crisis-response process (including role in supporting/collaborating with collateral's crisis response process) as well as the spectrum of emergency services, including different levels and types of response. Discusses with youth/ family when to use different levels of support and the possible results of using each.	Executes Continuum's safety protocols, mandatory reporting, and/or Continuum crisis response process without discussing with family, inviting them to be part of the process, and helping them understand the need to do so.	Provides misinformation about safety protocols, Continuum response, etc. or indicates the need to follow up with youth/family with more information but does not do so.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
DEVELOPING A USABLE SAFETY PLAN FOR PREVENTION AND INTERVENTION		
» Develops/updates the written (and/or visual) safety plan in proportion to safety concerns present, in collaboration with youth/family, Family Team, and others (consent permitting). » Tailors the safety plan to include youth/family's safe and protective relationships and specific viable action steps for each involved person. Includes strategies that have been successful in the past that youth/family can take to prevent crisis as well as those to use in the moment of crisis. » Always includes emergency contact and other relevant support's information. » Gathers feedback from youth/family and explores whether they can actually take all identified steps in the safety plan. Explores alternative feasible options when needed. » Assists youth/family in having their safety plan in the modality/location (paper on fridge/in wallet, entered in cell phone, etc.) that works for them.	» Develops a generic plan that isn't tailored to youth/family. Uses some language unfamiliar to youth/family. » Provides phone numbers of formal supports but doesn't talk with family about whether they have numbers of natural supports in a place they can access in a crisis. » Ignores, doesn't inquire about, or doesn't consider steps that have been successful in the past. » Ask youth/family about feasibility of plan and explores alternatives but doesn't fully incorporate feedback into the plan. » Obtains some but not all youth and family input. Prioritizes some family input over others. » Omits the process of exploring what will help youth/family use the safety plan in the moment of crisis. Lacks exploration of options for where youth/family will locate the plan, such as on paper in wallet, in cell phone, keeping numbers in speed dial, etc.).	» Writes a safety plan using language that the family doesn't use/is unfamiliar with. » Develops plan in isolation, without youth/family input. Tells youth/family what the plan will be or hands them an already-developed plan to sign. » Doesn't explore with family if they can actually take the steps in the safety plan. Dismisses youth and family feedback/perspective on feasibility of action steps in the plan. Doesn't amend safety plan with youth/family when it's been determined that steps aren't feasible. » Tells youth/family where to keep their safety plan (e.g., "hang it on the fridge").

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
DEVELOPING A USABLE SAFETY PLAN FOR PREVENTION AND INTERVENTION		
» Includes strategies that may work across settings (home, school, community, etc.) and those that need to be different for each location. Encourages continuity across settings. Includes all relevant parties (consent permitting) in safety planning discussions with the youth/family. Reviews their expectations and existing safety plans (if any). » Engages in ongoing consideration of the need for different safety strategies for different types of risk (suicide, arrest, parental medical/psychiatric emergency, bullying, youth parenting, etc.) in different settings (home, school, neighborhood, etc.).	» Develops a basic plan with strategies to be used in all settings regardless of suitability for each of those settings. » Focuses safety plan actions only on youth and parent/caregiver, to the exclusion of what other household members and supports could plan to do during a crisis.	» Develops a plan for all settings without considering the need for specific/unique strategies that are needed in some settings. » Avoids addressing uncomfortable risk areas with family, such as parental medical/mental illness. » Develops a plan with youth/family without paying attention to other safety plans and strategies they have in place already. Creates a new plan that negates existing strategies that are working for youth/family.
» Explores and includes strengths that can be used to prevent crises. » Engages in ongoing exploration of specific youth and family strengths with all family members and develops a sheared understating of how these strengths can be used in the moment.	» Omits the youth's strengths and enjoyable activities from inclusion in safety planning strategies/ actions the youth can use in the moment. » Discusses strengths but doesn't adequately develop a shared understanding with youth/ family and team around how strengths can be used to prevent/manage crisis.	» Explores strengths that can be used to prevent crisis one time but not on an ongoing basis. » Omits any consideration of strengths during the safety planning process.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
DEVELOPING A USABLE SAFETY PLAN FOR PREVENTION AND INTERVENTION		
» Explores and includes formal and informal supports in the plan, that, if needed, may be available to help prevent or deescalate a critical incident; develops specific actions that can be taken by each to help the youth be safe over time.	» Only explores formal or informal supports but not both. Tells youth/family when to use different levels of formal/informal supports without first exploring who they have used/ currently use and would like to use. » Explores creative options for how family can use natural supports but doesn't assist family with the next step of making arrangements to use that specific action with the natural support.	» Only explores formal or informal supports but not both. Tells youth/family when to use different levels of formal/informal supports without first exploring who they have used/ currently use and would like to use. » Explores creative options for how family can use natural supports but doesn't assist family with the next step of making arrangements to use that specific action with the natural support.
» Once completed and consent permitting, promptly shares safety plan document with other providers, supports, and Family Team members who share responsibility for supporting youth/ family safety. Shares plan (as appropriate) with local MCI team and Continuum on-call staff. » Revises plan with youth/family when needed and promptly communicates any proposed amendments or new concerns to all.	» Only shares part of the safety plan with Family Team members. » Waits to share safety plan. » Shares the initial plan when completed but not again in anticipation of a crisis.	» Doesn't share plan with youth, family, and relevant collaterals. » Doesn't amend plan when new concerns arise.

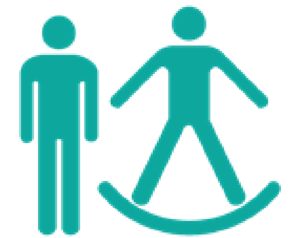
IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
PROVIDING ONGOING CRISIS SUPPORT AND REVISION OF SAFETY PLAN		
» Regularly discusses effectiveness of safety plan with youth/family and among Core Team, referring agency, Family Team, and other relevant natural and formal supports (consent permitting). » Checks in with youth/family and collaterals around identified crisis cues/triggers youth/family are experiencing at home, school, or in community locations. Explores what aspects of the plan are working/not working (and why) as well as any new crisis cues/triggers they are experiencing. » Role plays or practices actions on the safety plan with youth/family and relevant formal and informal support persons.	» Only focuses on new crisis/cues/triggers and not on what's working. Doesn't explore why plan is/isn't working. » Only checks in/discusses effectiveness with some Family Team members. » Doesn't identify patterns of behavior occurring in multiple areas of the youth's life that may affect safety planning. » Does not role play or practice actions on the safety plan with youth/family and relevant formal and informal support persons. » Offers own opinion about effectiveness of plan without first asking youth/family if they feel its working.	» Completes initial check-in about plan but not on an ongoing basis. » Excludes family members in the process of reviewing the effectiveness of the plan. » Relies solely on one's own assessment of why a behavior is occurring or why the plan isn't working. Omits exploring this with the youth/family. » Doesn't check in with all the collaterals from multiple settings where behavior/incident(s) keeps occurring. » Doesn't explore with youth/family and Family Team members what might be driving crisis. » Doesn't debrief with youth and family following a crisis to learn what worked and didn't work and why.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
PROVIDING ONGOING CRISIS SUPPORT AND REVISION OF SAFETY PLAN		
» Identifies the central need for continuous safe and supportive adult/family relationships and the importance of the maximum level of youth's contact with and access to them —in preventing crisis, supporting them through crisis, and following a crisis. » Identifies the need for and increases Continuum service time with youth/family in order to prevent crisis, support them through a crisis, and support them following a crisis. » Explores the ongoing need for new supports (e.g., alerting MCI, referring to outpatient therapy) as well as the need to increase the time spent with other current formal and informal supports before, during, and after a crisis.	» Decides independently on increasing time with youth/family in order to prevent crisis. » Recognizes the need for additional support but prioritizes maintaining current schedule instead of reprioritizing, rescheduling, and/or coordinating with other Continuum staff to provide support to youth/family. » Excludes Family Team members or doesn't conduct outreach to them to provide additional support.	» Ignores the youth/family need for increased time with current support or new supports. » Ignores youth/family need for assistance in asking Family Team members for additional support.
» Always reviews and revises safety plan when new crisis cues/triggers are identified, if there are changes youth's/family's clinical status, following a clinical/crisis/risk incident, when the plan isn't working, and during preparation for a transition (change in living environment, school, or out-of-home treatment intervention, etc.). » Verifies that supports listed in safety plan are still able and willing to carry out identified steps. » Promptly communicates any proposed amendments or new concerns to Family Team and other relevant persons.	» Misses the need to update safety plan for settings outside the home. » Expects supports listed on plan as to carry out tasks without verifying if supports are still available. » Updates plan but doesn't share it with full Family Team and/or other relevant supports. » Waits too long to update the Family Team about proposed changes to plan (e.g., waits until next Family Team meeting).	» Ignores the need to review and amend the plan with youth/family and others when circumstances change. » Makes changes to the plan without disseminating the updated safety plan document. » Makes changes to the plan without youth and family involvement.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
	PROVIDING ON-CALL CRISIS SUPPORT	
» Responds promptly to youth/family in-the-moment need for crisis support. » Partners with youth/family to address imminent and non-imminent crisis in an empathic manner that validates the youth's/family's experience of the crisis situation. » Provides phone-based coaching and support around implementation of the safety plan. Assesses the need for, offers, and provides youth/family with 24/7 face-to-face crisis response when and where the support is needed (family's home, school, community, MCI/ED location, or group home setting as agreed upon). » Explores with the youth/family the steps they can take to manage during the crisis. Provides support in implementing the safety plan. » Identifies the need for and collaborates with family to alert the youth's/family's support persons to implement their steps in the safety plan.	» Does not access appropriate support persons during a crisis because of uncertainty about their roles. » Acts with uncertainty during a crisis because of lack of clarity about own role. » Doesn't encourage implementation of action steps in the safety plan or consider options and next steps with youth/family. » Jumps to using MCI without assessing if safety plan can be tried first. » Suggests the use of safety plan as a reminder of what can be done in the moment but doesn't explore with youth/family which actions steps they've tried already and/or which they want to try next. » Operates independently and doesn't involve/reach out to other individuals on the safety plan for support.	» Waits to respond to family. » Validates and addresses imminent crisis and dismisses non-imminent crisis. » Defers to MCI without first exploring whether/how Continuum can support youth/family through the crisis. » Doesn't follow Continuum safety protocols. » Rigidly adheres only to action steps listed in the safety plan even though youth/family indicate they are not helping. Doesn't recognize the opportunity for in-the-moment exploration of additional potential strategies with youth/family. » Doesn't offer youth/family 24/7 response on weekends and or evenings as a rule. » Refuses to go to youth's home during crisis even when youth/family has requested and it is safe to do so. Tries to convince youth/family they don't need a face-to-face intervention in order to avoid going out.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
PROVIDING ON-CALL CRISIS SUPPORT		
» Collaborates and coordinates with relevant formal and informal support persons/collaterals (such as MCI/ED, police, group home, Family Team members, natural supports, etc.) prior to, during, and following a crisis. Continues with regularly-planned Family Team meetings in times of crisis and calls additional Family Team meetings as necessary when crisis planning and decision making is needed. » Uses de-escalation skills and intensive short-term interventions to stabilize behavior during a crisis response. Teaches and encourages youth/family in development, use, and practice of self-calming and de-escalation skills. Considers the need for youth and family to have a break by taking the youth out of home (e.g., to go for a walk or engage in an activity) for a brief "cool down" period.	» Doesn't contact/coordinate with Core Team members and collaterals in a timely manner. » Doesn't utilize a face-to-face intervention when necessary and appropriate. » Coordinates initially with MCI and/or other collaterals but doesn't remain available or doesn't hand off collateral to person(s) on next on-call shift. » Engages in face-to-face crisis response but doesn't always use best approach to deescalate a situation.	

