**Dr. John Lyons Video Transcript Part 2**

So I know most people come to these kind of events because as a true professional, you should be able to speak in sentences that are strictly acronyms and verbs so it’s important to collect acronyms, so I don’t want to disappoint. So you have CANS, let me make sure you get a second acronym, which is TCOM, so that’s the name of the framework. Transformational Collaborative Outcomes Management – transformation means it’s about personal change. That’s actually… profound. As soon as you understand that it’s about change, it changes things.

For instance, let me give you an example: Did you know that the states with the best permanency rates actually have among the worst systems? Because what they do they is they just turf out, they take everybody, right? If you take everybody, then, of course, you can return the easy ones easier. So the really effective systems do a good job at the front door and they prevent entry into child welfare but then you're left with the most challenging youth in your child welfare system, which then your return to permanency is actually much harder. So, that’s a status indicator; that’s not a transformation, right? So return to permanency is a status indicator; it’s not talking about change; it’s not talking about change in this person’s life that leads you to believe that they’re in a better place to raise those kids.

Did you know, for those of you who work in mental health, did you know that there’s a vast literature demonstrating the people who get the most out of outpatient mental health treatment are the people who need it the least? You know why we came to the belief that the people who get the most out of outpatient mental health treatment are actually the people who need it the least? It’s because we use a status at discharge indicator for outcome. So, if you use “are you in the normal range,” who’s the most likely people to leave treatment in the normal range? The people who start treatment in the normal range. So all that vast literature demonstrates is nothing happened. All it does. If you actually look at personal change, do you know who actually gets the most out of outpatient mental health treatment? The people who need us the most. Here’s the deal: They never get in the “normal range”; they just live their lives a little more successfully because they got some help. That’s the difference between a transformational system and a service system.

Collaboration is the second important word. Collaboration, the concept of a collaborative, and the CANS is done as a collaborative; the whole thing is a collaboration, so everything that happens gets shared. So there are literally tens of thousands of people around the U.S. that will give you everything they’re working on. You can have it, it’s yours. So it’s a collaborative. The concept of a collaboration is that if the collaborative is successful, then every individual in the collaborative is successful. That’s the concept; that’s why people join collaboratives because they know that if they help work towards a common good, everybody, including them, benefit from that common good. The only way a collaborative ever works is if there is a shared vision. So the concept of collaboration here, at the individual child-family level means engagement. At the program level, it means teaming. At the system level, it means system integration. It’s exactly the same concepts. We just use different language across the system to talk about the same basic fundamental issues, let's get everybody together working together towards a common purpose.

The common purpose should be the best interest of our children and families. So that’s the concept behind this approach, which means for those of you who are Star Health folks, this is a shared-visioning approach. If you think people are going to get a referral or you’re going to go and do your CANS thing and fill it out and send it in and then complain because nobody reads it, you’re not thinking about it the right way. It’s in fact a collaboration so the idea is you take information from the caseworker and hopefully the structure of that will be the family needs and strengths assessment. You then use your clinical expertise to advance that information and then you feed the information back to the caseworker because, in fact, they have the frontal responsibilities. So you’re informing them because information is good and learning how to use information actually helps you be more effective. And that’s the concept. That’s really easy for me to say. But I’m getting on a plane this afternoon and flying out of here, right?

Actually learning how to play well together is the challenge, right? Because sometimes we don’t have a long history of that. But that’s the idea of collaborative is we’re all in the same business; we all care about kids, let’s work together and be as effective as possible. We all have different gifts. Can we share our gifts to be as effective as possible for the people we serve? That’s the idea.

Outcomes means its relevance to the transformational goals. So in child welfare, we’re talking about well-being predominately, or the CANS. Then management is actually the hard part, which is actually driving it into practice. The easy thing is getting certified in the CANS. That’s actually pretty easy. The hard part is actually embedding it in the work because that actually takes the change. And this is a practice model approach; it’s not really a measure. It’s a practice model approach, and it does require personal change in order to do this well. Some people already do it already, exactly like this, but a lot of people don’t and so it forces people to think about things a little bit differently sometimes. So, this is no fun; it’s not sexy. It’s kind of boring, it’s engineering, it’s grinding.

