




IN-HOME THERAPY
PRACTICE PROFILE



ACKNOWLEDGEMENTS
IN-HOME THERAPY **PRACTICE PROFILE**

The In-Home Therapy Practice Profile was developed in a series of work sessions held during several months in 2016. This rigorous process is described in a webinar that can be found on the Children's Behavioral Health Knowledge Center website: http://www.cbhknowledge.center/ihtpp/.

We are grateful for the expertise, honesty, professionalism, and good humor that these individuals devoted to this work. Each one is genuinely committed to improving lives of children, youth, and families through quality in-home therapy services.

Amy Porreca	Advocates
Elaine M. Gatewood	BAMSI
Janelle Santos	Bay State Community Services
Carisa Pajak	Beacon Health Options
Gwen Rahilly	Behavioral Health Network
Jackie Gelb-Bicknell	Community Ventures Consulting
Maria Jose Arana	Child & Family Services
Stephanie Sladen	Children's Friend and Family Services
Jennifer Arbour	Children's Friend and Family Services
Salesia Hughes	Children's Services of Roxbury
Tarshe Derival	Children's Services of Roxbury
Melissa Lajoie	Community Healthlink
Karen Snyder	*Rosie D.* Court Monitor
Sandi Walters	Clinical & Support Options, Inc.
Deborah A. Fauntleroy	Consultant
Lisa Garcia	The Gándara Center
Rebeca Hierro-Pardo	The Gándara Center
Carey Jacobs	The Gándara Center
Silvia Vernaza	The Gándara Center
Indira Andrade	The Gándara Center
Jennifer Rifkin	Institute for Health and Recovery
Morganne Crouser	Justice Resource Institute GRIP Community Based Services
Colleen McKenna	Lahey Health Behavioral Services
Satya Montgomery	Lahey Health Behavioral Services
Beth Barto	LUK inc.
Marissa Beane	LUK, Inc.
Lisa Pineo	LUK, Inc.
Rebecca Ahlfors	LUK, Inc.
Beatriz Maimone	Massachusetts Alliance of Portuguese Speakers
Soledade Dinis	Massachusetts Alliance of Portuguese Speakers
Diane Grillo	Massachusetts Behavioral Health Partnership
Kristen Tripp	The MENTOR Network
Stephanie Judy	The MENTOR Network
Anna Sachs	North Suffolk Mental Health Association
Sara Frazier	South Bay Mental Health
Nancy Rhoads	The Edinburg Center
Helen McCreedy	The Home for Little Wanderers
Shannon Ahern	Wayside Youth & Family Support Network
Marcy West	Wayside Youth & Family Support Network
Sarah Valois	YOU, Inc.
Judi Rock	YOU, Inc.
Michael Barney	YOU, Inc.

CBH KNOWLEDGE CENTER

MassHealth
CHILDREN'S BEHAVIORAL HEALTH INITIATIVE (CBHI)

IN-HOME THERAPY **PRACTICE PROFILE**

TABLE OF CONTENTS

INTRODUCTION

I. The Vision, Mission, and Values of the Children's Behavioral Health Initiative

VISION
Massachusetts places families and children at the center of our state's service delivery system and maintains a coordinated system of behavioral health services to meet their needs. Policies, financing, management, and delivery of publicly funded behavioral health services are integrated so that families can find and use appropriate services. This system is intended to ensure that all families feel welcomed and respected, receiving services that meet their needs as the families themselves define them.

MISSION
The mission of the Children's Behavioral Health Initiative (CBHI) is to ensure that children with MassHealth who have significant behavioral, emotional, and mental health needs and their families get the services they need for success in home, school, community, and throughout life. This is done by strengthening, expanding, and integrating Massachusetts behavioral health services into a comprehensive, community-based system of care. CBHI partners with child- and family-serving state agencies, providers, and payers to ensure that services

- meet the individual needs of the child and family,
- are easy for families to find and access, and
- make families feel welcomed and respected.

CBHI VALUES

- Youth-Centered and Family-Driven
  Services are driven by the needs and preferences of the child and family, developed in partnership with families, and accountable to families.
- Strengths-Based
  Services are built on the strengths of the family and their community.
- Collaborative and Integrated
  Services are integrated across child-serving agencies and programs.
- Culturally Responsive
  Services are responsive to the family's values, beliefs, and norms, and to the socioeconomic and cultural context.
- Continuously Improving
  Service improvements reflect a culture of continuous learning, informed by data, family feedback, evidence, and best practice.

II. The In-Home Therapy Principles of the Children's Behavioral Health Initiative

In-home therapy (IHT) is intended to align with the values that are important to families; support positive outcomes; and manifest the best intentions and expectations of CBHI, which in turn reflect the principles of high-fidelity wraparound as described by the National Wraparound Initiative. CBHI aspires to and expects the highest professional standards of clinical and support work in IHT, including collaboration with other professional and natural supports to assist families in securing integrated, effective care. In-home therapy is flexible, accessible, responsive, and driven by family expertise. It uses the strengths inherent in children, youth, and families as the basis for treatment and responds to both the wider cultural context of families and the individual beliefs and values that distinguish each family from all others.

III. The Purpose of In-Home Therapy

In-home therapy is a structured, strengths-based, collaborative therapeutic relationship among a clinical team, a youth, and the youth's family, developed with the purpose of treating the youth's behavioral health needs. IHT works to enhance the family's present understanding of the youth's needs and to support changes that promote healthy functioning where the youth lives, learns, works, and plays. Interventions draw on youth and family strengths, astute clinical judgment, evidence-informed practices, and creative change agents to assist each family in moving toward its vision. Work begins with a collaborative effort to set and prioritize goals that build incrementally one upon another. Successful interventions help youth and families attain the developmental, behavioral, relational, and emotional competencies that are the basis for success in family, school, and community life. They strengthen the family's capacity to prevent or reduce the disruptions caused by a youth's admission to an inpatient hospital or other treatment setting outside the youth's home environment. Interventions include intensive family therapy, education, skill-building, identifying and understanding the youth's needs, practical supports, attentive care coordination, and the strengthening of community connections. The impact of working collaboratively for change is a future that is more hopeful than the present.

This Practice Profile defines nine Core Elements that comprise IHT. Each Core Element begins with a definition, followed by a description of how that Element contributes to the CBHI vision for services. A matrix for each Core Element provides detail at the level of what we do and say to practice in-home therapy.

IV. Using the Matrix for Each Core Element

Each Core Element includes by a matrix describing the item-by-item practices that make up that Element. The Ideal Practice column shows the level of practice that we aspire to achieve consistently across the state. The Developmental column describes evolutionary stages that naturally occur with the implementation of a new practice model or with a newly trained workforce. Finally, the Unacceptable column lists practices that do not meet basic standards for in-home therapy.

Tasks under each Element often occur simultaneously, as they should. They almost never happen only once, nor should they. At the start of each matrix, we suggest reviewing the Practice Profile as a whole, and we offer certain Elements in particular to compare to one another in order to see the interconnectedness.

We use the terms "family" and "family members" throughout the profile to describe the various relationships that constitute family groupings, including biological, foster parent, adoptive, and other attachment relationships, as defined by each grouping.

The work of in-home therapy is shared between an IHT clinician and a Therapeutic Training and Support practitioner. Unless specifically noted as the province of the clinician only, the practices are based on the expectation of teamwork and refer to either or both roles, as fits each family situation. We include this teamwork reminder at the start of each matrix.

Finally, both the Collaborative Intervention Planning and the Care Coordination and Collaboration Elements have notable differences depending on whether IHT is the hub service or is working in collaboration with Intensive Care Coordination (ICC). We have described practices for both IHT as the hub and IHT when the youth also has ICC in these two Elements, and we note these differences in the heading for each matrix.

BRINGING IT ALL TOGETHER

These nine Core Elements of IHT form the basis for solid clinical and support work and ensuing discussions with the family. Each matrix defines the practices that will lead to understanding the family and youth: through family and youth history; current family and youth worries, desires, traumas, and life experiences; and collateral information such as school testing, treatment records, observations, and the perspectives of other providers. In turn, how you think about all you have learned provides the basis for the initial discussions with the family about ideas for interventions that could impact the youth's needs and help the family achieve its goals.

The nine Core Elements are the ingredients of IHT; the items are not a checklist of things to do! Items need to be contextualized into a coherent approach, learned, and deepened over time. As practitioners gain mastery over the synthesis of individual items, the work is increasingly creative, rewarding, and effective.

IN-HOME THERAPY **CORE ELEMENTS**

PRACTICING CULTURAL RELEVANCE: In the context of in-home therapy, practicing cultural relevance is: 1) the ongoing process of acquiring an understanding of how the values, beliefs, attitudes, and traditions of racial, ethnic, religious, sexual orientation, gender identity, socio-economic, and other groups contribute to our own and other people's cultures; 2) learning about personal circumstances, conditions, nature, and experiences that influence our own and other people's thinking, behavior, and community roles; 3) acknowledging differences and similarities in power and privilege among groups of people; and 4) using this knowledge to work effectively with all people.

Contribution to the Outcome: Actively working to understand the broadly defined, overall norms for each family's identified culture, the conditions of the family's local community, and the family's specific beliefs and traditions demonstrates that the IHT team values diversity and can adjust treatment to each family's situation. Discussing cultural considerations with each family highlights differences and similarities with the clinician's own culture that may either enhance or interfere with collaboration. Evidence of cultural considerations throughout the work — from first to last meeting with the family — underlines the strengths-based approach of IHT. Continuous learning about each family's culture shows commitment to reducing health disparities through ongoing learning and improvement.

ENGAGEMENT: Engagement is the process of effectively joining with family members to set shared goals for treatment by establishing a relationship of respectful curiosity about individual and family strengths and needs. It involves empathy, careful listening, sensitivity, humor, and compassion. It demonstrates mutual engagement: that you are where you want to be — with this family at this time — and ready to give your full attention. Engagement is not a point in time, but every point in time can contribute to engagement.

Contribution to the Outcome: The practitioner's stance with a youth and family is the foundation for effectively joining in a positive, family-centered therapeutic relationship that endures throughout the course of treatment. Engagement contributes to a relationship in which the family, IHT practitioners, and other team members can work together to improve the youth's emotional, social, and behavioral health. Ongoing engagement demonstrates that IHT is flexible and responsive to practical considerations, respectful of family culture, and intentionally seeking and building on family strengths. Engagement reinforces shared hope for the future.

ASSESSMENT AND CLINICAL UNDERSTANDING: Assessment is the process of gathering a sufficiency of information about the needs and strengths of a youth and family, evaluating the relevance of that information, and developing a comprehensive narrative of the youth and family in the context of their environment, experiences, culture, and present situation. Clinical understanding results in an interpretive summary and diagnostic formulation that can be understood and supported by family members, professional helpers, and natural supports. Both assessment and clinical understanding change over time as new information emerges and the family situation evolves.

Contribution to the Outcome: A successful intervention relies on a thorough, accurate discovery of the history, strengths, and needs of the youth, their family, and the larger community. Youth and family voices in the assessment process help ensure that the prioritization of needs is driven by the family. Arriving at understanding requires knowledge of both past experience and current functioning as well as clinically astute evaluation to determine the relevance of the information gathered. Strengths that are clearly articulated and incorporated into the assessment serve as a basis for building positive change. A quality assessment draws a picture of the family situation as a whole, describes specific clinical concerns, and evolves as the practitioner's understanding deepens. Revising the assessment over time shows a willingness to learn from experience and feedback.

IN-HOME THERAPY **CORE ELEMENTS**

RISK ASSESSMENT AND SAFETY PLANNING: Risk assessment and safety planning consist of anticipating and preventing risks to a youth's and family's well-being. Safety plans developed with families help them use their current capacities to resolve potential dangers. Safety plans also offer a range of external supports to intervene when preventive measures cannot avert a crisis. Input from all relevant partners results in a single, unified plan to address the assessed risks and to promote effective collaboration in urgent situations.

Contribution to the Outcome: Youth and family safety is basic for any successful intervention. Effective safety planning takes account of both risk and protective factors, demonstrating a commitment to finding signs of safety in the family, home, and community. A risk and safety plan that uses the family's own resources and past successes shows commitment to building on strengths. In order to remain sustainable after treatment ends, safety planning relies on family members and natural supports as first safety responders. It backs up their efforts with progressively more intensive supports for emergent situations. Good safety plans are clear and understood by all participants in the plan.

COLLABORATIVE INTERVENTION PLANNING: Collaborative intervention planning is a nuanced developmental process that follows from the picture of youth and family that emerges during assessment. The plan starts with the family's vision for a positive future. Working from a shared understanding of youth and family hopes, needs, and strengths, the IHT team joins with family members to develop a plan of intervention that prioritizes needs, sets measurable goals and objectives, identifies the interventions most likely to succeed, and specifies who is responsible for each piece of the work. Collaborative intervention planning takes into account the family's circumstances, culture, and readiness to participate; plans evolve with ongoing assessment of progress. Collaborative intervention planning follows the same process whether IHT is the hub or the youth also has Intensive Care Coordination; in the former case, the IHT team takes the lead role for intervention planning, and in the latter the ICC team leads the process.

Contribution to the Outcome: Partnering with families in selecting priority needs, treatment goals, and interventions shows commitment to the CBHI value of family-driven service. Customized planning varies for each family. For all families, intervention planning must be clearly based on the clinical understanding generated in the assessment and on treatment goals that are measurable, observable, and doable. The family and provider use the identified strengths of the youth, family, and community to build specific actions into the plan that apply strengths to meet needs. Because the desired outcome of care is improved functioning across the domains of the youth's life, IHT may focus on therapeutic interventions that enhance problem-solving, limit-setting, risk management/safety planning, communication, skills to strengthen the family, and productive ways to use community resources. Selecting research-informed interventions demonstrates commitment to continuous learning.

IN-HOME THERAPY **CORE ELEMENTS**

INTENSIVE THERAPEUTIC INTERVENTION: The heart of in-home therapy is the intensive therapeutic intervention that enhances both the well-being of the youth and the capacity of caregivers to provide a safe and supportive environment for the youth and family. The therapeutic intervention consists of the strategies and actions most likely to promote healing, strength, and lasting change. High-quality interventions make every meeting count with specific purposes for each session, plans for conducting sessions, a clear correlation between the session plan and treatment plan goals, and actions to practice between sessions. They use strengths in real and tangible ways to address needs. Family reports of both improvements and setbacks directly inform next steps, as do collateral perspectives and direct observation by the IHT team. Therapeutic intervention is a live process of discovering what works with a specific youth and family in their own context.

Contribution to the Outcome: Intensive therapeutic intervention serves the overall purpose of in-home therapy: to enhance the family's capacity to understand its own and the youth's needs and to make changes that promote healthy functioning. Interventions embody CBHI's values of child-centered and family-driven services when they respond to the priorities of the youth and family, and are developed in partnership with families. Effective interventions build on the strengths of the family and its community; they are responsive to the family's values, beliefs, and norms, and to socioeconomic and cultural context. By integrating services across agencies and programs, interventions support collaboration. Both the IHT practitioners and the system as a whole strive to improve continuously as interventions unfold and adapt.

CARE COORDINATION AND COLLABORATION: Care coordination and collaboration engages family members, treatment providers, community resources, and natural supports as a cohesive group with shared goals for working with a youth and family. Care coordination includes forming and meeting face-to-face with a treatment team, developing teamwork among participants, sharing relevant information on a regular basis, planning together, measuring treatment progress together, and working collaboratively to add, change, or end services. Care coordination and collaboration follows the same process whether IHT is the hub or the youth also has Intensive Care Coordination; in the former case, the IHT team takes the lead role for care coordination; in the latter, the ICC team leads the process with IHT as an active participant.

Contribution to the Outcome: The foundation for child-centered, family-driven treatment is a team that *always* includes family. Collaborative care strives to join all stakeholders in a youth's life to ensure effective work across domains. Different perspectives on a team create opportunities to find and use strengths. Consistent collaboration between the IHT team and the range of natural supports and service providers working with the family results in cohesive efforts to achieve desired outcomes, foster the family's community connectedness, and promote sustainability of treatment gains. Ideal communication takes a variety of forms that are organized, timely, culturally responsive, and inclusive.

IN-HOME THERAPY **CORE ELEMENTS**

ENGAGING NATURAL SUPPORTS AND COMMUNITY RESOURCES: Engaging natural supports is the process of discovering and connecting with the enduring supports in a family's environment who celebrate with the family in good times, comfort it through difficult times, contribute to a sense of belonging, and may provide tangible assistance. They may be extended family, friends, a faith community, neighbors, mentors at school or work, or acquaintances who play a small but important encouraging role in a family's life. Engaging community resources offers opportunities for families to join in volunteer, play, learning, worship, and social activities that build resiliency. Informal resources are the naturally occurring, healthy forces that carry families beyond the reach of formal services.

Contribution to the Outcome: Natural supports and community resources — or "informal supports" — focus on building and maintaining family, friends, and community connections. These connections can help to carry out interventions and sustain improved functioning after the IHT service ends. Informal supports that are included in teamwork, treatment planning, and ongoing collaboration strengthen healthy community bonds. Engaging informal supports, guided by the cultural context of each family, demonstrates shared hope in the youth's and family's ability to resolve treatment needs and move toward a positive future.