INCORPORATING PSYCHIATRY AND OCCUPATIONAL THERAPY CONSULTATION



As part of the assessment process, the Core Team engages the occupational therapy consultant (OT) in a consultative screening, and together they develop a plan for the OT's involvement going forward. This may include, but is not limited to, the OT providing a consultative assessment; recommendations to the family, Core Team, and Family Team; and/or coaching to the family.

As agreed upon with the OT, the Core Team engages the OT to assist with assessing and addressing youth and family processing patterns and environmental factors that contribute to presenting concerns as well as developing individualized interventions that focus on establishing pro-social habits, such as healthy attachment, parenting skills and routines, using occupations of the family and of childhood to enhance and promote self-regulation and relaxation, and developing strategies for managing symptoms that are associated with the use of problematic behaviors (e.g., stress, anger, anxiety). The Core Team may also coordinate with the OT to provide training/coaching to the Family Team to support their implementation of the occupational therapy recommendations.

The Core Team engages in an ongoing assessment of the need for psychiatric consultation with the Core Team and the Family Team. The Core Team consults with the psychiatry consultant as needed to assist with diagnosis, clinical formulation, and intervention planning, especially when addressing clinical complexities or when improvements have plateaued or high-risk behaviors are present.

Please see the following matrices for additional information related to incorporating psychiatry and occupational therapy consultation:

- Engaging Youth and Family
- Continuity with Higher Levels of Care
- Assessing Risk, Safety Planning, and Supporting Families through Crisis
- 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
COLLABORATING WITH THE OCCUPATIONAL THERAPIST (OT) CONSULTANT AND INCORPORATING THEIR CONSULTATION		
» Engages OT in consultative screening for every youth/family during the initial assessment. » Explores with the OT and youth/family whether an OT consultative assessment is needed. » Coordinates with the OT and collaterals so that the OT consultation includes all necessary settings such as home, schools, community centers, hospitals, and group home.	» Provides incomplete information to the OT when obtaining a consultative screening and/or determining the need for consultative assessment. Fails to provide the full assessment or pertinent portions such as the early developmental history, trauma history, or other history that will enrich OT's consultative screening/assessment. » Limited or narrow understanding of the OT role. Underestimates the usefulness of the OT role. Provides the family with minimized definition/explanation of OT role. » Solicits the OT for a narrow scope of work (e.g., only to discuss safety planning). » Suggests a limited need for the OT consultant to coordinate with only one collateral, or setting, rather than considering all collaterals and settings together. » Communicates limited information about OT consultative screening/assessment recommendations to family, Family Team, and/or other collaterals.	» Neglects to engage OT for screening consult during initial assessment. » Provides family with no explanation or inaccurate explanation of OT's role. » Discounts OT consultation as needed/viable resource to the Core Team, family, and Family Team. » Insists Core Team has the answers/knows what to do without ever consulting the OT.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
COLLABORATING WITH THE OCCUPATIONAL THERAPIST (OT) CONSULTANT AND INCORPORATING THEIR CONSULTATION		
Throughout provision if Continuum services, consults with the OT proactively and when there is a new disruptive/maladaptive behavior or current approach to maladaptive behavior isn't working, especially when there are possible or established concerns relative to: sensorimotor, sensory modulation, learning, social and cognitive development, or other factors persistently interfering with and impacting youth's engagement in meaningful participation in social relationships, education/vocation, eating, sleeping, daily living, leisure, activities of daily living (ADLs) and instrumental activities of daily living (IADLs).	» Engages OT "reactively" and not for proactive support of screening, assessment, and treatment planning. » Requests a specific type of OT screening (e.g., a sensory profile) rather than engaging the OT in a general consultative screening. Considers limited areas of consultation (e.g., sensory only) rather then the full spectrum in which OT can consult. » Seeks consults inconsistently throughout the course of treatment. » Doesn't include OT in identifying and overcoming barriers to engaging youth/family (e.g., how cognitive impairment, communication disorder, or physical disability of family member may interfere with family engagement). » Focuses on obtaining OT consultation when there are issues with youth and doesn't consider OT consultation when there are issues in youth's environment and with family/household members.	» Considers need for OT consultation once only, not throughout the course of Continuum service provision. » Provides OT with historic information but not updated information regarding new behaviors and response to approaches. » Disregards the need to share supporting reports/testing, such as psychological testing, with OT.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
COLLABORATING WITH THE OCCUPATIONAL THERAPIST (OT) CONSULTANT AND INCORPORATING THEIR CONSULTATION		
» Incorporates and implements OT recommendations into ongoing assessment process, treatment interventions, safety interventions, and transition and discharge planning. » Uses OT consultation to assist the Core Team's assessment and development of strategies to address environmental factors that contribute to disruptive and maladaptive behaviors. » Uses OT consultation to inform the development of interventions that can support youth's development of healthy attachment, affect-regulation skills, social skills, positive coping skills, daily routines, family rituals, participation in education, play, leisure, social activities, sleep, school/work, activities of daily living, and independent living. Prioritizes involvement of parent/caregiver/family in all OT interventions and prepares and supports them to take on these roles. » Uses OT consultation to educate family, Core Team, and Family Team members to support their understanding of factors contributing to current presentation.	» Incorporates recommendations into initial assessment, treatment plan, etc. but doesn't continue to modify them with additional recommendations over time. » Inconsistently implements OT recommendations. » Has restricted frame of how to utilize OT consult (e.g., applies it only to social skill development at school). » Isn't sure when to share information with OT or doesn't realize the need to keep OT informed. » Uses OT consultation to inform the development of interventions but misunderstands the intent behind "fun" activities the OT recommends (e.g., refers to them as rewards when the intent is to teach skills). » Uses OT consult as a last resort after all the Core Team interventions have failed. » Only partially integrates OT recommendations into interventions. » Encourages the family to implement OT recommendations but doesn't follow up to see how they are working.	» Ignores recommendations when in disagreement with them (rather then discussing them and coming to consensus). Doesn't integrate and/or document OT recommendations. » Dismisses OT theory of cause of maladaptive/disruptive behavior (e.g., refers to behaviors as intentionally manipulative in nature rather than serving a particular function). » Makes unilateral decision to utilize OT tools (e.g., uses weighted blanket for youth during family therapy because it worked for other youth) without consulting with OT about the specific youth's needs. Uses different interventions/tools then those recommended by the OT. » Doesn't encourage family to follow through with OT recommendations and/or minimizes or dismisses them in discussion with family. » Makes unilateral decision about the youth/family and/or their environment (e.g., being too unstable, chaotic, overburdened, etc.) to have OT involved at a given time without exploring this with the OT and the youth/family. » Fails to follow up or follow through on communications with OT.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
COLLABORATING WITH THE OCCUPATIONAL THERAPIST (OT) CONSULTANT AND INCORPORATING THEIR CONSULTATION		
» Determines with OT how to include them/ their recommendations and updates in the Family Team meetings. Discusses how to use information from OT consultation to assist the Family Team in exploring and generating OT-informed options to address clinical complexities, especially when disruptive/ maladaptive behavior is persistent, improvements have plateaued, or high-risk behaviors are present. » As agreed upon with OT consultant, includes consultant in or presents information from them at Family Team meetings and ensures that they have the opportunity to be involved in ongoing treatment planning, review, and modification.	» Makes plan with the OT on how the Core Team will share OT recommendations but is unclear, incomplete, or vague when explaining them to the Family Team. » Overcommits the use of the OT consultant or OT-specific tool(s) and interventions to the Family Team without explaining that further OT consultation is needed to ensure that specific tools/intervention and their definitive usefulness are good options for the particular youth.	» Makes unilateral determination (without collaboration with OT) on how to update the Family Team regarding OT consultation. » Misrepresents OT (e.g., describes them as "fixers of all [the youth/family's] problems"). » Makes unilateral decision that the OT won't have time to attend Family Team meetings without first discussing it with the OT.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
COLLABORATING WITH THE PSYCHIATRY CONSULTANT AND INCORPORATING THEIR CONSULTATION		
Evaluates and considers the need for psychiatry consultation when: » Youth/family reports side effects of medication or lack of targeted effect of current prescriber's treatment plan. » Youth has comorbid mental health and medical diagnoses. » Core Team's comprehensive assessment and OT consult have not identified the factors driving or maintaining disruptive/ maladaptive behaviors. » Risk mitigation and management concerns are present. » Assistance in focal treatment planning and recovery-oriented approach is needed. » There is a need to address/improve linkage with the youth's primary care physician or psychiatrist. » Youth does not have a psychiatrist and interventions have not strengthened, developed, or maintained desirable behaviors or reduced or eliminated complex, challenging behaviors related to the youth's mental health condition.	Uses psychiatry consultation for a limited scope of situations (e.g., only talks with the consultant if the youth doesn't have a treating psychiatrist/prescriber or only considers need for/seeks consultation when there is a crisis).	» Ignores or dismisses the potential contribution psychiatry consultation can make. » Obtains psychiatry consult in an attempt to coerce/ persuade family into a particular perspective. » Determines need for consultation but doesn't request one or isn't aware Continuum has access to one.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
COLLABORATING WITH THE PSYCHIATRY CONSULTANT AND INCORPORATING THEIR CONSULTATION		
Obtains psychiatry consultation (as needed) and presents a comprehensive youth/family presentation with specific questions for the consultant.	» Presents case to psychiatry consultant focuses only on the current presenting problem and omits history, or vice versa. » Poorly articulates consultation question(s). » Limits the consultation to the youth. Omits information or questions about family system interactions and family member concerns.	» Excludes outreach worker, peer mentor, family, or other pertinent Family Team members in consultation. » Gives a biased case presentation. » Gives case presentation lacking details the psychiatrist needs for an informed consultation (e.g., missing information on diagnosis, medications, needs, strengths, etc.).
» Determines with psychiatry consultant how to include them/their recommendations and updates in the Family Team meetings. Discusses how to use information from consultation to assist the Family Team in exploring and generating psychiatry-informed options to address clinical complexities, especially when a comorbid medical and psychiatric diagnosis exists, disruptive/ maladaptive behavior are persistent, improvements have plateaued, and/or high-risk behaviors are evident. » As agreed upon with psychiatry consultant, includes the consultant in or presents information from them at Family Team meetings.	» Makes a plan with psychiatrist for how the Core Team will share their consultation recommendations with Family Team members but is vague or unclear when explaining to the Family Team.	» Makes unilateral determination (without collaboration with psychiatrist) on how to update the Family Team regarding psychiatry consultation. » Makes unilateral decision that psychiatrist won't have time to attend the Family Team meeting, without first discussing it with the psychiatrist.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
COLLABORATING WITH THE PSYCHIATRY CONSULTANT AND INCORPORATING THEIR CONSULTATION		
» Incorporates and implements recommendations into ongoing assessment process, treatment interventions, safety interventions, and transition and discharge planning. » Uses psychiatry consultation to explore how to make a better linkage to treating psychiatrist and/or determine when to coordinate a consultation between treating psychiatrist/ prescriber and psychiatry consultant. » Uses psychiatry consultation to assist treating psychiatrist in understanding the youth/family constellation and situation and incorporating key family/natural supports that best sustain or advance permanency for the youth. » Uses psychiatry consultation to help family explore readiness for psychiatry evaluation and treatment (help them consider the pros and cons of medication, address general questions, etc.). » Uses psychiatry consultation to assist in focal treatment planning and recovery oriented approach.	» Is aware of potential barriers to implementing consultant's recommendations but doesn't discuss these with the consultant. » Uses consultant inconsistently. » Makes poor use of psychiatry consultants because of lack of understanding of the role and scope of the psychiatry consult.	» Incorporates recommendations that aren't feasible for the family without first exploring feasibility with them. » Makes unilateral decision that consulting psychiatrist should not meet with youth/family because they are not treating the youth. » Describes/explains consultation to family in language that isn't familiar or meaningful to them (e.g., uses professional terms and acronyms without explaining them). Doesn't ask family if the explanation was clear. Ignores need to try and re-explain with different words. » Downplays consultant recommendations as insignificant given that they are not the treating psychiatrist.

