In-Home Team-Based Treatment Practice Profile

Providing Therapeutic Interventions

Continuity with Higher Levels of Care

Incorporating Psychiatry & Occupational Therapy Consultation

Supporting Life Transitions

Bridging Community Integration

Strengthening Wellbeing through Respite

CBH KNOWLEDGE CENTER

Mass DMH Department of Mental Health

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In-Home Team-Based Treatment Practice Profile

This Practice Profile describes best practice for DMH's contracted in-home team-based treatment programs. Although there is a variety of in-home team-based treatment models and staffing approaches, most of the practices described in this document are relevant to all services that are delivered to youth and their families in a home setting.

The work of in-home team-based treatment services is shared among team members. The practices described are based on the expectation of teamwork and refer to the roles that comprise the team as fits each family situation. Thus, any variation in applicability of these practices results from variation in team composition. For example, not all teams include an occupational therapist or a psychiatrist.

This Practice Profile builds on one developed in 2017 for the Continuum service. Similar to the development of that practice profile, we engaged a wide array of stakeholders in a comprehensive review process to ensure this document reflects current knowledge and insights about best practice. As our evolving collective practice experience and expertise informs each iteration of program design, we are also incorporating it into the practice profile.

All DMH-funded services are designed to reflect our Family Collaboration Principles.

DMH Family Collaboration Principles

DMH recognizes that mental health services are most effective when parents/caregivers, youth, and providers work collaboratively as partners in a youth's treatment. Youth need every opportunity to be involved with and stay connected to their parents/caregivers and family members. Parents/caregivers are essential sources of support for their children throughout their lives and need to be actively involved with their children and their services. Parents/caregivers also need timely and accurate information about their children's needs and the range of available interventions and services. While parents/caregivers, youth, and professionals bring different perspectives, each benefit from understanding the other's vantage point. Policies, services and supports must be designed and evaluated collaboratively and be family-driven, youth-guided, strength-based, culturally and linguistically competent, individualized, informed by best practices and evidence, and consistent with the research on sustained positive outcomes.

DMH also recognizes that a variety of factors can impact a youth and/or family's engagement and participation in services, including but not limited to:

- the needs of siblings
- caregiving responsibilities related to other family members' physical and/or mental health needs
- parent/caregiver's own physical and/or mental health needs
- access to transportation to/from services
- parent/caregiver's work responsibilities
- community dynamics, and
- other social determinants of health, such as, but not limited to, race and racism, ethnicity, gender, gender identity, sexual orientation and socioeconomic status.

DMH works with youth and families to understand these factors and manage services with these factors in mind. DMH also recognizes that successful services must be grounded in a trusting therapeutic relationship between youth, families, and providers; and that these relationships can take time to develop. DMH services allow the time needed to establish positive therapeutic relationships. They provide flexible scheduling of services to accommodate youth and family schedules and allow for fluctuations in how often a youth and family meets with service providers. They assist families in understanding and accessing the array of services and supports that may be available to them in their local communities, through their insurance benefits, and through a youth's school.

Using The Practice Profile

Each Core Element describes the practices that make up that Element. It breaks down large concepts, such as "engagement", into discrete activities that can be taught, learned, and observed. Activities within each Element often occur simultaneously, as they should. They almost never happen only once, nor should they. It is important to read and use each Element as part of a whole and to see the interconnectedness of practice activities. We've simplified the format by focusing on best practice only. Practitioners told us they did not find the previous inclusion of developmental and unsatisfactory practice to be useful.

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.

Bringing It All Together

These eleven Core Elements form the basis for solid clinical and support work and ensuing discussions with the family. Collectively, they describe 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 Core Elements are the ingredients of good in-home team-based practice; the items are not a checklist of things to do! Items need to be contextualized into a coherent approach, one that is learned and deepened over time. As practitioners gain mastery over the synthesis of individual items, the work is increasingly creative, rewarding, and effective.

Core Elements (If viewing digitallly, you can click the icon to jump to the section.)

The practice profile describes eleven Core Elements that reflect the practice-level work of the team members individually and collectively (i.e., what they are saying and doing when delivering in-home, team-based services).

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

Practicing Cultural Relevance

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

Engaging Youth and Family

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

Conducting a Comprehensive Collaborative Assessment

Conducting A Comprehensive Collaborative Assessment
The Team conducts a comprehensive collaborative assessment that involves the ongoing process of gathering necessary, accurate historic and current information about the needs, strengths, and culture of a youth and their family.

Collaborative Treatment Planning and Care Coordination

Collaborative Treatment Planning and Care Coordination
The Team engages in a structured collaborative care coordination approach that promotes continuity in treatment planning and results in the ongoing collaborative development, implementation, and amendment of the youth and family's treatment plan.

Assessing Risk, Safety Planning, and Supporting Families through Crisis

Assessing Risk, Safety Planning, and Supporting Families Through Crisis
The Team engages in ongoing identification and anticipation of risks to a youth's and family's safety, permanency, and wellbeing and develops an evolving, shared understanding of what precipitates, drives, and helps to mitigate risk and crisis for the youth and family.

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

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

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

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

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

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

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PRACTICING CULTURAL RELEVANCE

The Team engages in the lifelong process of:

1. Acquiring an understanding of how values, beliefs, attitudes, and traditions of an individual's multiple identities (such as race, ethnicity, religion, age, sexual orientation, gender identity, economic, social, educational status, health impairments or disabilities, and other affiliate groups) contribute to one's own and others' culture;

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

3. Understanding and acknowledging the power and privilege differences and similarities between and among groups of people on a personal, institutional, and systemic level; and

4. Incorporating this knowledge to work collaboratively and effectively with all people.

Practicing Cultural Relevance

CONDUCTING CULTURAL SELF-ASSESSMENT IN THE CONTEXT OF WORK

- Prior to working with each youth and family, takes an inventory of one's own values, beliefs, attitudes, biases, knowledge, and awareness relative to the youth and family being served.
- Routinely conducts a self-assessment of one's own privilege status (and its potential impact) in relation to the family and youth's status in multiple dimensions (such as, but not limited to, gender, race, ethnicity, economic status, and social status). This includes reflection on one's personal family history, experiences, and circumstances and how these affect biases or judgments about the family and youth's family situation, relationships, or preferred permanency outcome.
- Takes responsibility for one's own continued growth in their education and comprehension of multiple cultural identities with whom one works. Part of learning should include being open to seeking and accepting feedback from others (e.g., colleagues, families, youth, etc.).
- Explores cultural differences among team members (e.g., clinician, outreach worker, peer mentor, supervisor, etc). Engages in ongoing dialogue with one another and in supervision regarding one's own values, beliefs, attitudes, biases and potential implicit biases, and their impact on work with youth/family.

DISCOVERING YOUTH'S/FAMILY'S CULTURE

- Creates "safe space" and pacing in which to explore youth and family culture. Explains that exploring and discovering youth's/family's culture can help the Team avoid engaging in a way that does not respect their culture.
- In order to ensure culturally relevant interventions and to respect family boundaries, engages in ongoing discussion with youth/family members about their unique values, beliefs, attitudes, assumptions, and life experiences within the larger racial, ethnic, religious, sexual orientation, gender identity, socio-economic, immigrant/ refugee, or other groups with which they identify or feel an affiliation. Explores individual family culture as another layer of diversity and honors the wide variance of parenting that is safe and supportive to youth well-being.
- Explores with curiosity what youth's and family's affiliations/identities mean to the youth and family.
- Engages in ongoing discussion with youth and individual family members to discover differences and similarities among family members and between generations. Explores roles and privilege differentials within family (e.g., sons allowed to stay out later then daughters, fathers are disciplinarians, mothers cook for everyone). Acknowledges youth's values/beliefs that are different from or conflicting with their families.
- Acknowledges the wide range of safe and "good enough" parenting strengths, styles, techniques, and strategies as well as a similarly wide range of youth responses to, acceptance of, and benefits from their parenting.
- Explores the resilience and vulnerabilities that emerge from the youth/family members' culture and experiences.
- Engages in initial and ongoing discussion specifically about strengths—including individual, family, and community strengths —related to youth and family culture.
- Helps youth/family to recognize and explore strengths; shares/reflects on youth's/family's potential strengths even when youth/family are not initially aware of them.

DISCOVERING THE CULTURE OF YOUTH'S/FAMILY'S COMMUNITY

- Acknowledges and explores, initially and on an ongoing basis, the neighborhood/community environment of the youth and family. Explores how family identifies/doesn't identify with the culture of the community in which they live.
- Explores available resources, community crime rates, socio-economic conditions, and tensions (e.g., racial, LGBTQ related) at school and the impact they have on behavior, symptoms, and diagnoses.
- Explores the impact and specific needs of youth who have experienced immigration-related and/ or other separations from community or family (such as homelessness, kinship, foster home and long-term residential placements, adoption, imprisonment and deportation).
- Explore family views and experience with utilizing police and other community interventions as part of the safety plan.

PREVENTING AND RESOLVING CULTURAL BARRIERS/MISUNDERSTANDING BETWEEN YOUTH/FAMILY AND TEAM

- Asks about youth and family members' preferred language for spoken, sign, and/or written communication at intake. Offers options for ensuring effective communication across language/literacy differences.
- Considers Team's cultural fit with family preferences for fit.
- Recognizes and acts on any practical concerns about meeting times and locations that relate to culture (e.g., holy days, family privacy boundaries, concern about stigma).
- Inquires with youth/family about experiences with how formal and informal supports have interacted with, understood, and/ or misunderstood their cultural identity.
- Routinely checks in with family/youth around relevance of Team's approach to youth's/ family's cultural identity needs and concerns. Notices when there is a misstep by the Team in the form of racism, microaggression, cultural bias, misgendering or misunderstanding. Encourages and supports youth and family to inform Team of their experiences of bias or misunderstanding by the Team. Promptly acknowledges, apologizes for, and corrects one's own actions and engages in repair work.
- Assesses whether one's own cultural self-disclosure meets youth/family clinical needs and self discloses only based on those needs.
- Acknowledges and opens discussion of differences and similarities in culture and in power and privilege. Reflects actively with youth/family on how these affect dynamics of working with individuals/families.
- Uses therapeutic alliance and adjusts practice approaches to bridge gap between culturally influenced perspectives of youth/family and Team.
- Identifies the need for and obtains culturally relevant consultation and supervision around counter transference.

SUPPORTING RESOLUTION OF CULTURAL MISUNDERSTANDING WITH FAMILY TEAM AND OTHER SUPPORTS/ENTITIES

- Invites and supports family to discuss and address behaviors by team members that result from misunderstanding of culture. Supports family in addressing teamwork concerns.
- Offers options for facilitating discussion between youth/family members and other external team members regarding youth- and family-preferred cultural considerations that may impact teamwork and decisions about culturally specific interventions. Facilitates joint conversations between team members and youth/family in order to clarify any misinformation or misunderstandings related to the youth's/family's unique permanency strengths or situation. Acts as an advocate in helping team members understand the youth's/family's unique permanency strengths or situation.
- Addresses directly and respectfully with other team members and youth/family when observing actions that appear insensitive to youth/family culture or experience.
- Recognizes that institutionalized and systemic racism and linguistic barriers exist and may be experienced by youth/family. Supports empowerment, educates, and models ways they can advocate for their needs (e.g., requesting a translator, family partner, etc.).
- Collaborates/coordinates around ways to educate Family Team and/or other supports regarding systems of oppression that continue to impact the youth/family.
- Respectfully informs/educates family on how cultural norms (e.g., discipline of children, expectations of women, etc.) may be in conflict with state laws and prevailing customs and how this could be problematic in some domains.
- Explores family's current strategies and options (such as alternative behavior/ actions) to prevent/resolve potential conflict with U.S. laws and/or customs that could be problematic for the youth/ family.

ENGAGING YOUTH AND FAMILY

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

It involves empathy, careful listening, sensitivity, humor, and compassion and establishes an expectation of shared decision making in which the youth and families' voice, experiences, and opinions are prioritized and are persistently sought and validated. It demonstrates mutual engagement: that you are where you want to be—with this family at this time—and ready to give full attention. Engagement is a critical aspect across the Team's essential functions, not just at a point in time, and takes into account youth and family readiness for change and meets them where they're at.

RESPONDING TO REFERRAL

- Within no more than three calendar days of receipt of the referral, calls DMH and collaborates to establish a plan for the provider's initial contact with the family.
- Determines whether the initial contact meeting will occur via phone, in person or virtually, who will schedule and facilitate the meeting, and what the provider's role will be in the meeting.
- Determines who will contact the parent/caregiver ahead of the meeting in order to ask the parent/ caregiver and youth (as developmentally appropriate) who they would like to have attend the initial meeting.
- When the provider contacts the parent/ caregiver ahead of the initial meeting, the following possible attendees are explored: parent/ caregiver (and youth as applicable), other family members, natural supports, Family Partner (when in place), DMH staff, provider staff, and other applicable collaterals. Determines together who will invite the selected individuals.
- Explores parent/caregiver's expectations about the meeting including what they feel is important to discuss. Considers options to engage the youth in the initial contact meeting (e.g., attend part of the meeting, plan to discuss with youth in a follow-up meeting, etc.). Considers how to prepare youth to participate based on age, developmental level, and individual needs as well as which team member is best to prepare the youth.