PREPARING TO EXIT: Preparing to exit from IHT begins with the family vision for a preferred future and flows through all stages of the intervention. With regular checks on progress, the IHT team and the family move toward this vision. Specific actions as the family approaches the planned discharge include validating youth and family progress, planning for setbacks and sustainability, and learning about family members' experience of the service. Unplanned exits from interventions, or a severe increase in youth needs, require efforts to ease difficult transitions, re-engage family members, and learn what we can in order to prevent abrupt discharges in the future.

Contribution to the Outcome: Planning for exit from the point of intake emphasizes the hope that changes will endure over time with less professional intervention. Planning attends proactively to safety, community connections, changes in life circumstances, and other variables that may affect the end of treatment and after-care. Careful collaboration is essential to guide when and how to complete an episode of care. Ending treatment may be an occasion for celebrating a family's strength in improving its situation. Unplanned exits are an opportunity to learn about how practitioners, collaborating partners, and the system of care can better support positive outcomes.

CORE ELEMENT:
PRACTICING CULTURAL RELEVANCE

In the context of in-home therapy, **Practicing Cultural Relevance** is: 1) the ongoing process of acquiring an understanding of how the values, beliefs, attitudes, and traditions of racial, ethnic, religious, sexual orientation, gender identity, socio-economic, and other groups contribute to our own and other people's cultures; 2) learning about personal circumstances, conditions, nature, and experiences that influence our own and other people's thinking, behavior, and community roles; 3) acknowledging differences and similarities in power and privilege among groups of people; and 4) using this knowledge to work effectively with all people.

CONTRIBUTION TO THE OUTCOME: Actively working to understand the broadly defined, overall norms for each family's identified culture, the conditions of the family's local community, and the family's specific beliefs and traditions demonstrates that the IHT team values diversity and can adjust treatment to each family's situation. Discussing cultural considerations with each family highlights differences and similarities with the clinician's own culture that may either enhance or interfere with collaboration. Evidence of cultural considerations throughout the work — from first to last meeting with the family — underlines the strengths-based approach of IHT. Continuous learning about each family's culture shows commitment to reducing health disparities through ongoing learning and improvement.

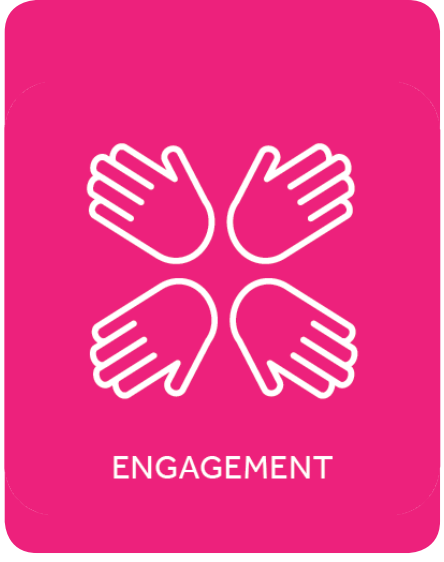
REMINDER: Review all Elements. See especially: Engagement, Assessment and Clinical Understanding, Collaborative Intervention Planning, and Engaging Natural Supports and Community Resources. Each matrix describes the work of IHT as a practice shared between a clinician and a Therapeutic Training and Support (TT&S) staff member. Unless specifically noted as the province of the clinician only, the practices expect teamwork and refer to either or both staff members, as fits each family situation.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
Cultural self-assessment in context of IHT work		
• Routinely conducts a self-assessment of practitioner's own privilege status in multiple dimensions (gender, race, ethnicity, socio-economic status) in relation to IHT work. • Takes an inventory of practitioner's own values, beliefs, attitudes, knowledge and awareness prior to working with each family. • Takes responsibility for continued growth in comprehension of the racial, ethnic, religious, and other affiliate groups connected to the work. • Addresses cultural differences between clinician and TT&S partner.	• 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.	• No self-assessment or inventory. • No effort at growth. • Unaware of privilege status. • Ignores or denies differences/similarities between clinician and TT&S. • 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.
Resolving practical barriers		
• Invites each family member to share their preferred identities (race, ethnicity, religion, sexual orientation). • Amplifies understanding in subsequent discussions. • Asks about youth and family members' preferred language for signed, spoken and/or written communication at intake. • Assesses literacy status and cues to ensure effective communication. • Offers options for ensuring effective communication across language/ literacy differences. • Identifies and acts on any practical concerns about meeting times and locations that relate to culture (e.g. religious observances, family privacy boundaries, concern about stigma, inclusion of specific family members). • Regularly assesses quality of communication between family members and IHT.	• Engages in discussion at intake but limited or no follow up. • Discusses superficially or one-dimensionally. • Discusses with only a subset of family. • Tries to discuss but stops if topics are uncomfortable. • Does not consider possibility that family members may have limited understanding of communications and be covering up due to shame or embarrassment. • Explains available options for working in preferred language but does not follow through. • Uses vocabulary or jargon that family is unlikely to understand. • Adapts to family needs but communicates that the flexibility is a burden.	• Assumes race, ethnicity, religion, or other identity based on superficial data without discussing. • Assumes family has "no culture" and/or culture has no role in their work without explanation. • Assumes similarities without discussion. • Places burden on family to bring up and share cultural considerations. • Assumes language or literacy needs without discussion. • Uses child as interpreter. • Disregards needs and concerns that are based on culture. • Fails to offer options.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
Family culture discovery		
• Invites initial and ongoing discussion with 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. • Explores the vulnerabilities and resilience that emerge from the family members' culture and experiences. • Engages in initial and ongoing discussion with individual family members to discover differences and similarities among family members and between generations. • Explores roles and privilege differentials within family. • Creates "safe space" in which to explore.	• Engages in discussion at intake but limited or no follow up. • Superficial or limited exploration of impact of culture. • "Asks" rather than "explores" or "invites." • Discusses only with the family as a whole without recognizing possible differences among individuals. • Discusses only with youth or caregiver without bringing views together with whole family. • Gathers general cultural information (race, language) without exploring what is unique to this family (values, attitudes). • Completes CANS items without narrative. • Engages in conversation but does not incorporate into treatment.	• Assumes without discussion. • Attempts to "homogenize" family culture without acknowledging individual differences. • Assumes family is "just like me" based on generic categories. • Assumes experiences of culture are the same for all family members. • "Takes sides" in treatment based on generational or other differences.
Community culture discovery		
• Acknowledges and explores, initially and on an ongoing basis, the neighborhood and community environment of the youth and family (available resources, community crime rates, socio-economic conditions, racial tensions at school) and the impact on behavior, symptoms, and diagnoses. • Explores the impact and specific needs of youth who have experienced immigration-related separations from community or family. • Explores other displacements (homeless shelter, foster home placement). • Uses awareness of community impact when assessing behavior.	• Engages in discussion at intake but limited or no follow-up. • Superficial or partial discussion of community factors or impact of immigration-related disruption in attachment. • Confuses practitioner's sense of discomfort in a neighborhood with being "unsafe." • Minimizes impact of community/ neighborhood.	• No consideration of community. • Pathologizes behavior ("oppositional" or "conduct disordered") without considering impact of community factors. • Talks about community with stereotypical or negative descriptions ("bad neighborhood," "ghetto," "soccer mom lifestyle").
Cultural differences among family members and clinical team members		
• Opens discussion of differences and similarities in culture and in power and privilege. • Reflects actively with family on how these affect dynamics of working with families.	• Engages in this step once without revisiting. • Minimizes power differential. • Discloses aspects of self without checking in with family on impact.	• No awareness or no effort to discuss or reflect. • Self-disclosure for own benefit. • Shares, but with a "hidden agenda."

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
• Shares aspects of own values, beliefs, attitudes, and life experiences with purpose and intent to partner in shaping an effective treatment alliance with the child and family. • Always assesses whether disclosure meets youth/family or practicioner need. • Implements changes in practice to improve work with family members as a result of shared understanding of cultural identities.	• Makes a mistake with unintended impact, but does not address or resolve impact. • Does not explain the reason for sharing. • Fails to document purpose and intent of self-disclosure. • Attempts to improve practice but without full shared understanding or full collaboration with family members. • No ongoing check-in on whether changes are an improvement.	• Conveys self-disclosure in judgmental way ("You should have done what I did"). • Claims to "know exactly how you feel." • No shared understanding. • No effort to make changes, or makes wrong changes without learning from them.
Strengths in the context of culture		
• Engages in initial and ongoing discussion specifically about strengths — including individual, family, and community strengths — related to youth and family culture. • Helps family to recognize and "discover" strengths in cultural differences; shares potential strengths even if family members cannot.	• Engages in discussion at intake but limited or no follow-up. • Superficial discussion of strengths (listing activities, generalizations about strengths). • Bases ideas of strength on narrow definition of culture or what is acceptable as strength (mother "should" speak up, father "should" help with child care). • Documents only youth or only caregiver. • Over-identification by practitioner with certain roles that exaggerate strengths.	• Discusses problems only, with minimal or no discussion of strengths. • Assumes strengths based on stereotypes ("All black people go to church," so church community is a strength). • No conversation linking strengths to culture; interpreting strengths based on own culture. • Mistaking strengths (family roles, beliefs about mental health) for concerns. • Disrespects others' cultural practices.
Beliefs about treatment		
• Explores in initial and ongoing discussion family members' beliefs regarding physical health, mental health, behavioral and emotional responses, substance use, attitudes toward medication, and treatment. • Uses therapeutic alliance and other practice approaches to align culturally influenced perspectives (if different) of family and practitioner.	• Partial or superficial discussions. • Explores beliefs but only as "issues," not as strengths. • Discusses family beliefs without sharing practitioner's own beliefs (when appropriate) or finding common ground.	• Assumes without discussion. • Disregards beliefs, imposes own cultural values, or tries to convince family to comply with "shoulds" and "shouldn'ts" without regard to their culture.
Addressing cultural misunderstandings		
• Offers options for facilitating discussion between family members and other external team members about cultural considerations that may impact teamwork and decisions about culturally specific interventions.	• Engages in partial or superficial discussion with team. • Brings up discussion with team, but without preparing family. • Suggests that family "call out" concerning behaviors but without offering effective support	• Assumes without discussion. • Addresses "family culture" with team, but without including family. • Insists that family address issues even when family does not want to. • Sees problem, but says nothing.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
• Invites and supports family to address behaviors by team members that result from misunderstanding of culture. • Supports family in addressing teamwork concerns. • When observing actions that appear insensitive to family culture or experience, addresses this directly and respectfully with other team members and family. • Models effective advocacy around cultural differences. • Promptly acknowledges and corrects own actions that may indicate cultural bias or misunderstanding.	or coaching in how to do it. • Does not explore range of options for family communicating with team. • Addresses behaviors indirectly or in sugar-coated way, or addresses in hostile manner. • Addresses behaviors with some team members but avoids confronting others. • Acknowledges own mistakes belatedly. • Acknowledges, but doesn't know what to do next and fails to ask for family's input on how to avoid similar behavior in future.	• Sees no problem. • Creates conflict in team due to manner of addressing problem, or by ignoring problem. • Blames family for being "too sensitive." • Joins negativity of team members. • Blames someone else: - "I'm sorry but..." - "My supervisor made me do it." - "You're too sensitive." - Overly apologetic so family feels sorry for practitioner.
• Educates families to understand how cultural norms (for example, discipline of children, expectations of women) may be in conflict with U.S. laws and prevailing customs and how this could be problematic in some domains.	• Discusses only the most obvious safety concerns, or only in relation to Department of Children and Families. • Over- or under-emphasizes impact of different practices.	• Communicates that families "should" adapt to U.S. prevailing customs regardless of their own identities.



CORE ELEMENT: ENGAGEMENT

Engagement is the process of effectively joining with family members to set shared goals for treatment by establishing a relationship of respectful curiosity about individual and family strengths and needs. It involves empathy, careful listening, sensitivity, humor, and compassion. It demonstrates mutual engagement: that you are where you want to be — with this family at this time — and ready to give your full attention. Engagement is not a point in time, but every point in time can contribute to engagement.

CONTRIBUTION TO THE OUTCOME: The practitioner's stance with a youth and family is the foundation for effectively joining in a positive, family-centered therapeutic relationship that endures throughout the course of treatment. Engagement contributes to a relationship in which the family, IHT practitioners, and other team members can work together to improve the youth's emotional, social, and behavioral health. Ongoing engagement demonstrates that IHT is flexible and responsive to practical considerations, respectful of family culture, and intentionally seeking and building on family strengths. Engagement reinforces shared hope for the future.

REMINDER: Review all Elements. See especially: Practicing Cultural Relevance, Assessment and Clinical Understanding, Collaborative Intervention Planning, Engaging Natural Supports and Community Resources, and Preparing to Exit. Each matrix describes the work of IHT as a practice shared between a clinician and a Therapeutic Training and Support (TT&S) staff member. Unless specifically noted as the province of the clinician only, the practices expect teamwork and refer to either or both staff members, as fits each family situation.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
First contacts		
• Provider agency calls family within 24 hours of receiving referral and repeats contact attempts, as appropriate. • Determines family interest and any special considerations (e.g. language preference) affecting clinician assignment. • Provides overview of IHT service and offers contact by IHT clinician within 24 hours. • Offers alternative services or providers (if IHT has waitlist). *Above items may be done by someone other than assigned IHT team.* • IHT calls family within 24 hours of assignment to review and confirm above information, explain team approach, and arrange first meeting at family's convenience. • Assesses readiness to participate, if referral from source other than family.	• Returns calls late without documented explanation. • Gathers insufficient information for appropriate match of clinical skills. • Does weekly check-ins with family (if IHT not available immediately) but does not offer other options. • Phone orientation too quick and not checked for understanding. • Omits description of flexibility.	• Returns calls late more than 50% of time. • Waits for opening before returning calls. • Neglects to offer alternatives to meet needs of family if no appropriate match. • Neglects to check in with families on wait list. • Indicates to family that referral source "mandates" the service. • Sets time limits on length of service. • Sets arbitrary frequency of meetings.
Orienting family to service and agency		
• Discusses with the family in person: - Family expectations of IHT, including past experiences (positive and negative); - What IHT can do and what its limitations are, including mandated reporting and confidentiality; - Both family therapy and care coordination functions; - Team approach of pairing IHT clinician and TT&S practitioner; - IHT in relation to other CBHI hub and hub-dependent services; - Criteria for participation in IHT (youth's	• Explains to only one family member, but not all. • Avoids exploration of past negative experiences with treatment. • Provides information (forms, brochure) without checking for understanding. • Provides superficial description ("family therapy in the home") without full scope. • Neglects to describe care coordination. • Neglects to explain family focus (not individual treatment for child). • Explains overview without revisiting for possible change in services or needs. • Assumes understanding of IHT from prior	• Hands out written information with no explanation. • Perpetuates the myth that IHT will "fix" child without family effort. • No consideration of family preferences, learning styles, or past experience with services. • Uses referral form information only. • Fails to discuss roles for TT&S or clinician. • Treats TT&S as "lesser" member of IHT team. • Only discusses CBHI services available at own agency. • Devalues other CBHI services (ICC) to

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
and family's voluntary agreement). • Obtains consent for treatment. • Provides orientation to agency, including rights and responsibilities of family and providers. • Explores family members' preferences (forms of address, preferred modes of communication, learning styles) and past experience with treatment (what helped, what did not).	episode of treatment. • Explores some but not all questions, or assumes answers.	discourage participation. • Does not describe any service that might be hard to access.
Respectful understanding of family configuration and hopes		
• During assessment and intervention planning, explores with child and family which individuals they consider family members and who they expect/hope will participate in family therapy sessions and in what roles. • Invites each identified family member to discuss youth and family strengths and needs. • Listens carefully to the family's narrative, and summarizes verbally back to each family member to make sure of shared understanding. • Uses range of strategies to engage all identified family members. • Invites identified family members to describe the changes they hope to see as a result of IHT. • Uses range of specific engagement skills (active listening, strengths-based language) in discussions and adapts to differences in home setting (distractions, locus of control, boundaries).	• Includes family members based on "typical" family configurations or only those present in home. • Insufficient effort to invite full family configuration identified by youth and caregiver. • Explores only at intake without revisiting. • Listens without reflecting back. • Explores with only subset of family members. • Allows concerns to dominate discussion without probing for meaningful, usable strengths. • Misses opportunities to adjust clinical skills to home environment.	• Uses referral form information only. • "Decides" who should be included in therapy without family input. • Includes only family members in household at time of meetings. • Discusses needs only (not strengths). • Develops ideas about change based on own clinical training without family input. • Assumes home environment "should" replicate office-based environment.
	Practical considerations	
• Engages family members in developing options for locations and frequency of meeting, (within performance requirements), and schedules meetings based on family preference, transportation, safety, and other needs. • Explores both logistical and perceptual barriers (trust, quality of engagement). • Revisits preferences and barriers as service progresses.	• Offers options of times and locations that work better for clinician than family, and/or appear formulaic (office or home as only choices). • Neglects to explore possible safety concerns. • Considers only logistical barriers. • Explores only at intake without revisiting.	• Sets rigid expectations for time and location of meetings without considering family situation.
• Provides contact information (office location	• Gives business card or pamphlet with written	• Fails to provide options for contact outisde of