PROVIDING THERAPEUTIC INTERVENTIONS

The Core Team engages youth and their family members in culturally-informed therapeutic interventions (strategies, activities, and actions) that build autonomy and self-efficacy as well as strengthen permanency of relationships with caregiver(s)/parent(s), siblings, and other family members and important people in the youth's life (including "chosen family"). Therapeutic interventions also build connection and relationships with peers and natural supports. Therapeutic interventions assist families in resolving conflicts, building and strengthening relationships, promoting healing, supporting lasting changes and enhancing and sustaining functioning in the community and home. In-session actions and strategies and in-between session activities (interventions and follow-up via phone, etc.) have a specific plan and purpose related to the goals in the established individualized action plan/ treatment plan. Intensity, frequency, and duration of interventions are flexible, individualized, and build on youth/family strengths in real and tangible ways that help them address their needs toward the goal of remaining at home, transitioning home, and improving youth's functioning in home, school, and their community. Youth's and family's reports of both improvements and challenges inform next steps as do Family Team member/collateral perspectives (including, but not limited to, occupational therapy (OT) and psychiatry consultation as clinically indicated and agreed upon by the consultants) and direct observation by the Core Team.

Therapeutic intervention is an active and ongoing process of discovering what works with a youth and family in this context and builds on their strengths. The Core Team effectively uses elements of evidence-based practice as well as practice-based evidence in developing interventions. Youth's peer mentor, parent/caregiver's family partner, and natural supports are included in interventions with the youth and parent/caregiver as agreed upon with the youth and parent/caregiver. The Core Team engages in ongoing coordination with OT and others around interventions they are providing. Nontraditional and innovative interventions may be used.

Please see the following matrices for additional information related to providing therapeutic interventions:

- 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
- Collaborative Treatment Planning and Care Coordination
- Supporting Life Transitions
- Strengthening Wellbeing through Respite
- Conducting a Comprehensive Collaborative Assessment

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
	MAINTAINING THERAPEUTIC ALLIANCE	
» Even in times of disagreement, continues to promote partnership with youth and family. Listens, acknowledges, and validates youth's and family's feelings, perspectives, and values using respectful curiosity. » Exercises unconditional positive regard for youth and family members. » Meets family "where they are at" and where they envision themselves to be. » Communicates that everybody is doing the best that they can under difficult circumstances. » Reframes deficit-based language to strengths-based or neutral language (e.g., attributes positive motives to actions that could be seen as a barrier or describes how parent "keeps working" to achieve sobriety vs. parent "keeps relapsing." Supports youth and family members in separating problems from their identity, e.g., "I feel hopeless" rather than "I am hopeless".	» Acts on preconceived notions about family rather than an authentic stance of respectful curiosity. » Listens to understand but lacks attention to what is not said or to nonverbal communication. » Validates family's perspective and notices when they express hopelessness, etc., but struggles to find the language to reframe it. » Overuses a particular reframe or strategy such that it loses meaning for the youth/family. » Misses opportunities to point out the smallest successes and thus unable to highlight them for family. » Misses strategic opportunities to acknowledge youth/ family accomplishments, progress, and successes.	» Attributes all challenges in the youth's/family's life to one area. » Expresses judgment; imposes own beliefs or values on family. Uses negative, shaming, or blaming language. Focuses on deficits and faults. » Reframes excessively in an inauthentic manner. Invalidates the youth's/family's experience.
» Explores ongoing readiness for change and commitment to treatment and other therapeutic interventions. » Applies understanding of stages of change and adapts interventions to fit different levels of readiness among family members. » Artfully plans and facilitates session interventions that are in tune with youth/and family members' readiness for change. Engages key family members in action when they are ready for change and supports all others in moving onto their next stage of change.	» Engages in limited strategies/interventions, lacks adaptation to each individual family member's readiness for change. » Exclusively focuses interventions for those that are ready to change and never revisit other's readiness overtime. » Struggles to target interventions to youth/ family member's readiness for change, especially if under pressure from others/Family Team members to disregard family's readiness.	» Ignores youth/family member's readiness for change or attributes lack of readiness to resistance. » Avoids meeting with family members who are pre-contemplative rather than targeting interventions to help them contemplate.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
SELECTING THERAPEUTIC INTERVENTIONS TO BE USED IN YOUTH/FAMILY SESSIONS		
» Building on the assessment and Family Team's treatment planning process, the Core Team collaborates with the parent/caregiver in ongoing exploration, selection, and modification of therapeutic interventions and strategies. » Includes interventions youth, family, and others report to have been effective and can be adapted for use in the family and community setting. Revisits interventions that may not have worked in the past that the youth/family would like to try again. Asks the youth/family specifically what would help this intervention work at this time or better than it did in the past. » Considers other providers/supports' interventions that are being used with family and chooses complementary interventions. » Incorporates the use of approaches, strategies, or recommendations made by OT/psychiatry consult. » Considers both evidence-based practices and practice-based evidence to guide intervention approach and fits established evidence-based practice elements to a particular youth and family, rather than fitting family to manualized treatment. Assures that interventions selected support the primary healing role of parent/family and maintain or advance permanency progress and outcomes. » Considers culturally-informed interventions that make use of youth/ family strengths.	» Only utilizes information provided by one source (e.g., the referral source) instead of fully exploring interventions/strategies and their effectiveness with family. » Waits too long to adjust interventions or evidenced-based practice that isn't effective. » Discusses past interventions but does not explore their effectiveness or what contributed to their level of effectiveness. Rules out trying past strategies without considering how they could be effective now. » Incorporates recommendations made by OT/ psychiatry consult but never follows back up with consultants to discuss effectiveness of interventions. » Offers strategies without full consideration of cultural preferences, values, and practices. » Jumps into engaging in interventions without first considering whether they will be a good cultural fit for youth/family.	» Selects interventions that aren't in line with identified needs. » Disagrees with family about concerns they have with intervention or about the priority needs driving intervention. Disregards the need to adjust/change or select a new intervention after receiving feedback from family. » Takes an expert stance and ignores family's expertise on their own life. » Doesn't take time to learn about and/or find a way to incorporate methods and strategies that the family identifies as useful (e.g., doesn't learn about the ARC model when the family has expressed that it has been useful).

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
PREPARING FOR THERAPEUTIC INTERVENTIONS AND SKILL BUILDING		
» Clinician, outreach worker, and peer mentor collaborate on objectives and interventions to meet goals. » Core Team members consider together how to apply and integrate support activities, such as coaching skills, to enhancing communication and social connectedness. » Core Team members discuss together how they will strategically prioritize, prepare, and partner with family/natural supports and community resources in intervening. » Core Team members highlight for one another the youth and family successes they notice and troubleshoot together around strategies to address challenges. » Core Team members anticipate and plan together for addressing logistical barriers and supporting overall congruence of the treatment plan interventions, strategies, activities, and actions each Core Team member is carrying out.	» Core Team members check in with one another but not often enough to coordinate interventions in an ongoing seamless way. » Core Team members check in with one another often but lack in-depth discussion regarding target skills for development, activities to be utilized, and progress made. Conversations lack the detail needed to coordinate and integrate interventions. » Core Team members point out youth/ family challenges but spend too much time dwelling on problem without moving onto troubleshooting and acknowledging successes. » Care Team members only point out large, obvious successes without acknowledging the smaller "micro-successes."	» Core Team members act in a silo without planning individual or family sessions together or without communicating with one another. » Core Team members fail to coordinate schedules and overwhelm the youth/ family with too many meetings. » Core Team members engage the youth/ family in incongruent strategies. » Core Team members challenge each other about strategies/interventions in front of the family, making family uncomfortable.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
PREPARING FOR THERAPEUTIC INTERVENTIONS AND SKILL BUILDING		
Coordinates and includes others in the session (e.g., OT consultant, extended family, other Core Team or Family Team members, natural supports, and group home staff) as applicable and agreed upon. Engages in ongoing collaboration with others on integrated and complementary interventions.	» Considers including some, but not all, relevant Family Team members and supports or only considers professionals, not natural supports. » Focuses on the perspective of one individual over others. » Obtains insufficient input from family and Family Team members to make well-informed choices about which interventions will complement and not conflict with the interventions the youth/family are already engaged in (with other supports.)	» Dismisses the need to include other Family Team members and collaterals in session. » Ignores roles of Family Team and other collaterals during the session. » Plans to include key Family Team members and other collaterals as agreed upon with family but schedules session at a time that conflicts for them. » Arranges for individuals to be present in intervention but fails to prepare youth and parent/caregiver regarding sharing of certain information with the invited person(s). » Misrepresents parent/caregiver's or other's perspective to the youth (e.g., tells youth the parent/caregiver/other said something that the person did not actually say).
Arranges to engage in interventions at the location where challenges occur and/or locations where youth/family need support/coaching to practice skills, such as at home, during activities in the community, at school, etc., as identified with the family.	Lets logistics get in the way of practicing interventions and strategies at the most relevant time and location (where practice is most needed).	Engages family in interventions at a pace, location, and/or time that is based on staff preferences without considering or listening to youth/family needs and readiness (e.g., holds a family session at home when all household members are present even though not all are ready to engage in the particular intervention).