Give you a little flavor: one of my doctoral students was leaving for internship last year we were chatting and she said, you know, John, one of the things I really respect about your career is you spent so much of your time doing something that’s so inherently uninteresting. Absolutely right. To do this well is grinding. You have your message and you stay on your message and you repeat the message over and over and over again. So my life is actually like that movie, Groundhog Day. I’m hoping to get it right eventually because that’s what it is. You have to stay on message. You have to drive this process and if you get distracted from that, then it’s not going to be as effective as it could be.

That’s all well and good, let’s think about our kids but you have to have a strategy. We have all sorts of good ideas that never get fully engineered and they become the flavor of the month. The only way you actually make good things happen is you drive it into practice. You absolutely have to drive it into practice, that’s the strategy. So the CANS, the strategy represent the philosophy, and the tactics are how do you use it. So I’m going to talk a little bit about that and show you some examples.

Now, I’m not going to talk too much about this except to say that the CANS is completely different from other kind of measures. It’s a communal metric measure; it’s not a psychometric measure. So most existing measures…well-being…come from psychometric theory. The problem with that is that those come from traditional research. And I said before that I didn’t think we were talking about translating research into practice. I thought we were talking about engineering, right? And there’s some problems that develop.

So let me see if we can…if I can kind of drill down that comment a little bit more completely. So let’s see if there is a moment of consensus. Would everybody agree, if our job is helping people, is it true to say, is it fair to say, that the first stage of successfully helping people is to understand them? Is that a reasonable statement? OK. So what you mean by understanding is fundamentally different than what a researcher means by understanding. So if you ask a researcher, they’ll tell you, my entire life’s work is about understanding. I’m looking, I’m seeking understanding. I’m seeking the clarity that you seek. That’s what it’s about. So, what they’re telling you is understanding is the output of their work. For helpers, understanding is the input of the work. You actually can’t start trying to help until you at least understand something. So when you talk about the word understanding, you’re really talking about understanding a little about a lot. Whereas a researcher is talking about understanding a lot about a little. So they need to go deep and you need to go broad. If you try to go broad and deep at the same time, it falls apart at some point because it’s just too much.

The way I think about it…I travel constantly so I’m in hotels a lot so I was here…next week I’m in Boise, Idaho. The week after that I’m in Nevada, New Jersey, and I’m in Oakland. So, I travel constantly. When you travel this much, it’s not a vacation so this was not my opportunity to see the sights of Austin. I end up spending time in hotel rooms all the time. There’s nothing to do in a hotel room except work, sleep and watch TV. So I do watch some TV. Sometimes it’s good, sometimes I get desperate. Have you ever seen those bodybuilding shows? Now that’s truly desperate, right? So, you get up on stage and you have at least six cuts in your abs. And if you’re going to be a champion you’d have seven or eight distinct muscles in your stomach alone. I don’t know about you all but I look at those and I say, you care a little too much about your muscle definition. Me personally, I’m looking for gently rounded and that’s good enough. That’s the difference between research, which is trying to be buff, and helping people, which is trying to be reasonably fit. You have a completely different standard of information in practice than you do in research, and it’s a mistake to apply a standard of information for research into practice. It’s simply never going to work, right? So that’s why the CANS come from completely different theory, come from communication theory. It’s a communal metric measure.

If you want to know about it, email me and I will send you the PDF of a book called Communimetrics. It’s particularly good if you have a sleep problem, so you’re welcome to it. You can also download it from the Praed Foundation website. You can also download from the training website. It’s there…if you want to read about it. Chapter five is the history and implementation of the CANS. So that might be useful, interesting for you. Anyway, so this is where the six characteristics come from. The concept of communication is you’re trying to create a common-language framework. So the basic concept is what’s relevant, what’s timely and what’s the shared vision, right? That’s the idea, that’s what those things are is how do you create a shared vision and make the information relevant and timely. That’s all that stuff is. So the first item is you’re only including items that are relevant and each item could lead you down a different pathway for treatment planning. The second is that it’s action level so the key to the CANS is that every number has immediate meaning, so you don’t actually need to store it if you don’t want to know what it means because every single item rating has immediate meaning. It’s a non-arbitrary measure unlike psychometric measures.