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
answering service) for both regular interactions and emergency situations, with clear explanation of the contact process and which to call for which situation. • Responds within 24 hours to all contacts by family members throughout duration of service and provides clear guidelines to family members about exceptions.	information without checking for understanding or ability to use. • Neglects explanation of process (e.g. answering service). • No coordination between clinician and TT&S about who responds. • Takes more than 24 hours to return calls, without explanation. • Responds by text only, or in ways that do not fit youth and family preferences.	session times. • Provides 911 as primary emergency contact. • Uses answering service for off-hours calls that has no resources for callers who do not speak English. • Responds late to family contacts, or not at all.
Family voice at all times		
• Elicits input and questions from all family members *during all stages of intervention* planning and implementation as service proceeds. • Explores commitment to treatment at all stages. • Asks open-ended questions and probes for understanding as needed. • Checks in with youth and family members at beginning and end of each session to hear their firsthand reports of progress, setbacks, and changes. • Uses recent clinical documentation to guide check-in process.	• Discusses at start but does not revisit. • Discusses only with subset of family members. • Solicits information without probing for understanding. • Touches base about challenges but no discussion of progress or strengths. • Allows check-in to become venting session. • Allows one voice to dominate check-ins.	• Fails to initiate discussions. • Elicits input from one family member "on behalf" of all. • Makes assumptions about treatment progress based on own experience or agenda. • Ignores recent indications of setbacks. • Routinely schedules when youth or key family members are not present.
Sharing information		
• Describes importance of gathering relevant information from other sources important to family. • On an ongoing basis, requests permission to gather information from other providers, agencies, and schools involved with youth and family. • Shares information from other sources with family.	• Gathers some but not all relevant consents. • Requests consents at start of services but does not revisit as other sources emerge. • Shares information partially with family but withholds some information. • Focuses on consents to gather information from formal supports only.	• Accepts "verbal consent" in place of signed document. • Gathers consents without explaining reason for seeking information. • Neglects to share information with family. • Assumes that everyone in household can be spoken to (without consent of family members).
• Plans any meetings with other stakeholders around family availability and options for preferred locations; works with other stake-	• Allows collaterals to dictate times for meetings even when impossible for family. • Requests translation support but doesn't insist.	• Plans meeting based on provider convenience. • Neglects to hold face-to-face team meetings

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
holder meetings (school, provider, Department of Children and Families [DCF]) to accommodate family participation. • Reschedules if youth/family is unable to attend. • Ensures translation service/support is arranged as needed. • Requests pauses in meeting to make time for translation. • Prepares ahead of time with youth and family for participation in different types of meetings (school, DCF, medical). • Discusses with family how family vision for IHT will guide participation in meetings. • Discusses ahead of time any sensitive information that may be brought up and develops strategies with family members for framing sensitive information. • Makes sure youth and family have time and encouragement to participate fully in discussions at meetings. • Checks in during meeting to ensure that family members understand and can continue. • Recaps meeting at end for family and provider participants.	• Uses TT&S to translate without seeking other options. • Uses other forms of communication even when face-to-face is needed. • Insists on face-to-face when other forms of communication are more effective. • Invites people to attend but not effective in bringing them to the table. • Does not follow up with invitees who miss the meeting. • Talks only with subset of family about what to expect and how to handle sensitive subjects. • Checks in with family but omits discussion of purpose and expectations. • Does not invite age-appropriate youth to meetings. • Allows one voice (provider or family members) to dominate meeting. • Brings family members to table but does not make space for them to contribute. • Speaks "for" family members rather than supporting them to speak for themselves.	when needed, or to attend other stake-holder meetings. • Deliberately excludes youth or family members from meetings. • Excludes youth or family by scheduling (or agreeing to) times that are too inconvenient. • Fails to arrange/request translator. • Brings up sensitive topics without first discussing with family. • Shows up unprepared for meeting. • Has had no prior contact with team members. • Treats providers as experts without pausing to acknowledge family voice or include family members in discussion. • Uses "professional" language that is inaccessible to youth or family. • Uses pejorative, condescending, or stigmatizing language to label individuals, motives, conditions.
• Shares all relevant communication about the family with family members in clear, family-friendly language. • Writes all information (assessment, progress notes) in ways that are respectful and clear enough to be shared with family. • Translates documents into family's preferred language when sharing. • Shares assessment, treatment plan, and progress notes with family members as applicable. • Considers writing documents collaboratively with family members. • Includes family members in updates with collaterals between sessions. • Develops strategies with family for discussing difficult information obtained from collateral sources.	• Writes information for clinical eyes only. • Shares information but in ways that are not clearly understood by family. • Translates documents verbally but no written version provided. • Shares information inconsistently or with some but not all family members. • Tells information without checking for understanding and response.	• Uses judgmental or pejorative tone in documents not typically shared with family. • Makes no effort to provide documents in family's preferred language. • Shares or seeks information without written consent of family. • Deliberately withholds information that is difficult to discuss.

ASSESSMENT & CLINICAL UNDERSTANDING

CORE ELEMENT:
ASSESSMENT & CLINICAL UNDERSTANDING

Assessment is the process of gathering a sufficiency of information about the needs and strengths of a youth and family, evaluating the relevance of that information, and developing a comprehensive narrative of the youth and family in the context of their environment, experiences, culture, and present situation. **Clinical understanding** results in an interpretive summary and diagnostic formulation that can be understood and supported by family members, professional helpers, and natural supports. Both assessment and clinical understanding change over time as new information emerges and the family situation evolves.

CONTRIBUTION TO THE OUTCOME: A successful intervention relies on a thorough, accurate discovery of the history, strengths, and needs of the youth, their family, and the larger community. Youth and family voices in the assessment process help ensure that the prioritization of needs is driven by the family. Arriving at understanding requires knowledge of both past experience and current functioning as well as clinically astute evaluation to determine the relevance of the information gathered. Strengths that are clearly articulated and incorporated into the assessment serve as a basis for building positive change. A quality assessment draws a picture of the family situation as a whole, describes specific clinical concerns, and evolves as the practitioner's understanding deepens. Revising the assessment over time shows a willingness to learn from experience and feedback.

REMINDER: Review all Elements. See especially: Practicing Cultural Relevance, Engagement, Risk Assessment and Safety Planning, Engaging Natural Supports and Community Resources, and Collaborative Intervention Planning. Each matrix describes the work of IHT as a practice shared between a clinician and a Therapeutic Training and Support (TT&S) staff member. Unless specifically noted as the province of the clinician only, the practices expect teamwork and refer to either or both staff members, as fits each family situation.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
First meetings and initial assessment		
• Fully informs family of the assessment process and purpose. • Elicits each individual family member's impression of core concerns, including risk and safety, in their own words. • Uses family member language in subsequent descriptions of needs and strengths. • Attends to pace and timing of information-gathering when families feel overwhelmed. • Within 24 hours, clinician completes a brief initial assessment with family input regarding needs and strengths, youth/family vision for their future, what helps, what gets in the way, and next steps to guide first stages of IHT intervention prior to comprehensive assessment.	• Discusses with some but not all key family members. • Uses only clinical language without family-friendly language. • Late or incomplete initial assessment. • Leaves out family concerns, strengths, or expressed vision for future. • Slanted toward provider view of what family "should" work on.	• No youth voice and no attempt to initiate contact or discussion. • Ignores family's concerns in favor of provider bias. • No initial assessment. • Relies solely on another provider's assessment. • Ignores or weeds out important concerns due to lack of expertise of IHT team.
Exploring needs, vision, history of help, and strengths		
• In gathering further information for comprehensive assessment, explores family members' perspectives on identified needs — what causes them, what keeps them going, what stressors make them worse. • Invites family members to describe times in the past when needs were less acute and what was different. • Invites discussion of why choose IHT at this time (why now?).	• Explores needs but not family perspective on context. • Discusses with only a subset of family members or discusses only as a group. • No follow-up to clarify how family thinks about needs; too superficial. • Too narrow a scope for what might cause problems or distress. • Looks at only limited range of possible stressors. • Looks only at general or external stressors but not intergenerational issues.	• Lacks curiosity about family. • Biased toward provider view of what causes problems; does not balance with family view. • Exaggerates or minimizes challenges that family is experiencing. • Assumes knowledge of stressors. • Discusses stressors without acknowledging coping strategies.
• Invites family members to envision and describe a time in the future when their family is able to manage these challenges more effectively. • Discusses this future-oriented vision as a way to	• Talks about discharge from IHT without linking to family vision. • Alters vision to make it more "realistic" or "achievable."	• No discussion of future or discharge. • Expresses pessimism, hopelessness about change. • Generates vision without family endorsement.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
know when IHT will end.	• Elicits vision from some but not all. • IHT generates vision and gets family endorsement.	
• Explores family member perceptions of what types of support have helped manage the needs in the past or at present when the needs are less acute. • Discusses with family members their history of professional help (types, sequence), what they have perceived as most effective, what their understanding of IHT is, and how they hope it may be delivered. • Inquires specifically about history with psychiatric medications and their impact.	• Asks only about therapeutic support (treatment) not informal supports. • Explores only what didn't work, not what did. • Overwhelms family with suggestions for support rather than eliciting their perceptions. • Discusses with family but unable to validate/manage family emotions (hopelessness, anger) about past experiences. • Partial or superficial discussion.	• Does not address past supports. • Dismisses supports that family found helpful but IHT does not see why. • Limits options for supports to what is known by IHT. • Does not consider past experience with systems and services. • Assumes services that are offered will be sufficient. • Dismisses family concerns or experiences. • Neglects medication history.
• Invites each family member to identify and describe skills, abilities, knowledge, interests, and other strengths of the youth, individual family members, and family as a whole.	• Superficial or incomplete exploration. • Inquires about strengths narrowly (talents, accomplishments) and misses likes, motivations, "things that give joy." • Identifies strengths and talents without considering their use in intervention.	• Focuses only on needs, not strengths. • Assumes strengths without discussion. • Asks only caregivers, not youth.
Filling in the contextual understanding with the family		
• Explores and gathers understanding of all of the following, including youth and family member perspectives and histories: - Structure and routines in the home - Limit-setting and discipline practices - Caregiver needs (mental health, life skills, basic needs) - Past history of trauma, losses, and other adverse experiences - History of substance use/abuse - Protective and risk factors in the community environment, and their impact - Full family configuration (custodial parents, marital status, foster parents) - Practical barriers (work schedule, child care, physical health) - Intangible barriers (distrust of mental health concepts, fear of violence in neighborhood, stigma)	• Asks questions at overwhelming pace for family. • Discusses with subset of family, not all. • Asks without persevering to understand. • Asks too vaguely rather than explicitly addressing possible adverse experiences; avoids difficult topics. • Fails to scale the degree of adverse experiences, or sees each as black and white with no gray areas. • Narrows the definition of community environment. • Limits possibilities for "family" to nuclear family or those who are easy to reach. • Limits idea of barriers to practical items only. • Identifies barriers without offering possible ways to mitigate or adjust intervention.	• Uses judgmental language; asks questions in "inquisition" style. • Uses only referral information or external reports. • Considers only current situation (no exploration of past). • Judges substance use without discussing. • Focuses on community risk; neglects community protective factors; neglects community impact. • Decides without consulting family which members to include or exclude. • Fails to establish who has legal custody of youth. • No consideration of absent family members. • No discussion of barriers. • Considers it "not the job" of IHT to problem-solve with family about barriers.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
Observation		
• Takes time to get to know the youth, observing and continuously assessing: interactions with others, impulse control, communication and cognitive abilities, sensory processing, social/emotional development, health and wellness, risk behaviors, and overall mental status. • Observes changes in youth's behavior and capacities with different caregivers and other adults. • Observes (over time) youth's strengths and how they use these strengths.	• Observes youth but only in context of family. • Assesses some but not all relevant aspects of development. • Interacts with youth only with caregivers present. • Misses opportunities to assess different capacities in different relationships.	• Accepts caregiver perspective without interacting with or observing youth. • Neglects to consider developmental age and capacities as relevant to intervention. • Looks only for deficits, not strengths.
Young adult concerns		
• Explores young adult ability to meet developmental expectations in essential areas of education, employment, housing, financial literacy, physical and mental health care, healthy social relationships, community connections, personal safety, substance use, and overall health and wellness.	• Explores some but not all aspects of young adult development and preparation for independence.	• Makes assumptions about readiness for independence. • Ignores developmental stages of transition to adulthood.
Filling in the contextual understanding with other stakeholders		
• Obtains (with consent) relevant information via live conversations whenever possible and written documents, as follows: - Assessments (including CANS) and other clinical information from current and recent treatment providers - Medical history of youth with documentation of any physical health concerns, current wellness status - School records (IEP, evaluations, report cards) and information about attendance, behavior, academic progress, and any known risk factors - State agency documents and information relevant to current risk, family history, needs and strengths • Identifies primary school support ("champion," mentor, person with most understanding) for	• Makes initial attempts but does not follow up. • Tries to do all contacts without sharing tasks with TT&S. • Postpones work of prioritizing and triaging family's immediate needs while gathering information. • Gathers some information but not thoroughly. • Accepts family's denial of consent without explaining purpose of obtaining records. • Obtains information from school without incorporating into broader assessment and recommendations. • Identifies strengths related to school but does not include in possible interventions. • Does not identify person(s) for future contact. • Has conversations without obtaining written records. • Considers only Department of Children and	• Does not consider importance of collateral conversations and documents. • Uses past clinical information or diagnosis without citing source. • No attempt at medical history. • Asks only about problems at school. • Does not recognize importance of school domain for youth. • Gets information without communicating with family about the information. • Obtains information without written consent. • No persistence in contacting collaterals.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
this youth. • Educates family, as needed, on importance of integrating behavioral and physical health. • Demonstrates persistence when response is slow.	Families, not other state agencies. • Obtains documents without reading or incorporating information into assessment.	
Contemplating the written comprehensive assessment		
• Clinician* regularly uses critical thinking and clinical judgment during the initial assessment and ongoing process of understanding the youth and family. • Clinician assesses the validity and relevance of information gathered and suspends conclusions until information is gathered from multiple sources, including CANS and other providers. • Clinician evaluates need for specialized assessments (e.g. fire-setting, neuro-psychological testing) or outside consultation. **Clinician may refer to clinical team consisting of IHT clinician and others involved in deliberation; clinician is designated as individual responsible for final plan.*	• Uses diagnosis (and other information) that came with the youth without further exploration. • Recommends specialized evaluations without explaining and assisting with access. • Aligns with one party in assessment rather than balancing all information through strong clinical filter. • Ignores differences in CANS ratings by other providers without considering rationale. • Attempts to pack all information into assessment without prioritizing the most relevant.	• Uses initial referral information without further exploration. • Gets stuck in Us/Them stance. • Jumps to conclusions without well-rounded information.
• Within 14 days, based on what is known to date, clinician compiles information into a written comprehensive assessment, inclusive of the CANS, which communicates a well-rounded understanding of youth and family. • Addresses both needs and strengths. • Addresses risk and safety. • Assesses youth's mental status. • Includes both family and professional input. • Writes in clear, respectful language that family members and others can understand. • Acknowledges areas for further exploration.	• Uses too much clinical jargon ("psycho-babble"). • Focuses on needs without exploring strengths. • Omits family's own words in descriptions. • Writes insufficient narrative. • Focuses on youth to exclusion of whole family. • Does not discuss how diagnosis impacts family functioning. • Completes CANS (or updates) in isolation, without family input. • Neglects to incorporate new information into assessment.	• No assessment. • Writes assessment as point in time without revisions or updates. • Writes assessment in ways that sound judgmental and could not be shared with family. • No initial CANS, or no updates. • Does CANS only, and considers it to be the comprehensive assessment.
• Clinician provides a clear interpretive summary and diagnostic formulation that synthesizes available evidence, explains rationale for diagnosis, gives specific information to support rationale, and addresses differences from other diagnoses (if any).	• Does some of these steps, but not all, or does all the steps but without sufficient clarity, explanation, or depth. • Summarizes information without synthesizing and interpreting.	• Presents the assessment as "final" to family without prior review by supervisor. • Unfamiliar with changes in DSM-V.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
• Clinician makes recommendations for treatment with corresponding support for proposed level of care. • Clinician reviews assessment with supervisor for consultation with TT&S as needed.	• Assumes TT&S is knowledgeable about diagnosis.	
• Clinician engages in two-way conversation about the assessment with family in family-friendly language, shares both strengths and needs, discusses any areas of disagreement, revises as needed, and ensures consensus with family members about completed assessment. • Clinician discusses specific diagnosis with family, explains basis for diagnosis, and offers further information as needed. • Clinician documents discussion; obtains signatures.	• Focuses on needs or strengths with family, but not both. • Shares assessment but does not share recommendations. • Shares assessment but without inviting family input or possibility of revisions. • Presents diagnosis as definitive.	• Does not share assessment with family. • Discourages family input into "expert" document. • Uses language that family does not understand. • No discussion of diagnosis with family.
Ongoing evolution of assessment		
• Clinician reviews and updates the assessment (including CANS) at least every 90 days. • Discusses at each meeting with family members any changes which may affect understanding. • Clinician continues to incorporate new information, amending assessment as needed. • Clinician considers diagnostic accuracy in light of new information. • Clinician reviews all changes to the assessment with family, explains reasoning, and discusses any impact that changes may have on diagnosis, treatment options, or expected end of treatment.	• Updates sections that were previously addressed, but does not explore areas where information was incomplete. • Updates rating changes on CANS without narrative explanation. • Reassesses diagnosis without family input. • Updates family but does not elicit input from family members. • Rushes through discussions without fully exploring. • Discusses intermittently or with only some of the key family members.	• Neglects updates or fails to share changes with family. • Excludes family members who speak another language. • No updates.