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
PREPARING FOR THERAPEUTIC INTERVENTIONS AND SKILL BUILDING		
» Attends sessions prepared with a strategy to achieve an agreed-upon goal of the session and adapts the strategy as needed to meet the needs of the moment. » Attends sessions prepared to articulate the reasoning behind the intervention, approach to treatment, and the structure of each session as well as how the various other team members' interventions compliment this one.	» Attends session with a strategy but is unable to clearly articulate reason/purpose behind activity/interventions to the youth/family. » Explains purpose of strategy/intervention without articulating how activity is connected to what was agreed upon previously. » Is unstructured, lacking focus or direction in discussion. Starts with a general check-in and then focuses on whatever comes up, ignoring the planned strategy.	» Attends unprepared or attends prepared with strategy to meet a goal towards which youth/family isn't agreeable to working. » Attends session unprepared, conducting open-ended check-in without a plan/strategy. » Is rigid about strategies that need to be used. » Initiates a planned activity without validating and attending to the in-the-moment needs of youth/family. » Takes an expert stance, telling family what they need to do.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
STRENGTHENING AND BUILDING YOUTH'S AND FAMILY'S SAFE AND PERMANENT RELATIONSHIPS		
» Identifies the need for and develops strategies to build on and strengthen youth/family relationships, connections, and attachments. » Targets individualized interventions to strengthen and build youth's safe and lasting relationships and emotional relationships/connections with siblings, parents, other relatives, attachment figures, and important people in their life. » Creates opportunities to nurture healthy, lifelong relationships and connections with immediate and extended family and other important people who reside near and far. » Facilitates clarification of past life events and experiences and emotional healing, reconciliation, or reconnection to lost relationships as necessary and helps Family Team members understand the critical role that relational readiness work can have on lasting treatment gains, trauma recovery, and success of permanency.	» Suggests strategies based on own frame of reference that are not an individualized match for the youth/family (e.g., staff connects with own sibling through movies and suggests this as a way youth can connect with their siblings without knowing whether movies are an interest for them). » Acknowledges tense relationships in the family system without exploring ways family can navigate through the conflict and open opportunities for relationship building. » Misses/ignore natural events in youth's/family's life that could be opportunities to build relationships (e.g., time alone together in the car, bedtime routines, mealtime, etc.). » Lacks exploration of and building upon what the family states a healthy relationship looks like and means to them.	» Relies only on prescriptive, artificial activities or provider-preferred strategies to build supportive relationships and connections between youth and family. Never inquires with youth/family on strategies that they think might help them strengthen their relationships with one another. » Downplays, ignores, or denies healthy aspects of relationships/connections that exist between youth and family members. » Ignores cultural components of how family members relate to one another. » Ignores or disregards the need to strengthen relationships and connections with extended family. » Focuses on parent-child relationship without regard for sibling relationships and family system.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
STRENGTHENING AND BUILDING YOUTH'S AND FAMILY'S SAFE AND PERMANENT RELATIONSHIPS		
» Supports youth and family in developing new memories of fun and enjoyment together. » Explores family member's memories of past times having fun together. Asks about specific activities they have enjoyed and any new ones they may enjoy doing together. » Engages family members in practicing new ways of engaging with one another that promote feelings of safety, closeness, empathy, love, and joy among family members.	» Lacks use/consideration of options or ways Core Team can help family members build fun and positive experiences together (e.g., fails to consider how Core Team can engage in the activity with youth/ family to provide initial support/practice and/or to help them find resources to do the activity). » Limits exploration. Does not explore/support family in selecting a mix of one-time experiences and ongoing, sustainable experiences that will foster new fond memories together. » Neglects to consider the possibility of using flex funds to support family engagement in an activity for the sole purpose of building new memories together.	» Focuses only on deficits, rather than strengths or moments of fun. » Takes youth on a fun activity without consideration of whether it could be an opportunity for youth and family to engage in something fun together. » Dismisses the need to foster fun and enjoyment shared between youth and family. » Engages youth/family in activities that conflict with the youth's/family's culture.
» Creates opportunity for parents/caregivers to reflect on how they were parented and how this may have affected the way that they parent and build relationships with their own children. Encourages parent/caregivers to identify positive parenting qualities they want to be known for and leave as a legacy to their children. » Collaborates with parent/caregiver to identify if/ when adaptive parenting strategies could help support their specific youth's temperament, experiences, or behaviors and explores opportunities to strengthen and support what is working. » Collaborates with youth/family to identify any need for new patterns of interaction, communication, and coping and explores ways to help them implement these through modeling, practice, and/or other strategies and interventions.	» Attempts to consider culture in parenting style by expressing assumptions rather than respectful curiosity and intention to learn. » While exploring how parent/caregiver was parented, only focuses on current needs and ignores future needs of the youth. Lacks anticipation with parent/ caregiver around future scenarios in which family members reach maturation milestones that may be different or similar to parents' own experiences as well as how it may impact the family system. » Moves too quickly to a solution without holding space for assessing/understanding trauma history. » Jumps into engaging family in adaptive parenting strategies without first explaining how they work and the steps parent/ caregiver can take to maximize success.	» Uses judgmental, shaming language when discussing parent/caregiver's parenting style. » Fails to recognize the best in people. Jumps to or focuses on deficit-based conclusions or assumptions about needs or problems. » Ignores family's concerns about parenting strategies and the likelihood strategies will strengthen and support what is working. » Disregards the need to adjust/change interventions to better support new patterns of parenting interaction, communication, etc.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
STRENGTHENING AND BUILDING YOUTH'S AND FAMILY'S SAFE AND PERMANENT RELATIONSHIPS		
» Address attunement, trauma, and emotional regulation concerns that interfere with family members forming and maintaining meaningful relationships with one another. » Practices attunement and attachment activities and helps family increase the various ways in which they express attachment, compassion, hope, and empathy with one another. » Practices trauma-informed responses to crisis and stress reactions with youth/family members. Allows time to defuse emotion and validates family and youth's sense of loss, shame, guilt, frustration, anger, and/or other emotions related to conflicted youth-parent and sibling relationships. » Assesses the need for and explores with parent/caregiver ways to channel overwhelming emotions into action steps that will allow them to make changes, focusing on what they can do now to make life better for the youth and/or strengthen the youth-family relationship.	» Supports family attunement to youth exclusively instead of considering and supporting attunement among all family members. » Uses techniques to address attunement, trauma, and emotional regulation concerns within the immediate family only. Misses opportunities to broaden approach to include extended or chosen family members. » Recognizes need for attunement and attachment activities but struggles to develop activities to strengthen this or uses generic activities without individualizing them to the youth/family. » Avoids sharing awareness of family dynamics that may lead to barriers in taking action steps (e.g., avoids difficult conversations). » Over- or under-responds to stress reactions with excessive alignment/attunement to one family member's experience of stress reaction, not fully attentive to impact on others.	» Excludes siblings and other relevant family members who can benefit from interventions and/or practicing attunement and attachment activities. » Dismisses family member's or youth's feelings. » Becomes stuck with family in overwhelming emotions and never explores/initiates action steps. » Provides and practices attunement and attachment activities with family that is not clinically applicable to this youth/family. » Mirrors family's stress reaction rather than engaging as a calming presence, deescalating, and/or using the opportunity to model skills.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
STRENGTHENING AND BUILDING YOUTH'S AND FAMILY'S SAFE AND PERMANENT RELATIONSHIPS		
» For youth who have lived with a variety of individuals, families and/or in institutions, explores the youth's sense of belonging, family memberships, and loyalty conflicts with all these individuals, families, and systems (especially those with birth parents/family and other parents/ families with whom they need reconciliation or they want to be lifelong/lasting relationships). » Helps youth understand who had meaning to them and for whom they had meaning. » Supports youth's acceptance that they don't have to choose between people. Weaves a thread of continuity and integration of all the various relationships and families that the youth has been a part of. Uses their working relationship strategically to bridge relationship gaps and facilitate reconnection or reconciliation between youth and family or between youth's family members. » Helps youth preserve a sense of relationship/ connection with other important family members (birth, extended, resource families, and significant others) concurrently with those providing parenting/care now. » Uses tools like timelines, ecomap, life books, life maps, etc. to help youth reflect on and visualize historic, current, and future membership and shifting roles of family/chosen family and other important relationships in their life.	» Describes time youth spends in the home as "visits." » Dwells on loss of past relationships rather than also exploring ways youth is still connected and positively impacted by those who are not physically near. » Expresses support for one family system over another. » When youth describes group home peers/ staff as "like family to me," insists that they are not family, rather than exploring ways in which they feel like family to the youth. » Uses a tool (like timelines, ecomap, life books, life maps, etc.) but doesn't complete it together with the youth or use it to help them reflect on and integrate various relationships, connections and family memberships they hold. » Completes a tool (e.g., timelines, ecomap, life books, life maps, etc.) at a point in time without ever revisiting it with family as a "living" document to add to over time.	» Tells youth the group home is their "family." » Discusses current family relationships and connections only and ignores past family-system connections and relationships the youth has experienced. » Aligns with a Family Team member's negative perception of a family system. » Tells youth which individuals, families, and/or in institutions were meaningful for them or how they were meaningful rather than exploring the meaning youth attributes to these people/events.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENGAGING YOUTH/FAMILY IN STRATEGIES TO STRENGTHEN A BROAD RANGE OF SKILLS		
» As needed, agreed upon, and prioritized with family, implements skill-building strategies with the youth, parent/caregiver, and family separately and together to develop and practice skills to achieve goals. » Pays special attention to developing skills that will help the youth and family continue to reside together or to prepare for youth's return home. » Engages family in specific, individualized, skill-building activities that promote emotional regulation, stress management, self-care, recovery, resilience, social and interpersonal relationships, hopefulness, and awareness of effective and ineffective response to symptoms of mental illness. » Engages family members in skill building that supports youth's medication use (such as scheduling strategies, ongoing communication with prescriber, preparation for medical appointments, etc.). » Engages family in skill-building activities that promote physical health maintenance (e.g., diet, exercise, participation in primary medical and dental care, etc.).	» Focuses on a few areas of skill building or focuses on all skills rather then prioritizing one or two. » Leaves insufficient time for youth/family to practice, master, and sustain skills without the Core Team. » Moves on to teach new skills before the youth/family is ready. » Focuses on youth skill building only or family skill building only, but not both. » Makes suggestions and engages in building skills without considering the need to consult with other relevant entities (such as OT consultant, prescriber, primary care clinician, and dentist).	» Tells family which skills they need to build rather than discussing and coming to agreement on what to prioritize first. Directs/assists family in building skills that family hasn't agreed they need. » Focuses skill building only on areas that feel more comfortable to staff. » Disregards the OT, prescriber, or other's recommendations and expertise relative to the skills that need to be developed.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENGAGING YOUTH/FAMILY IN STRATEGIES TO STRENGTHEN A BROAD RANGE OF SKILLS		
» Supports skill development around household members' roles and responsibilities, daily structure, routines, rituals, and use of home and community environments. » Engages family/chosen family and youth's natural network in supporting preparation for adulthood and skill attainment as developmentally appropriate (e.g., money management, purchasing and caring for personal items, meal planning and preparation, housekeeping, laundry, transportation use, leisure interests, and vocational achievement). Prioritizes roles for family/chosen family and youth's natural network in teaching or supporting youth in learning these skills as another avenue to building or strengthening youth/family relationships and preserving the gains beyond Continuum involvement.		