FACILITATING INITIAL (PRE-INTAKE) MEETING WITH YOUTH/FAMILY

- Facilitates or attends a pre-intake meeting with the youth, their family, DMH referrer or designee, Family Partner (if one is in place), natural supports, and other collaterals (consent permitting) as agreed upon with the family and DMH.
- Clearly states the central purpose of the home-based treatment services (to support youth and families in a manner that helps youth remain in and/or return to their home in a safe and timely manner and function successfully at home, school, and in their community).
- Describes services and how they might be helpful to the youth and family, including:
  - Approach to home-based work and in-home and out-of-home interventions.
  - Roles of the clinician, outreach worker, and other team members.
  - Family therapy, skill building/coaching, care coordination activities
  - Family Team Meeting process, with encouragement of family to begin considering possible team members.
  - How the team bridges with other service providers, and with schools.
  - Criteria for participation in services (youth's clinical needs and youth and family's voluntary agreement).
  - Confines of service such as mandated reporting and confidentiality.
- Answers questions and provides any additional information needed to ensure family has sufficient information to make informed consent for services.
- Explores who youth/family and legal authorized representative (LAR) identify as "family" using a broad definition of family that is not restricted by blood or legal relationships. Uses youth/ family engagement tools (e.g., Scaling Question, Timeline, Three Houses, Bulls Eye Family Safety Circle, I want to Say Something, etc.) to facilitate this discussion as appropriate.
- Inquires how family members prefer to be addressed and addresses them in that manner.
- Explores youth/family and other participants' hopes, worries, needs (including safety and risk) and goals (focal treatment goals) for the youth/family as well as family's strengths and progress on activities/goals thus far.
- Asks about past experiences (what did and didn't help) with service providers and natural supports.
- Explores family's expectations of the service, clarifies any confusion regarding what the service can offer and explores family's level of interest and readiness to participate.
- Inquires whether the family is ready to consent to receive services and, if so, arranges the first meeting at the family's convenience. If consent is not given, arranges a time check back in on their decision. Asks youth/family what would assist them in being ready to consent.
- Explores and identifies any special considerations affecting Team Staff assignment.
- Asks family members about:
  - Preferred modes of communication,
  - Learning styles
  - Cultural practices
  - Preference for staff's cultural/linguistic background and assigns staff who fit this preference, whenever possible. When linguistic fit is not possible, uses interpreters to support ongoing engagement in all aspects of service (assessment, treatment, skill development, therapy, crisis/safety planning and response, etc.).
- Discusses most convenient times and locations for the family to participate in meetings and activities, such as evening hours, weekend(s), at family's home/community, or other accessible locations. Schedules and holds meetings and interventions at these times and places.
- Explains conditions under which staff will have to use non-preferred modes of communication (due to electronic access, HIPAA, etc.).

FACILITATING YOUTH/FAMILY INTAKE

- Meets, preferably in person, with the youth and family to provide any needed (re)orientation to the service and orientation to agency, reviews intake paperwork and obtains consent for treatment, if it has not yet been obtained.
- Reminds family of the central purpose of all interventions and activities as well as the Team approach described during the pre-intake meeting. Asks for and clarifies any questions. Orients youth and/or others who were not part of the initial meeting. Asks all participants if there's anything else they want to review from the initial contact conversation/pre-intake meeting and reviews that information as requested/needed.
- Informs the family in writing about their right to withdraw consent as well as other rights and responsibilities of the youth and family and responsibilities of the provider. Informs the youth/ family of the process and contact information for expressing concerns and complaints about the service as well as the organization's formal grievance process.
- Provides written contact information (office location, on call service, etc.) and explains to family and youth, when developmentally appropriate, the process for contacting the provider during regular interactions and emergency situations.
- Describes the importance of gathering and sharing relevant information to/from other sources important to youth/family.
- Requests permission to gather/share information to/from other providers, agencies, and schools involved with youth and family and clearly explains why and how it will be used to assist them in achieving their goals. Gains written consent.
- Explores any concerns or reluctance to obtaining/ sharing information and presents options for providing only information that the family feels comfortable sharing.
- Gathers/shares information to/from other sources as consented to by family.
- Conducts a current risk assessment including risk of harm to self and others, and risk of harm by others.
- Includes an assessment of risks to psychological safety as well as physical safety – specifically how to sustain attachments and other protective relationships, prevent separation, loss, loneliness, and disconnection whether the youth is living at home or in an out-of-home intervention.
- Develops an initial safety plan with the youth and the family to address physical and psychological safety concerns identified with strategies agreeable to the family.
- Initiates a plan for strengthening/maintaining educational access in the youth's home community school and for supporting educational attainment (once later finalized, includes educational plan in the Treatment Plan).
- Develops an initial understanding of how the family, youth and team will know the youth is ready for discharge.

ONGOING FOSTERING OF FAMILY-DRIVEN THERAPEUTIC ALLIANCE

- Identifies, encourages, and reinforces parent/ caregiver and sibling's patience and perseverance in raising a child with mental, emotional, and/or behavioral health needs.
- Acknowledges youth and family strengths and successes in residing together.
- Uses a range of specific engagement skills (active listening, open-ended questions, appreciative inquiry, strengths-based language, etc.).
- Adapts to differences in home setting (distractions, locus of control, boundaries, etc.) and individualizes approach to the various stages of readiness for change experienced by each family member.
- Provides written contact information (office location, on call service, etc.) and explains to family and youth, when developmentally appropriate, the process for contacting the provider during regular interactions and emergency situations.
- Uses language that is respectful of the parent/ caregiver, youth, and family's culture.

- Values the family's knowledge of what works for their family by exploring and listening for strategies of problem-solving and solution- seeking they've tried (including what's worked and what hasn't) and utilizing that information to customize helping approaches and to fit the youth's/family's uniqueness, personality, culture, and interest. Uses tools such as solution-based or exception questions.
- Has regular discussions with the youth/family to hear about their evolving perspectives on their hopes and worries, strengths, needs, short-term goals and long- term vision as well as to learn about their involvement with natural and formal supports.
- Provides nonjudgmental, unconditional, positive regard to the youth and family and validates their expressed experiences, feelings, struggles, and hopes. Works to maintain engagement with and holds perspective of all members of the family.
- Reinforces central purpose of service (to support youth and families in a manner that helps youth remain in and/or return to their home in a safe and timely manner and function successfully at home, school, and in their community) and references specific treatment goals during each session. Concludes each session with agreed-upon next steps and person responsible in advancing progress toward goals.
- Checks in with youth and family members at beginning and end of each session to hear and validate their firsthand reports of progress, challenges, and changes. Summarizes what was covered and next steps at the end of each session.
- Elicits questions and input (including what's helping and not helping) from all family members during all stages of intervention planning and implementation as service proceeds. Opens discussion about processes, perspectives, roles, interventions, and strategies that conflict with youth's/family's expectations.
- Helps family recognize the meaning of unsafe behavior. Does not get overly focused on crisis to the exclusion of goals.
- Explores satisfaction with the effectiveness of Team's engagement and partnership with the youth and family and shifts approaches as needed.
- Explores logistical and perceived barriers (trust, beliefs, quality of engagement, etc.) to engagement and revisits this as service progresses. Explores practical barriers (work schedule, childcare, physical health) and intangible barriers (distrust of mental health concepts, fear of violence in neighborhood, stigma).
- Supports youth's/family's engagement and rapport with other new formal and informal supports by providing information and answering questions about them.
- Explores youth's/family's experience and relationships with current formal and informal supports (e.g., providers, school personnel, state agency staff, natural supports). Acknowledges and validates expressed discomfort and/or conflict; and asks what might help them youth/family feel more comfortable and/or manage conflict going forward.
- Explores options for resolving conflict with providers and other support people and assists youth/family in trying their chosen option through practice, role play, letter witting, etc. If the initial option doesn't work, helps them explore additional options. Offers to be a supportive presence when youth/family engage in chosen action steps to resolve conflict with other providers/supports.
- Strategically facilitates conversations between youth/family and informal or formal supports to assist in building or strengthening relationships, reaching consensus, and resolving conflict.
- Develops strategies with the family to discuss any difficult information obtained from collateral sources. Based on family's preferences, includes them in between-session communications with collaterals or updates them separately. Shares all relevant communication with the family in clear, family-friendly language.
- Selectively shares aspects of one's own values, beliefs, attitudes, and life experiences only when deemed appropriate and clinically beneficial to the youth/family (e.g., in order to partner and engage in a treatment alliance with a reluctant, pre-contemplative, or difficult- to-engage youth or family member).
- Promptly acknowledges mistakes and corrects own actions if they have resulted in misunderstanding or other disruptions. Involves others (Team members, supervisor, Family Partner, etc.) who can help support resolution as needed.
- Discusses, validates, and apologizes when youth/family express feeling minimized, ignored, or otherwise disenfranchised in past system interventions.

CONDUCTING A COMPREHENSIVE COLLABORATIVE ASSESSMENT

The Team conducts a comprehensive collaborative assessment that involves the ongoing process of gathering necessary accurate historic and current information about the needs, strengths, and culture of a youth and their family. The Team evaluates the relevance of that information and also develops a comprehensive life history, a psychosocial narrative of the youth and family in the context of their environment, experiences, culture, and present situation.

Conducting a Comprehensive Collaborative Assessment

Clinical understanding is informed by (but not limited to) initial consultation with the youth, family, and treatment providers as well as others on the home based team such as occupational therapist, consulting or treating psychiatrist (when clinically warranted), and DMH. The assessment process results in an interpretive summary and clinical formulation that can be understood and supported by family members, professional helpers, and natural supports on the Family Team.

The assessment process helps the Family Team (inclusive of the youth/parent/caregiver/legal authorized representative [LAR]) identify focal needs and prioritize treatment goals. The clinical formulation prioritizes the psychological safety and wellbeing risks for youth placed out-of-home and promotes urgency to resolve barriers to safely remaining home or transitioning home. Assessment and clinical understanding changes over time as new information arises and the family situation changes.

FURTHER DEVELOPING THERAPEUTIC ALLIANCE

- Fully explains the assessment process and purpose to the youth and family. Asks for and clarifies questions.
- Explores with the family who they expect, and hope will participate in assessment conversations, family therapy sessions, and Family Team meetings and how they envision services being delivered.
- Specifically explores whether the parent/caregiver wants their Family Partner (if they have one) or other supports to be part of the assessment meetings and includes them accordingly.
- Takes time to get to know the youth and family. Demonstrates curiosity about their experiences. Exhibits respectful persistence when response is slow and paces the gathering of information when family is overwhelmed.
- Listens carefully to the family's narrative and summarizes verbally what each family member has said to make sure it's understood.

EXPLORING NEEDS, VISION, STRENGTHS, AND HISTORY OF HELP

- Engages youth and family members to identify and describe skills, abilities, knowledge, interests, and strengths of the youth, individual family members, and family as a whole.
- Elicits each individual family member's impression of primary concerns.
- Specifically inquires about concerns related to risk for sexual exploitation, substance use, bullying, gang involvement, and other risky situations.
- Explores youth and family members' perspectives on what contributes to primary concerns. Inquires about what keeps the concerns going, what stressors make them worse, and what helps relieve them.
- Explores the impact that medical/physical wellbeing has had on youth's and family's mental and behavioral wellbeing and vice versa.
- Explores family's preventative care practices such as immunizations, wellness check-up, disease prevention, and dental services. Identifies and collaborates with family and providers around care coordination needs in these areas.
- The clinician conducts a youth and family screening for past and current substance use/abuse within twenty (20) days from intake. This may be conducted as part of an ongoing risk assessment, CANS, or a standardized assessment tool.
- Engages youth and family members in describing times in the past when needs were more or less acute and explores what was different.
- Asks about the types of supports that have helped manage needs in the past and at present. Asks about formal help (such as state agency involvement, out-of-home treatment, community services, prescribers, alternative healing approaches, etc.) and natural supports (such as friends, coworkers, neighbors, clergy, etc.). Explores what youth/family experienced as most/ least effective and validates their experience.
- Explores medication usage, target symptoms, and possible side effects with family and prescriber. Explores beliefs about medications, access to and resources to fill prescriptions, and how they are taken (e.g., according to directions or not) on an ongoing basis.
- Explores youth's and family's future-oriented vision. Invites youth and family members to envision and describe a time in the future when their family is able to manage challenges more effectively. Uses tools such as miracle question to help the family generate ideas.
- Supports the youth/family in developing a written vision statement that will help guide the Team and the Family Team's work with the family.
- Explores how the youth/family and the Team will know when it's time to transition out of services.
- Explores home routines, structure, limit-setting and discipline practices as well as parent/caregiver needs (mental health, life skills, and basic needs).
- Asks about past family history of trauma, losses, and other adverse experiences as well as family history of substance use/abuse.
- Explores protective and risk factors in the community environment and their impact on the youth/family.