CORE ELEMENT:
RISK ASSESSMENT & SAFETY PLANNING

Risk Assessment and Safety Planning consist of anticipating and preventing risks to a youth's and family's well-being. Safety plans developed with families help them use their current capacities to resolve potential dangers. Safety plans also offer a range of external supports to intervene when preventive measures cannot avert a crisis. Input from all relevant partners results in a single, unified plan to address the assessed risks and to promote effective collaboration in urgent situations.

CONTRIBUTION TO THE OUTCOME: Youth and family safety is basic for any successful intervention. Effective safety planning takes account of both risk and protective factors, demonstrating a commitment to finding signs of safety in the family, home, and community. A risk and safety plan that uses the family's own resources and past successes shows commitment to building on strengths. In order to remain sustainable after treatment ends, safety planning relies on family members and natural supports as first safety responders. It backs up their efforts with progressively more intensive supports for emergent situations. Good safety plans are clear and understood by all participants in the plan.

REMINDER: Review all Elements. See especially: Engagement, Assessment and Clinical Understanding, Care Coordination and Collaboration, and Engaging Natural Supports and Community Resources. Each matrix describes the work of IHT as a practice shared between a clinician and a Therapeutic Training and Support (TT&S) staff member. Unless specifically noted as the province of the clinician only, the practices expect teamwork and refer to either or both staff members, as fits each family situation.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
First meetings and initial assessment		
• In first meetings, as part of initial assessment, observes family member interactions and invites each family member (as appropriate to situation) to describe any immediate safety concerns of identified youth, risk to other family members in the home (including homes of separated caregivers), or risk of property damage. • Explores concerns regarding both self-harm and harm to others. • Observes conditions in home and assesses for risk and safety (child-proofing, weapons, pets, fire hazards).	• Addresses safety with some family members but not all. • Asks about known safety issues without observing or probing for other potential risks. • Minimizes level of risk. • Considers safety only in primary household but not household(s) of other primary caregivers. • Considers only risks related to youth self-harm without broader context of risks in family. • Identifies risks without evaluating importance of each.	• Makes plan without family input. • Composes plan in clinical jargon. • Uses generic template for plan. • Fails to assess risk, discuss safety issues, or make plan.
• Adjusts safety planning as appropriate to role as hub or working with ICC as the lead. • Discusses with family members any previous written (or visual) plan for safety, including plans with other parenting adults when separated. • Reviews existing plans (if any) with family members and discusses any adjustments needed. • Elicits external input from other collaterals (school, community programs, providers). • Obtains copies of any existing safety plans. • Ensures that family has one consistent plan across providers and other supports.	• For IHT as hub: Develops risk assessment and safety plan without leading process among stakeholders. • For IHT working with ICC: Develops risk assessment and safety plan without consulting the Care Plan Team. • Reviews plans without considering changes. • Reviews other plans in isolation from team members. • Communicates with formal supports only, not appropriate natural supports. • Communicates with subset of team. • Requests copies but no follow-through. • Obtains copies but fails to integrate.	• Assumes plan is in place without verifying. • No awareness or inquiry about other plans. • Assumes plan is someone else's responsibility. • Neglects to share plan. • Uses generic template for plan. • Makes plan without external input.
Evaluating full range of risk and safety concerns		
• Discusses with family members (individually as needed) any risk/safety issues of youth in school, other community situations, and on social media. • Explores with youth individually (when	• Focuses on some but not all elements of risk. • Focuses only on primary community without considering youth splitting time between communities. • Talks with youth only in group with caregivers.	• Ignores community and social media risks. • Avoids asking child about safety with caregivers. • Considers only caregiver point of view. • Assumes family has no strategies in place.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
appropriate) any safety concerns in youth's environments (at home, in the community, on social media). • Considers carefully the distinctions between self-harm and suicidality. • With family members, identifies things they experience as cues/triggers to a crisis at home or in community locations and what they already do to safeguard youth and others in times of emergent crisis. • Gathers information about safety precautions/ actions in school and other community locations.	• Discusses only superficially what the family experiences as crisis. • Minimally assesses current practices; does not consider effectiveness of current practices. • Does not crosswalk existing strategies to all types of risk and different environments. • Considers only the risks that family knows how to deal with. • Responds to all risks of self-harm with same urgency without distinguishing possible different causes. • Minimizes risk identified by family or doesn't challenge when family minimizes risk.	• Dictates strategies to family.
Developing a usable plan for prevention and intervention		
• Discusses with family how a written or visual plan can enhance prevention of crisis, support their currently available responses, and manage provider participation in crisis situations. • Considers the need for different types of plans for different types of risk (suicide, youth arrest, parental medical emergency). • Revisits discussion of making a written (or visual) plan if family declines at first.	• Discusses superficially or passively accepts family's reluctance without persisting in discussion. • Does not document discussion in which family declined safety plan. • Accepts initial decision to decline without revisiting. • Considers planning only for youth behavioral health risk.	• Dictates that family is required to write a plan. • No discussion of benefits of a plan.
• Explores with family members what specific youth and family strengths can be used to prevent crisis and how those strengths will be used in the moment. • Explores informal supports that may be available to help prevent or de-escalate a critical incident, if needed, and develops specific actions that can be taken by each.	• Explores with only some family members or only with youth. • Skims over strengths and prevention methods without clarifying specific actions to take. • Discusses superficially or with only some family members. • Uses "informal supports" terminology without explaining to family what that means. • Identifies supports but not action steps.	• Fails to address strengths that can help in a potential crisis. • Dictates what to do. • Includes only emergency numbers (Mobile Crisis Intervention [MCI], 911) without any strategies for de-escalating. • No consideration of informal supports. • Assumes knowledge of supports (or assumes lack of knowledge). • Ignores family member concerns about a specific "natural support."
• Provides system education on the spectrum of emergency services, including different levels and types of response. • Provides contacts for IHT provider, after-hours number, and mobile crisis team.	• Describes only benefits of each level of support without discussing possible negative impact. • Defines crisis levels without fully considering the family's own definitions. • Assigns rigid thresholds for each response type.	• Provides only MCI or 911 contacts.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
• Discusses with family when to use different levels of support and possible outcomes of each choice. • Helps caregivers develop language to use for different levels of response.		
• Within 7 days of initial meeting, collaborates with family on developing or revising a written or visual safety plan. • Always includes initial steps that have been successful in the past that family can take to prevent crisis before calling for help. • Verifies with family that they can actually take all identified steps. • Always includes emergency contact information. • Provides copies to family members. • Revisits safety plan regularly.	• Writes plan that is too complex to follow. • Writes plan that is understandable only to some family members. • Considers only crisis situations without attending to prevention. • Uses template rather than individual plan. • Writes plan that lacks specificity about what to do, by whom, when.	• Lists contacts but without phone numbers. • No written plan. • Includes behaviors or coping mechanisms that are unsafe or present increased risk; does not discuss or explore alternatives with family.
Sharing and reviewing the plan		
• Promptly shares safety plan documents with other providers and supports who share responsibility for safety of family. • Shares plan (as appropriate) with local MCI team. • Verifies that supports listed in plan are able and willing to carry out identified steps. • Promptly communicates any proposed amendments or new concerns to all other stakeholders. • Regularly reviews and discusses plan among IHT team, family, natural and formal supports. • Always revisits safety plan after a critical incident.	• Shares only with subset of involved stakeholders. • Shares only initial plan and not revisions. • Dictates to family how to share plan. • Shares plan without reviewing for understanding and for ability to perform tasks. • Amends plan but communicates only with subset of the collaterals who need to know. • Informs others of changes but not in timely manner.	• No sharing, or not prompt in sharing. • Shares more information about risk than family agreed to. • No communication about critical incidents.

CORE ELEMENT:
COLLABORATIVE INTERVENTION PLANNING

Collaborative Intervention Planning is a nuanced developmental process that follows from the picture of youth and family that emerges during assessment. The plan starts with the family's vision for a positive future. Working from a shared understanding of youth and family hopes, needs, and strengths, the IHT team joins with family members to develop a plan of intervention that prioritizes needs, sets measurable goals and objectives, identifies the interventions most likely to succeed, and specifies who is responsible for each piece of the work. Collaborative intervention planning takes into account the family's circumstances, culture, and readiness to participate; plans evolve with ongoing assessment of progress. Collaborative intervention planning follows the same process whether IHT is the hub or the youth also has Intensive Care Coordination; in the former case, the IHT team takes the lead role for intervention planning, and in the latter the ICC team leads the process.

CONTRIBUTION TO THE OUTCOME: Partnering with families in selecting priority needs, treatment goals, and interventions shows commitment to the CBHI value of family-driven service. Customized planning varies for each family. For all families, intervention planning must be clearly based on the clinical understanding generated in the assessment and on treatment goals that are measurable, observable, and doable. The family and provider use the identified strengths of the youth, family, and community to build specific actions into the plan that apply strengths to meet needs. Because the desired outcome of care is improved functioning across the domains of the youth's life, IHT may focus on therapeutic interventions that enhance problem-solving, limit-setting, risk management/safety planning, communication, skills to strengthen the family, and productive ways to use community resources. Selecting research-informed interventions demonstrates commitment to continuous learning.

NOTE: All practices below are expected of IHT. When IHT is the hub, the IHT team takes the lead role in intervention planning. When the youth also has ICC, the IHT team joins and supports the ICC process. These differences are noted in the appropriate rows.

REMINDER: Review all Elements. See especially: Practicing Cultural Relevance, Assessment and Clinical Understanding, Care Coordination and Collaboration, Engaging Natural Supports and Community Resources, and Preparing to Exit. Each matrix describes the work of IHT as a practice shared between a clinician and a Therapeutic Training and Support (TT&S) staff member. Unless specifically noted as the province of the clinician only, the practices expect teamwork and refer to either or both staff members, as fits each family situation.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
Context for intervention plan		
• Discusses the purpose and process of intervention planning with youth and family members. • Revisits family vision statement(s) to inform planning. • Engages in discussion of possibilities for TT&S role specific to each family situation. • Clarifies roles of clinician and TT&S (who will do what) as planning proceeds. • Reviews with family members the specific types of information to share with each collateral, and written consent for each. • Obtains consent of youth over 18. • Addresses confidentiality within family and clarifies limits regarding "family secrets."	• Jumps into planning without fully discussing process with family. • Includes only a subset of family. • Excludes non-custodial parent. • Uses vision of only one subset of family. • Discusses TT&S and clinician roles only at intake without revisiting. • Provides boilerplate definition of roles without individualizing for family needs. • Obtains consent without discussing what can be shared with whom. • Shares within family without discussing limits of confidentiality among family members or handling of "family secrets."	• Inaccurate or non-existent explanation of intervention planning. • Dictates vision to family. • Focuses only on problems. • Does not offer team option. • Excludes TT&S provider in engagement process. • Always or never holds sessions together with TT&S, without clinical rationale. • Coerces sharing of information. • Shares information indiscriminately (after consent). • Shares without consent.
• **When youth has ICC:** Explains role of IHT in relation to Intensive Care Coordination and wraparound process. • Joins the Care Plan Team (CPT) with family and reviews family vision statement(s) developed in CPT.	• Jumps into planning without fully discussing role of IHT in relation to ICC. • Creates new vision with family separately from vision created in CPT.	• Inaccurate or non-existent explanation of treatment planning. • No consideration of vision statement from CPT.
Prioritizing needs		
• Based on needs identified in Assessment, explores with youth and family the needs to prioritize in initial intervention plan. • Links interventions to prioritized needs from assessment to ensure presence of "golden thread" in documentation. • Incorporates insights from comprehensive assessment, including other individuals working	• Intervention plan too long, too many goals. Needs not prioritized. • Includes only subset of family; focuses only on youth needs, not other family members. • Explores readiness to change with some family members but not all. • Struggles to ask questions about good times while also validating family's intense	• Prioritizes needs without family agreement. Insists on priorities set by external parties (Court, Department of Children & Families). • Sets goals without adequate assessment. • No evidence of eliciting "good" times.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
with family. • Elicits examples of times when prioritized needs were less acute and what helped to manage the need. ("Was there ever a time in the past when this problem was less than it is now? What was different then that helped?") • Makes specific efforts to engage young adults in exploring future-oriented needs, goals, and priorities in the context of turning 18.	concentration on current "bad" times. • Identifies times when need was managed but no discussion of what helped. • Misses opportunities to validate family changes.	
• **When youth has ICC:** Reviews with youth and family the needs for which the CPT has referred them to IHT. • Incorporates insights from CPT comprehensive assessment in the discussion.	• Intervention plan exceeds agreed-upon purpose from CPT without communication with CPT. • Prioritized needs not aligned with CPT.	• Prioritizes needs without family or CPT agreement. • No communication with CPT.
Using strengths in intervention plan		
• Works with family to continue to elicit strengths of youth and family members individually and as a family group. • Describes where each strength appears and which parts of each strength are notable (taking directions, working as part of a team, practicing empathy, thinking ahead). • Explores with youth and family members how these may be transferrable skills that can be used to achieve goals. • Links strengths to the times when problems have been less intense ("exceptions" to patterns of difficulties).	• Bases strengths on CANS ratings only. • Does not persist in identifying strengths when family has difficulty doing so. • Itemizes strengths without analyzing further or assessing usefulness in intervention planning. • Focuses too heavily on either strengths or problems without recognizing the tension between them. • Documents strengths but does not discuss with family.	• No identification of strengths. • Asks only caregiver, not youth (or vice versa). • Asks only about youth strengths, not family strengths. • No consideration of strengths in intervention planning.
• **When youth has ICC:** Works with family to continue to elicit strengths of youth and family members individually, and family as a group, incorporating insights from CPT comprehensive assessment.	• Bases strengths on CANS ratings only. • Identifies strengths without communicating with CPT.	• No identification of strengths. • No communication with CPT.
Setting goals		
• Works collaboratively with youth and family to develop an overall goal for each priority need and related SMART objectives — Specific, Measurable, Achievable, Realistic, Time-bound	• Confuses goals and objectives. • Confuses goals with interventions, or includes goals for provider ("Refer to outpatient therapy").	• Equates a goal with a service. • Assumes or imposes provider's goals. • Goals and objectives not individualized to the specific youth and family.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
— for each goal. • Prioritizes goals with family to ensure that too many simultaneous goals do not overwhlem family or clinical team.	• Objectives too vague, or lacking one or more components of SMART. • Discussion is superficial or too limited in family input. • Too many goals attempted at once.	
Needs and strengths in context of existing treatment		
• Reviews and discusses any existing treatment/ service/action/intervention plans from collateral sources. • Consults with medication provider to ensure that medication management is incorporated into broader treatment and coping strategies. • Acknowledges differences among plans, and facilitates discussions to make use of meaningful tensions among perspectives. • Establishes a single, coherent set of goals with family and collateral input. • Revisits differences periodically with family and collaterals.	• Collaterals have too much or too little involvement in establishing goals. • Talks separately with family and other stakeholders without facilitating communication among them. • Discusses differences during initial planning, but neglects to revisit over time. • Makes effort to contact all collaterals even if not 100% successful; may not know pathways, may not be persistent. • Medication not well integrated into overall intervention plan.	• Collaterals set agenda for goals. • No consideration of collateral views. • No explanation to family of purpose of a particular recommendation or intervention. • Minimal or no effort to contact relevant collaterals. • No consideration of medication.
• **When youth has ICC:** Reviews and discusses IHT intervention plan and ICC Care Plan with ICC to ensure that IHT intervention aligns with CPT's overall treatment goals. • Brings any differences to the CPT for discussion.	• Establishes plan separately from CPT without communicating with them. • Discusses differences during initial planning, but neglects to revisit over time.	• No consideration of CPT planning. • Does not collaborate in implementing CPT plan. • Does not attend CPT meetings.
Considering treatment options		
• Brainstorms options for intervention with family members and other stakeholders as needed, including non-traditional and creative strategies. • Clinician* uses best clinical judgment from all sources (supervisor, TT&S, colleagues, past treatment), combined with youth's and family's prior experiences with treatment, to match potential intervention options to needs and strengths. • Clinician explores use of evidence-based practices as options. • Clinician considers options for supporting services (TM, Family Partner) to enhance intervention.	• Demonstrates developing knowledge of Evidence Based Practices (EBPs) but not confident in using; aware of gaps in knowledge. • Plans interventions that are too general; not clear about what the intervention is. • Intervention not well matched to full range of needs. • No face-to-face meetings to discuss intervention planning. • TT&S not included in planning. • Insufficient family voice in intervention planning. • Insufficient use of hub-dependent services or other creative strategies. • Unclear plan for assessing sufficient progress on each goal.	• Plans intervention without input. • Uses "one size fits all" approach. • No discussion of when to end intervention.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
• Clinician* explores non-traditional and creative strategies for intervention. • Clinician ensures that intervention strategies are developmentally appropriate for youth. • Clinician explains rationale for suggestions to family members and decides on intervention options collaboratively with youth and family. • Clinician decides with family on initial dosage and duration for each intervention, including discussion of progress indicators that will indicate completion. **Clinician may refer to clinical team consisting of IHT clinician and others involved in deliberation; clinician is designated as individual responsible for final plan.*		
Measures		
• Discusses with family members how youth and caregivers will know if intervention is "working" to improve youth's wellness and reduce family distress. • Reaches consensus with youth and family on clear, observable measures of change for each objective. • Actively addresses any conflicting perspectives among family and/or collaterals. • Discusses with collaterals the relevant indicators of change. • Measures change in both increasing strengths and decreasing problems. • Discusses with family members and stake-holders that priority needs and strengths will likely change over time. • Plans check-ins on progress with family and collaterals. • Discusses indicators of readiness to exit service. • Revisits discussion frequently.	• Includes every measure without synthesizing. • Looks only at decreasing problems, not increasing strengths. • Looks only at youth, not family as a whole. • Unclear discussion of end point for IHT service. • Does not reconcile differences among family members and/or among collaterals. • Uses only one person's indicators. • Indicators too general, not measurable. • Revisits priority needs and strengths only at required 90-day intervals. • Superficial check-in without depth or persistence. • Assumes that family will see progress without measures. • Checks in with subset of family or collaterals but not all.	• No discussion of measures with family or with collaterals. • No discussion of when progress is sufficient to end service. • Ignores family or collateral input. • Imposes own agenda of what is acceptable or not. • Avoids conflict when family members and/or collaterals don't agree. • Intervention plan "set in stone" with no plan to change or update.
• **When youth has ICC:** Discusses with CPT the indicators of change that will show whether IHT intervention is effective. • Includes discharge vision of family in discussion.	• Looks only at decreasing problems, not increasing strengths. • Looks only at youth, not family as a whole.	• No discussion with CPT. • Does not attend CPT meetings.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
Creating a comprehensive plan		
• Within 14 days of first meeting with family, clinician drafts intervention plan detailing above information, incorporating the family's words in the document. • Specifies responsibilities of clinician and TT&S. • Shares draft plan with youth and family, in youth's and family's preferred language(s), and ensures that it is understood by all. • Invites feedback and allows for adaptation in discussion with family. • Obtains signature(s) of youth/caregiver(s). • Provides copies of plan. • Shares plan with all other providers, collaterals, and natural supports involved with intervention actions and ensures understanding with each.	• Writes plan without documenting efforts to include family members and collaterals in planning. • No documentation of legitimate delays in treatment plan completion. • Uses language that is overly clinical, or not in preferred family language, or not incorporating family's descriptions or words. • Reviews with only a subset of family. • TT&S not included in process. • Discusses without providing copies. • Provides copies without discussing. • Shares only with subset of team.	• No Intervention plan within required time. • No family input in plan. • No review of plan with family members; no opportunity to adapt. • Written plan shared without ensuring that family can read and understand it. • Signatures obtained late or not at all. • TT&S deliberately excluded from process. • TT&S and clinician disagree on plan and take "sides" with family members. • Shares with external parties before discussing with family. • Shares without consent.
Adapting to changes		
• Specifically adapts to changes and plans for transition needs of youth and family (changes in residence, school, or family composition; transition to adulthood) throughout intervention and as situations arise. • Anticipates barriers and assists in developing strategies to overcome.	• Recognizes and plans for some transitions but not all.	• No attention to transitions. • Intervention remains "fixed" despite changes.
• Processes with family members any staff changes in IHT team; reviews plan with new staff. • Reviews plan with any new collateral providers/supports whenever providers or other team members change.	• Superficial review only, even when major staff changes occur.	• No transition meeting when IHT clinician or TT&S changes.
• Reviews intervention plan with youth, family, and collaterals at minimum every 90 days and whenever significant changes occur. • Continually reassesses intervention options as family situation or information changes. • Clinician maintains clear documentation of eachchange to plan and shares changes with all involved.	• Reviews at 90-day intervals but insufficiently to address changes. • Reviews with only a subset of family or team. • Acknowledges changes but does not consider other intervention options. • Makes adjustments only at required 90-day intervals. • Shares changes verbally but does not document.	• No reviews or updates. • No family or team input. • Avoids conflicts about or changes to plan. • No discussion of family vision and progress toward discharge planning. • Interventions not linked to goals, so progress checks are meaningless. • Blames family for lack of progress ("resistant client") when intervention stumbles.
• **When youth has ICC:** Processes with entire CPT all changes, including transitions, staff changes, and treatment adjustments.	• Processes only with subset of CPT.	• No discussion with CPT. • Does not attend CPT meetings.

