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.

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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.

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— 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.

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• 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.

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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.