EXPLORING PERMANENCY, STRENGTHS, NEEDS, AND BARRIERS

- Specifically assesses for the presence and sustainability of youth's relationship with at least one committed adult who provides a safe, stable, and secure parenting relationship, love, unconditional commitment, and lifelong support. Engages in initial and ongoing exploration (with youth, family, and relevant collaterals) of strengths, needs, and obstacles for youth and family in maintaining, strengthening and/or achieving such a relationship.
- Considers youth and family's readiness when timing the exploration of the topic.
- Explores and gathers understanding of the full family configuration (including "chosen family," custodial parents, marital status, foster parents, and siblings). On an ongoing basis, explores whom the youth and family consider to be family members. Explores the roles those family members have within the family.
- Explores family's interpersonal relationships with the youth. Assesses readiness and invites family members to describe their past and current relationships with the youth, including frequency of contact and quality of contact. Invites family members to describe their hopes, wishes, or vision for the relationship they want to have with the youth.
- Supports family members when something impactful is disclosed.
- Adjusts questions to the specific family, especially when working with transitional-aged youth
- Considering the youth's readiness for this exploration, asks them to name and describe their past and present relationships, including frequency of contact, quality, and nature of contact (e.g., asks about memories, things they liked to do together, etc.), with important people in their lives to whom they feel connected, such as family members and "chosen family," whether living near or far.
- Offers youth the option to have a peer mentor or other supports participate in this conversation.
- Assesses readiness and invites youth to describe their hopes, wishes, or vision for their desired relationship with these individuals.
- Explores with LAR, family, and collaterals to identify past and present familial and non-familial connections and important people in the youth's life. Asks about their perceptions of the nature of the youth's and family's relationship with these individuals and those the youth identified. Explores opportunities to strengthen youth's connections and relationships with them.
- Explores (with youth, family, and collaterals) all potential obstacles to treatment continuing with youth at home full time on an ongoing basis. If an out of home treatment option is used, explore any barriers to return home with family (such as complex clinical/trauma needs, family isolation, youth/ family violence, youth/ family readiness) on an ongoing basis.
- Explores what maintains these obstacles, what makes them worse, and what makes them better.
- Explores complex safety needs, including what each person needs in order to have an optimal degree of physical safety and emotional security within the context of the family relationship and home environment.harge.
- Uses a genogram, ecomap and/or other tools to help youth/family visualize different relationships in the youth's life.

CONDUCTING CONTINUOUS EVALUATION

- Clinician, with youth and family, assesses the validity and relevance of information gathered and suspends conclusions until information is gathered from multiple sources, including from DMH, school, other providers, and collaterals.
- Continuously observes, assesses, and explores changes in youth's behavior, interactions, and level of functioning with different caregivers, adults, siblings, school personnel and peers relative to impulse control, communication, cognitive abilities, sensory processing, social/emotional development, health and wellness, risk behaviors, overall mental status, strengths and interests, and other factors, in different settings and accounting for developmental stage. Also observes the behavior of others interacting with youth.
- For young adults, also observes and assesses level of functioning in employment, independent living skills, financial literacy, and activities of daily living.
- Explores and assesses youth and parent/ caregiver need for skill development.
- Clinician evaluates, with family, the benefits, and contraindications of obtaining specialized assessments (e.g., fire-setting, neuro-psychological testing) and/or outside consultation.
- Clinician continuously evaluates need for and coordinates the addition of peer mentoring as well as consultations from an occupational therapist and/or psychiatrist.
- Uses input obtained from occupational therapist, psychiatrist, and peer mentor to inform ongoing assessment.

FILLING IN CONTEXTUAL UNDERSTANDING WITH STAKEHOLDERS

- Consent permitting, obtains relevant information via written documents and conversations with Family Team members and other relevant collaterals.
- Asks about and obtains state agency and other provider assessments, CANS, and other documentation relative to youth/family history, needs and strengths, and risk factors.
- Asks about medical/dental history of youth and documentation of any physical health concerns and current wellness status.
- Asks about school attendance, behavior, academic progress, and social/emotional functioning at school. Asks about bullying, being bullied, and any known school-related risk factors. Asks about/obtains school records (e.g., IEP, evaluations, report cards, etc.)
- Clinician reviews assessment with supervisor, outreach worker, peer mentor, occupational therapist, and psychiatrist for consultation as needed.

COMPLETING THE WRITTEN ASSESSMENT

- Within 20 calendar days of intake, the clinician gathers available information (including family and professional input) into a written comprehensive assessment that describes a well-rounded understanding of youth and family in their words (as agreed upon with youth and family).
- Incorporates available information regarding youth's and family's needs, strengths, stressors, and risk factors including history and current mental health, social/emotional/financial wellbeing, medications and target symptoms, interpersonal relationships with family, peers, and natural supports, substance use, trauma, protective factors, court/criminal involvement, and developmental milestones (e.g., communication, vocation, education, etc. and related support), functioning (uses CANS to help document functioning).
- Explains the implication, relevance, or support of the current assessment of documents referred to in written assessment report.
- Describes youth's interests and aspirations as well as a family vision for their future.
- Clinician writes a clinical formulation that provides diagnostic clarification (explains rationale synthesizing available evidence for diagnosis), identifies and prioritizes focal treatment needs and articulates recommendations for how needs will be addressed by team, group care staff (when involved), other formal and informal supports, family, and youth.
- When a youth's relationships with parents, family, caregivers, and other attachment figures are interrupted, removed, broken, or disconnected, the clinical formulation includes psychological safety and wellbeing risks.
- Includes prioritized clinical needs to be addressed, deferred, referred out or declined.
- Focal needs include but are not limited to those related to permanency and community tenure.
- Clinician shares assessment with the parent/caregiver/LAR and engages in a collaborative conversation using language the family is familiar with (explains unfamiliar terminology).
- Reviews strengths and needs as well as the specific diagnosis with family and explains basis for diagnosis.
- Helps family to decide on which needs and goals are prioritized to be addressed first
- Explores areas of disagreement and consensus and makes needed revisions/additions to the assessment before obtaining signatures.

ENGAGING IN ONGOING ASSESSMENT

- In collaboration with youth and family, clinician reviews and updates the assessment as needed and annually at minimum.
- Incorporates new information into the formulation and understanding of how to work with youth and family. Amends written assessment as needed.
- Considers diagnostic accuracy in light of new information.
- Reviews all changes to the assessment with family, explains reasoning, and discusses any impact that changes may have on diagnosis, treatment options, or expected transition out of services.

COLLABORATIVE TREATMENT PLANNING AND CARE COORDINATION

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

Collaborative Treatment Planning and Care Coordination

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

ESTABLISHING A FAMILY TEAM

- Reviews the purpose and role of the Family Team with the family, including how it may be different/ similar to other types of team meetings. Ensures that youth and family know that Family Team membership can change over time as youth/family needs change.
- Explores and identifies, with youth/family and DMH, the individuals they wish to include on the Family Team. Considers whether there are important missing Team members (such as natural supports, Family Partner, group care staff, medication prescriber, school personnel, peer mentor, DMH case manager, non-custodial parent, caregiver, therapist, etc.). Uses diligence and persistence in reaching out to engage family and natural supports.
- Fully explores and periodically revisits with family and DMH the decision to leave out a particular stakeholder, including possible outcome of that decision.
- Schedules Family Team at a time and location feasible for the youth/family, in person or virtually.
- Includes youth in meetings as developmentally appropriate.
- Plans for and schedules any needed special arrangements or accommodations, such as professional interpreters.

PREPARING FAMILY/YOUTH FOR FAMILY TEAM MEETINGS

- Meets with parent/caregiver and youth to prepare them for the Family Team meeting.
- Determines meeting structure together (such as youth and family leadership/participation, seating, and ways to take a break if one is needed). Prioritizes Family Team meeting agenda items together.
- Explores youth and parent/caregiver expectations and any concerns they may have about the meeting and agenda items. Explores and discusses ahead of time any sensitive information youth and parent/caregiver anticipate may be brought up and develops strategies to respond to it.
- Role plays/practices team meetings, as needed.
- Explains that Family Team members may hold different points of view and this is to be expected at times. Explains that there may be team decisions (and occasional external decisions by the state agency) that they disagree with or will be disappointed by and explores options for how to respond.
- Prepares youth and parent/caregiver to meet any team members whom they have not previously met in person.
- Plans for post-meeting debrief and support.
- Engages youth and peer mentor (or other Family Team member of youth's choosing) in exploration of ways to support youth's involvement in Family Team meetings. Explores ways of having youth's voice in the meeting even if they cannot attend in person.
- Uses youth engagement tools as appropriate to bring youth voice into team meetings (such as, "Three Houses–Dreams/Wishes, Worries, Good Things and "I Want to Say Something" tools).

PREPARING TEAM MEMBERS FOR FAMILY TEAM MEETINGS

- Underscores the central importance of and advocates with the parent/caregiver/LAR for full inclusion of safe, caring, and committed parent/family relationships as primary in youth's treatment, healing, and trauma recovery.
- Outreaches new potential Family Team members identified/agreed upon by the youth, parent/ caregiver/LAR (together with family members if they choose) prior to the Family Team meeting.
- Describes the service and the Family Team structure, process, and purpose.
- Describes roles of Family Team members and how they partner with one another and family members. Explores and clarifies the role/ responsibilities of the particular team member.
- Invites individuals to the Family Team meeting and asks about their needs and preferences for meeting.
- Reaches out to and prepares old and new Family Team members prior to every Family Team meeting.
- Reviews evolving hopes, worries, strengths, needs, goals, and progress that the youth/ family holds for themselves and those that each Family Team member holds for the youth and family.
- Reviews format and topics to be discussed and solicits agenda items. Reminds team members that the agenda will include various participants' agenda items that these are prioritized by youth/parent/caregiver/LAR
- Explores any reluctance from Family Team members to participate in a Family Team meeting and/or to support youth's/family's goals and vision. Explores options to move forward.

CONVENING FAMILY TEAM MEETINGS

- Convenes and facilitates Family Team meetings within 30 calendar days of intake, and at 90-day intervals thereafter (at minimum) and at greater frequency when needed (e.g., youth is in group care setting or is in crisis) to address the intensive needs of the youth/family.
- Reschedules meeting if youth or parent/ caregiver/LAR is unable to attend.
- Creates a welcoming atmosphere and assists in building relationships among Family Team members. Facilitates agreement on and commitment to a set of ground rules for Family Team meetings.
- Expresses value for each Family Team Member and honors everyone's input and perspectives. Brings team members together in exploring ideas, uniting, planning, and moving the planning process forward.
- Helps all Family Team members engage in a process of shared decision making. Makes sure that youth and family have the time and encouragement needed to participate fully in discussions at meetings. Facilitates Family Team discussions that leverage team member's best clinical judgment combined with youth's and family's expertise in order to collaboratively identify and address the needs/goals in the youth's Treatment Plan/ Individualized Action Plan.
- Helps team members address and resolve conflicts in processes, perspectives, roles, and strategies both in the moment and with any needed follow-up.
- Invites the Peer Mentor or other Family Team member selected by the youth to assist them in voicing their opinions, experiences, etc. Invites the Family Team member or natural support to assist parent/caregiver in voicing their opinions, experiences, etc. as agreed upon with parent/caregiver.
- Ends Family Team meeting with a recap of action items and timelines for activities between meetings and clearly identifies who will work on what. Encourages Team members (who youth/family believe or agree are best fit for each task) to volunteer for tasks/action items that need to occur between meetings.
- Develops/confirms a plan (frequency and medium) for Family Team members to communicate updates between meetings.
- As youth approaches transition out of services, holds Family Team meetings to plan and decide collaboratively with family members on next steps (attempts to meet youth/family at least virtually to support transition and discuss next steps even if family terminates abruptly).
- Progressively engages, encourages and expects youth, family, and natural supports in taking on – to the best of their ability – supportive roles previously played by professionals.

FOCUSING FAMILY TEAM ON MAINTAINING, STRENGTHENING, OR ACHIEVING PERMANENCY

- For youth who live with their family or are planning to return to live with their families, uses the Family Team meeting process (pre-meetings and Family Team meetings) to establish action plan and agreement around how the Family Team will help maintain or strengthen emotionally secure family relationships.
- Brainstorms individualized strategies and interventions to help the youth build emotionally secure and lifelong relationships with parents, siblings, relatives, and other important people in their life and help the parent/family provide safe, supportive, and unconditionally committed, lifelong and/or legal family relationships for the youth.
- Facilitates Family Team identification of youth-related, parent/family-related, and system-related needs and barriers.
- Facilitates exploration of and collaboration on goals, objectives, interventions, and strategies to address needs and barriers to youth and family returning to or continuing to reside together.
- For youth whose parent/caregiver becomes unable to continue in the role of safe, unconditionally committed parent, uses the Family Team meeting process to develop an action plan and establish agreement around how to increase parental capacity and confidence to safely care for their child.
- Provides assistance (as needed and agreed upon with LAR) in the assessment of potential lifelong relationships as well as connecting the youth with relatives and other important persons from near and far locations.
- As developmentally appropriate, gives youth the opportunity to express their own ideas to Family Team members about how and with whom they want to build lifelong and secure family relationships.
- Explores and identifies the need for and coordinates and obtains specialized consultations, such as a permanency consultation, with experts in the field to mitigate barriers (e.g., complex parent/caregiver/family medical concerns) to achieving permanency. Integrates permanency consultation (and other specialty consultation) recommendations into strategies with youth, family, and Family Team members.