The third characteristic…actually three, four and five are about shared visioning. So shared visioning is you want to make it about the person, not about the person in care. To give you an obvious example: If you’ve got young person who runs away all the time and they violate their probation and you put them in locked detention for 30 days, are you resolving their running away? No, you’re stopping them from running, right? In a traditional measurement, you say, I see no evidence of runaway behavior in the last 30 days. But that would be nonsense, wouldn’t’ it? So, this is a different approach. This is saying the only reason they’re not running is they can’t run, and as soon as the doors swing open, all of the factors that are leading them to run in the first place come back into play. That’s why the Star Health caseworker model might be really effective because you have the capacity to teach caseworkers a little bit more sophisticated clinical thinking if you choose to take that opportunity.

I hope you choose to take that opportunity because that’s how you create effective systems. We all have our responsibilities and the best way to meet your responsibility is to have information that helps you do that. OK. You need to consider culture and development before you apply the action levels. That’s also a shared visioning because it’s a common language but you also want to be culturally sensitive. You also want to be developmentally sensitive. And the last one that’s about the shared visioning is the…it’s about the what not about the why because…two things, right? You want to make sure you’re reaching a consensus. So this is consensus-based tool, which includes families and youth. So, places that do this really well is they do convenings either literally or sequentially and they get everybody on the same page, including youth and foster parents and biological parents, everybody. So, a lot of people use this in child-family team kind of models to have this as the output of a teaming process, which makes good sense, right? So that’s the reason for this particular characteristic about the what and not about the whys because it’s a lot easier to reach consensus about the what than about the why. It’s also…the other reason for this one is because a fully engineered system…what, why, how, what.

What’s going on in the life of this child and family? Why do we thing this is? How are we going to address it? And then you check back in on the what to see whether or not you’re successful. So, I think in your design, the Star Health folks, really important establishing a clear what but also important in getting to that why because the only way you can actually make a good plan is to convert the what into a why so that you prioritize based on the why because you could be… have a three on school attendance because you’re…because you’re truant and you could have one because you’re expelled. Those are two completely different reasons why you have a different plan based on that theory of why.

And the last one is a 30-day rating period and that’s just to keep it fresh. The way the 30 days works is, is it relevant in the last 30 days not did it happened in the last 30 days? That’s what this grid is…this is an example of tactics. So, I always tell people there’s one answer to every single question when it comes to the CANS, and that is, it depends. Because it’s a highly contextualized approach. As you can see, it’s pretty subjective, right? Is it subjective if you read through those characteristics? Is that a bad thing?

Some people might have learned in graduate school that subjective means unreliable. If you learned that, you were lied to. Subject means judgment is involved, judgment is required. You can’t do the CANS without thinking. You know what we’re learning? Thinking is good, alright? You actually do better work if you think than…If you think this is a plug and play, you’re wrong. It’s not a plug and play approach; it’s a practice model approach. It is designed to facilitate improved work, which requires people to, in fact, think.

But let me tell you a story about this objective-subjective thing. I got my Ph.D. in 1981 so I’m old. So for those of you…some of you probably weren’t born then but some of you might remember that 1981 was the Halcion days of behavioral assessment. That’s how I was trained. I was trained that the truth is in the behavior. Everything else was called ephiphenomenal. We want to know the truth about behavior. Everything else was stuff human beings created because they have this need… So, that’s how I was trained. That’s how I did my dissertation I published in a prestigious journal. (The editor) said this is ground breaking. I’m sure he would like to take that back. Too late. So, here’s what I was able to demonstrate. I was able to demonstrate that depressed people in the hospital, as they got better, they moved their arms more in the lunch room. Does anybody care? You can look it up. It’s evidence-based, right? It’s highly objective. Oh look. They moved their arms. We can all agree they moved their arms, right? It’s highly objective but wouldn’t you agree it’s rather trivial? You know what the back story was? They were eating. Depressed people lose their appetite. When they’re less depressed, their appetite returns. In a hospital, you’re only actually allowed to eat in the lunch room. So to watch at lunch, most people don’t do a face plant; they actually move the food to their mouth. Yes, in fact, they are moving their arms. But as it turned out, the behavior is epiphenomenal. The truth is actually in the meaning.