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENGAGING YOUTH/FAMILY IN STRATEGIES TO STRENGTHEN A BROAD RANGE OF SKILLS		
» As needed, agreed upon, and prioritized with the parent/caregiver, implements skill-building strategies with the parent/caregiver. » Strategizes with parent/caregiver to help them strengthen skills in self-care, co-parenting, balancing the care of all children, keeping family members safe (at home, school, and in the community), and meeting the family's basic needs (food, shelter, clothing, personal hygiene, medical and wellness, etc.). » Validates and addresses items that make parenting more complicated, such as parenting with mental illness, substance use, multiple jobs, extended family/friends living in the house, challenging physical living environment, lack of natural supports, etc. » Supports parent/caregiver skills in nurturing, fostering, and strengthening their children's relationships with one another. » Helps parent/caregiver build resiliency in the face of guilt, shame, disappointment, regrets, grief, loss, and morning over expectations held for youth as well as past traumatic experiences and other difficult experiences the youth had.	» Lacks needed focus when helping parent/caregiver practice skills to master and sustain them. » Makes suggestions and engages in building skills without thinking about the need to consult with other relevant entities, such as OT and psychiatry consultants. » Over-identifies or under-identifies certain skills that hinder parent/caregiver's ability to prioritize. » Validates that parenting is more complicated due to particular environmental challenges but doesn't open up this discussion with family. » Doesn't explore enough to understand the type of skills that need to be developed.	» Prioritizes areas of skill building without the parent/caregiver. Moves on to teach new skills before discussing parent/caregiver readiness to move on. » Focuses on youth skill building only and ignores or excludes parent/caregiver from activities to help them build needed skills. » Focuses on "doing for" rather than teaching/coaching skills and structuring specific support needed to help ensure parent/caregiver success. » Uses language that blames parent/caregiver. » Minimizes how particular environmental challenges can make parenting more difficult or complicated (e.g., "you can do this," "external circumstances don't matter").

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENGAGING YOUTH/FAMILY IN STRATEGIES TO STRENGTHEN A BROAD RANGE OF SKILLS		
» Identifies the need for and uses participatory practice/role play, coaching, skill building, and modeling of new skills in a variety of locations such as home, school, and community. » Gives youth/family members specific tasks to practice and explores successes and challenges with tasks in between sessions and during sessions. » Creates opportunities for youth/family to test, practice, and adjust strategies that were used in one environment and will now be used in another (such as generalizing the use of skills from the group home to the home, school, and community environments). Fosters and provides multiple opportunities for parents/caregivers and youth to experience mastery in using new skills.	» Describes skills/strategies or makes suggestions on strategies to try without modeling them or gives youth/family opportunity to practice them. Uses only one method of skill building (e.g., only didactic). » Uses interventions without youth/family input or agreement (imposes new ways without family agreement). Assigns tasks without first discussing options for strategies that could be tried and deciding together with youth/family what to try first. » Only focuses coaching and skill building with youth or parent/caregiver, not both, or only focuses on providing in-between session tasks to one and not both. » Tasks are too general or vague for youth/family and staff to measure success. Advises family on what not to do without helping them explore options for what to do differently.	» Suggests/practices skills/strategies that aren't suited to the specific needs or culture of the youth/family. » Doesn't engage youth/family in active preparation for return home. » Assigns tasks without attention to how emotions, past experiences, and youth/family level of readiness may impact success or challenges with task. » Lacks follow-up with family on tasks or doesn't invite feedback/input on their experience of interventions. » Does not collaborate with out-of-home treatment program to coordinate interventions and integrate them across settings. » Gives suggestions/advice without observing functions of current behaviors.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENGAGING YOUTH/FAMILY IN STRATEGIES TO STRENGTHEN A BROAD RANGE OF SKILLS		
» Promotes youth's and family's individual self-worth and builds their confidence to participate in a shared decision-making process by exploring and developing skills to strengthen their articulation of thoughts, feelings, opinions, and questions in a variety of forums. Reinforces the primary role of parent/family/protective adult relationships in youth's healing, recovery, and sustaining of treatment gains. » Explores the need for and coaches youth/family around leadership skills they can apply in treatment, care coordination, home, community, and Family Team meetings. » Builds skills and self-efficacy toward leadership and collaboration with Family Team and other entities. Supports skill development around parent/caregiver engagement with youth's school to ensure that their educational needs are met (e.g., understanding IEP process). » Builds/strengthens skills needed for attaining other services, entitlements, support groups, and benefits for themselves and family members as well as the attainment of ongoing education/information regarding youth's diagnosis/medication and ways to anticipate future changes.	» Misses opportunities to promote youth/family inclusion. Misses opportunities to coach skills that promote empowerment and leadership. » Provides coaching around leadership skills in some environments but ignores the need to expose youth/family to different venues where they can further practice, master, and generalize these skills. » Empowers leadership without exploring the need and desire for coaching/support. » Supports parent/caregiver leadership style in whatever manner it is expressed without opening dialogue around shaping one's style to get the most out of an encounter with a particular event or person. » Shares feedback on leadership strengths but avoids discussing possible ways to lead differently in order to achieve a different result.	» Expresses that Core Team/providers will fix things instead of communicating how they will work together with family to figure out a way to help improve things for themselves. » Does things for family when family is ready for skill building and coaching to do it themselves. » Takes an expert stance, telling family what to do, or takes over for parent/caregiver, suggesting they are incapable. » Uses blaming language. » States areas for improvement but without coaching to address those areas.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
EXPLORING PROGRESS AND TRACKING CHANGE		
» Asks about and seeks input from youth/family on their experience with interventions, skill building strategies, and assigned practice tasks. Explores barriers as feedback about (not resistance to) the intervention. » Makes direct observations of youth's/family's strategies, reinforcing, or supporting and encouraging effective ones. Uses in-the-moment opportunities to model/suggest different strategies to try. » Throughout intervention and skill building, uses data (rating scales, tracking school attendance, etc.) on measurable objectives in order to clarify family, youth, and/or Family Team member's impressions of progress as well as to inform future interventions.	» Only seeks feedback at sessions and not in between sessions. » Solicits minimal or no feedback and data from all Family Team members (relies on data from one source). » Obtains feedback and data without using it to inform future interventions in a way that is meaningful to the youth/family. » Doesn't use data to support youth/family and Family Team members' understanding of one another's stage of readiness for change and options for interventions most appropriate to that stage of change.	» Fails to solicit feedback from youth/family members on how task/session went. » Misattributes one family member's perspective/feedback as that of the whole family without exploring it with each family member. » Labels family as resistant. Fails to see the function and/or adaptive aspect of why they may be reluctant to engage in something. » Dismisses how sharing data can have an impact on how the family or Family Team recognizes progress. » Only considers data when progress is well known and established, rather then using it to highlight and further encourage incremental progress. » Maintains the same skill-building approach even when it repeatedly fails to result in any changes for youth/family.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
EXPLORING PROGRESS AND TRACKING CHANGE		
» Continuously explores and observes youth's/family's overall response to interventions, treatment, and skill building. » Explores impact on youth/family functioning and adjusts interventions accordingly. » Recognizes and addresses changes in mental health and substance abuse symptoms as well as illegal or risky activities (gang involvement, drug dealing, sexual exploitation, etc.). Obtains any necessary consultation to address these need areas adequately and coordinates and links youth/family to specialty services and treatment interventions when indicated. » Updates safety plan, including updating the names, roles, and tasks of safe and protective adult relationships, with youth/family as appropriate.	» Only explores and observes youth's response to intervention, seeing them as the identified patient and not as part of a larger family system. » Only relies on own observations, without inquiring with other Family Team members or family members about their observations. » Does not consider the ways symptoms of mental illness and substance use/abuse complicate one another. » Refers to specialty service without first considering and engaging in applicable interventions. » Refers to services but lacks follow-up with youth/family to see if they connected and how it went. Refers on and follows up with family but does not coordinate or collaborate with specialty service provider.	» Ignores, dismisses, or downplays substance use and/or abuse or illegal and risky activities. » Recognizes some signs of substance use/abuse but doesn't act on them. Unsure of how to screen for it further and determine need for addressing it in treatment. » Fails to engage specialty services, Family Team members, and/or referring agency to support youth's/family around specialty needs. » Observes youth's/family's presentation and symptoms through one diagnostic lens and disregards all others.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
	PROVIDING PSYCHO-EDUCATION	
» Acknowledges complexity of youth's and family's situation and provides information to help answer youth/family questions regarding youth's diagnosis, common symptoms, treatment approaches, etc. » Provides information, as appropriate, regarding developmental and functional expectations for youth. » Provides information/answers questions about trauma and loss reminders, post-traumatic stress reactions, rage-and-loss reactions, grief reactions, and the impact thereof on development. » Provides/links family to resources to better understand medications and alternative healing practices (consults with psychiatrist regarding psychoeducation around medication as needed). » Builds understanding of family systems:- that individual family member's behavior, feelings, expectations, and functioning within various domains impacts other individual family members as well as the family system as a whole. Builds understanding that the environmental contexts in which family members live and engage impacts them as well.	» Acts independently, seeking out resources to obtain needed information for youth/family and misses the opportunity to include youth/family in a way that helps them develop these skills. » Answers questions from an expert stance without allowing the opportunity for a collaborative dialogue. » Avoids providing education on certain topics for fear of opening a discussion that will be uncomfortable to the staff (e.g., avoids mentioning loss and grief reactions).	» Listens to family and answers questions in scope of own knowledge but ignores the need to seek resources or consultation to obtain additional information for youth/family. » Answers questions outside the scope of own knowledge and provides misinformation. » Uses pathologizing, deficit-based language. Lacks compassion and empathy while educating and informing.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
	PROVIDING PSYCHO-EDUCATION	
» Discusses with youth and family the fact that others have similar experiences. Shares support-group information. Extends an ongoing invitation to youth and family members to participate in relevant trainings, conferences, and groups related to youth's/family's experiences (explores with the parent/caregiver the option of inviting Family Partner to provide support to them during training). » Assists youth/family in seeking out and accessing resources to increases understanding and support for family members and youth regarding youth's experiences, symptoms and diagnosis.	» Chooses trainings/conferences for family to attend rather than discussing applicable options with them. » Invites family to training without exploring what they hope to learn and how they can get the most out of the training. » Overlooks the option of parent/caregiver inviting their Family Partner to training.	» Does not share information about trainings with family or restricts their attendance to trainings based on personal beliefs about what is appropriate. Dismisses the value of inviting family members to attend trainings and learn alongside staff. » Makes assumption about which support groups to refer family to instead of sharing different options. » Suggests support groups/trainings that aren't in line with youth/family interests/needs.