FOCUSING FAMILY TEAM ON MAINTAINING, STRENGTHENING, OR ACHIEVING ACADEMIC SUCCESS

- Explores (and revisits) supports and advocacy needed to assist youth in accessing educational services. Brainstorms ways to help family access educational and supportive forums that assist family in supporting and advocating for their child. Connects family with resources to help them obtain information regarding educational laws, statutes, and regulations.
- Specifically communicates, coordinates, and collaborates with family, youth, OT consult, out-of-home provider, and school around youth's educational needs.
- Obtains and reviews youth's current IEP (if one exists) and participates in IEP meetings.
- Regularly discuss educational concerns. Proactively shares successful behavioral support techniques with teachers/school personnel as appropriate.
- Asks about establishing a school support person for the youth as needed.
- Collaborates as needed to establish/ maintain a school routine that promotes regular, prompt attendance and supports participation in extracurricular activities.
- Collaborates and brainstorms around options to support preparations for upcoming activities (tests, performances, athletic events, homework concerns, etc.).
- Facilitates agreement on school enrollment prior to any needed group care admission.

FACILITATING FAMILY TEAM INDIVIDUALIZED ACTION (TREATMENT) PLANNING

- Encourages Family Team discussion of strengths of youth and family members as individuals and as a family system. Elicits specific, notable aspects of strengths and where each strength appears.
- Encourages the Family Team to consider how strengths can be used and built upon to meet goals.
- At the initial Family Team meeting and throughout services, develops and reviews specific, measurable, achievable, realistic, time-targeted goals that are based on youth's/family's priority needs. Assists the family in prioritizing goals with the Family Team to ensure there aren't too many simultaneous goals overwhelming family or team members.
- Anticipates and discusses how strengths and priority needs may change and impact goals over time.
- Makes specific efforts to continuously anticipate and discuss shifting priority needs, goals, and strengths of youth from the point of intake. For youth approaching their 18th birthday, uses the Family Team as the primary vehicle to plan interventions to address any urgent risk to the lack of permanency.
- Engages the Family Team in a process of brainstorming formal and informal options (interventions, services, creative strategies, etc.) to meet the youth's/family's prioritized needs/goals.
- Establishes shared understanding of which options are most likely to succeed and promotes agreement on which ones to try first.
- Explores with Family Team members how they will know if chosen option is effective. Reaches consensus on clear, observable measures of change as well as indicators of readiness to transition out of service.
- Engages Family Team members to share progress, successes, and challenges with chosen options (interventions, services, creative strategies, etc.) attempted since the last meeting as well as the measurable impact of these on goals and readiness to transition out of service. Helps team members express and celebrate successes.
- Explores the specifics of what worked, what did not, and what might help make the chosen options more effective.
- Explores ongoing and new needs (especially including those related to upcoming life transitions and safety/risk).
- Involves the entire Family Team in making decisions about ending or modifying services, treatment approaches, and safety interventions and brainstorms new options to meet new/ongoing needs.
- Reviews Family Team member's goals for, expectations of, and work with the youth/family.
- Acknowledges similarities and differences among approaches and facilitates discussions to make use of meaningful tensions among perspectives.
- Helps family team members avoid the use of jargon, abbreviations, rehabilitative or clinical language unfamiliar to family. If used, ensures it is explained.
- Based on goals agreed upon in Family Team meeting, documents goals (in youth/family agreed-upon language) in youth's treatment plan/ individualized action plan within 30 calendar days, and at 90-day intervals thereafter at minimum (greater frequency when needed to address the intensive needs of the youth/family).
- Shares draft treatment plan/individualized action plan with youth and family, in youth's and family's preferred language(s), and ensures that it is agreed upon and understood by all. Invites feedback and revises as agreed to with youth and parent/ caregiver/LAR and then obtains youth and parent/ caregiver/LAR and other required signatures and provides Family Team members with copies of plan.

COORDINATING CARE IN BETWEEN FAMILY TEAM MEETINGS

- Establishes and maintains weekly communication with Family Team members (or other frequency based on youth/family and DMH need). Communicates in mode preferred by family (email, text, phone call, etc.)
- Checks in with each Family Team member to learn about their progress on agreed-upon tasks. Explores tasks measurable impact on goal(s). Troubleshoots, problem solves, and empowers team to complete tasks and helps plan for next steps especially when encountering challenges/barriers to task completion.
- Helps youth/family and the Family Team recognize and celebrate "micro" successes week to week, as they occur.
- Actively addresses conflicting perspectives among youth, family, and Family Team members and revisits differences periodically.
- Gathers information on effectiveness in order to improve services to youth/family.
- Attempts persistently to include team members in care coordination. Makes diligent outreach efforts (secure email, telephone, in person) to contact any family team members that family identifies during initial assessment and intervention planning in order to include their perspective in written documents and to provide them with information relevant to their role in context of interventions.
- Helps family establish a two-way communication plan with prescriber to monitor medication (benefits, compliance, side effects, and changes) or does so directly if family needs assistance. Gathers input from prescribing practitioner at minimum before each Family Team meeting and treatment plan update.
- Consent permitting, shares information regarding youth/family permanency plan and status with family team members to maximize full understanding and ongoing support of the youth's/family's situation.
- Invites members of the care team (individual therapist, afterschool program, PCP, prescribing practitioner, etc.) to Family Team meetings as agreed upon with parent/caregiver/LAR.
- Explores the need for support around and attends prescribing practitioner meeting with youth/family as requested and/or helps youth/ family prepare for meetings (considering information to share, questions to ask, etc.).

BRIDGING WITH ALL ENTERING AND EXITING PROVIDERS/SUPPORTS

- Helps family navigate the service system and links youth/family with needed services, including but not limited to specialty consultations (OT & psychiatry); clinical services; social, educational, and vocational services; and formal and informal community resources.
- Coordinates with family and Family Team members to arrange or provide transportation as needed.
- Coordinates with youth/family as well as sending and receiving providers to ensure direct communication and continuity among them when necessary (e.g., coordinating psychiatrist-to-psychiatrist direct communication when there is a change in psychiatrist).
- Creates a bridge to services, schools and programs by creating opportunities for transition meetings with staff, family, and youth that are designed to assist the youth and family in establishing a comfort level with new services. Invites (consent permitting) new providers to Family Team meetings and intervention sessions. Engages in "warm" hand-offs (directly introduces the youth/family to a new service provider during which all three parties are present in person or virtually during a visit, meeting, or conference call as part of the process for supporting youth/family transition to a new service).
- Meets with the youth/family and any entering/exiting provider/supports (regardless of whether they are on the Family Team) to transfer information and practices to help sustain treatment gains and continuation of effective therapeutic/ behavioral interventions, safety plan approaches, skill-building activities, and care coordination.
- Ensures particular attention is paid to youth/ family voice, including specific interventions, skill development activities, and crisis prevention tactics that the youth/family reports to be helpful.
- Establishes an agreed-upon transition time frame that is viable and specific to the individual needs of the youth/ family.
- Exchanges necessary documentation (CANS, safety plan, discharge summary, etc.)

ASSESSING RISK, SAFETY PLANNING, AND SUPPORTING FAMILIES THROUGH CRISIS

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

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

Assessing Risk, Safety Planning, and Supporting Families through Crisis

COMPLETING INITIAL RISK ASSESSMENT AND SAFETY PLANNING

- At time of intake but no later than eight (8) hours after consent for services, conducts a risk assessment, and develops an initial safety plan with the youth and family to address any safety concerns that are identified at that time.
- Guided by available referral, any existing safety plans, intake, assessment, collateral information, and observation, invites each family member (as appropriate to situation) to describe any immediate safety concerns.
- Explores youth's risk of harm to self and others as well as their risk of harm by others. Explores family and youth medical concerns, fire safety, problematic sexual behavior, sexual exploitation, substance use, domestic violence, and elopement.
- Explores how the youth/family typically responds to crisis and who they reach out to, particularly natural supports and protective relationships, in moments of crisis, risk, and high stress.
- Gathers history of experience using formal and informal crisis plans and supports, including natural supports and emergency psychiatric services.

- Inquires about history of psychiatric hospitalization.
- Begins to develop a shared understanding with youth/family as to what they experience as moments of crisis, risk, and high stress.
- Explores and/or observes conditions in home and community and assesses for risk and safety (childproofing, weapons, pets).
- Provides contact information for on call/after-hours number and mobile crisis service.
- Provides contact information for on call/after-hours number and mobile crisis services . Discusses when to contact each entity, especially youth's/family's natural supports and protective relationships, and typical crisis response(s) by each entity during imminent and non-imminent risk.

CONDUCTING ONGOING EVALUATION OF THE FULL RANGE OF RISK AND SAFETY CONCERNS

- Engages in ongoing individual exploration with the youth, parent/caregiver, household members, and collaterals regarding youth safety concerns.
- Asks youth who they feel most safe with and when they feel most safe; uses youth/family engagement tools as appropriate to gather this information.
- Explores safety in environments youth/family frequent such as home, school, neighborhood, social media, etc., as well as any risk and safety precaution in place in these settings. Explores risks to psychological safety related to loss, disconnection from or removal of attachment, and protective adult relationships.
- Explores with each household member (youth, parents, siblings, etc) what they experience as cues/triggers to a crisis at home and in community locations and what they already do to safeguard youth and others in times of crisis (if any). Explores coping function of current safeguarding strategies and any unintended worsening of crisis.
- Explores cultural and community norms that parents/ caregivers ascribe to in order to keep their children safe. Approach with cultural humility and recognize that families may define safety differently than the way the system may define safety.
- Carefully considers the distinctions between self- harm and suicidality and provides family with psychoeducation on distinctions between these when needed. Explores intention, means, access to objects that may be used to cause harm to self/others.

ORIENTING YOUTH AND FAMILY TO THE SAFETY PLAN DEVELOPMENT PROCESS

- Discusses with youth/family how written (or visual) safety plan(s) can prevent or deescalate a crisis, as well as support their approach and manage provider, school, other collaterals, and support persons' participation in crisis situations.
- Discusses the benefit of involving others (Family Team members, DMH, OT/psychiatry consults, school, crisis support services, out-of-home provider, natural supports, police, family, etc.) in planning how they might help youth/family prevent risk and/or provide support in the moment of crisis.
- Explores youth/family concerns when they are ambivalent about or decline to make a safety plan and/or decline to involve people who may be a support in the planning process. Revisits discussion as clinically indicated. Uses tools such as a scaling question to identify what would help them move one or two step forward in involving safe and supportive adults.
- Provides ongoing, needed education on service's safety protocols, mandatory reporting, and crisis-response process (including role in supporting/collaborating with collateral's crisis response process) as well as the spectrum of emergency services, including different levels and types of response. Discusses with youth/ family when to use different levels of support and the possible results of using each.

DEVELOPING A USABLE SAFETY PLAN FOR PREVENTION AND INTERVENTION

- Develops/updates the written (and/or visual) safety plan in proportion to safety concerns present, in collaboration with youth/family, Family Team, and others (consent permitting).
- Tailors the safety plan to include youth/family's safe and protective relationships and specific viable action steps for each involved person. Includes strategies that have been successful in the past that youth/family can take to prevent crisis as well as those to use in the moment of crisis.
- Always includes emergency contact and other relevant support's information.
- Gathers feedback from youth/family and explores whether they can actually take all identified steps in the safety plan. Explores alternative feasible options when needed.
- Assists youth/family in having their safety plan in the visible and easily accessible location (paper on fridge/in wallet, entered in cell phone, etc.) that works for them.
- Includes strategies that may work across settings (home, school, community, etc.) and those that need to be different for each location. Encourages continuity across settings. Includes all relevant parties (consent permitting) in safety planning discussions with the youth/family. Reviews their expectations and existing safety plans (if any).
- Engages in ongoing consideration of the need for different safety strategies for different types of risk (suicide, arrest, parental medical/psychiatric emergency, bullying, youth parenting, etc.) in different settings (home, school, neighborhood, etc.).
- Explores and includes strengths that can be used to prevent crises.
- Engages in ongoing exploration of specific youth and family strengths with all family members and develops a shared understating of how these strengths can be used in the moment.
- Explores and includes formal and informal supports in the plan, that, if needed, may be available to help prevent or deescalate a critical incident; develops specific actions that can be taken by each to help the youth be safe over time.
- Once completed and consent permitting, promptly shares safety plan document with other providers, supports, and Family Team members who share responsibility for supporting youth/ family safety. Shares plan (as appropriate) with local crisis support team and on-call staff.
- Revises plan with youth/family when needed and promptly communicates any proposed amendments or new concerns to all.