Give you another example. This is actually evidence-based. This is clear research finding. What’s the most violent program on TV? This is clear. Research is clear on this. What’s the most violent program on TV? Anybody know? Cartoons, that’s exactly right. Why do we know that cartoons are the most violent program on TV? Cause here’s how we define violence on TV: We take the number of violent behaviors…we take a segment of the program and we count the number of times violent behaviors happen. So, here’s a thought problem for you. You have a vulnerable person who if exposed to violence might become violent. Which would you rather have them watch: Wylie Coyote trying to drop an anvil on the roadrunner somehow missing and having the anvil come back around and striking Wylie on the head. The objective violence. Or Criminal Minds, which actually never shows actual violence. They always sets up an incredibly sick situation, that show is sick, and then they cut, as soon as they’re right at the violence, right? So which would you rather have a vulnerable person watching? The objective violence or the subjective violence?

The key is we live in a subjective world. Subjectivity is a good thing. You can’t be culturally sensitive and not be subjective. The key is to not pretend that we’re not subjective. You make judgments every single day you work, that’s a good thing. The key is don’t make judgments about people without their full participation. Consensus. And don’t make judgments that don’t matter. Transparency. You do those two things, you end up with the most reliable approach in the field. And the reliability of the CANS is higher than any existing research measure because it matters. It becomes the common language of how people talk to each other. As soon as you create those two things – consensus and transparency – then it’s going to work really well for you. That’s actually some work. It’s easy to say, hard to do.

The concept of this approach is once you have that shared vision, what do you do with it? So, the concept of this grid is there’s four inputs to every choice you make: information, theory, divine inspiration and intuition. God’s mouth to your ear is probably the best but most of us don’t have that consistent level of input so that leaves us with information, intuition and theory. There is no unified theory of human behavior, making theory-based decisions as probably an exceptionally bad idea. Probably the most famous bad theory bad decision is Bruno Bettelheim who actually was down the street from where my office is at the Orthogenics School at the University of Chicago who refused to allow parents of children with autism to visit them for the first six months of treatment because in Bruno’s theory, those parents were causing the autism and Bruno had to detox those kids for at least six months…before he would allow the parents back into the lives of their own children.

We used the CANS in the autism sector in Ontario, you know what the number one strength of kids with autism is? Family, right? Bad theory. Bad decision. So that leaves information and intuition. The vast majority of people make the vast majority of their decisions based on intuition. And I guarantee you, good gut is a powerful thing. But here’s what you should always remind yourself about intuition. Intuition is only influenced by vivid experiences. And what’s vivid in our work? Problems. Problems are by far and away the most vivid.

So, let me tell you two stories. So they implemented TCOM at the hospital where I was affiliated in Ottawa before I moved there. Believe it or not, people didn’t want to do and I know that’s shocking. But people didn’t want to do it. One more piece of paperwork, right? And so there are literally thousands of reasons not to do this kind of thing. There’s only one reason to do this: It’s the right thing to do. But there are literally thousands of reasons not to do it. And so there reason not to do it is they were experienced staff, right? There were people at the hospital who had been working there 20 years. It’s a pretty stable environment. It’s a good place to work. And so they said, you know, we’ve been doing this for 20 years. What possible value would it be for us to use a common assessment. We already know our kids. We’ve been doing this forever.