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.

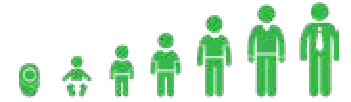
IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENSURING CONTINUITY DURING GROUP-HOME TREATMENT INTERVENTION		
» Meets—quarterly at minimum—face-to-face with out-of-home treatment provider, youth, family, and Family Team Members to revise the youth's treatment plan. » Coordinates with the 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.

SUPPORTING LIFE TRANSITIONS



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

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

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

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

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

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

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

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

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

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

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

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

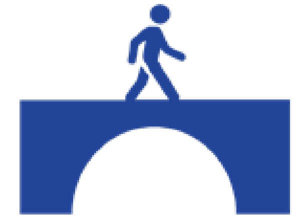
IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
BRIDGING YOUTH'S TRANSITION OUT OF CONTINUUM		
» Collaborates with youth/family in determining who will refer them to needed services (i.e., self-referral vs. provider referral). Assists in addressing access barriers by discussing wait lists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

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

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

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

BRIDGING COMMUNITY INTEGRATION



The Core Team engages in an ongoing process of exploring, discovering, and strengthening interests, relationships, connections, and supports in the youth and family's environment who can celebrate with the youth/family in good times, comfort them through difficult times, contribute to a sense of belonging, remain unconditionally committed, and may also provide tangible assistance. They may be extended family, friends, faith community, neighbors, people from school or work, or acquaintances and other natural supports who play a positive role in the youth's/family's life. They may also be places where the youth/family can volunteer, play, learn, worship, socialize, and build resiliency. They involve naturally occurring community resources and supportive people that align with youth's/family's interests, support the youth's/family's goals, and carry them beyond the reach of formal services. The Core Team thoughtfully uses flex funds to support and build family and youth's interests and resources. The Core Team helps family members consider ways to involve natural supports and include them in Family Team meetings and interventions (as agreed upon with the youth/family). The Core Team collaborates with the youth and family to help them connect to and sustain connections with naturally occurring relationships, resources, and supports.

Please see the following matrices for additional information regarding bridging community integration:

- Collaborative Treatment Planning and Care Coordination
- Supporting Life Transitions
- Practicing Cultural Relevancy
- Continuity with Higher Levels of Care
- Strengthening Wellbeing through Respite

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
	EXPLORING NATURAL SUPPORTS	
» Explores (ongoing) with youth/family their current sources of social, emotional, and practical support. Validates the basic, essential and universal human need for support that comes from family, neighbors, friends, faith community, support groups, coworkers, etc. (natural supports). » Uses brainstorming, ecomap, timelines, or other tools for robust discovery of youth/family support networks. Asks curious conversational questions about the people with whom the family interacts on a daily basis (e.g., curious inquiry about photos hanging in the house or people with whom they exchange gifts, favors, babysitting, etc.).	» Identifies/validates natural supports in a limited manner. Gives a narrow description of what natural supports are. Explores one type of natural support (e.g., only asks about friends, not neighbors, family, coworkers, faith community, etc.). » Ignores or is unable to recognize unique natural supports for the family. » Only explores natural supports during assessment phase, not ongoing. » Proceeds with exploration but is not in tune with family readiness to brainstorm (e.g., moves forward with brainstorming when family expresses need to talk about other things instead). » Uses limited, non-creative techniques to explore supports. Asks closed-ended questions that solicit names but doesn't continue exploring the ways in which those people are/could be supportive.	» Uses the term "natural supports" without explaining the working definition. » Discounts the need for community involvement as a means to leading a fulfilling life. » Explores supports within home/family only. » Expresses own opinion/options in a manner that shuts down conversation rather than opening it up.
» Brainstorms with the youth/family ways of developing support from people they know (neighbors, friends, faith community, support groups, coworkers) as well as ways of discovering and connecting to new individuals for emotional, practical, and/or social support. » Discusses possibilities for cultivating a reciprocal supportive relationship with natural supports to help prevent burnout.	» Conducts limited, surface-level exploration of developing supportive relationships. » Asks closed questions that limit discussion about what a reciprocal relationship means or looks like to the youth/family. » Accepts barriers that the family raises without exploring them. » Doesn't research, explore, or share ways family can connect with new people/potential supports from existing/new activities.	» Takes note of supports listed in paperwork received but doesn't inquire about those people with family. » Involves Family Team members instead of brainstorming who/how natural supports could help. » Doesn't consider family's culture of reciprocation/helping one another out. » Echoes negative comments family make about challenges to helping others.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
EXPLORING NATURAL SUPPORTS		
» Assists youth/family in identifying important relationships that have been lost or damaged and their wishes or needs for healing, reconnection, or reconciliation. Assists youth and family in repairing relationships with each other and with natural supports. Considers with youth/family ways of rebuilding and strengthening natural supports when family feels they have too few/none due to isolation, conflict, damaged relationships, or burnout, which may occur on either side of the relationships. » Helps youth/family share progress made, how things are different, what has been learned and their new ways of relating and coping.	» Explores natural supports but doesn't inquire about important relationships that have been lost or damaged and youth's/family's wishes or needs for healing. » Fails to foster an environment that promotes healing/repairing of relationships. » Omits exploration of ways to cultivate a reciprocal relationship to prevent burnout. » Jumps into problem solving or brainstorming without acknowledging/validating family's feelings of isolation, shame, worry, etc. about reconnecting with natural supports. » When engaging family in repair work with others, doesn't acknowledge the strengths of all parties.	» Moves forward without permission from the natural support (i.e., underestimates the history of events that have impacted the relationships). » Invites natural supports without consideration of need to repair relationship with youth/family first. » Explores past and current supports but doesn't explore the need for repair work. » Uses judgmental language rather than respectful curiosity about the barriers or experiences in the past.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
INCLUDING NATURAL SUPPORTS IN MEETINGS AND INTERVENTIONS		
» Has ongoing discussion with youth/family members regarding how their natural supports could be included in Family Team meetings and in interventions. Explores practical solutions to the question, "what would it take?" for each of these natural supports to be included. » Explores the type, extent, and benefits of involvement that identified persons could contribute (e.g., respite care, phone support, occasional shared activity, good ideas, etc.). » On a routine basis, revisits family readiness (sometimes expressed as reluctance, fear, worry, shame, etc.) to bring natural supports into the Family Team meeting and interventions. Uses tools such as a scaling question to identify "what would it take?" for youth/family to include natural supports.	» Maintains ongoing discussion about including natural supports but doesn't explore "what would it take?" for each of these natural supports to be included. » Limits options for the type of support natural supports can provide. Only focuses on concrete or traditional definitions of support rather than a wide range of various types of support that identified persons could provide. » Explores natural supports for youth or parent/caregiver but not both.	» Demands that natural supports be included. » Doesn't consider any options for ways to include natural supports. » Schedules meeting times when natural supports are not available. » Describes pre-contemplation or reluctance as resistance.
» Collaboratively creates actionable steps with youth/family to engage natural supports, including who will contact and follow up with each person. Uses urgency and persistence in reaching out to natural supports (consent permitting) and is not deterred when these individuals do not respond to initial engagement efforts. » Invites and welcomes natural supports to Family Team and Family Team meetings and/or interventions. Invites participation according to an established plan that has been developed with youth/family. Includes natural supports in face-to-face and/or virtual Family Team meetings and in ongoing communication, as established with family.	» Discusses plan to contact supports but lacks next steps and concrete planning regarding who will follow up with each person and what the purpose of the contact will be. » Lacks urgency/persistence; is easily deterred by a lack of initial response. » Doesn't address disconnect between family's identified natural supports and barriers to using those natural support (e.g., DCF restrictions regarding specific persons). » Only discusses with youth/family once without ever revisiting.	» Consistently excludes natural supports from meetings or interventions. » Ignores opportunities to reach out to and/or include natural supports. » Dismisses the importance of warmly engaging and welcoming the natural support.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
EXPLORING AND STRENGTHENING INTERESTS		
» Explores with youth/family members who and what interests them, brings them joy, and helps them meet their basic needs and/or make life a little easier or fuller. Explores hobbies, activities, faith, and culturally-based events and people that bring them enjoyment. Asks what they like to do on the weekends, after school, after work, and during vacations. Asks what they like to do as a family and on their own. » Explores youth's/family's use of old, current, and potential new community activities and resources (local community center, community theater, other community groups, diversity and cultural clubs, youth sports league, Boys & Girls Club, lessons, classes, clubs, parent support groups, sibling support groups/activities, adult sports leagues, food pantries, etc.) that match their interests, strengths and needs. » Explores youth's and family members' level of current access to and need for connection to these activities and resources. » Accesses OT consults during the process of exploring youth/family strengths/interests.	» Proposes a generalized list of activities without exploring interests and considering individual needs of youth/siblings. » Overlooks youth or family not identifying activities/interests. » Limits exploration to old, current, or new potential community activities but not all. Limits exploration to traditional activities without recognizing relevant alternative or cultural activities that the youth/family might enjoy. » Fails to recognize need to explore new ideas/activities during times of transition (e.g., when starting high school). » Does not explore accessibility or feasibility of identified activities (issues such as location and transportation). » Uses a narrow range of strategies to solicit interests from youth, family, and siblings. Does not consider OT consult.	» Ignores or supports continued hobbies/activities that are maladaptive, illegal, or emotionally/physically harmful. » Places judgment on interests identified by youth/family. Offers ideas solely based on own personal interests. Dictates ideas/activities to youth/family. » Suggests activities that are not appropriate for the youth/family culture, values, and norms (e.g., only suggests gender-normative activities for family that values gender non-confirming activities). » Lacks follow-through or planning with youth/family around to accessing opportunities to explore interests they have identified. » Signs youth/family up for activities without consent.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
LINKING YOUTH/FAMILY TO INTERESTS/RESOURCES		
» Makes a plan with family that identifies how Core Team will "do for, do with, or cheer on" youth/family in researching, contacting, enrolling, and participating, in community activities. Coaches family on needed skills to engage in activities. » Revisits plan regularly. Follows up with youth/family in ongoing discussion to see if activities meet social, emotional, and practical needs/goals or if additional skill building coaching/support is needed. » Continues to support family in coordinating youth's participation in these continued and new community activities during and after group-home stay.	» Doesn't ascertain the level of support youth/family members need to engage in an activity (i.e., doesn't distinguish among "do for," "do with," and "cheer on"). » "Does for" or steps in to make application, etc., for the family rather then first discussing the approach with them and considering whether this is an opportunity to "do with" in order to develop their skills. » Makes connections to activities but doesn't help family consider the process to engage in them (e.g., how to enroll/apply, anticipating what the first meeting will be like, and transportation/drop off location). » Develops an initial plan with youth/family but doesn't revisit it and adjust it as needed. » Doesn't anticipate and resolve barriers to participation.	» Focuses on completing the task of connecting family to resources/activities and ignores the need to help family benefit from the experience of participating in these tasks. » Determines family's role in tasks without discussing with them. » Lacks follow-up and exploration of youth/family experience/participation in new activity.
» Brainstorms with family and Family Team around needed resources (flex funds, scholarships, free activities, etc.) to help youth and family explore, discover, and/or develop interests in an activity that supports their social and emotional growth and wellbeing. » Collaborates with youth and family to identify what activities and resources will be short-term and which will need to be sustained for a longer period of time. » Plans with parent/caregiver around timeline for stopping or a shifting funding source.	» Limits brainstorming to activities that can be sustained after the use of flex funds. » Overlooks the need to include family in the shared decision of whether an unsustainable activity is still a good one-time enrichment experience (e.g., exposure to and/or participation in a one-time art class or a brief gym membership). » Neglects to explore sustainability all together.	» Isn't transparent about or doesn't clarify access to or duration of flex funds. Doesn't consider flex funds as an option. » Tells family which activities must be sustained by them and which will be one-time enrichment events. » Tells family they don't have the resources to support an activity rather than exploring whether they do.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
LINKING YOUTH/FAMILY TO INTERESTS/RESOURCES		
» Collaborates and coordinates with youth, family, Family Team, OT consultant, and others to create opportunities for youth to participate in everyday, typical enrichment experiences (recreational, creative, vocational, employment) that sustain and promote community integration and friendships with peers in the community. Facilitates parent/caregiver/family in playing key roles in connecting youth to these opportunities—involving them in selection of, registration for, transportation to, and staying in communication with sponsors/leaders of these activities. » In partnership with OT, youth, and family, coordinates with individuals from a community activity to develop and carry out any needed adaptive strategies for integrating youth into that community activity. Considers use of flex funds for adaptive tools to support participation in activities. » Coaches youth on skills needed to engage in the activity.	» Explores activities with youth but doesn't recognize or discuss adaptive needs. » Collaborates with family/youth on identifying activities but fails to recognize how OT can consult around adaptation to make activities successful. » Doesn't explore ways to make room in youth's schedule for natural and community-based activities. » Discusses with parent/caregiver/ family ways they can play a key role in connecting youth to opportunities but doesn't provide the level of assistance or support the parent/caregiver/family needs to follow through.	» Takes on expert role and tells youth and/or assigns youth community activities vs. discussing and exploring options with youth. » Discusses concerns or adaptive strategies with individuals facilitating activities without consent or involvement of parent/caregiver. » Tells family what role they will take in connecting youth to opportunities rather than exploring which roles they see themselves taking and what support might be needed to take them.