PROVIDING ONGOING CRISIS SUPPORT AND REVISION OF SAFETY PLAN

- Regularly discusses effectiveness of safety plan with youth/family and among Team, DMH, Family Team, and other relevant natural and formal supports (consent permitting).
- Checks in with youth/family and collaterals around identified crisis cues/triggers youth/family are experiencing at home, school, or in community locations. Explores what aspects of the plan are working/not working (and why) as well as any new crisis cues/triggers they are experiencing.
- Role plays or practices actions on the safety plan with youth/family and relevant formal and informal support persons.
- Identifies the central need for continuous safe and supportive adult/family relationships and the importance of the maximum level of youth's contact with and access to them —in preventing crisis, supporting them through crisis, and following a crisis.
- Identifies the need for and increases service time with youth/family in order to prevent crisis, support them through a crisis, and support them following a crisis.

- Explores the ongoing need for new supports (e.g., alerting crisis support services, referring to outpatient therapy) as well as the need to increase the time spent with other current formal and informal supports before, during, and after a crisis.
- Always reviews and revises safety plan when new crisis cues/triggers are identified, if there are changes in youth's/family's clinical status, following a clinical/crisis/risk incident, when the plan is not working, and during preparation for a transition (change in living environment, school, or out-of-home treatment intervention, etc.).
- Verifies that supports listed in safety plan are still able and willing to carry out identified steps.
- Promptly communicates any proposed amendments or new concerns to Family Team and other relevant persons.

PROVIDING ON-CALL CRISIS SUPPORT

- Responds promptly to youth/family in-the- moment need for crisis support.
- Partners with youth/family to address imminent and non-imminent crisis in an empathic manner that validates the youth's/ family's experience of the crisis situation.
- Provides phone-based or virtual coaching and support around implementation of the safety plan. Assesses the need for, offers, and provides youth/ family with 24/7 face-to-face crisis response when and where the support is needed (family's home, school, community, or group care setting as agreed upon).
- Explores with the youth/family the steps they can take to manage during the crisis. Provides support in implementing the safety plan.
- Identifies the need for and collaborates with family to alert the youth's/family's support persons to implement their steps in the safety plan.
- Collaborates and coordinates with relevant formal and informal support persons/collaterals (such as mobile crisis services, police, group care, Family Team members, natural supports, etc.) prior to, during, and following a crisis. Continues with regularly planned Family Team meetings in times of crisis and calls additional Family Team meetings as necessary when crisis planning, and decision making is needed.
- Uses de-escalation skills and intensive short-term interventions to stabilize behavior during a crisis response. Teaches and encourages youth/family in development, use, and practice of self-calming and de-escalation skills. Considers the need for youth and family to have a break by taking the youth out of home (e.g., to go for a walk or engage in an activity) for a brief "cool down" period.

INCORPORATING PSYCHIATRY AND OCCUPATIONAL THERAPY

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

Incorporating Psychiatry & Occupational Therapy Consultation

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

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

COLLABORATING WITH THE OCCUPATIONAL THERAPIST (OT)

- Engages OT in consultative screening for every youth/family during the initial assessment.
- Explores with the OT and youth/family whether an OT consultative assessment is needed.
- Coordinates with the OT and collaterals so that the OT consultation and assessment includes all necessary settings such as home, schools, community centers, hospitals, and group care.
- Throughout provision of services, consults with the OT proactively and when there is a new disruptive/ maladaptive behavior or current approach to maladaptive behavior isn't working, especially when there are possible or established concerns relative to: sensory processing, gross and/or fine motor skills, visual motor or visual perceptual skills, social, cognitive skills or developmental factors persistently interfering with and impacting youth's engagement in meaningful participation in social relationships, education/vocation, eating, sleeping, daily living, leisure, activities of daily living (ADLs) and instrumental activities of daily living (ADLs).

- Incorporates and implements OT recommendations into ongoing assessment process, treatment interventions, safety interventions, and transition and discharge planning.
- Uses OT consultation to assist the Team's assessment and development of strategies to address environmental factors that contribute to disruptive and maladaptive behaviors.
- Uses OT consultation and assessment to inform the development of interventions that can support youth's development of healthy attachment, affect-regulation skills, social skills, positive coping skills, daily routines, family rituals, participation in education, play, leisure, social activities, sleep, school/work, activities of daily living, and independent living.
- When indicated, OT provides direct services to youth/family in accordance with agreed upon treatment goals.
- Prioritizes involvement of parent/caregiver/ family in all OT interventions and prepares and supports them to take on these roles.
- Uses OT consultation to educate family, Team, and Family Team members to support their understanding of factors contributing to current presentation.

COLLABORATING WITH THE OCCUPATIONAL THERAPIST (OT)

- Determines with OT how to include them/ their recommendations and updates in the Family Team meetings. Discusses how to use information from OT consultation to assist the Family Team in exploring and generating OT-informed options to address clinical complexities, especially when disruptive/ maladaptive behavior is persistent, improvements have plateaued, or high-risk behaviors are present.
- As agreed upon with OT consultant, includes consultant in or presents information from them at Family Team meetings and ensures that they have the opportunity to be involved in ongoing treatment planning, review, and modification.

COLLABORATING WITH THE PSYCHIATRY CONSULTANT AND INCORPORATING THEIR CONSULTATION

- Evaluates and considers the need for psychiatry consultation when:
  - Youth/family reports side effects of medication or lack of targeted effect of current prescriber's treatment plan.
  - Youth has comorbid mental health and medical diagnoses.
  - Team's comprehensive assessment and OT consult have not identified the factors driving or maintaining disruptive/ maladaptive behaviors.
  - Risk mitigation and management concerns are present.
  - Assistance in focal treatment planning and recovery-oriented approach is needed.
  - There is a need to address/improve linkage with the youth's primary care physician or psychiatrist.
  - Youth does not have a psychiatrist and interventions have not strengthened, developed, or maintained desirable behaviors or reduced or eliminated complex, challenging behaviors related to the youth's mental health condition.
- Obtains psychiatry consultation (as needed) and presents a comprehensive youth/family presentation with specific questions for the consultant.
- Determines with psychiatry consultant how to include them/their recommendations and updates in the Family Team meetings. Discusses how to use information from consultation to assist the Family Team in exploring and generating psychiatry- informed options to address clinical complexities, especially when a comorbid medical and psychiatric diagnosis exists, disruptive/ maladaptive behavior is persistent, improvements have plateaued, and/or high-risk behaviors are evident.
- As agreed upon with psychiatry consultant, includes the consultant in or presents information from them at Family Team meetings.

- Incorporates and implements recommendations into ongoing assessment process, treatment interventions, safety interventions, and transition and discharge planning.
- Uses psychiatry consultation to explore how to make a better linkage to treating psychiatrist and/or determine when to coordinate a consultation between treating psychiatrist/ prescriber and psychiatry consultant.
- Uses psychiatry consultation to assist treating psychiatrist in understanding the youth/family constellation and situation and incorporating key family/natural supports that best sustain or advance permanency for the youth.
- Uses psychiatry consultation to help family explore readiness for psychiatry evaluation and treatment (help them consider the pros and cons of medication, address general questions, etc.).
- Uses psychiatry consultation to assist in focal treatment planning and recovery-oriented approach.

PROVIDING THERAPEUTIC INTERVENTIONS

The Team engages youth and their family members in culturally informed therapeutic interventions (strategies, activities, and actions) that build autonomy and self-efficacy as well as strengthen permanency of relationships with caregiver(s)/parent(s), siblings, and other family members and important people in the youth's life (including "chosen family"). Therapeutic interventions also build connection and relationships with peers and natural supports. Therapeutic interventions assist families in resolving conflicts, building, and strengthening relationships, promoting healing, supporting lasting changes and enhancing and sustaining functioning in the community and home. In-session actions and strategies and in-between session activities (interventions and follow-up via phone, etc.) have a specific plan and purpose related to the goals in the established individualized action plan/ treatment plan.

Providing Therapeutic Interventions

Intensity, frequency, and duration of interventions are flexible, individualized, and build on youth/ family strengths in real and tangible ways that help them address their needs toward the goal of remaining at home, transitioning home, and improving youth's functioning in home, school, and their community. Youth's and family's reports of both improvements and challenges inform next steps as do Family Team member/collateral perspectives (including, but not limited to, occupational therapy (OT) and psychiatry consultation as clinically indicated and agreed upon by the consultants) and direct observation by the Team.

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

MAINTAINING THERAPEUTIC ALLIANCE

- Even in times of disagreement, continues to promote partnership with youth and family. Listens, acknowledges, and validates youth's and family's feelings, perspectives, and values using respectful curiosity.
- Exercises unconditional positive regard for youth and family members.
- Meets family "where they are at" and where they envision themselves to be.
- Communicates that everybody is doing the best that they can under difficult circumstances.

- Reframes deficit-based language to strengths-based or neutral language (e.g., attributes positive motives to actions that could be seen as a barrier or describes how parent "keeps working" to achieve sobriety vs. parent "keeps relapsing.") Supports youth and family members in separating problems from their identity, e.g., "I feel hopeless" rather than "I am hopeless".
- Explores ongoing readiness for change and commitment to treatment and other therapeutic interventions.
- Applies understanding of stages of change and adapts interventions to fit different levels of readiness among family members.
- Artfully plans and facilitates session interventions that are in tune with youth/and family members' readiness for change. Engages key family members in action when they are ready for change and supports all others in moving onto their next stage of change.

SELECTING THERAPEUTIC INTERVENTIONS TO BE USED IN YOUTH/FAMILY SESSIONS

- Building on the assessment and Family Team's treatment planning process, the Team collaborates with the parent/caregiver in ongoing exploration, selection, and modification of therapeutic interventions and strategies.
- Includes interventions youth, family, and others report to have been effective and can be adapted for use in the family and community setting. Revisits interventions that may not have worked in the past that the youth/family would like to try again. Asks the youth/family specifically, what would help this intervention work at this time or better than it did in the past.
- Considers other providers/supports' interventions that are being used with family and chooses complementary interventions.
- Incorporates the use of approaches, strategies, or recommendations made by OT/psychiatry consult.
- Considers both evidence-based practices and practice-based evidence to guide intervention approach and fits established evidence-based practice elements to a particular youth and family, rather than fitting family to manualized treatment. Assures that interventions selected support the primary healing role of parent/family and maintain or advance permanency progress and outcomes.
- Considers culturally informed interventions that make use of youth/ family strengths.

PREPARING FOR THERAPEUTIC INTERVENTIONS AND SKILL BUILDING

- Team members) collaborate on objectives and interventions to meet goals.
- Team members consider together how to apply and integrate support activities, such as coaching skills, to enhancing communication and social connectedness.
- Team members discuss together how they will strategically prioritize, prepare, and partner with family/natural supports and community resources in intervening.
- Team members highlight for one another the youth and family successes they notice and troubleshoot together around strategies to address challenges.
- Team members anticipate and plan together for addressing logistical barriers and supporting overall congruence of the treatment plan interventions, strategies, activities, and actions each Team member is carrying out.
- Coordinates and includes others in the session (e.g., , extended family, other Family Team members, natural supports, and group care staff) as applicable and agreed upon. Engages in ongoing collaboration with others on integrated and complementary interventions.
- Prioritizes family therapy interventions versus individual focused interventions only.

- Arranges to engage in interventions at the location where challenges occur and/or locations where youth/family need support/coaching to practice skills, such as at home, during activities in the community, at school, etc., as identified with the family.
- Attends sessions prepared with a strategy to achieve an agreed-upon goal of the session and adapts the strategy as needed to meet the needs of the moment.
- Attends sessions prepared to articulate the reasoning behind the intervention, approach to treatment, and the structure of each session as well as how the various other team members' interventions compliment this one.

STRENGTHENING AND BUILDING YOUTH'S AND FAMILY'S SAFE AND PERMANENT RELATIONSHIPS

- Identifies the need for and develops strategies to build on and strengthen youth/family relationships, connections, and attachments.
- Targets family and individualized interventions to strengthen and build youth's safe and lasting relationships and emotional relationships/connections with siblings, parents, other relatives, attachment figures, and important people in their life.
- Creates opportunities to nurture healthy, lifelong relationships and connections with immediate and extended family and other important people who reside near and far.
- Facilitates clarification of past life events and experiences and emotional healing, reconciliation, or reconnection to lost relationships as necessary and helps Family Team members understand the critical role that relational readiness work can have on lasting treatment gains, trauma recovery, and success of permanency.
- Supports youth and family in developing new memories of fun and enjoyment together.
- Explores family member's memories of past times having fun together. Asks about specific activities they have enjoyed and any new ones they may enjoy doing together.
- Engages family members in practicing new ways of engaging with one another that promote feelings of safety, closeness, empathy, love, and joy among family members.
- Creates opportunity for parents/caregivers to reflect on how they were parented and how this may have affected the way that they parent and build relationships with their own children.
- Encourages parent/caregivers to identify positive parenting qualities they want to be known for and leave as a legacy to their children.
- Collaborates with parent/caregiver to identify if/ when adaptive parenting strategies could help support their specific youth's temperament, experiences, or behaviors and explores opportunities to strengthen and support what is working.
- Collaborates with youth/family to identify any need for new patterns of interaction, communication, and coping and explores ways to help them implement these through modeling, practice, and/or other strategies and interventions.
- Address attunement, trauma, and emotional regulation concerns that interfere with family members forming and maintaining meaningful relationships with one another.
- Practices attunement and attachment activities and helps family increase the various ways in which they express attachment, compassion, hope, and empathy with one another.
- Practices trauma-informed responses to crisis and stress reactions with youth/family members. Allows time to defuse and process emotion and validates family and youth's sense of loss, shame, guilt, frustration, anger, and/ or other emotions related to conflicted youth-parent and sibling relationships.
- Assesses the need for and explores with parent/ caregiver ways to channel overwhelming emotions into action steps that will allow them to make changes, focusing on what they can do now to make life better for the youth and/ or strengthen the youth-family relationship.