So the clinical director, smart lady, now she may not be that smart because she married me. But she’s pretty smart, right? She said, OK, I’ll make you a bet. If you can successfully predict the top three needs of kids coming into the hospital…you’ve proven you know your kids and you don’t have to do this. So they took that bet; they knew their kids, right? So they picked…this is a tertiary care psychiatric hospital you might pick the same thing. They went with psychosis, suicide and danger to others. They ran the CANS for two months. You know what they found? You know what the number one need of kids coming to the hospital actually was? Sleep.

What’s vivid? Crazy and dangerous is vivid. After 20 years, what do you think you’d do? Psychotic, suicidal, homicidal kids. What’s not so vivid? Getting a full night’s sleep. Was there any programming for safety? Oh, you bet. Was there any programming for the treatment of major mental illness? Yes, for both parents and for youth. Was there any programming for sleep. No, unless you consider Benadryl at bedtime programming. Those of you who work in residential treatment know what I’m talking about. Why? Well, here’s how they designed their programs: They got together their experienced staff who knew their kids and like moths to flame, you’re drawn to the vivid experiences. The stuff that’s under the radar just goes right under. So information is good.

Let me give you another example. If you’re a direct-care person, what do you take to your supervisor? Problems, right? If you learn nothing else from today, that’s the most important thing to learn: It’s not the crime; it’s the cover up, right? So, if there’s a problem, you better run it upstream, right? What’s the supervisor take to the program director? Bigger problems. What’s the program director take to the agency director? Still bigger problems. When does the agency director contact the board of the state? Really big problems. So here’s what happens in all systems: The information, as it goes up the chain, gets filtered to be more and more about problems. And so, people at the system level can tell you everything that’s wrong with the system and they’re hard-pressed to tell you what’s right with the system because they get no information about team successes. We do more good than not. We do more good than not, but nobody ever talks about the good. So what happens is the bad stuff gets filtered, right?

So, most people say information is good. So, the concept of this grid is that information is the best way to make decisions. So, there’s basically three types of application of information. Decision support. What are you going to do? Outcome monitoring. Is it working? Quality improvement. Can I do it better? And there’s actually application of the CANS for all three of those uses of information at all the levels of the system. So this is a simple grid. It’s got three levels. It’s got the individual child, family, it’s got the program and the system, right? But you can get more nuanced if you want but that’s the most, the simplest, version of the grid. And so there’s actually applications in every grid that are different. So, service plan, I think you’re calling it here, is decision support at the individual level. And there are models that have been developed, we’ll go through that in training and so it will allow you to shift from the whats to the why to create a prioritized plan that help the plan be as effective as possible to meet the needs of that child successfully and that’s just creating a theory of why with the plan with a what.

The decision support at the program level, those are algorithms, those are models that are decision support to decide about level of care, placement. There’s a bunch of those around. This is a very different approach. It’s not arbitrary measures, right? It’s not like a psychometric measure where you hit norms and you have cut off space on T-scores and so forth. This is based on actual complexity indicators, so the logic is called Boolean so it’s patterns of actual needs so there’s actually real differences between kids and each of the suggested levels. We now have established in independent research in four different states their reliability and validity and utility of these kinds of decision models. You actually have better outcomes if you make decisions based on kids rather than letting the system make decisions based on other priorities, right? So not particularly surprising, I suspect.

Decision support at the system level is resource mapping. I’m going to show you a quick example from one of my colleagues at Chapin Hall. So, this is the state of Illinois. So with the action levels of the CANS, you can actually analyze stuff in a different kind of way. So this is looking across the behavioral health indicators, so they have about ten different behavioral emotional needs and so the items, the action levels, are no evidence, watchful waiting prevention, action, immediate or intensive action. This is asking, Does the young person have any actionable behavioral health needs?

So, a two or three out of any one of those 10 behavioral emotional needs, that would qualify them for suggesting a treatment would be indicated. That’s how this works. There’s a clear link between what are you going to do and what are the needs of the child. So it’s all action-oriented. So this is the…you take those kids who are the children in child welfare who have an actual behavior health need and map them based on the location in foster care. So those blue dots are actual children living in Illinois who have an actual need in behavior health, where we need to serve them in the behavior health system. They’re living in child welfare, in foster care.

