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.

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• 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.

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• 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.

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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.

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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.

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• 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.

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• 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.