- For youth who have lived with a variety of individuals, families and/or in congregate care settings, explores the youth's sense of belonging, family memberships, and loyalty conflicts with all these individuals, families, and systems (especially those with birth parents/family and other parents/ families with whom they need reconciliation, or they want to be lifelong/lasting relationships).
- Helps youth understand who had meaning to them and for whom they had meaning.
- Supports youth's acceptance that they do not have to choose between people. Weaves a thread of continuity and integration of all the various relationships and families that the youth has been a part of. Uses their working relationship strategically to bridge relationship gaps and facilitate reconnection or reconciliation between youth and family or between youth's family members.
- Helps youth preserve a sense of relationship/ connection with other important family members (birth, extended, resource families, and significant others) concurrently with those providing parenting/care now.
- Uses tools like timelines, ecomap, life books, life maps, etc. to help youth reflect on and visualize historic, current, and future membership and shifting roles of family/chosen family and other important relationships in their life. Help youth grieve relationships that are no longer possible.

ENGAGING YOUTH/FAMILY IN STRATEGIES TO STRENGTHEN A BROAD RANGE OF SKILLS

- As needed, agreed upon, and prioritized with family, implements skill-building strategies with the youth, parent/ caregiver, and family separately and together to develop and practice skills to achieve goals.
- Pays special attention to developing skills that will help the youth and family continue to reside together or to prepare for youth's return home.
- Engages family in specific, individualized, skill- building activities that promote emotional regulation, stress management, self-care, recovery, resilience, social and interpersonal relationships, hopefulness, and awareness of effective and ineffective response to symptoms of mental illness.
- Engages family members in skill building that supports youth's medication use (such as scheduling strategies, ongoing communication with prescriber, preparation for medical appointments, etc.).
- Engages family in skill-building activities that promote physical health maintenance (e.g., diet, exercise, participation in primary medical and dental care, etc.).
- Supports skill development around household members' roles and responsibilities, daily structure, routines, rituals, and use of home and community environments.
- Engages family/chosen family and youth's natural network in supporting preparation for adulthood and skill attainment as developmentally appropriate (e.g., money management, purchasing and caring for personal items, meal planning and preparation, housekeeping, laundry, transportation use, leisure interests, and vocational achievement).
- Prioritizes roles for family/chosen family and youth's natural network in teaching or supporting youth in learning these skills as another avenue to building or strengthening youth/family relationships and preserving the gains beyond home based service involvement.
- As needed, agreed upon, and prioritized with the parent/caregiver, implements skill- building strategies with the parent/caregiver.
- Strategizes with parent/caregiver to help them strengthen skills in self-care, co-parenting, balancing the care of all children, keeping family members safe (at home, school, and in the community), and meeting the family's basic needs (food, shelter, clothing, personal hygiene, medical and wellness, etc.).
- Validates and addresses items that make parenting more complicated, such as parenting with mental illness, substance use, multiple jobs, extended family/friends living in the house, challenging physical living environment, lack of natural supports, effects of systemic racism etc.

- Supports parent/caregiver skills in nurturing, fostering, and strengthening their children's relationships with one another.
- Helps parent/caregiver build resiliency in the face of guilt, shame, disappointment, regrets, grief, loss, and morning over expectations held for youth as well as past traumatic experiences and other difficult experiences the youth had.
- Identifies the need for and uses participatory practice/role play, coaching, skill building, and modeling of new skills in a variety of locations such as home, school, and community.
- Gives youth/family members specific tasks to practice and explores successes and challenges with tasks in between sessions and during sessions.
- Creates opportunities for youth/family to test, practice, and adjust strategies that were used in one environment and will now be used in another (such as generalizing the use of skills from the group care to the home, school, and community environments). Fosters and provides multiple opportunities for parents/caregivers and youth to experience mastery in using new skills.
- Uses de-escalation skills and intensive short-term interventions to stabilize behavior during a crisis response. Teaches and encourages youth/family in development, use, and practice of self-calming and de-escalation skills. Considers the need for youth and family to have a break by taking the youth out of home (e.g., to go for a walk or engage in an activity) for a brief "cool down" period.
- Promotes youth's and family's individual self- worth and builds their confidence to participate in a shared decision-making process by exploring and developing skills to strengthen their articulation of thoughts, feelings, opinions, and questions in a variety of forums. Reinforces the primary role of parent/family/ protective adult relationships in youth's healing, recovery, and sustaining of treatment gains.
- Explores the need for and coaches youth/ family around leadership skills they can apply in treatment, care coordination, home, community, and Family Team meetings.
- Builds skills and self-efficacy toward leadership and collaboration with Family Team and other entities. Supports skill development around parent/caregiver engagement with youth's school to ensure that their educational needs are met (e.g., understanding IEP process).
- Builds/strengthens skills needed for attaining other services, entitlements, support groups, and benefits for themselves and family members as well as the attainment of ongoing education/information regarding youth's diagnosis/medication and ways to anticipate future changes.

EXPLORING PROGRESS AND TRACKING CHANGE

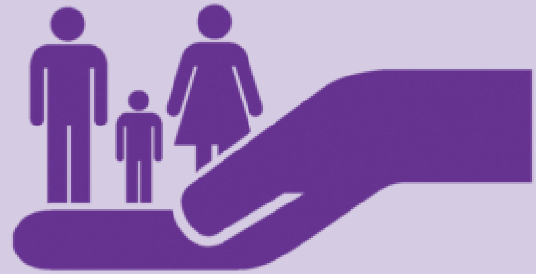
- Asks about and seeks input from youth/family on their experience with interventions, skill building strategies, and assigned practice tasks. Explores barriers as feedback about (not resistance to) the intervention.
- Makes direct observations of youth's/ family's strategies, reinforcing, or supporting and encouraging effective ones. Uses in- the-moment opportunities to model/ suggest different strategies to try.
- Throughout intervention and skill building, uses data (rating scales, tracking school attendance, brief survey, etc.) on measurable objectives in order to clarify family, youth, and/or Family Team member's impressions of progress as well as to inform future interventions.
- Continuously explores and observes youth's/ family's overall response to interventions, treatment, and skill building.
- Explores impact on youth/family functioning and adjusts interventions accordingly.
- Recognizes and addresses changes in mental health and substance abuse symptoms as well as illegal or risky activities (gang involvement, drug dealing, sexual exploitation, etc.). Obtains any necessary consultation to address these need areas adequately and coordinates and links youth/family to specialty services and treatment interventions when indicated.
- Updates safety plan, including updating the names, roles, and tasks of safe and protective adult relationships, with youth/family as appropriate.

PROVIDING PSYCHO-EDUCATION

- Acknowledges complexity of youth's and family's situation and provides information to help answer youth/family questions regarding youth's diagnosis, common symptoms, treatment approaches, etc.
- Provides information, as appropriate, regarding developmental and functional expectations for youth.
- Provides information/answers questions about trauma and loss reminders, post-traumatic stress reactions, rage-and-loss reactions, grief reactions, and the impact thereof on development.
- Provides/links family to resources to better understand medications and alternative healing practices (consults with psychiatrist regarding psychoeducation around medication as needed).
- Builds understanding of family systems: - that individual family member's behavior, feelings, expectations, and functioning within various domains impacts other individual family members as well as the family system as a whole. Builds understanding that the environmental contexts in which family members live and engage impacts them as well.
- Discusses with youth and family the fact that others have similar experiences. Shares support- group information. Extends an ongoing invitation to youth and family members to participate in relevant trainings, conferences, and groups related to youth's/family's experiences (explores with the parent/caregiver the option of inviting Family Partner to provide support to them during training).
- Assists youth/family in seeking out and accessing resources to increase understanding and support for family members and youth regarding youth's experiences, symptoms, and diagnosis.

CONTINUITY WITH HIGHER LEVELS OF CARE

The Team collaborates and coordinates with all relevant Family Team members (especially parents, family, and youth's and family's natural supports) and collaterals (such as providers, school personnel, professional and natural supports, group care, hospital staff, etc.) to support continuity of treatment and supportive approaches with the youth/family while the youth is in an out-of-home treatment intervention (such as group care or hospital, etc.).



Continuity with Higher Levels of Care

When clinically indicated and authorized, the Home-based team may be paired with group care as a short-term, flexible treatment intervention that is integrated with the Home-based team treatment plan and incorporates clinical and therapeutic interventions necessary to strengthen youth's and family's skills that promote flourishing together at home.

The Team coordinates the use of consistent effective strategies and approaches with youth and family across all of these entities and settings. The Team shares successful approaches with the other levels of care (as agreed upon with youth/family) and also utilizes other's approaches that youth and family has had success with. The Team supports continuity of treatment by continuing to provide seamless initiation or continuation of the same intensity of family treatment, ongoing family engagement, youth and parent skill building, peer mentoring, care coordination, and linkage to the community when a youth is participating in an out-of-home treatment intervention. They continue to promote and build connections between youth/family and natural network of supports as well as professional long-term, community-based supports while the youth is in an out-of-home setting. They help to coordinate, as clinically appropriate, the youth spending as much time as home as possible to provide practice for a smooth transition back to home.

ENSURING CONTINUITY DURING ENCOUNTERS WITH MOBILE CRISIS SERVICES

- Anticipates crisis intervention needs. Proactively provides on-call staff and mobile crisis service with needed alert information, consent permitting.
- Offers to be an in-person supportive presence to youth and family during mobile crisis service encounter. Explores with youth/family the natural support persons best suited to provide in-person support and presence during a crisis.
- Exchanges and updates information with mobile crisis service daily through the duration of the mobile crisis encounter, consent permitting.

SUPPORTING YOUTH/FAMILY ORIENTATION TO OUT-OF-HOME INTERVENTION (HOSPITAL, DETOX, GROUP CARE, ETC.)

- Explores youth/family experience with the specific level of care (group care, hospital, detox, etc.) and the particular facility youth will or may be admitted to.
- Empowers family as experts on their youth/ family. Explores and validates youth and family concerns about using this level of service/ facility and provides psychoeducation on what to expect when youth is admitted.
- Reviews roles and responsibilities of Team members relative to group care, hospital, and detox staff.
- Explores youth's and family's expectations around frequency and type of contact they hope to have with youth once admitted. Encourages daily contact.
- Assists parent/caregiver/LAR and out-of-home facility in exploring options for daily contact between youth and family members (such as phone, email, in person, etc.).
- Plans for, anticipates, and addresses barriers to maintaining daily contact between youth and family members.
- Offers to be present during acute treatment admission (psychiatric hospitalization, medical hospitalization, detoxification, etc.) and remains with the youth during the admission process.
- As agreed upon with youth/family, assists with contacting/engaging natural support persons best suited to provide physical support and presence to youth/family during a crisis.
- Provides needed information to acute facility during the admission process, consent permitting.
- Serves as a resource to aid acute facility in their assessment. Consent permitting, provides current Home-based team assessment, individualized action plan/ treatment plan, and safety plan in writing to the acute treatment provider as soon as possible but no longer than one business day after the admission.
- During the youth's acute treatment intervention, maintains a therapeutic relationship with youth and family.
- Reaches out to youth and/or family daily by phone or in person (unless otherwise agreed upon). Checks in with youth/family regarding necessary ongoing frequency of this contact.
- Explores frequency of visits family has with youth and needed support to help visits occur.
- Provides ongoing treatment interventions, assessment, and safety planning.
- Continues to bridge youth/family relationships with Family Team members and supports relationship development with acute facility team members. Helps support communication between inpatient psychiatrist with outpatient psychiatrist.
- Provides the acute facility team members with contextual information re: permanency situation to prevent disruption or disconnection of relationships, promote continuity for youth, and reinforce primary role of parents/ family in treatment, healing, and trauma recovery process.
- Reaches out to acute provider daily to exchange progress updates and build a shared understanding of clinical formulation, strengths, treatment goals, and discharge plan.
- Coordinates and collaborates around LGBTQ, cultural, and dietary considerations for integration into the acute setting, group care, school, and home and/or community settings.
- Collaborates and coordinates with youth, family, and acute treatment team on integrating treatment approaches, interventions, recommendations, and medication changes. Incorporates them, as agreed upon with youth/family, into the existing Home-based team treatment plan.
- Prior to discharge, explores step-down options, new supports, and interventions needed. Comes to agreement around any action items and begins developing/ integrating new approaches at home, group care, community, school, etc.
- Coordinates with acute provider to ensure a discharge meeting is held. Participates in or co-facilitates discharge meeting with acute provider prior to discharge.

