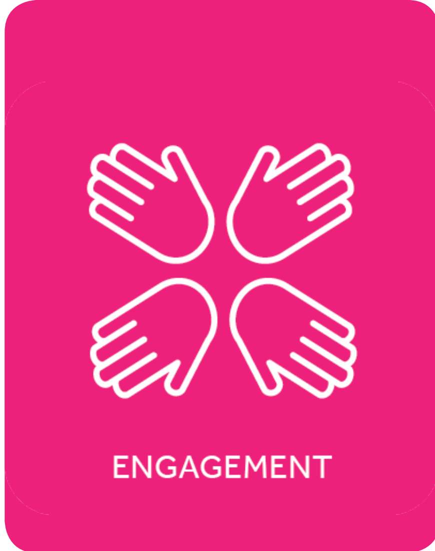

CORE ELEMENT: ENGAGEMENT

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

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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

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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

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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.