CORE ELEMENT:
INTENSIVE THERAPEUTIC INTERVENTION

The heart of in-home therapy is the **Intensive Therapeutic Intervention** that enhances both the well-being of the youth and the capacity of caregivers to provide a safe and supportive environment for the youth and family. The therapeutic intervention consists of the strategies and actions most likely to promote healing, strength, and lasting change. High-quality interventions make every meeting count with specific purposes for each session, plans for conducting sessions, a clear correlation between the session plan and treatment plan goals, and actions to practice between sessions. They use strengths in real and tangible ways to address needs. Family reports of both improvements and setbacks directly inform next steps, as do collateral perspectives and direct observation by the IHT team. Therapeutic intervention is a live process of discovering what works with a specific youth and family in their own context.

CONTRIBUTION TO THE OUTCOME: Intensive therapeutic intervention serves the overall purpose of in-home therapy: to enhance the family's capacity to understand its own and the youth's needs and to make changes that promote healthy functioning. Interventions embody CBHI's values of child-centered and family-driven services when they respond to the priorities of the youth and family, and are developed in partnership with families. Effective interventions build on the strengths of the family and its community; they are responsive to the family's values, beliefs, and norms, and to socioeconomic and cultural context. By integrating services across agencies and programs, interventions support collaboration. Both the IHT practitioners and the system as a whole strive to improve continuously as interventions unfold and adapt.

NOTE: This is the heart of the work. Review each matrix as it applies to the Intensive Therapeutic Intervention implementation.

REMINDER: Each matrix describes the work of IHT as a practice shared between a clinician and a Therapeutic Training and Support (TT&S) staff member. Unless specifically noted as the province of the clinician only, the practices expect teamwork and refer to either or both staff members, as fits each family situation. Each element refers to interventions that should be considered, as appropriate, for families. The inclusive nature of the elements does not mean every item will apply to every family.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
Grounding the intervention in the family vision		
• Reviews comprehensive assessment, treatment plan, and roles of TT&S practitioner and IHT clinician with family members, as appropriate. • Reviews youth and family vision(s) for the future and purpose of intervention (move toward vision, change what gets in the way) with the family. • Frames intervention based on goals and specific, measurable, positive, behavioral objectives. • Throughout intervention, considers contradications for each treatment option. • Collaborates throughout intervention with "hub-dependent" services (TM, Family Partner) to ensure teamwork in intervention.	• Uses vision statement in provider's language, not family's. • Intervention strategies not matched fully to intervention plan. • Strategies framed as "stop doing" rather than positive change. • Strategies not realistic for family situation. • No role clarification between clinician and TT&S. • Minimizes or limits role of TT&S. • TT&S and clinician team meet only sporadically. • Team meets with TT&S but does not fully collaborate with other supporting services.	• No complete assessment or treatment plan. • Plans interventions without reference to assessment, treatment plan, and family vision. • Uses same interventions without regard to family differences (cookie cutter approach). • Clinician and TT&S roles not applied. • No team approach considered. • Strategies not aligned with IHT level of care. • Intervention not related to medical necessity. • Automatically refers to TM or Family Partner without rationale. • Fails to include "hub-dependent" services in teamwork.
Clarifying the diagnosis		
• Assists family in seeking out resources related to the youth's symptoms and diagnosis to support family's understanding of youth's condition. • Describes interventions as episodes of care for a particular condition; expresses expectations that the condition will improve and that youth (and family) will experience healthier functioning.	• "Does for" families without teaching/modeling for families how to seek their own resources. • Shares diagnosis information with caregivers but not youth (when age-appropriate). • Limits options for treatment with family. • Lacks flexibility in adapting to family needs. • Communicates hopelessness about possibilities for a healthier future.	• No consideration of other resources. • Provides inaccurate information about diagnosis or symptoms. • Makes judgments about diagnosis or symptoms.
Developing a therapeutic alliance		
• Develops and maintains a therapeutic alliance by listening, acknowledging, and validating youth and family feelings, perspectives, and values, with non-judgmental curiosity ("appreciative inquiry"). • Communicates empathy to build relationship.	• Over-identifies with one family member over others. • Struggles to find real empathy towards family. • Sees setbacks as "back to square one" or as family not trying. • Expresses frustration with family behavior.	• Confuses therapeutic alliance with "befriending" family members. • Takes sides with some against others in family. • Fails to work with Department of Children and Families or other caregivers/guardians.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
• States out loud throughout intervention that everyone is doing the best they can under difficult circumstances. • Attributes positive motives to actions that could be seen as problematic (parent keeps "working to achieve sobriety" vs. parent keeps "relapsing"). • Exercises "unconditional positive regard" for family members.	• Does not validate youth and family strengths. • Accepts caregivers' withholding of validation for youth strengths.	• Focuses only on negatives. • Expects all families to respond to stress or crisis the same way. • Jumps to conclusions without exploring underlying motives.
• Balances understanding of problems with empathy and exploration of strengths ("How have you managed to keep going through so many stresses?"); identifies strengths (persistence, commitment) that may be foundation for the work.	• Explores one family member's strengths but not others'. • Recognizes strengths but doesn't tie back to goals and intervention. • Over-identifies with strengths without acknowledging problems. • Lists interests as strengths.	• Discusses stressors without exploring strengths. • Allows "venting" about problems without considering past successes and strengths. • No acknowledgment of what family has been through.
Implementing the collaborative intervention plan		
• Based on assessment and intervention plan, continuously considers strategies to meet needs; considers both evidence-based practices and practice-based evidence to guide intervention approach. • Fits evidence-based practice (EBP) elements to a particular youth and family in an individualized manner when appropriate.	• Incomplete hypothesis about youth's and family's needs. • Trained in EBPs but applies them without sufficient individualizing or flexibility. • Relies on EBPs without considering evidence from own experience (what works, what doesn't in a given situation).	• No hypothesis to guide treatment adaptations. • Applies EBP in rigid or formulaic way without acknowledging family differences (forcing family into EBP frame). • No consideration of any other approach. • Refuses to adapt EBP to IHT setting.
• Articulates the reasoning behind the chosen approach to treatment and reaches understanding with family about interventions. • Explains approach to supervisor and other systems and supports working with the family.	• Develops interventions but unable to articulate to family or provider team. • Has overall plan but unable to "connect the dots" between activities and plan. • Has plan but does not document steps, activities, progress as plan proceeds.	• No attempt to articulate. • No guiding approach. • Uses approach without regard to feedback.
Approaches to discussing problems with family		
• Describes problems/concerns in the youth's and family's words and in the context of family's experience. • Supports family members in separating problems from their identity ("I feel hopeless" vs. "I am hopeless").	• Does not effectively separate problem from identity. • Uses clinical terms rather than family language. • Acknowledges problem but not how it relates to context.	• Tells family members that they are the problem. • Fails to see the family context and experience of problems. • Ignores family language and team determines problems.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
• Offers plausible reframes of problems as "patterns of interaction" which impede or promote healthy functioning ("vicious cycles" or "virtuous cycles"). Recognizes interactions outside of the pattern of problematic cycles. • Asks questions that elicit exceptions to the problem (when things are going well). • Discusses with family the specific competencies and practices that make these exceptions occur. • Uses consistent, positive reframing to amplify and sustain exceptions.	• Accepts patterns of interaction as they are. • Reframes with family but unable to reframe with team members. • Misses some patterns of behavior that perpetuate unhealthy functioning. • Recognizes successes but does not examine competencies (how this was accomplished). • Does not fully credit family role in successful interactions. • Notices successes but does not relate back to family progress.	• Blames family for problems. • Aligns with negative view of family. • Ignores patterns of behavior. • No recognition of successes or strengths. • Claims one success as mastery of skill. • No recognition of family role in success (all about the clinical team).
Planning family sessions		
• Brings to each treatment session a plan and rationale for the work to be done in that session, including both clinician and TT&S work. • Helps family to understand structure of each session and to focus on therapeutic tasks.	• Plan not adequately processed with family at start or as therapy proceeds. • Plan for session not balanced with current events and issues in family. • Plan for ongoing work gets lost in immediate concerns. • Therapeutic tasks based on clinician's strengths and comfort level.	• No planned therapeutic activity, just check-in at meetings with family. • Does not modify session plan according to family needs. • Tasks in session not related to intervention approach. • Activities are the same at every session, regardless of progress. • TT&S not included in planning.
Teamwork between clinician, TT&S, family members		
• Clinician* guides TT&S in applying useful support activities, such as practicing skills, enhancing communication, exploring natural support possibilities, connecting with community resources, and addressing logistical barriers as consistent with treatment plan. **Clinician may refer to clinical team consisting of IHT clinician and others involved in deliberation; clinician is designated as individual responsible for final plan.*	• TT&S works with youth (or other family member) in isolation from family. • TT&S role defined by their own strengths rather than by family need. • TT&S and clinician roles not delineated. • Clinician assigns tasks to TT&S without collaborative planning. • TT&S is assigned "case management" role without working with family.	• No plan for TT&S activities. • TT&S activities not included in treatment plan. • TT&S relegated to primarily concrete supports (transportation, child care).
• Applies understanding of stages of change and adapts interventions to fit different readiness levels among family members. • Artfully plans intervention to begin with key family members who are open to change.	• Does not recognize an opening for therapy when change occurs. • Tries to persuade family members of where they "should" be in readiness. • Team plans based on its own preferences and comfort level. • Engages only with family members who are "safe" or appear more motivated.	• Fails to start where family is; pushes agenda regardless of readiness. • Fails to assess whether family is ready for IHT. • Works on "engagement" without recognizing that family is not engaged in goals. • Avoids working with reluctant family members.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
Choices for therapeutic interactions		
• Explores with the family their communication patterns with each other. • Tries, models, and practices alternate communication tactics to enhance connectedness and reduce negativity and blame. • Evaluates with family.	• Clinician focuses on incendiary content of communication at expense of seeing communication pattern. • Identifies ineffective patterns but doesn't help family to try different patterns. • Clinician prescribes how people "should" communicate or attempts skills that are too ambitious for current situation.	• No recognition of cultural differences in communication. • Assigns values to communication styles.
• Explores the roles of each family member (including those not present in home) in the family constellation and in the intervention, the relative influence of different family members, and how the patterns of interaction among them may enhance or obstruct their family vision. • Explicitly discusses changes in roles and relationships that occur as youth reach maturity and legal adulthood. • Helps family to enact new patterns of interaction through modeling and practice.	• Works with subset of family without considering full grouping. • Discusses influence and interactions without offering alternatives or assisting family to change balance of influence. • Does not assist family in sustaining changes.	• Allies with one family member over others; allows "splitting" among family members along lines of influence. • Reinforces ineffective interaction patterns.
• Explores with family the ways family members express attachment and empathy. • Provides and practices attunement and attachment activities.	• No awareness of how own feelings influence behaviors with family. • Fails to reframe behaviors in a way that supports attachment. • Misses signs of attachment. • Discusses attachment without developmentally appropriate interventions to enhance attachment. • Addresses attachment without preparing to deal with feelings of loss.	• Intervention exacerbates conflict in destructive way. • No acknowledgement of signs of attachment.
• Provides education to the family about the developmental expectations for youth within social, emotional, cognitive, behavioral, and physical domains.	• Considers and discusses some but not all elements. • Thinks through developmental expectations but does not share them with family. • Uses jargon that may be unknown to family.	• Assumes family knowledge of typical development. • Judgmental about youth not meeting "typical" milestones; uses "should" language. • No consideration of cultural differences that might influence expectations.
Planning for transitions		
• Throughout intervention, anticipates transitions of all kinds (maturational, planned and un planned, situational) and adjusts intervention to	• Attends to some but not all transitions. • Closes IHT services before significant transitions without planning with family to	• No attention to transitions.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
respond to changes in home, school, developmental stage, family life, and community connections.	handle the impending changes.	
Parenting typical children and exceptional children		
• Assists caregivers in strengthening overall parenting practices, such as positive discipline, effective communication, and healthy routines, as appropriate to age and developmental stages. • Works with caregivers to develop and practice adaptive parenting strategies to best care for and support this specific youth's temperament, experiences, and behavioral health conditions. • Makes direct observations of family in their natural environment and uses "teachable moments" to model suggested effective practices.	• Uses "standard" approaches, based on diagnosis or other category, without adapting to family situation. • Accepts ineffective or potentially harmful discipline without exploring alternatives. • No exploration of past successes in teaching youth. • Suggests changes in discipline without explaining rationale. • Allows youth to be "excused" from essential limits due to "special needs." • Suggests parenting practices without observing current parental behavior.	• Judges current practices as "right" or "wrong" (stated or implied). • No acknowledgement of positive discipline. • No consideration of cultural differences (volume of voice, family roles). • Expects all youth to have same response to discipline strategies. • Joins with caregivers in limiting possibilities of growth for youth.
Safety as part of intervention		
• Observes and discusses family member perception of risk both at home and in community settings, including school. • Seeks to learn about interactions in both family and community settings that are associated with unsafe behavior by the youth. • Processes safety issues with family and community members in context of intervention. • Practices Safety Plan interventions. • After a crisis, processes how risk and safety were handled.	• Deals with some but not all steps. • Struggles to address risk with youth and to support parents in confronting this issue with youth. • Addresses risk only with subset of family. • Validates youth or caregiver concerns about risk without bringing them together. • Misses interactions which may "provoke" unsafe behavior. • Involves family but not relevant community resources. • Limited use of community capacity to intervene in high-risk situations. • No consideration of transferring success in home to other situations out of home (and vice versa).	• No processing of risk. • No practice with Safety Plan. • Joins with one family member to blame others. • Dictates risk based on own values. • Dismisses family concerns about risk. • Attributes risky behavior to another ("Mom sets him off," "Teacher dislikes her.") • Discusses with community members but not with family.
More choices for therapeutic interactions as intervention unfolds		
• Works with youth, individually and in the family group, to develop and practice coping skills that enhance functioning (anger management, physical and emotional regulation, problem solving, effective communication).	• Teaches skills without practicing or modeling. • Over-emphasizes caregiver role in managing emotions without requiring/teaching self-regulation to youth.	• Works only with youth. • No consideration of learning styles, capacity, or current successful practices. • Blames parents for problems of youth.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
• Uses assessment data, open communication with youth and family, and clear clinical judgment to guide decision-making about who should do trauma work, when, and where. • Provides education about trauma and loss reminders, post-traumatic stress reactions, "rage and loss" reactions, and grief reactions, and their impact on development. • Develops interventions that recognize rage, loss, grief, and other trauma reactions. • Practices with family members trauma-informed responses to stress reactions.	• Uses jargon that family members may not understand. • Provides education but not appropriate interventions. • Applies some but not all of the ideal measures.	• Assumes that IHT is the treatment of choice for the family's trauma. • Assumes that trauma work is "not my job." • Ignores trauma history. • Exaggerates traumatic events to fit clinician bias toward trauma treatment.
• Addresses substance use by youth or parents in a process of ongoing assessment and explores influence on family functioning. Addresses substance abuse impact on functioning with family members. • Refers to services for recovery from substance abuse/addictions.	• Identifies substance use and automatically refers out to specialty service. • Intervenes only when asked or when family members are ready to address. • Addresses substance use only when unsafe or severely damaging. • Makes referrals without necessary follow-up.	• Ignores substance use/abuse. • Identifies but does nothing.
• Addresses illegal activities (gang involvement, prostitution, drug dealing) by youth or parents and explores influence on family functioning. Addresses impact on functioning with family members. • Refers to appropriate specialty services.	• Makes referrals without knowing whether specialty is right fit or without necessary follow-up. • Addresses only with subset of family.	• Ignores signs of illegal activity. • No assessment of safety for family members when activity is identified. • Reports family to authorities without informing/addressing with family. • Enables continued illegal activity by neither addressing with family nor reporting known activity.
Mastering new skills		
• Throughout intervention, provides opportunities for youth and caregivers to experience mastery and confidence in using new skills. • Gives family members specific tasks to practice and monitor between family therapy sessions. • Discusses at each session with family members their responses to assigned tasks. • Explores barriers and expresses family's response as feedback about the intervention (not "resistance"), which may call for adjustments. • Throughout intervention, uses data on measurable objectives to clarify progress.	• Describes skill without creating opportunities for practice. • Assigns tasks without checking in on family use and responses. • Mistakes lack of progress for "resistance." • Sticks to same tasks without adapting to family and to progress. • Neglects measurable data and verifying information from external sources.	• Assigns tasks that family lacks the resources (time, money) to accomplish. • No acknowledgement of family progress. • Never assigns tasks between sessions.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
• Works with family members to expect inevitable setbacks; brainstorms possible helpful responses. • Practices helpful responses to setbacks prior to end of treatment. • Assists family and youth in connecting with resources that can help them sustain gains in times of setback.	• Anticipates setbacks without validating with family that setbacks are a normal part of change process. • Teaches coping skills without sufficient practice. • No adjustment to intervention after setback. • Planning started too late in intervention to allow time for practice.	• No planning for setbacks. • Blames family for setback. • No supports established to help after IHT.
Respectful communication		
• Throughout course of treatment, maintains professionalism and intentionally models effective communication between clinician and TT&S, especially around areas of conflict.	• Inconsistent modeling of effective communication. • Models teamwork in front of families but allows conflict to dominate at other times.	• Team argues together in front of family. • Fails to communicate between sessions. • Aligns family against other team members. • Indulges in emotional, defensive, or blaming responses.
• Respects each family member's confidentiality with each other, even when not governed by law. • Reinforces healthy boundaries among family members.	• Values confidentiality of one family member over another. • Realizes some information needs to be shared but does not encourage disclosure by family member. • Doesn't identify what needs to be shared and what does not.	• No discussion of confidentiality among family members.