- Develops/updates the safety and crisis prevention plan with the youth, family, and acute treatment team as part of acute-treatment discharge process, making sure to include the identified roles of youth's/family's safe and protective relationships/natural supports.
- Coordinates with the acute treatment provider in support of their discharge paperwork, follow-up appointments, and other pertinent information and materials (e.g., prescription, prior authorizations, personal belongings, etc.) being provided to the appropriate entities (family, Team, group care, school, prescriber, and outpatient and other treatment providers, etc.).

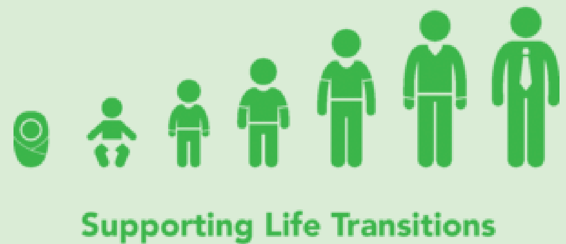
ENSURING CONTINUITY DURING GROUP CARE TREATMENT INTERVENTION

- Coordinates, co-facilitates, and participates in a pre-intake meeting with group care staff, youth, and family. Prioritizes participation of youth and parent/caregiver/LAR in exploration, selection, and decision about group care.
- Attends intake meeting with group care staff, family, and DMH and is present at admission to group care.
- Establishes roles and responsibilities of group care, Team, and Family Team. Discusses process for coordinating care and integrating treatment planning and safety planning with the group care.
- Co-creates initial goals of group care treatment.
- Facilitates agreement on initial plans for youth to have continued contact with family by phone and in person at the group care. Develops an initial plan for time spent at home.
- Coordinates with the family, LAR, and the group care provider to ensure that youth and family have in-person contact at the family's home and community as often as possible during a time of day that is reasonable, practical, and convenient for them, including evenings and weekends (lack of imminent risk permitting).
- Considers transportation needs, use of natural supports, creative approaches, or other factors that will set youth/family up for successful time together.
- Coordinates a plan with group care, youth, and family/LAR that helps youth/family structure home/community time. Considers and plans for multiple factors (such as length of time at home, who will be present, how time will be spent, level of structure needed, how crisis will be anticipated and dealt with, etc.).
- Safety plans with youth, family, and group care. Updates/amends the safety plan document.
- Plans for and provides 24/7 face-to-face crisis response and support to youth and family while youth is in the home and community.
- Meets—quarterly at minimum—with out-of-home treatment provider, youth, family, and Family Team Members to revise the youth's treatment plan.
- Coordinates with the group care to ensure that the goals, objectives, and interventions of the group care are aligned with and integrated with the treatment plan. Co-creates, reviews, develops, and integrates goals of the group care treatment intervention into the treatment plan.
- Considers how to integrate activities of the family partner and peer mentor with the group care.
- Coordinates with group care, family, school, and community programs to support continuity of youth connection with, engagement in and participation in school and community activities to every extent possible while in group care.
- Provides family treatment, parent/caregiver support, outreach, and peer mentoring in the home, community, and/or at the group care.
- Identifies the need for and engages youth/ family in any skill building and coaching needed to support youth and family spending the maximum amount of time together at home and community as well as their participation in school and community activities.
- Has weekly contact with the out-of-home treatment provider to exchange progress updates, coordinate care, and integrate treatment approaches, interventions, and goals.
- Exchanges updates on progress in treatment as well as updates on youth's and family's strengths, challenges, and use of safety plan.

- Coordinates support to families around planning for activities related to time spent at home and community. Explores progress with and ways group care and home-based team are attempting to maximize amount of time youth and family spend together at group care and at home and in their community.
- Explores, coordinates, and revisits ways group care and home-based team are supporting caregiver/parents' continued or new engagement in parenting activities that are feasible for the particular parent (e.g., attending PCP or dentist appoint with youth, taking youth shopping or for a haircut, providing holiday gifts, saying goodnight to youth each night, etc.) and that are congruent with their cultural practices.
- Plans for Family Team meetings, discharge, care coordination activities, and any needed follow up with youth, family, DMH, and school around action items and next steps to integrate new approaches at group care, community, home, school, etc.
- Anticipates and plans for challenges, transitions, and crisis prevention/safety planning. Coordinates safety planning, implementation, and updates to the safety plan.
- Coordinates the sharing of documentation.
- Explores with the out-of-home treatment provider, youth, family, and other Family Team members which support services are needed to help youth and family return to living together in the community.
- Provides interventions that support youth and family living together. Bridges them to any additional formal and informal supports that are needed to help them return to living together.

SUPPORTING LIFE TRANSITIONS

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



ANTICIPATING AND PLANNING FOR LIFE TRANSITIONS

- Anticipates life transitions (such as changes in school/class/grade, school vacation, sibling or friend moving, parental change in work schedule, change in an important member of the treatment team, anniversaries, etc.).
- Navigates anticipated and unexpected life transitions. Discusses anticipated transitions in ongoing Family Team meetings. Holds ad- hoc meetings with Family Team to address unplanned transitional needs.
- Explores need to change the intensity, frequency and/or type of services and interventions to support youth/ family through transition. Brainstorms strategies with Family Team to meet youth/family need for support through these transitions.
- Develops a transition support plan with strategies to support youth/family through the life event and address the potential impacts on other aspects of life (e.g., impact of change in parent's work schedule on youth's morning routine and transportation to school).
- Collaborates with youth/family/Family Team to determine ways to sustain necessary routines during time of transition.
- Considers influence of youth's developmental stage on transition.
- Considers and validates the unique impact and experience this youth/family might have with the transition.
- Explores with the youth/family which individuals (teachers, Family Team members, natural supports, etc.) need to be proactively notified of life transition. As agreed upon, shares potential techniques to support youth/ family navigating through the transition.

SUPPORTING YOUTH/FAMILY THROUGH LIFE TRANSITIONS

- Considers the need for and engages in collaboration with family, youth, and school to ensure maintenance of successful school routines throughout any life transition.
- Validates and normalizes youth/family feelings, fears, hopes, and worries associated with life transitions. Processes youth/family loss and grief associated with life transitions. Helps the youth/ family identify hopes and celebrates successes.
- Adjusts service approach and interventions in order to provide targeted support and skill-building coaching to the youth/family during times of life transition.

- Explores need for and encourages connections with natural supports during transition period.
- Provides continuous encouragement to both youth and family in using plans to support youth through transition. Celebrates successes.
- Explores with youth, family, and Family Team aspects of the transition support plan that are/are not successful. Updates plan with all relevant parties to increase success.
- Collaborates with OT around potential strengths and challenges of youth's transition to young adulthood. Considers the use of various tools to assess youth's strengths and needs in preparing for young adulthood within the context of ongoing parent/caregiver/family relationships.
- Partners with the youth/family to anticipate and identify strengths and challenges in preparedness for adulthood (especially for those leaving group care or any youth who will be living independently after discharge).
- Considers the lack of safe and permanent parent/caregiver/family at the time of transition to be an acute need (emergency) that must be immediately addressed and remediated by the youth's Family Team. Underscores with youth and Family Team the risks for youth who transition from out of home treatment interventions without safe and permanent family relationships.
- Collaborates with youth, school and family, OT Consultant around opportunities that will help youth achieve educational success and skill attainment for post-secondary educational advancement and/or gainful employment, and other preparations for independent living.
- Educates youth on and helps them identify and develop skills to navigate the transition from school to work.
- Provides and/or links youth to needed assistance with employment, college, and/or financial aid applications.
- Explores frequency of visits family has with youth and needed support to help visits occur.
- Provides ongoing treatment interventions, assessment, and safety planning.
- Explores with youth and parent/caregiver/LAR the needs that youth has that could result in the use of adult services/benefits.
- Shares and/or links youth and parent/caregiver/ LAR to others with expertise in resources and services available to adults and ways to navigate the adult service system.
- Encourages, coaches, and empowers youth in securing documentation (i.e., social security card, birth certificate, Mass ID, etc.) as well as applying for and accessing adult services and benefits (e.g., Mass Rehab, Job Corp, vocational training). Involves youth's family and natural supports in securing these items and services together with the youth whenever possible, promoting this as another tool to strengthen relationships, work positively together, and enhance self-advocacy skills as well as decreasing ongoing reliance on professionals and systems.

SUPPORTING YOUTH IN TRANSITION TO YOUNG ADULTHOOD

- Normalizes and prioritizes youth's need for supportive relationships as they transition into adulthood.
- Explores, with youth and parents, how they are navigating their transitioning relationship as it relates to shifting responsibilities, custody status, decision making, etc.
- Discusses with youth and parent/caregiver/LAR each person's vision for how they will/will not stay involved in each other's lives as the youth moves into adulthood.
- Explores with youth and parent/caregiver which relatives and other caring adults will provide the youth with support as they move into adulthood. Facilitates purposeful joint conversation between youth and family/natural supports about what, specifically, the youth can expect from each adult relationship and what each adult can expect from the youth.
- Assesses and strategizes with the youth, parent/ caregiver/LAR and Family Team around the unique physical, relational (and potential legal) permanency needs of transition-age youth, especially those leaving foster care or a group care who will be living independently.

- Provides information and/or linkages to resources including those relevant to guardianship needs as indicated.

BRIDGING YOUTH'S TRANSITION OUT OF HOME-BASED SERVICE

- Explains at intake and throughout service delivery, to youth/family and Family Team, that continuation of home-based services depends on family choice and DMH determination of clinical need.
- Begins discharge planning (including the youth's vision for themselves as a young adult) at intake and throughout the service with youth/family and Family Team. Increasingly over time, creates opportunities for parent/caregiver and family/natural supports to adopt roles and responsibilities together with the youth, rather than the professionals/system.
- Builds consensus among youth/family and Family Team members regarding how they will know when it is time to end home-based services and how they will measure progress toward that end.
- Addresses different perceptions to reach consensus on readiness to end home-based team intervention.
- Reviews readiness for transition out of services on a quarterly basis, at minimum, with the Family Team (and more frequent as needed and agreed upon especially during active transition).
- Continually monitors youth/family, Family Team members, and other relevant formal and informal supports' perspectives on challenges and progress toward increasing readiness to transition out of Home-based team services. Builds ongoing, congruent understanding of strengths, treatment goals, strategies, and interventions needed to progress toward transitioning out of Home-based team services.
- Uses data on measurable goals (# of school days attended, # of times successfully used coping skills) to reflect progress and readiness for exiting services. Validates the youth's and family's progress, readiness, and apprehension.
- Explores the drivers that move progress/readiness forward and the challenges that restrict progress/ readiness for transition out of Home-based team.
- Brainstorms and prioritizes options to overcome challenges and strengthen drivers of success and readiness.
- Prepares with youth/family for planned transition out of Home-based team.
- Gradually engages the youth/family in less frequent sessions/interventions. Discuss loss of Home-based team support and any other changes in youth/family support network.
- Discusses success, reviews internalized skills, and ensures that family members can coordinate care. Plans with youth/family for a final Family Team celebration of successes. Helps youth/family prepare reflections they may want to express during the meeting.
- Prior to discharge, uses challenges and moments of crisis as opportunities to learn and plan for a future with less intensive supports.
- Identifies and bridges to ongoing and new connections to formal and informal resources and clinical services likely to sustain healthy functioning after Home-based team Services end.
- Establishes an agreed-upon transition time frame that accounts for youth's/family's specific individual needs, waitlists, potential barriers, delays to transition, and the time needed for bridging overlap with other providers/supports.
- Collaborates with youth/family in determining who will refer them to needed services (i.e., self-referral vs. provider referral). Assists in addressing access barriers by discussing wait lists with family, advocating for priority access with new providers when appropriate, and partnering with youth/family on follow-up actions.
- Anticipates challenges that may arise after transition. Plans with the youth/family and remaining/ongoing team members around potential challenges to sustaining functioning after Home-based team services end.
- Develops a post-transition crisis plan with youth/ family that addresses potential risks, coping skills for reducing risk, behaviors that precede crisis, and specific steps for youth/family members to respond effectively to risks (avert or manage crisis).
- Reinforces family/natural supports and includes the specific relationships that are most protective and easily accessible to the youth in a time of crisis.

RESPONDING TO UNPLANNED SERVICE ENDINGS

- When youth/family show signs of risk for unplanned ending of Home-based team or other service, the Team makes respectfully persistent efforts to contact and reengage the family/youth in the service. Discusses/ offers changes in approach that might work better for youth/family. Explores the family's interest in meeting with Team and/or Home-based team leadership to explore options for strengthening the work of the Team with the youth/ family.
- When Home-based team or other service ends in an unplanned manner, contacts family to understand reason for ending and discusses next steps, including referral back to DMH to help with any needs that the family may still have.
- Informs Family Team members of unplanned ending and works with DMH and relevant providers to determine if there is a way for the Family Team to offer youth/family support recommendations, say goodbye, and refer youth/ family to others who can meet their needs.