STRENGTHENING WELLBEING THROUGH RESPITE

The Core Team supports the idea that everyone needs periodic respite breaks that reduce youth, family, and caregiver fatigue and restore energy. The Core Team orients the family, youth, and Family Team to the impact that regular, planned respite can have on promoting safety and strengthening permanency, wellbeing, resiliency, and recovery from the effects of trauma, mental illness, and physical illness. The Core Team explores parent/caregiver's and youth's access to and need for respite time and resources that reenergize, soothe, and provide relief from the day-to-day stress and exceptional demands of living with and parenting a child with emotional, behavioral, and mental health needs.

The Core Team supports the parent(s)/caregiver(s), youth, natural supports, Family Team members, and others (as appropriate) to develop and make decisions about respite plans. These plans coordinate resources that ensure parent(s)/caregiver(s), family, and youth and have regular reenergizing respite breaks. The respite plan supports parent/child attachment and prioritizes the use of a family member or natural support's home for respite care whenever possible. Respite care may also include the use and provision of in-home/community-based respite provided by the Continuum as well as out-of-home respite care via the use of a respite bed in a facility.

Please see the following matrices for additional information related to strengthening wellbeing through respite:

- 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
- Collaborative Treatment Planning and Care Coordination
- Supporting Life Transitions
- Conducting a Comprehensive Collaborative Assessment
- Providing Therapeutic Interventions