CORE ELEMENT:
CARE COORDINATION & COLLABORATION

Care Coordination and Collaboration engages family members, treatment providers, community resources, and natural supports as a cohesive group with shared goals for working with a youth and family. Care coordination includes forming and meeting face-to-face with a treatment team, developing teamwork among participants, sharing relevant information on a regular basis, planning together, measuring treatment progress together, and working collaboratively to add, change, or end services. Care coordination and collaboration follows the same process whether IHT is the hub or the youth also has Intensive Care Coordination; in the former case, the IHT team takes the lead role for care coordination; in the latter, the ICC team leads the process with IHT as an active participant.

CONTRIBUTION TO THE OUTCOME: The foundation for child-centered, family-driven treatment is a team that *always* includes family. Collaborative care strives to join all stakeholders in a youth's life to ensure effective work across domains. Different perspectives on a team create opportunities to find and use strengths. Consistent collaboration between the IHT team and the range of natural supports and service providers working with the family results in cohesive efforts to achieve desired outcomes, foster the family's community connectedness, and promote sustainability of treatment gains. Ideal communication takes a variety of forms that are organized, timely, culturally responsive, and inclusive.

NOTE: All practices below are expected of IHT. When IHT is the hub, the IHT team takes the lead role in care coordination. When youth has ICC, the IHT team joins and supports the ICC process. These differences are noted in the appropriate rows.

REMINDER: Review all Elements. See especially: Collaborative Intervention Planning, Intensive Therapeutic Intervention, and Preparing to Exit. Each matrix describes the work of IHT as a practice shared between a clinician and a Therapeutic Training and Support (TT&S) staff member. Unless specifically noted as the province of the clinician only, the practices expect teamwork and refer to either or both staff members, as fits each family situation.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
Context for intervention plan		
• Discusses with family the importance of developing an ecological perspective of youth's needs and possible locations of intervention in context of family, school, and community. • Reviews with family the purposes of care coordination, role of IHT in coordinating care, and option for Intensive Care Coordination (ICC). • As needed, refers for ICC and functions as interim hub until ICC begins. • Plans transition to ICC with maximum continuity and fewest repeat experiences possible; holds joint meeting with ICC, IHT, and family. • Communicates any change in hub to referral source.	• Provides unclear or overwhelming explanation of ICC or IHT care coordination. • Refers for ICC, but does not facilitate smooth transition. • Neglects care coordination while ICC referral is in process. • Does not notify referral source about referral for ICC.	• Does not offer or explain ICC. • Does not explain IHT role in care coordination as hub. • Declines to make referral, or discourages use of ICC, even when family requests it.
• <u>When youth has ICC:</u> Assesses with family/ referral source whether IHT is the best option for care coordination. • Discusses with family the purposes of care coordination and role of IHT as part of the Care Plan Team (CPT).	• Provides unclear or overwhelming explanation of ICC or IHT care coordination. • Explains roles as silos without discussing how they will coordinate.	• No explanation of care coordination. Non-existent or negative communication about ICC.
Forming a team		
• Explores with family members the idea of a larger "Team" of stakeholders to work together with IHT. • Ensures that youth and family know that Team membership can change over time. • Explores with family members whom to include on Team and whether there are important "missing" members (medication prescriber,	• Discusses idea of Team but gives up if family is disinclined. • Sets rigid standards for developing Team (who should be on it, how often it should meet) rather than individualizing for family. • Focuses on relationship titles (Guidance Counselor, Aunt) rather than stakeholder's function in youth's and family's life.	• Decides unilaterally on Team members. • No consideration of natural supports. • Does not consider Team meetings to be part of IHT. • Accepts family preferences without question, even when important stakeholders are left out. • Expects family to configure Team and keep

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
school personnel, youth peer support, Department of Children and Families social worker, non-custodial parent, caregiver therapist, natural supports). • Explores possible "virtual" Team members (not able to attend in person), including technology for virtual meetings, written or recorded contributions by absent members, etc. • Fully explores with family the decision to leave out a particular stakeholder, including consequences of decision. • Reconsiders Team membership regularly and changes as needed.	• Assesses membership at start but does not revisit over time. • Limits participants to formal supports. • Explores only superficially, without probing for valuable relationships or natural supports. • Accepts a family's decision about exclusion of a particular person without discussing consequences.	IHT updated. • Considers Team to be family and IHT only.
• **When youth has ICC:** Supports ICC in exploring with family members whether there are any new participants to invite to the CPT and in revisiting CPT membership regularly.	• Accepts CPT membership without exploring options to include or exclude members.	• Decides unilaterally on inviting CPT members. • Does not consider CPT membership discussions to be part of IHT. • Fails to collaborate with ICC.
Initial meeting for care coordination		
• Plans with family members to meet face-to-face with proposed Team at least once near start of IHT to develop clear, shared understanding of communication plan, priority needs, and proposed intervention. • Invites Team members to meet, per plan made with family, to discuss complexity and the need for coordination; documents Team formation efforts. • Prepares Team participants for meeting format and topics to discuss.	• Plans superficially or too concretely without clearly developing the purpose. • Invites only subset of proposed members. • Minimal or no follow-up to encourage attendance. • Does not adequately prepare Team for participation.	• No evidence of Team planning. • No preparation of family for Team meeting. • No preparation of Team members. • Allows difficult topics to come up as "surprises" to family.
• **When youth has ICC:** Joins existing Care Plan Team at the first meeting after IHT starts, attends all meetings, and collaborates per expectations of the CPT.	• Inconsistent attendance or participation.	• Does not attend CPT meetings or attends but does not share. • Fails to collaborate with ICC.
Coordination with medication prescriber		
• Attends specifically and persistently to including medication prescriber in care coordination, including prescriber at 24-hour level of care (LOC) placements. • Makes diligent outreach efforts (email, tele-	• Makes attempts to contact prescriber but without persistence. • Checks in with prescriber for initial assessment but neglects further communication. • Leaves contacting prescribers up to caregivers	• No contact with prescriber. • No effective communication at assessment and/or throughout intervention. • Misinformation about medications. • No discussion with family about medication

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
phone, in person) to contact prescriber during both initial assessment and intervention planning, to include prescriber perspective in written documents, and to provide prescriber with information relevant to role of medication in context of intervention. • Invites prescriber to all face-to-face Team meetings. • Includes prescriber in regular Team updates between meetings. • Establishes a communication plan (preferably written) with prescriber to monitor medication (benefits, compliance, side effects, changes). • Gathers input from prescriber at minimum before each Team meeting and intervention plan update. • Accesses consulting psychiatrist for second opinion as needed.	without discussing the importance of integrating medication into the overall intervention. • No invitation to Team meetings; assumes that prescriber won't attend meetings. • Insufficient attention to medication benefits and concerns. • Fails to obtain second opinion on medication questions.	as part of intervention. • Medication monitoring not considered part of Team discussion.
Team participation		
• Facilitates Team discussion to establish shared understanding of intervention and to maintain strengths-based, solution-focused stance. • At initial Team meeting, collaborates with family members to share family vision, strengths and needs, initial treatment plan, proposed roles of each Team participant, and current safety plan. • Invites input from Team members at each step. • Actively facilitates inclusive participation among Team members. • Addresses and resolves conflicts among Team members, both in the moment and with any needed follow-up.	• Uneven facilitation skills (too rigid, too lenient, off-topic, not everyone is heard). • Recognizes conflict on Team but does not resolve. • Ends meeting without a time frame for future meetings. • Allows Team to dwell on problems only. • Elicits input from only a subset of Team.	• Holds meeting without family. • Allows some Team members to dominate so not everyone is heard. • No agenda. • Avoids conflict, or discusses only later with other Team members. • Speaks for the family. • "Tells" the Team rather than discussing mutually.
• **When youth has ICC:** Collaborates with family members to share proposed IHT intervention plan and invite input from CPT.	• Reports IHT intervention plan without allowing CPT input.	• Presents IHT plan at CPT without preparing family for discussion. • Fails to collaborate with ICC.
Ongoing coordination with Team		
• Explores with family how they prefer to communicate (frequency, medium) with IHT between sessions and with other Team	• Communicates according to pattern set by IHT without individualizing. • Agrees on verbal plan but no written	• No discussion or plan for communication. • Minimal or no communication. • Overcommunication, more than "need to know"

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
stakeholders between face-to-face meetings. • Communicates weekly with all Team members based on family preferences. • Agrees on communication plan with Team, including both meetings and ongoing contact. • Models effective, collaborative communication between IHT clinician and TT&S practitioner. • Communicates all urgent developments promptly (preferably within 24 hours) to relevant Team members.	communication plan. • Communicates inconsistently, infrequently, or with only a subset of Team. • Tries to maintain communication but gives up when no response to first attempts. • TT&S and clinician communicate partially, inconsistently, or superficially. • Waits for regularly scheduled communication to update, even in urgent matters. • Leaves communication about crisis up to MCI rather than contacting Team.	• Non-existent or negative communication between TT&S practitioner and IHT clinician.
• **<u>When youth has ICC:</u>** Maintains regular communication with all Team members according to communication plan made with family and CPT. • Communicates all urgent developments between meetings promptly to relevant CPT members.	• Communicates inconsistently, infrequently, or with only a subset of CPT. • Waits for regularly scheduled CPT to update, even in urgent matters.	• No communication between scheduled meetings. • Leaves all communication up to ICC. • Fails to collaborate with ICC.
• Engages Team members (including family) in reporting on progress toward measurable treatment goals at 90-day intervals, and when significant changes occur. • Ensures that progress towards building strengths is part of each discussion. • Considers other service options/ transitions in consultation with Team members.	• Inconsistent progress reports, or only with subset of Team. • Not enough measurable progress indicators. • No balance of discussion between strengths and needs. • Does not reconcile different perspectives. • Lack of organization, haphazardness in communications.	• Allows other Team members to overpower family voices. • Allows Team members to dictate next steps. • No measurable objectives.
• **<u>When youth has ICC:</u>** Joins CPT members in reporting on progress toward measurable treatment goals at 90-day intervals, and when significant changes occur.	• Inconsistent progress reports, or only with subset of CPT.	• No participation in CPT progress discussions. • Fails to collaborate with ICC.
Mobile Crisis and other emergency care coordination		
• Communicates proactively with Mobile Crisis Intervention (MCI) provider whenever youth is at risk of needing emergency intervention. • Shares Safety Plan and Advanced Communication. Follows up with MCI after intervention. • Communicates immediately with any 24-hour LOC where youth is placed in crisis and	• Shares intervention information at start but does not update MCI regarding possible crises. Communicates with MCI only after crisis. • Talks with MCI but does not include other Team members. • No discussion with Team about potential use of MCI and when to call. • Responds to crisis without sufficient urgency	• No prior communication or follow-up to crisis. • No discussion of MCI with Team. • No additional communication or actions following out-of-home placement.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
continues with daily communication during stay. • Attends discharge meeting from 24-hour LOC.	regarding timeliness, additional family time, communication with Team.	
Team meetings to assess changes		
• Meets face-to-face with the Team to evaluate efficacy of services at approximately 90-day intervals to ensure effective collaboration and resolution of differences. • Convenes Team meeting when IHT clinician or TT&S changes. • Convenes additional meetings when family circumstances change significantly (including emergency placement out of home), when intervention is "stuck," or when providers change. • Re-evaluates need for ICC when youth and family situation changes (new state agency involvement, Special Education change, added treatment providers).	• Waits too long to meet with Team. • Holds meetings but with superficial discussion of intervention. • Ineffective facilitation hampers consensus about adjusting to changes. • Relies primarily on phone or email; minimal face-to-face meetings. • Considers ICC only at beginning of service. • Not sure of different roles of ICC and IHT. • No mention that Family Support and Training (FS&T) can continue when either IHT or ICC ends.	• No face-to-face meetings. • Minimizes/ignores when intervention is "stuck" or blames on others. • Closes IHT when "stuck" without consulting Team. • No transition meeting when providers change. • Dictates level of care coordination needed. • Makes referral to ICC without telling family. • No mention of FS&T role with either service.
• **When youth has ICC:** Participates in all CPT meetings. Requests additional CPT meetings when family circumstances change significantly.	• Rushes discharge without full CPT agreement. • Superficial plan for next steps without considering options with CPT. • Plans next steps with subset of CPT only.	• Rushes discharge based on conflict with CPT. • No plan for supports after transition. • Does not attend CPT meeting for end of services.
• Holds face-to-face meeting as end of IHT approaches to review intervention and decide collaboratively with family members on next steps. • Meets (at least virtually) even if family terminates abruptly. • When family ends treatment in unplanned manner, debrief with all team members to discuss reason(s) and what can be learned from the experience. • Assembles relevant Team members for "warm hand-off" to new providers at close of IHT service, as needed/ according to family wishes.	• Rushes discharge without full Team agreement. • Discusses discharge only at end of service, not throughout. • Superficial planning for next steps without considering full range of options. • Plans next steps with subset only. • Develops transition plan but shares only with subset of Team. • Holds only virtual meeting at end of service. • Superficial discussion of unplanned ending without focusing on learning opportunity.	• Rushes discharge based on false claims of limits on services. • Does not request additional authorization even when warranted. • No plan for supports after discharge. • No transition meeting. • No discharge planning. • No plan for hub-dependent services when hub ends. • No discussion of unplanned ending.
• **When youth has ICC:** Joins CPT discussions as end of IHT intervention approaches to review progress and decide collaboratively with CPT on next steps, continuity of care, and service transitions, if any. • Assures space at CPT for "warm hand-off" to new providers at close of IHT service, as needed and according to family wishes.	• Rushes discharge without full CPT agreement. • Superficial plan for next steps without considering options with CPT. • Plans next steps with subset of CPT only.	• Rushes discharge based on conflict with CPT. • No plan for supports after transition. • Does not attend CPT meeting for end of services.