DEVELOPING A DISCHARGE PLAN

- Clinician develops a discharge plan with the youth, parent/caregiver/LAR, and Family Team and shares it with youth, parent/caregiver/ LAR, Family Team members and new providers to whom the youth is transitioned.
- Completes and uses the discharge CANS for discharge planning purposes, outcome measurement, and baseline indication of the youth's and family functioning at discharge.
- Attaches the post-transition safety plan to the discharge plan.
- Shares discharge plan (with attached safety plan) with family and Family Team members and other relevant parties, consent permitting.
- Writes a discharge plan in everyday language that reflects hope, possibility, and explicitly states signs of resiliency.
- Includes a summary which describes the youth/ family culture and language preferences, vision, review of needs and strengths, progress toward goals, current medications, anticipated challenges, and next steps for sustaining gains. Elicits and describes youth's/family's input on their progress and experience of Home-based team services.
- Describes successful behavioral support strategies that can be followed in the future (includes crisis prevention and intervention strategies).
- List future provider/collateral appointments with date, time, location, and contact information. Includes contact information for all formal and informal supports, resources, and community-based services to be used as part of the aftercare plan.
- Describes actions/support plan to ensure continuity of all remaining/incoming treatment services, including psychopharmacology.
- Describes actions/support plan relative to employment/education that has been worked out with the school or school district, where applicable. Includes provisions to ensure a seamless transition to a new school, if applicable.

BRIDGING COMMUNITY INTEGRATION

The Team engages in an ongoing process of exploring, discovering, and strengthening interests, relationships, connections, and supports in the youth and family's environment who can celebrate with the youth/family in good times, comfort them through difficult times, contribute to a sense of belonging, remain unconditionally committed, and may also provide tangible assistance. They may be extended family, friends, faith community, neighbors, people from school or work, or acquaintances and other natural supports who play a positive role in the youth's/ family's life. They may also be places where the youth/family can volunteer, play, learn, worship, socialize, and build resiliency.

Bridging Community Integration

They involve naturally occurring community resources and supportive people that align with youth's/ family's interests, support the youth's/ family's goals, and carry them beyond the reach of formal services. The Team thoughtfully uses available flexible funds to support and build family and youth's interests and resources. The Team helps family members consider ways to involve natural supports and include them in Family Team meetings and interventions (as agreed upon with the youth/family). The Team collaborates with the youth and family to help them connect to and sustain connections with naturally occurring relationships, resources, and supports.

EXPLORING NATURAL SUPPORTS

- Explores (ongoing) with youth/family their current sources of social, emotional, and practical support. Validates the basic, essential, and universal human need for support that comes from family, neighbors, friends, faith community, support groups, coworkers, etc. (natural supports).
- Uses brainstorming, ecomap, timelines, or other tools for robust discovery of youth/family support networks. Asks curious conversational questions about the people with whom the family interacts on a daily basis (e.g., curious inquiry about photos hanging in the house or people with whom they exchange gifts, favors, babysitting, etc.).
- Brainstorms with the youth/family ways of developing support from people they know (neighbors, friends, faith community, support groups, coworkers) as well as ways of discovering and connecting to new individuals for emotional, practical, and/or social support.
- Discusses possibilities for cultivating a reciprocal supportive relationship with natural supports to help prevent burnout.
- Assists youth/family in identifying and processing important relationships that have been lost or damaged and their wishes or needs for healing, reconnection, or reconciliation. Assists youth and family in repairing relationships with each other and with natural supports. Considers with youth/family ways of rebuilding and strengthening natural supports when family feels they have too few/none, due to isolation, conflict, damaged relationships, or burnout, which may occur on either side of the relationships.
- Helps youth/family share progress made, how things are different, what has been learned and their new ways of relating and coping.

INCLUDING NATURAL SUPPORTS IN MEETINGS AND INTERVENTIONS

- Has ongoing discussion with youth/family members regarding how their natural supports could be included in Family Team meetings and in interventions. Explores practical solutions to the question, "what would it take?" for each of these natural supports to be included.
- Explores the type, extent, and benefits of involvement that identified persons could contribute (e.g., respite care, phone support, occasional shared activity, good ideas, etc.).
- On a routine basis, revisits family readiness (sometimes expressed as reluctance, fear, worry, shame, etc.) to bring natural supports into the Family Team meeting and interventions. Uses tools such as a scaling question to identify "what would it take?" for youth/family to include natural supports.
- Collaboratively creates actionable steps with youth/family to engage natural supports, including who will contact and follow up with each person.
- Uses urgency and persistence in reaching out to natural supports (consent permitting) and is not deterred when these individuals do not respond to initial engagement efforts.
- Invites and welcomes natural supports to Family Team and Family Team meetings and/or interventions. Invites participation according to an established plan that has been developed with youth/family. Includes natural supports in face-to- face and/or virtual Family Team meetings and in ongoing communication, as established with family.

EXPLORING AND STRENGTHENING INTERESTS

- Explores with youth/family members who and what interests them, brings them joy, and helps them meet their basic needs and/or make life a little easier or fuller. Explores hobbies, activities, faith, and culturally based events and people that bring them enjoyment. Asks what they like to do on the weekends, after school, after work, and during vacations. Asks what they like to do as a family and on their own.
- Explores youth's/family's use of old, current, and potential new community activities and resources (local community center, community theater, other community groups, diversity and cultural clubs, youth sports league, Boys & Girls Club, lessons, classes, clubs, parent/caregiver support groups, sibling support groups/activities, adult sports leagues, food pantries, etc.) that match their interests, strengths, and needs.
- Explores youth's and family members' level of current access to and need for connection to these activities and resources.
- Accesses OT consults during the process of exploring youth/family strengths/interests.

LINKING YOUTH/FAMILY TO INTERESTS/RESOURCES

- Makes a plan with family that identifies how Team will "do for, do with, or cheer on" youth/ family in researching, contacting, enrolling, and participating, in community activities. Coaches family on needed skills to engage in activities.
- Revisits plan regularly. Follows up with youth/family in ongoing discussion to see if activities meet social, emotional, and practical needs/goals or if additional skill building coaching/support is needed.
- Continues to support family in coordinating youth's participation in these continued and new community activities during and after group care stay.
- Brainstorms with family and Family Team around needed resources (flexible funds, scholarships, free activities, etc.) to help youth and family explore, discover, and/or develop interests in an activity that supports their social and emotional growth and wellbeing.

- Collaborates with youth and family to identify what activities and resources will be short-term and which will need to be sustained for a longer period of time.
- Plans with parent/caregiver around timeline for stopping or a shifting funding source.
- Collaborates and coordinates with youth, family, Family Team, OT consultant, Family Partner, Young Adult Peer Mentor, and others to create opportunities for youth to participate in everyday, typical enrichment experiences (recreational, creative, vocational, employment) that sustain and promote community integration and friendships with peers in the community.
- Facilitates parent/caregiver/family in playing key roles in connecting youth to these opportunities— involving them in selection of, registration for, transportation to, and staying in communication with sponsors/leaders of these activities.
- In partnership with OT, youth, and family, coordinates with individuals from a community activity to develop and carry out any needed adaptive strategies for integrating youth into that community activity. Considers use of available flexible funds for adaptive tools to support participation in activities.
- Coaches youth on skills needed to engage in the activity.

STRENGTHENING WELLBEING THROUGH RESPITE

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

Strengthening Wellbeing through Respite

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

ORIENTING PARENT(S)/CAREGIVER(S) AND YOUTH TO RESPITE

- Validates the need for parents/caregivers to have a respite or break from the daily challenges of parenting, especially when parenting children with emotional, behavioral, and/or mental health needs.
- Explains that respite or caregiving breaks support the primary parent/child attachment, include parent(s) as key decision makers, and occur within the network of family and natural supports whenever possible to promote family stability and prevent separation trauma for the child/youth.
- Explains that respite is a planned, brief period of time away from caregiving that offers the chance to reduce stress and restore energy by spending time engaged in activities of the caregiver's choice that a caregiver finds restorative. Expresses appreciation that individuals find a wide range of activities to be restorative. Gives a range of examples, such as resting, reading, visiting with a friend, running errands, getting a pedicure, being at work, etc.
- Explains that in order for caregivers to have this break, respite care for the youth may be provided through a variety of developmentally- appropriate in-home/ community and out-of-home options that can be brainstormed with the family, youth, and Family Team.
- Explains that youth and other family members can also benefit from this respite time.
- Validates the need for youth (not just adults) to take regular breaks from the day-to-day stress life can bring.
- Explains to the youth (in developmentally- appropriate manner) that respite is a brief break away from stressful events, people, and things. Describes how using break time to engage in activities they find fun or relaxing can reduce stress (e.g., playing, reading, visiting with friends/extended family, etc.).

EXPLORING RESPITE NEEDS

- Explores parent/caregiver's level of caregiving fatigue as well as the family system's fatigue from the demands of living with the youth's emotional, behavioral, and mental health needs.
- Explores family member's level of access to time and activities that provide self-care and breaks from caregiving and stress.
- Asks about specific activities that the parent/ caregiver, youth, and family members find most soothing and/or reenergizing and explores the need to (re)connect with or discover new interests, hobbies, classes, activities, time with friends, support groups, quiet time at home, reading, journaling, yoga, exercise, etc.
- Explores resources (time, money, transportation, childcare, etc.) needed for taking respite.

SUPPORTING PARENT/CAREGIVER, YOUTH, AND FAMILY TEAM IN PLANNING/ COORDINATING RESPITE

- Orients Family Team to ways youth and parent/caregiver have/will take respite.
- Shares how reenergizing, fun and/or soothing respite activities can help build resiliency and support recovery from the impacts of trauma, mental illness, physical illness, etc. as well as promote youth and family living together successfully.
- Considers purpose and intent of respite as part of treatment planning, family strengthening, and permanency and integrates respite as an intervention on the treatment plan.
- Collaborates with parent/caregiver and Family Team to identify and develop restorative respite plans that create regularly scheduled breaks from caregiving.
- Plans with Family Team around ways to support family taking respite in a manner that is sensitive to youth's clinical needs, age, developmental stage, culture, level of transition/separation anxiety, trauma history and potential for iatrogenic risk, etc. Assists family in selecting and preparing respite providers to support the primary parent/child attachment and the child's primary family membership.
- Brainstorms all possible options for respite childcare of youth (and siblings). Considers the possible use of family and natural supports, enrolling children in activities out of the home, Home-based team provision of in-home/ community respite and out-of-home/facility-based respite care.
- Includes a plan for reintegration back into home following out-of-home youth respite care.
- Brainstorms viable resources (including but not limited to flexible funds) to cover logistics such as activity fees, youth and sibling childcare, transportation, etc. Validates the need for and brainstorms options for reimbursement of respite services provided by family and natural supports.
- Explores the sustainability of the respite plan and options for how family can sustain respite.

ENSURING PROVISION OF YOUTH RESPITE CARE

- As needed and agreed upon, coordinates with youth, parent/caregiver, respite provider, Family Team members, natural supports, group care, and others to provide regular, short-term facility-based, in-home, or community-based respite care to the youth.
- Identifies and coordinates to address challenges to obtaining/using respite, including parent/caregiver concerns.
- When providing in-home/community respite care, (as developmentally appropriate), engages youth in activities they find soothing and/or reenergizing and teaches them about potential new ways to sooth, energize, and manage day- to-day stress.

- Encourages youth's interest in exploring, developing, and practicing old and new ways to have fun, manage stress, "reenergize" and care for them self.
- Prepares youth and parent/caregiver for youth's overnight respite stay by visiting the facility with them, orienting them to the daily routine and what to expect, describing the time away as an opportunity for reducing stress and reenergizing, and reframing any perceptions of respite being a punishment or the result of bad behavior.
- Coordinates with parent/caregiver and facility to ensure youth has everything they need with them when they attend facility respite (e.g., medications, book, music, games, etc. for restorative time)
- Coordinates with family members to be sure they have everything they need to engage in their identified restorative activities while youth is away.
- Prepares youth and family to reintegrate youth back home after respite.

DEBRIEFING RESPITE CARE EXPERIENCE

- Inquires with youth, parent/caregiver, respite provider, and Family Team around respite success, challenges, and options to overcome challenges. Facilitates joint conversations between respite providers and parent/ caregiver when differing perspectives occur or clarification of respite experience is needed.
- Specifically explores whether parent/ caregiver and youth found respite time and activities effective in providing each a break.
- Supports youth's expression of their respite perspective/experiences to parent/caregiver and Family Team.
- Bridges differing perspectives/experiences of respite. Explores reluctance, worries, and hopes for the use of the same or a new respite intervention.
- Coordinates with youth, family, respite provider/caregiver, and Family Team to revise respite plan as needed.