There are Medicaid providers who are willing to take children in child welfare who have a capacity to address behavior health, behavior emotional needs. Do you see where there are some problems?

So, everybody wants to work in Chicago, that’s the upper right hand place. We don’t really have an access issue in Chicago. But take a look down in Randolph County, which is just south of East Saint Louis, see those red spots tend to be in urban areas. As you get away from the urban areas, you’ve got some real problems in terms of access to care. This is done by Mike Stiehl who’s a colleague of mine at Chapin Hall. He also did an analysis that demonstrated the distance, the distance, between the front door of the foster home and the front door of the clinic directly predicted clinical outcomes. So access does matter. It does matter. Anyway, anybody know Illinois at all? See that big blue dot straight south of Chicago? It’s about an hour and a half drive. Anybody know what that is? Why would there be a concentration of children with behavior emotional needs in that one location? University of Illinois? No, good guess, though. A competing university. I got my Ph.D. from Illinois.

There’s a city…if I tell you the name of the city you’ll know exactly what’s there, I suspect. The name of the city is Jolliet. There’s a prison there. There’s a prison and a concentric circle around the prison there’s a large number of kids in foster care with behavior emotional needs. Look where the providers are, there’s nobody. There’s nobody. So if you’re going to invest in building a system that’s effective for kids, you need to consider that, right? So that’s where you’re going to put those investments. So that’s an example of how you use this kind of an approach to right side the system based on kids not based on who gets the money or you decide who gets the money based on kids is probably my favorite way to say that.

So, outcomes monitoring, those are transitions across the system. One child one CANS, so the first CANS is really, really important as you go through multiple CANS you’re just checking in on them. You’re not re-doing an assessment. The CANS is not actually an assessment; it’s the output of the assessment process. And so, what you do the first round, if you do a good job the first one, it’s literally very easy to update it because you’re saying what’s changed, what’s newly discovered and so forth, right? The outcome monitoring, for those of you who are providers, you could view this…you have choices, right? Choices are powerful and important. So you could view this…as an opportunity. A lot of people view it as an opportunity. You can actually use this to meet your other business needs.

If you’re a provider, you might have some needs to do program evaluation. You can actually use this for your program evaluation activities if you so choose. You can do outcomes with that, so there’s a bunch of ways to do that. I don’t think I’m going to take the…oh, it’s sort of interesting…we’ll see if there are questions and then I’ll show you an example. There are performance-contracting strategies that are used with this. As you begin to wrap your head around the fact that much of our work is transformational, then you want to value transformation. That just makes logical sense. Because valuing time spent…If you think about this from a behavioral health standpoint …if you think about it, mental health providers are actually incentivized in our current system to make people as messed up as you can make them and keep them as messed up as long as you can possibly keep them that way. I’m not saying that’s how people work; I’m saying that’s how the system is structured. That’s a disaster for us because it forces us to consistently prove what we’re doing is ineffective in order to justify continued investment. It’s a disaster. So we have to fix that because we do do good, right? We need to be able to see where we do good. Shifting to a transformational process is a very good idea from that perspective.

Case management, so if you think about what the caseworker actually is, the caseworker is in fact a quality improvement intervention at the individual child level. Because what you want is effective case managers bringing everybody together towards a common purpose in the best interests of children. So, giving caseworkers the skills and the tools that they need to be successful is in fact an aspect of this approach. There’s a bunch of work around the country on that stuff. Program redesign and so forth. I gave you an example from the hospital. And then ultimately this is about system transformation. Ultimately, that’s what this is really about, transformation at the system level, which is really probably shifting the business model so that we’re actually creating incentives in the system that are congruent with…how many times have the experience you have the business model and then you have the work and you’re trying to wedge the work into the business model, and it doesn’t really quite make sense. So the idea of this approach is let’s first understand the work and then create business models that support the work rather than trying to wedge good work within a business model that actually detracts from that good work.