CORE ELEMENT:
ENGAGING NATURAL SUPPORTS & COMMUNITY RESOURCES

Engaging Natural Supports and Community Resources is the process of discovering and connecting with the enduring supports in a family's environment who celebrate with the family in good times, comfort them through difficult times, contribute to a sense of belonging, and may provide tangible assistance. They may be extended family, friends, faith community, neighbors, mentors at school or work, or acquaintances who play a small but critical, encouraging role in a family's life. Engaging community resources offers opportunities for family members to join in volunteer, play, learning, worship, and social activities that build resiliency. Informal resources are the naturally occurring, healthy forces that carry families beyond the reach of formal services.

CONTRIBUTION TO THE OUTCOME: Natural supports and community resources — or informal supports — focus on building and maintaining family, friends, and community connections. These connections can help to carry out interventions and sustain improved functioning after the IHT service ends. Informal supports that are included in teamwork, treatment planning, and ongoing collaboration strengthen healthy community bonds. Engaging informal supports, guided by the cultural context of each family, demonstrates shared hope in the youth's and family's ability to resolve treatment needs and move toward a positive future.

REMINDER: Review all matrices. See especially: Practicing Cultural Relevance, Engagement, Collaborative Intervention Planning, and Preparing to Exit. Each matrix describes the work of IHT as a practice shared between a clinician and a Therapeutic Training and Support (TT&S) staff member. Unless specifically noted as the province of the clinician only, the practices expect teamwork and refer to either or both staff members, as fits each family situation.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
Existing network of natural supports		
• Explores with family members the sources of support in their extended family, friends, and community (includes eco-mapping). • Discusses with family members the meaning of "natural supports" (neighbors, friends, partner/spouse, faith community, support groups, co-workers) and types of support (emotional, practical, social). • Uses creativity in discovering unique social support networks that may be overlooked. • Consistently attends to possibilities for building connections among natural supports and community resources that can continue after IHT intervention ends. • Attends to changing emphasis in youth's preferred supports from family to peer groups and adapts natural supports accordingly. • Respects cultural taboos about sharing personal struggles with kin and others.	• Explores at point in time but not ongoing, or not in sufficient depth. • Asks about natural supports without ensuring that family understands meaning. • Explores with subset of family only. • Limits concept of natural supports to one or a few categories or roles, not full range of possibilities. • Limits discussion to local geographic area. Lists supports without exploring status of relationship with family. • Pressures family about informal supports in ways that are out of step with family readiness or cultural norms. • Considers supports for caregivers without exploring youth supports separately.	• No evidence of discussion. • No explanation of natural supports. • Makes assumptions about presence of natural supports. • Gives directives about who "should" be a support.
Family preferences about natural supports		
• Discusses with family members how their natural supports might be included in intervention in a culturally respectful manner. • Explores the type and extent of involvement that these supports could contribute (respite care, phone support, occasional shared activity, good ideas). • Discusses family preferences about what information can/can't be shared with each potential supporting person. • Assesses with family members their readiness to bring natural supports into the intervention and proceeds at family's pace.	• Lists supports without thinking through and discussing how they might be useful. • Accepts the current level of contribution without exploring other possibilities. • Explores supports without understanding family's readiness to engage with each. • Discusses supports without talking with family about barriers to engaging the supports. • Obtains consents but does not follow up with action.	• Makes assumptions about whether supports are helpful or not. • Directs family in how to use supports. • Overrides family concerns and preferences about using a natural support. • No plan to engage natural supports. • No contact with natural supports. • Contacts without consent.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
New and renewed natural supports		
• Empathizes and validates by listening to family concerns about barriers before moving to solutions. Uses creative ways of exploring with family, discovering, and refreshing natural supports when family feels that they have none due to isolation, conflict, or "burnout." • Discusses with family members possibilities for reciprocal support.	• Empathizes about barriers but without any planning for overcoming them. • Expects family to reconnect without IHT's help. • Unable to develop creative ways to reconnect with "burned out" supports. • Uses cookie cutter approach without any creative, individualized effort.	• No conversation about natural supports. • Accepts family hopelessness about supports without further exploration. • Identifies with burned-out supports, blames or shames family.
Including natural supports in intervention		
• Collaboratively creates an action plan to engage natural supports, including who will contact and follow up with each. • Invites participation of natural supports in intervention, according to clear plan with family about extent of participation and communication. • Includes natural supports in face-to-face and/or "virtual" Team meetings and other ongoing communications, as planned with family.	• Plan for engagement or participation not fully developed. • Minimal involvement of family in making a plan to engage natural supports. • Engages only a subset of supports. • Inconsistent efforts to invite participation. • Inconsistent communication with natural supports. • Discusses only at one point in time or only with a subset of family.	• Invites supports without family permission. • Overrides family voices by directing participation, ignoring family ideas, or arguing over their choices. • Engages in conversations with natural supports without family knowledge.
Exploring network of community resources		
• Explores with family members the community resources (Boys & Girls Club, lessons, parent support groups, food pantries) that might match strengths and needs. • Discusses resources already in use as well as new possibilities. • Joins with family in researching potential additional community resources. • Supports family in following through on contacting resources.	• Shares generic resources without customizing to family needs. • Limited knowledge of available resources. • Limited effort to learn about and share resources. • Provides superficial information (brochures, phone number) without follow-up. • Insufficient consideration of possible barriers (transportation, cost, language). • Overloads family members with too many resource suggestions.	• No discussion of community resources. • Signs up youth or family without their permission or knowledge. • Pressures family into using a resource. • Refuses to assist family with community resources ("not my job") or neglects because it is too hard. • Provides misinformation about resources. • No effort to overcome barriers.
• Assists family members in joining community activities, as needed (helping with enrollment, orienting to new activities, working to overcome barriers). • Follows up with family to see if resource is meeting goal.	• Provides information to families but expects them to join without help. • Offers some assistance but not all, or without consultation about what they need. • No follow-up over time to see if resource is matching expectations and goals.	• No follow-up to see if family members accessed resources. • No assessment of need for help with a resource.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
Adapting community resources to specific youth		
• Along with family, discusses in a mutually respectful "two-way" conversation with community resources how to adapt programming to support youth with behavioral health needs (learning style, behaviors). • Practices with family ways of transferring successful interactions from other settings (day care center, after-school program, sports teams) to the home environment. • Engages in similar process with natural supports (extended family, neighbors).	• Approaches community resource or natural support as "the expert" in dealing with a youth rather than as a collaborating partner. • Discusses strategies without including family. • Makes suggestions without considering what is possible for the supporting helpers.	• Shares willy-nilly. • No planning ahead with family about how to approach the conversation. • Joins with a program in expelling a child. • Joins with community resource or natural support in blaming youth or family for problems. • Joins with youth or family in blaming resource or support for youth's misbehavior.

CORE ELEMENT:
PREPARING TO EXIT

Preparing to Exit from IHT begins with the family vision for a preferred future and flows through all stages of the intervention. With regular checks on progress, the IHT team and family move together toward the family vision. Specific actions, as the family approaches the planned discharge date, include validating youth and family progress, planning for setbacks and sustainability, and learning about family member experience of the service. Unplanned exits, or a severe increase in youth needs, require efforts to ease difficult transitions, re-engage family members, and learn what we can in order to prevent abrupt discharges in the future.

CONTRIBUTION TO THE OUTCOME: Planning for exit from the point of intake emphasizes the hope that changes will endure over time with less professional intervention. Planning attends proactively to safety, community connections, changes in life circumstances, and other variables that may affect the end of treatment and after-care planning. Careful collaboration is essential to guide when and how to complete an episode of care. Ending treatment may be cause for celebration of a family's strength in improving their situation. Unplanned exits are an opportunity to learn about how practitioners, collaborating partners, and the system of care can better support positive outcomes.

REMINDER: Review all Elements. See especially: Assessment and Clinical Understanding, Collaborative Intervention Planning, Intensive Therapeutic Intervention, and Care Coordination and Collaboration. Each matrix describes the work of IHT as a practice shared between a clinician and a Therapeutic Training and Support (TT&S) staff member. Unless specifically noted as the province of the clinician only, the practices expect teamwork and refer to either or both staff members, as fits each family situation.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
Preparing from the start		
• Reviews with family members the family vision for healthier functioning in the future and how IHT intervention can help. • Builds consensus among family members on how they will measure progress. • Explains to family and all collaterals that continuation of service depends on family choice and medical necessity criteria (not on a pre-determined time limit). • Plans for exit throughout, from the first meeting.	• Plans for termination without linking to family vision. • Discusses termination without actual transition planning or ongoing processing. • Establishes goals for ending but without plan to track progress. • Shows confusion about "readiness" — for example, goals achieved but no exploration of family confidence to function without IHT. • Does not explain to the managed care entity (MCE) why child meets the medical necessity criteria (MNC). • Assumes other stakeholders understand MNC.	• Dictates vision or goals. • Avoids discussion with youth and family of ending until end is close. • Tells family or other stakeholders that IHT is "**short-term**" or other arbitrary length. • Allows other stakeholders to dictate length of treatment, overriding family voice. • Does not explain MNC.
Monitoring progress and setbacks		
• Continually monitors perceptions of progress and setbacks from perspectives of all family members and formal/informal supports. • Reviews progress on strengths and needs in CANS and other clinical tools. • Keeps data on the selected measures (days of school missed, number of tantrums) to support impressions. • Addresses different perceptions to reach consensus on readiness to end intervention. • Uses setbacks and moments of crisis as opportunities to learn and plan for a future with less intensive supports.	• Includes only a subset of family or provider perceptions. • Has measurable objectives but does not track relevant data. • Attends to achievements without acknowledging setbacks or continued concerns. • Ignores learning opportunities in setbacks and crises. • Uses limited set of data indicators (CANS only). • Checks in but without resolving conflicting perceptions among family and other Team members.	• No discussion of progress. • Uses only IHT perceptions of progress. • No progress measures. • Allows one voice to dominate all other input. • No evidence of checking with team. • Decides unilaterally that family is ready for discharge.
Supports after IHT		
• Identifies as early as appropriate the community resources and less intensive clinical services (outpatient) likely to sustain healthy functioning during and after IHT. • Facilitates appropriate connections to both formal and community resources.	• Makes referrals without follow-up. • Dominates referral process without engaging family in making self-referrals. • Considers only formal services for after-care. • Uses cookie cutter plan without individualizing to family.	• No identification of resources to continue after IHT. • Pressures family to use a certain resource. • Makes referrals without knowledge and consent of family.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
Transition to adulthood		
• Attends to unique challenges of transition-age youth, especially those leaving foster care or group care, who will be living independently after discharge.	• Plans for mental health needs without attending to young adult aspirational goals. • Makes referrals without follow up. • Considers young adult needs without consulting or considering parenting adults. • Addresses some but not all challenges of independent living.	• No planning for young adult moving to independence. • Assumes young adult wants to leave Department of Children & Families, parents, other supports. • Ignores parents as resource. • Ignores or fails to assess youth's practical skills for independence.
Exiting IHT to more intensive services		
• Considers new challenges that may require more intensive services (with or without continuing IHT). • Develops clear assessment of adjustment needs. • Holds face-to-face meetings with full Team of family and stakeholders to address new needs and unresolved conflicting perceptions about ending intervention. • When unable to reach consensus, makes interim plan with Team to monitor each disagreement with specific measures of acceptable and unacceptable occurrences of the event that is causing disagreement and to revisit within a specified time frame.	• Adds more services without assessment of need, rather than adapting IHT intervention. • Monitors challenges inconsistently. • Has no clear plan for addressing any identified setbacks. • Communicates individually with team but never holds face-to-face meeting. • Aligns with a particular team member to the exclusion of other points of view. • Holds meeting without preparing family. • Concludes Team meeting with unresolved next steps.	• No acknowledgement of setbacks. • No flexibility in adapting IHT and adjusting service mix. • Discusses setbacks only with collaterals, not family. • Advocates for a service that is not accessible to family. • Ignores differing opinions and makes decision on own. • No family input. • Purposely leaves out "difficult" Team members.
Planning for exit to less intensive services		
• Anticipates challenges after discharge and develops with family a post-transition crisis plan to address potential risks, coping skills for reducing risk, behaviors that precede crisis, and specific steps for family members to respond effectively to risks (avert crisis, manage crisis).	• Praises successes without discussing likelihood of setbacks as normal part of growth. • Plan addresses some but not all risks. • Plan relies on access to formal supports rather than family resources.	• No plan for setbacks after discharge from IHT. • Plan gives emergency contacts only.
• Prepares for planned discharge by gradually meeting less frequently, reviewing internalized skills, and ensuring that family members can coordinate care. • Facilitates a "pre-meeting" with family to prepare for presenting what the family hopes to accomplish by ending IHT (or making other changes in services). • Processes loss of IHT support and changes in support network with family. • Establishes connections with any new services prior to ending IHT.	• Discusses discharge with only a subset of family. • Superficial review of accomplishments without full comprehension of the work. • Acknowledges only family loss, no reciprocity. • Insufficient attention to solidifying gains as part of clinical process. • Ends without stepping down frequency of visits. • Opens discussion with family only when there are positive outcomes, not other types of ending. • Referrals made, but not early enough to allow time for a transition meeting.	• No evidence of family voice in transition phase. • No effort to solidify gains. • Family left holding the bag — for example, has phone numbers but no support or guidance to self-refer. • No recognition of access barriers. • No communication with other providers and supports. • Talks about referrals without making them. • Badmouths other services or waitlists.

IDEAL PRACTICE	DEVELOPMENTAL PRACTICE	UNACCEPTABLE PRACTICE
• Assists in addressing access barriers. • Participates in face-to-face "warm hand-off" transition meeting with family members and new providers; shares clinical documents. • Addresses any family reluctance to ending service and develops response to anything that might prevent ending. • Plans with family a final "graduation" celebration to conclude intervention as planned and validate successes. • When transition meeting is not possible, shares clinical documents, discusses wait lists with family, advocates for priority access when appropriate, and coaches family on follow-up actions.	• Referrals made without follow-up or without problem-solving family barriers to using them. • Discharge summary shared with some but not all relevant collaterals. • No face-to-face meeting (but other kinds of communication). • Makes insufficient plan to bridge gaps in service (when new service not yet available). • Empathizes with family reluctance to end service but has no plan to address. • Plans celebration without taking family wishes into account.	• Does not consider family concerns about preparing to exit. • No final meeting. • Invites participants without consulting with family.
Closing summary		
• **Clinician*** develops and shares with family members a discharge summary that includes family vision, review of needs and strengths, goals, progress, current medications, challenges, next steps for sustaining gains or continuing treatment, and contact information for all formal and informal supports. • Uses language of hope and possibility in discharge summary. • Explicitly states signs of resiliency. • Elicits family input on their experience of IHT. **Clinician may refer to clinical team consisting of IHT clinician and others involved in deliberation; clinician is designated as individual responsible for final plan.*	• Covers only some but not all areas. • Minimal or superficial treatment of important topics or contacts. • Summary developed but not shared with family. • Does not seek input from family on their experience of the service. • Discharge summary completed after discharge. • Includes generic next steps, not unique to family.	• No discharge summary. • No family input. • Focuses on remaining problems rather than accomplishments.
Unplanned exits		
• When IHT ends in unplanned manner (insurance interruptions, child removal from home, "firing" of IHT team, family displacement), makes diligent efforts to contact family for resolution prior to closing services. • Communicates with other Team members, and works with hub-dependent providers to find a way forward. • Reviews with team whether there were warning signs or missed opportunities that could have prevented premature ending.	• Minimal follow-up (phone message or letter only). • Minimizes IHT role in unplanned discharge.	• Contacts Team members even if consent withdrawn. • No effort at follow-up. • No communication with hub-dependent providers. • Blames family for abrupt ending.