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ORIENTING PARENT(S)/CAREGIVER(S) AND YOUTH TO RESPITE		
» Validates the need for parents/caregiver's to have a respite or break from the daily challenges of parenting, especially when parenting children with emotional, behavioral, and/or mental health needs. » Explains that respite or caregiving breaks support the primary parent/child attachment, include parent(s) as key decision makers, and occur within the network of family and natural supports whenever possible to promote family stability and prevent separation trauma for the child/youth. » Explains that respite is a planned, brief period of time away from caregiving that offers the chance to reduce stress and restore energy by spending time engaged in activities of the caregiver's choice that a caregiver finds restorative. Expresses appreciation that individuals find a wide range of activities to be restorative. Gives a range of examples, such as resting, reading, visiting with a friend, running errands, getting a pedicure, being at work, etc. » Explains that in order for caregivers to have this break, respite care for the youth may be provided through a variety of developmentally-appropriate in-home/ community and out-of-home options that can be brainstormed with the family, youth, and Family Team. » Explains that youth and other family members can also benefit from this respite time.	» Limits examples of ways parents/caregivers can take respite. Only describes respite as an out-of-home placement. » Describes respite as a break but doesn't explore or explain the concept of self care and how respite time can be spent reenergizing. » Only explains how parent/caregiver can benefit from respite time and doesn't explain how both the youth and other family members can "reenergize" during this time too. » Doesn't explain the importance of using family and natural supports whenever possible. » Explains respite as an activity for the youth.	» Dismisses the need for respite, uses blaming or shaming language. Doesn't describe respite as a universal need. Insists all parents/caregivers get stressed and questions why the family needs respite, rather than validating that all parents/ caregivers need some level of respite. » Dismisses parent/caregiver's ideas of what could provide them with respite/restored energy. » Only discusses respite when a crisis comes up. » Explains respite as an immediate response to crisis rather than a planned event. » Only explores respite when the youth's behavior can't be managed. » Doesn't explain the importance of respite supporting attachment between parent/caregiver and youth.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ORIENTING PARENT(S)/CAREGIVER(S) AND YOUTH TO RESPITE		
» Validates the need for youth (not just adults) to take regular breaks from the day-to-day stress life can bring. » Explains to the youth (in developmentally-appropriate manner) that respite is a brief break away from stressful events, people, and things. Describes how using break time to engage in activities they find fun or relaxing can reduce stress (e.g., playing, reading, visiting with friends/extended family, etc.).	» Describes respite narrowly (e.g., as only facility-based). Limits options/examples of ways youth can take respite. » Describes respite as a break but doesn't explore the concept of self care. Only describes respite as an out-of-home placement. » Explains respite as an activity for the parent/caregiver only.	» Describes respite in a punitive context or as punishment. » Dismisses youth's ideas of what could provide them with respite. » Explains respite as a response to crisis or only discusses respite when a crisis comes up or when the youth feels out of control. Doesn't explain the benefits and purpose of using respite proactively. » Dismisses the need for respite, uses blaming or shaming language. Doesn't describe respite as a universal need.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
EXPLORING RESPITE NEEDS		
» Explores parent/caregiver's level of caregiving fatigue as well as the family system's fatigue from the demands of living with the youth's emotional, behavioral, and mental health needs. » Explores family member's level of access to time and activities that provide self-care and breaks from caregiving and stress. » Asks about specific activities that the parent/caregiver, youth, and family members find most soothing and/or reenergizing and explores the need to (re)connect with or discover new interests, hobbies, classes, activities, time with friends, support groups, quiet time at home, reading, journaling, yoga, exercise, etc. » Explores resources (time, money, transportation, child care, etc.) needed for taking respite.	» Doesn't consider family culture around dealing with fatigue or taking a break from stressors and responsibilities. » Neglects to acknowledge or explore different levels of fatigue within the family. » Asks some, but not all, family members about the level of access to self-care and breaks from stress. » Doesn't inquire about naturally occurring opportunities in the family's life that can provide respite. » Considers respite care to be unimportant and doesn't prioritize exploration family's need for resources that will allow them to have respite time.	» Uses language that is shaming or blaming about a family member's level of fatigue. » Uses judgmental language in response to a family member's choice of respite activity. » Insists on there being a family respite need when family members deny such a need. » Expresses judgment about the appropriateness of activities the parent/caregiver or other family members find restorative.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
SUPPORTING PARENT/CAREGIVER, YOUTH, AND FAMILY TEAM IN PLANNING/COORDINATING RESPITE		
» Orients Family Team to ways youth and parent/caregiver have/will take respite. » Shares how reenergizing, fun and/or soothing respite activities can help build resiliency and support recovery from the impacts of trauma, mental illness, physical illness, etc. as well as promote youth and family living together successfully. » Considers purpose and intent of respite as part of treatment planning, family strengthening, and permanency and integrates respite as an intervention on the treatment plan.	» Orients some, but not all, Family Team members to the respite plan. » Limits description of the impact respite can have for youth and family. Describes potential impact on resiliency, recovery, or successes in living together, but not all. » Fails to clarify or discuss the purpose/ intent behind planning respite activities.	» Fails to tell the Family Team about any approach to respite or hopes the family holds up without formal respite. » Fails to explain how respite can help build resiliency, support recovery, and strengthen youth and family's successes in living together.
» Collaborates with parent/caregiver and Family Team to identify and develop restorative respite plans that create regularly-scheduled breaks from caregiving. » Plans with Family Team around ways to support family taking respite in a manner that is sensitive to youth's clinical needs, age, developmental stage, level of transition/separation anxiety, trauma history and potential for iatrogenic risk, etc. Assists family in selecting and preparing respite providers to support the primary parent/child attachment and the child's primary family membership.	» Collaborates with some Family Team members but not all. Doesn't include the youth in the Family Team planning process (e.g., in person, via written statement, or by including someone the youth chooses to speak on their behalf). » Develops a plan that can be used one time without consideration for ongoing planning. Doesn't revisit respite plan until respite is needed. » Doesn't consider frequency or duration of respite activities or resources to support respite plan. Doesn't help prepare respite provider to support primary parent/child attachment and the child's primary family membership.	» Ignores or disregards the Family Team in the respite-planning process. Tells youth of the respite plan after it is developed. » Fails to plan for youth's reintegration home after overnight respite. » Fails to engage the Family Team in any brainstorming of how they can support respite. Dictates to Family Team members how they will support the respite plan. » Ignores family's request for emergency respite rather than exploring whether the family needs crisis intervention.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
SUPPORTING PARENT/CAREGIVER, YOUTH, AND FAMILY TEAM IN PLANNING/COORDINATING RESPITE		
» Brainstorms all possible options for respite child care of youth (and siblings). Considers the possible use of family and natural supports, enrolling children in activities out of the home, Continuum provision of in-home/community respite and out-of-home/facility based respite care. » Includes a plan for reintegration back into home following out-of-home youth respite care. » Brainstorms viable resources (including but not limited to flex funds) to cover logistics such as activity fees, youth and sibling child care, transportation, etc. Validates the need for and brainstorms options for reimbursement of respite services provided by family and natural supports. » Explores the sustainability of the respite plan and options for how family can sustain respite.	» Explores ways Family Team can support respite to a limited extent. Doesn't brainstorm multiple respite options. Only considers individuals/ resources that the parent/caregiver identifies. » Doesn't consider how natural supports may need to be rebuilt/strengthened in order to use them for respite. » Doesn't explore short-term vs. long-term funding for respite. » Doesn't explain risks and strengths of different respite options (such as iatrogenic risk or clinical implications of facility-based respite for youth experiencing trauma or Reactive Attachment Disorder). Explains risks but doesn't brainstorm alternative respite options. » When family members disagree about the need for respite (e.g., parent wants it and youth doesn't), defers to parent's needs only rather than further exploring the youth's understanding, worries, etc., about respite and/or reframing the importance of respite for the youth.	» Limits discussion of respite to facilities or out-of-home options only. » Tells the family that respite is not an option or not available. Suggests respite planning is not appropriate/needed rather then exploring the need with youth/family and Family Team. » Fails to talk to referring agency regarding facility-based respite need. Places youth in facility-based respite without approval of State agency. » Makes or pursues respite suggestions that are incongruent with youth's clinical needs. » Only plans for and/or engages family in respite to the detriment of other components of service delivery (e.g., ignores the need for outreach interventions, OT consultation, peer mentoring, or other components of the services). » Acknowledges a youth's trauma history but doesn't connect this to how the youth might be negatively impacted by a particular respite option. Ignores iatrogenic risk.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENSURING PROVISION OF YOUTH RESPITE CARE		
» As needed and agreed upon, coordinates with youth, parent/caregiver, respite provider, Family Team members, natural supports, group home, and others to provide regular, short-term facility-based, in-home, or community-based respite care to the youth. » Identifies and coordinates to address challenges to obtaining/using respite.	» Doesn't coordinate/collaborate on all aspects of the respite plan. » Coordinates with some Family Team members but not all.	» Suggests that there are specific facilities/ resources for respite without first researching if they are available/feasible. » Doesn't coordinate around challenges with utilizing respite. » Coordinates without youth involvement.
» When providing in-home/community respite care, (as developmentally appropriate), engages youth in activities they find soothing and/or reenergizing and teaches them about potential new ways to sooth, energize, and manage day-to-day stress such as yoga, meditation, physical activity, writing, art, humor, play, friends, etc. » Encourages youth's interest in exploring, developing, and practicing old and new ways to have fun, manage stress, "reenergize" and care for them self.	» Ensures youth participates in respite but doesn't help them fully benefit from it. » Doesn't consider/integrate treatment benefit of activities (e.g., social skills, relationship building, etc.). » Doesn't consider activities within youth's area of comfort or consider cultural relevance of activities. Engages youth in activities in their "comfort zone" without introducing/exploring new opportunities. » Omits exploration of youth's past experiences when exploring and identifying activities.	» Engages youth in activities that the youth doesn't enjoy or finds stressful. » Restricts the type of activities and/or doesn't consider activities suggested by the youth (e.g., only engages youth in social skills or relationship-building activities even though youth finds drawing to be very calming.) » Engages youth in activities based on provider's own interests, not the youth's. » Imposes judgment/bias in selecting activities.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
ENSURING PROVISION OF YOUTH RESPITE CARE		
» Prepares youth and parent/caregiver for youth's overnight respite stay by visiting the facility with them, orienting them to the daily routine and what to expect, describing the time away as an opportunity for reducing stress and reenergizing, and reframing any perceptions of respite being a punishment or the result of bad behavior. » Coordinates with parent/caregiver and facility to ensure youth has everything they need with them when they attend facility respite (e.g., medications, book, music, games, etc. for restorative time) » Coordinates with family members to be sure they have everything they need to engage in their identified restorative activities while youth is away. » Prepares youth and family to reintegrate youth back home after respite.	» Acknowledges that youth views respite as punitive but doesn't talk with parent/caregiver, respite provider, and Family Team members about ways to reframe this for the youth. » Coordinates youth's preparation but not family preparation for respite time or return home.	» Ignores youth's complaints that respite feels punitive. » Doesn't facilitate youth/family visits to respite as part of preparing youth to attend. » Tells youth if they refrained from acting out, they wouldn't have to go to the respite program.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNSATISFACTORY PRACTICE
DEBRIEFING RESPITE CARE EXPERIENCE		
» Inquires with youth, parent/caregiver, respite provider, and Family Team around respite success, challenges, and options to overcome challenges. Facilitates joint conversations between respite providers and parent/ caregiver when differing perspectives occur or clarification of respite experience is needed. » Specifically explores whether parent/ caregiver and youth found respite time and activities effective in providing each a break. » Supports youth's expression of their respite perspective/experiences to parent/caregiver and Family Team. » Bridges differing perspectives/experiences of respite. Explores reluctance, worries, and hopes for the use of the same or a new respite intervention. » Coordinates with youth, family, respite provider/caregiver, and Family Team to revise respite plan as needed.	» Doesn't share feedback with Family Team members. » Asks about parent/caregiver respite experience but not about youth's, or vice versa. » Acknowledges differing perspectives but doesn't explore reluctance, worries, and hopes each had. » Explores experiences and asks for feedback but doesn't open up discussion around suggestions for revising respite plan.	» Doesn't ask or listen to youth feedback. » Minimizes/refutes youth feedback. » When the current respite plan is not effective, insists on continuing the same respite plan without changes. » Misleads youth, suggesting that they can stop their parents/caregivers/family from having respite time. » Fails to explore what youth and/or parent/caregiver feel would help make respite more helpful.

GLOSSARY OF KEY TERMS

CHOSEN FAMILY

Individual(s) who are emotionally close to the youth who mutually and deliberately choose one another to play significant roles in each other's lives and consider one another as 'family' even though they are not biologically or legally related.[1]

CORE TEAM

The Continuum clinician, outreach staff, and peer mentor staff. Not every youth works with a peer mentor, but when one does, the peer mentor is considered part of the Core Team. The Continuum practice profile guides the work of the clinician and the outreach staff on the Core Team while the work of the peer mentor is guided by the separate Young Adult Peer Mentoring Practice Profile.

FAMILY TEAM

The youth (as developmentally appropriate), youth's parent(s)/legal authorized representative, referring agency staff, and other formal and informal supports chosen by the parent(s)/legal authorized representative and youth (as developmentally appropriate). The Family Team supports the youth and family in brainstorming options to meet goals and in carrying out tasks in support of those goals.

LEGAL AUTHORIZED REPRESENTATIVE (LAR)

An individual or other body authorized under applicable law to consent on behalf of an individual.

PERMANENCY

The quality of enduring consistent parental and familial relationships that are safe and lifelong; offer legal rights and social status of full family membership; provide for physical, emotional social, cognitive, and spiritual wellbeing; and assure lifelong connections to birth and extended family, siblings and other significant adults, family history and traditions, race and ethnic heritage, culture, religion, and language[2].

WARM HANDOFF

Directly introduces the youth/family to a new service provider during which all three parties are present in person during a visit, meeting, or conference call as part of the process for supporting youth/family transition to a service.

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[1] Adapted from Gates, T. (2017). Chosen families. In J. Carlson & S. Dermer (Eds.), *The sage encyclopedia of marriage, family, and couples counseling* (Vol. 1, pp. 240-242). Thousand Oaks, CA: SAGE Publications Ltd.

[2] Fry, Lauren, et al. (2005). Call to Action: An Integrated Approach to Youth Permanency and Preparation for Adulthood. Casey Family Services in collaboration with California Permanency for Youth Project, Casey Family Programs and Jim Casey Youth Opportunities Initiative. New Haven, CT: Casey Family Services.

YOUNG ADULT PEER MENTOR (YAPM)

This position is also known as the "Peer Mentor" or "Youth Peer Mentor." YAPM is a staff position on the Continuum that holds specialty expertise based on sharing one's lived experience of mental health challenges with the purpose and intent to inspire hope and motivation in a young adult who is struggling with similar concerns. YAPMs use their lived experience as an active ingredient in a therapeutic process. YAPMs can make traditional behavioral health services more accessible and appealing to young adults as they manage their transition to adulthood and the underlying mental health conditions that can complicate their progress toward increased autonomy, reasonability, and potential periods of independence from and dependence on family members. For more information about the YAPM Practice Profile, visit: http://www.cbhknowledge.center/.

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