IN-HOME THERAPY PRACTICE PROFILE
APPENDIX: LITERATURE REVIEW

CORE ELEMENTS
Each practice profile matrix substantially aligns with the evidence, and the literature related to IHT highlights certain practice skills, theories and areas of emerging research.

Practicing Cultural Relevance
Overviews of the practice skills related to cultural relevance[1] can be found in several reference books, and certain selected chapters discuss the application of cultural relevance specifically to in-home therapy. Recent literature highlights the point that understanding unique cultural vulnerabilities and resilience across cultures and contexts is important to helping diverse families and refugee children and families. There are cultural and contextual differences related to resilience in children[2], and differing parental beliefs about children's mental health needs and treatment.[3] Engaging and serving Hispanic and African American adolescents and families call for culturally specific interventions and strategies.[4] Consider the specific needs of adolescents with behavior problems when they have experienced immigration-related separations.[5]

Activities in even one early session can have positive results (engagement, therapeutic alliance, activation) in bridging the gap between the family's culturally influenced perspectives of their child's behavioral and emotional responses and the perspectives of the clinician (cultural competence).[6] Occasional examples of how practice has been culturally adapted are provided in the literature to illustrate practical applications (engagement, interviewing skills, and new approaches to parenting and family relationships).[7] It is helpful for clinicians to have self-awareness and to reflect on their perceptions of privilege and oppression as it may affect the power differential between the clinician and client.[8]

Engagement
The engagement[9] process and the specific practice skills that are essential to in-home therapy are described in selected chapters of reference books. There is a period of critical timing and focus for engaging families. Families are better engaged and retained when their service providers focus the content of their earliest contacts in a way that is responsive to a sense of urgency and priorities (as identified by the family), specifically assisting them with initial problem-solving.[10] Barriers to engagement include transference issues, such as a family's past disappointments and negative experiences with treatment as well as other family circumstances such as stress and supports.[11] Good engagement moves beyond the blaming of parents (attributing a lack of family commitment to treatment) and empowers parents to understand and accept their child's diagnosis, and actively to join the treatment team.[12]

Specific IHT engagement skills (strategizing widely on whom to engage and involve in treatment, active listening, empathic responding, tracking and utilizing client language, recognizing and joining the family's interaction patterns, accepting and validating, using strengths-based language,

---

1 *Overview of cultural relevance (Hepworth, Rooney, Strom-Gottfried, Larsen, 2013, chapters 8, 10); related to serving young children (Cornett, 2014, chapter 18)*
2 *Cultural and contextual resilience (Unger, 2005)*
3 *Ethnic differences in parental beliefs about ADHD and treatment (Pham, Carlson, Kosciulek, 2010)*
4 *Culturally specific interventions and strategies (Bains, 2014; Santisteban, Mena, Abalo, 2012; Robbins, Szapocznik, Dillon, Turner, Mitrani, Feaster, 2008; Liddle, Jackson-Gilfort, Marvel, 2006; Santisteban and Mena, 2009)*
5 *Immigration-related separations (Mitriani Sanisteban, Muir, 2004)*
6 *Culturally enhanced video feedback aids engagement and therapeutic alliance (Yasui and Henry, 2014)*
7 *An example of an EBT Parent Child Interaction Therapy (PCIT) culturally adapted to support American Indian and Alaska Native families (Bigfoot and Funderburk, 2011)*
8 *Privilege and oppression related to clinician/ client power differential (Hays, Chang, Dean, 2004)*
9 *Overview of engagement (Hepworth, Rooney, Strom-Gottfried, Larsen, 2013, chapter 5; Fraser, Grove, Lee, Greene, Solovey, 2014, chapter 3; Cornett, 2014, chapter 1))*
10 *The critical timing and problem-solving (McKay, Nudelman, McCadam, Gonzales, 1996; McKay et.al, 2004))*
11 *Transference, family stress, social supports as potential barriers to engagement (Dadds and McHugh, 1992; Kazden and Wassell, 2000; McKay, Pennington, McCadam, 2001)*
12 *Beyond blame (Kelleher, 2015)*

adjusting to the family's response, framing) are embedded in systems theory.[13] Some of the engagement skills, such as joining, are different when providing treatment in the family's home, rather than in a clinic or office setting.[14] Good results have been associated with a strong therapeutic alliance. Strong therapeutic alliance with the client (mother, father, adolescent) related to lower distress symptoms.[15] Data reveals patterns of certain case characteristics and early terminations from treatment[16] and helps distinguish between logistical and perceptual barriers[17]; this may be useful in helping agencies address their areas needing attention for engagement. Engaging foster parents in home-based services is important to developing young children's relationship capacities and supporting them in foster care.[18]

Assessment and Clinical Understanding

Assessment[19] as a process of seeking sufficient information to guide the IHT provider's treatment decisions is summarized in selected chapters of reference books. The literature identifies the importance of considering various streams of information, which can be drawn from the child's and family's history as well as observations of the treatment team, information yielded from screening and standardized tools, and most importantly from details of current circumstances as described by the child and the family.

When assessing a child who is not emotionally or behaviorally self-regulated, consider trauma and survival circuits.[20] Children's behaviors and capacities change depending on who is present and on the nature of their relationship with their caregiver. Assessing families includes relationship assessments (what happens when they face problems) and an assessment of caregivers' needs and strengths.[21] Using tools such as genograms and eco-maps can be more family-friendly, while increasing the quality of information that might be used for assessment.[22]

While tools such as genograms and ecomaps are good conceptual tools, there is a wide range of valuable standardized instruments that can also be useful screening tools and assessment tools. Good interviewing and selective use of tools help the clinician to seek sufficient information and organize information to fulfill the purpose of assessment: formulation. For example, the CANS enlarges the scope of inquiry, a foundation of information from which to proceed to collaborative intervention planning.

Risk Assessment and Safety Planning

Risk assessment and safety planning[23] in IHT is consistent with the mental health literature, and goes beyond the most common focus on suicide risk to include a wider range of emergent situations and potential dangers such as youth arrest and parental medical emergency. The steps and actions are drawn from the tools and training[24] of Kappy Madenwald.[25] Additional Massachusetts Department of Mental Health tools[26], published online, appear to have been developed for the purposes of reducing restraints and seclusions for sub-acute and inpatient settings; these are of high quality and may be useful for adaptation for community-based work in IHT as well. It is important for clinicians to consider the distinctions between self-harm and suicidality, particularly in crisis planning.[27]

---

13 *Systems theory and engaging (Fraser, Grove, Lee, Greene, Solovey, 2014)*

14 *Joining and other skills differ in practice setting (Stinchfield, 2004)*

15 *Good results with strong therapeutic alliances (Johnson, Wright, Ketring, 2002)*

16 *Early terminations data (Gopalan et. al., 2010; Larsen-Rife and Brooks, 2009)*

17 *Logistical and perceived barriers to engagement (McKay and Bannon, 2004)*

18 *Importance of engaging foster parents (Cornett, 2014, chapter 20)*

19 *Overview of assessment (Hepworth, Rooney, Strom-Gottfried, Larsen, 2013, chapters 8, 9, 10; Cornett, 2011, chapters 7-12; Saxe, Ellis, Kaplow, 2007, chapter 7; Rast and Rastsmith, 2015, chapters 12, 13, 14)*

20 *Self-regulation, trauma, survival circuits (Saxe, Ellis, Kaplow, 2007)*

21 *Assessment includes relationship and caregivers' needs and strengths (Cornett, 2014, chapters 6, 7; Anderson, Lyons, Giles et. al, 2003)*

22 *Genograms and eco-maps (Butler, 2008; Rempel and Kishner, 2007)*

23 *Overview of risk and safety planning (Cornett, 2011, chapter 16; Stanley and Brown, 2011; Stanley and Brown, 2008; Rast and Rastsmith, 2015, chapter 19)*

24 *Crisis planning tools and training (Resources such as the safety plan template, advance communication to treatment providers, and supplemental documents are accessible on the MBHP web site https://www.masspartnership.com/provider/CrisisPlanning.aspx)*

25 *Sample of crisis planning training content (Kappy Maldenwald, 2011, accessible at the MBHP website https://www.masspartnership.com/pdf/EffectiveCrisisPlannin-April11and 132011FIN.52011.pdf)*

26 *MA DMH Safety Tool 2006 (http://www.mass.gov/eohhs/docs/dmh/rsri/safety-tool-for-kids-sample.pdf)*

27 *Crisis planning and discussions of non-suicidal self-harm (Fisher, 2011; Brausch and Gutierrez, 2010)*

Collaborative Intervention Planning

Collaborative Intervention Planning[28] must be developmentally informed, and understood within the context of unique characteristics of services to infants, toddlers, preschoolers, school-age youth, and transition-age youth.[29] Shared decision-making becomes complicated in medication management, and calls for some thinking about medication from the practitioner's perspective of "compliance." The therapeutic alliance supports long-term gains when clients' preferences and decision-making processes are valued, as they learn how to use medications along with other coping strategies.[30]

Intensive Therapeutic Intervention

This Core Element matrix emphasizes that the heart of in-home therapy is the intensive therapeutic intervention[31] that enhances both the well-being of the child with behavioral health needs and the capacity of caregivers to provide a safe and supportive environment for the child. The therapeutic intervention consists of strategies and actions that are most likely to heal, strengthen, and last. High-quality interventions make every meeting count with specific purposes for each session, plans for conducting sessions, clear correlation between the session plan and the goals established in the treatment plan, and actions to practice between sessions. Intensive therapeutic interventions use strengths in real and tangible ways to address needs. Family reports of both improvements and setbacks directly inform next steps as do collateral perspectives and direct observation by the IHT team. Therapeutic intervention is a live process that responds to changes in the family's treatment needs, including possibilities for higher as well as lower levels of intensity. IHT models may effectively use evidence-based practices[32] as well as practice-based evidence[33] in developing interventions.

When planning the intervention strategy, consider the appropriate intensity of services and potential concerns for each treatment option (contraindications) such as dangerous situations, acute medical conditions, or repeated negative outcomes of the family's prior experiences with similar treatment.[34] Research has shown that the use of manual-guided intervention does not necessarily harm the therapeutic alliance between the therapist and youth.[35] Consider how psychotropic medications integrate within the intervention technique(s), and how the use, prescriptions, or dosages of medications may change during the sequential stages of treatment.[36]

Parenting tasks and mental health challenges are related to child development phases and strategies for engagement, assessment, and clinical strategies for infant, toddler, and preschool children.[37] Clinical strategies must also be considered for children with difficult temperaments[38], children who are having difficulty regulating physical and emotional experiences[39], children who have difficulty forming attachments[40], and children with particular diagnoses, such as ADHD[41], mood disorders[42], sensory processing challenges[43], attachment disorders, or trauma history.[44] Parental substance abuse and parental mental health issues[45] affect family functioning and

---

28 *Overview of collaborative intervention planning (Rast and Rastsmith, 2015, chapters 17, 18; Cornett, 2011, chapters 13-15; Fraser, Grove, Lee, Greene, Solovey, 2014, chapter 5)*

29 *Developmentally appropriate services (Cornett, 2011), clinical strategies to support caregivers of young children (Cornett, 2014, chapter 15)*

30 *Shared decision making and medication management (Deegan and Drake, 2006)*

31 *Overview of intensive therapeutic intervention (Rast and Rastsmith, 2015, chapters 21, 22, 23; Fraser, Grove, Lee, Greene, Solovey, 2014, chapters 6, 7, 8)*

32 *A wide range of evidence based practices in IHT and home-based therapies, including FFT, MST, TST, I-FAST (Mazier, 2015, chapter 2), IFPS, MTFC (Maachi and O'Conner, 2010) ARC (Blaustein | and Kinniburgh, 2010); EBP's in infant and early childhood mental health (Cornett, 2014, chapter 17)*

33 *Common Factors Approach examples: I-FAST (Fraser, Grove, Lee, Greene, Solovey, (2014)*
MAPS, MATCH

34 *Contraindications (Maachi and O'Conner, 2010)*

35 *EBT manuals and therapeutic alliance (Langer, McLeod, Weisz, 2011)*

36 *Integration of medications and treatments (Saxe, Ellis, Kaplow, 2007, chapter 13)*

37 *Developmental considerations for working with families with young children (Cornett, 2014)*

38 *Clinical strategies for children with difficult temperaments (Cornett, 2014, chapter 11)*

39 *Clinical strategies to help children manage regulation (Cornett, 2014, chapter 10)*

40 *Clinical strategies to support attachment relationships (Cornett, 2014, chapter 14)*

41 *Clinical strategies to support children with ADHD (Cornett, 2014, chapter 8)*

42 *Clinical strategies for children with mood disorders (Cornett, 2014, chapter 12)*

43 *Clinical strategies for children with sensory processing challenges (Cornett, 2014, chapter 13)*

44 *Clinical strategies to support traumatized children (Cornett, 2014, chapter 9)*

45 *Parental mental health (Reupert, Maybery, Nicholson, Gopfert, Seeman, 2015; Nicholson, Wolf, Wilder, Biebel, 2014; Beardslee, Martin, Gladstone, 2012)*

must be incorporated into adaptations of the ongoing intervention. Tools and documents used in the clinical process of assessing and treatment planning, such as the CANS[46] and Treatment Plan[47], can also be used to support effective communication with families and aid in shared decision-making.

Care Coordination and Collaboration

The multiple perspectives of the child, family, school, community, and service providers come together in care coordination and collaboration. These perspectives help to develop the fullest picture of the strengths and challenges of the child and family, which also provides the context for how the IHT provider can accurately understand the priorities, work with the participants to set expectations, negotiate the decisions, sequences, and determine the most beneficial ways of helping. There are often competing demands in the family. Simultaneously attending to needs of the children and caregivers' challenges when there are issues of adult mental health, substance abuse, intellectual disabilities, and teen parents is important for the purpose of strengthening attachment relationships and supporting higher family functioning.[48] Children with serious emotional disturbance have much lower graduation rates than statewide averages of all children, such as in North Carolina where the rate was 42% compared to 76%.[49] The study indicates the need to keep academic progress in view during collaborative meetings, as those efforts have present day implications for learning, grades, and severity of behavior problems at school but also future graduation rates, employability, and life earnings.

Engaging Natural Supports and Community Resources

Engaging natural supports[50] is highly valued; however, more attention must be given to the tasks, time, and follow-through of doing so. The research shows that the actual use of natural supports in systems of care requires further development.[51] By what means can clinicians connect families in stronger ways to neighbors, friends, spouse or partner, family service providers, faith community, family support groups or organizations, and coworkers. A study of rural youth looked at help-seeking behavior and the likelihood of youth engaging natural supports on their own. The study described gender differences and patterns depending on what types of problems the youth were experiencing, and the severity of their problems. It is not surprising that as they got older, they chose friends as their first choice for help and were less likely to choose family members.[52]

Preparing to Exit

Preparation to discharge[53] as a process is described in selected chapters of reference books. Some studies have discovered patterns of unexpected exits from services[54], and the research topic of preparation for change (accessibility to supportive relationships that will continue, maintaining skills and progress, planning for crisis after the transition, and future focuses) primarily focuses on discharges from hospital and residential settings. The existing research in other child mental health settings examines family members' involvement in the transition plan, perceived readiness, and the need for ongoing supports. One study discovered an unexpectedly low priority on mental health (ranked by parents and youth). Youth and parents ranked supports and services related to community involvement, family, and independent living as more important, expand ing the topics beyond their immediate needs.[55] Another set of research studies focuses on transitions to adulthood, which may coincide with age eligibility and exit from treatment or entire service systems.[56]

---

46 *CANS (Anderson, Lyons, Giles et. al, 2003)*

47 *The treatment plan can be downloaded at the Massachusetts Standardized Documents Project (MSDP) website abhmass.org*

48 *Attending to caregivers needs (Cornett, 2014, chapter 15)*

49 *Educational outcomes in a SOC for children with emotional disturbance (Strompolis, Vishnevsky, Reeve, Munsell, Cook, Kilmer, 2012)*

50 *Overview of engaging natural supports (Cornett, 2011, chapter 3; Rast and Rastsmith, 2015 chapters 16, 24),*

51 *Supports for families in systems of care (Cook and Kilmer, 2010)*

52 *The importance of friends as natural supports for adolescents (Sears, 2004)*

53 *Overview of preparing for exit (Walker, Bruns, Vandenberg, Rast, Osher, Miles et al, 2004; Fraser, Grove, Lee, Greene, Solovey, 2014, chapter 8, Rast and Rastsmith, 2015, chapters 22, 26)*

54 *Early and late dropouts from treatment (Kazdin, 1994; McCabe, 202)*

55 *High priority supports for youth and their parents beyond mental health services (Trout, Hoffman, Huscroft D'Angelo, Epstein, Hurley, Stevens, 2014)*

56 *Transition to adulthood (Clark and Davis, 2000; Greenen and Powers, 2006; Schulenberg, Sameroff, Cicchetti, 2004; Davis and Sondheimer, 2005; Ringeisen, Casanueva, Urato et al., 2009)*