I’m going to stop at that point. As you might have noticed, my voice is strained a little bit. To tell you a quick story about when my daughter was a teenager. She used to say to me sometimes, Dad, stop talking, and I always saw that as a certain motivation on her part. But now I have discovered that actually she was concerned about my vocal health, so I think I probably should stop talking. Also it lets you have an opportunity to ask any questions you might have. So let me stop here and open it up for questions.

QUESTION: Talk about the 30-day rating period and give some examples.

I’ll give you two examples. If you are working with a young person who murdered somebody last year would you be worried about their safety around others? Yeah. Now they didn’t murder anybody in the last 30 days, right? But they murdered somebody, right? That’s something that sticks with you in terms of a risk factor so you have complete permission to say, because of the nature and severity of what they did, I continue to remain concerned about people’s safety around them. Here’s another example, my favorite example, you have a young guy he’s got a drinking problem, and he drinks and drives his car, he crashes it and ends up in the hospital in a coma for 90 days. And let’s say you’re charged with helping him plan his post-hospital care. Are you going to day, hey, you’ve been clean and sober for 90 days. I’m not worried about…and unless he has some serious enabling nursing staff, he has not touched a drop of alcohol in 90 days. That means nothing, right? Wouldn’t everybody in the world agree this guy’s a three, a dangerous and disabling substance about problem and your priority as he’s coming out of the hospital is to address that to made sure he doesn’t drink and drive and kill himself or somebody else?

So, you have complete and total permission to make him a three because that’s what represents him. So, that’s how that works. It’s what’s relevant in the last 30 days, not did it happen in the last 30 days. That’s particularly important in foster care because you get that honeymoon, right? You remove kids, you put them into foster care and they look like angels for about a month and then they start getting comfortable and you start seeing them, right?

It’s important to talk about them and not them in a structured setting. It’s one of the reasons why you get chemical restraint in residential treatment, right? How do you get a good outcome for acting out behavior? You medicate them, right? And then they don’t act out but does that actually treating this? No, it’s suppressing it. That’s not real treatment. That’s not a personal change. That’s managing. That’s why residential treatment programs have moved away increasingly, the progressive ones, from token economies and behavior management strategies. So, we know we can control behavior. That’s not the relevant question. The question is what are they gonna be like when they come out of the residential treatment facility. So, there’s a bunch of examples of why those two characteristics about the child and about the child in care for 30 days fit together nicely to make it representative of what people need and not anything else.

Question: If a child after 30 days is suicidal but wasn’t before the removal, can the CANS distinguish that it could be the removal itself that caused it?

The CANS itself doesn’t. The process of converting the CANS and the plan gives you the possibility to do that, right? Because that begins to be the why. The CANS is just the what, so you would have disruptions in caregiving and suicide as two different identified needs on your CANS. A good theory of why would suggest a relationship between those two, and if that’s your theory of why then you’re going to address the trauma secondary to the disruption of caregiving as a way of addressing the suicide. OK. So that’s how that works. So you create that theory and the way the theory works is…so the theory all of the actual needs, the background needs, things you can’t change but you need to know about…disruption in caregiving, you can’t change but you need to know about it. Treatment targets are what you think are the causes and anticipated outcomes are the effects and the strengths are either useful strengths or strengths to build. Everything has implications, right? And move from the CANS into the plan and that’s where that theory would be.

One of the tough things for clinicians to do is stop themselves and do the what before they get into the why. Lots of people jump to the why because that’s the sexy stuff but you have to establish the what first. Because otherwise you’re going to get mislead and you’ll underestimate the value of what we do and also you don’t establish the what first. So, sometimes it’s important to slow down and make sure you get the what established well and then move to the why. What, why, how, what. There’s one group, one county, they're sort of a county-based kind of system, and so…there’s one particular county – Dane County – which is where Madison, Wisconsin is, which the smartest people in Wisconsin live there. So, they didn’t want to do it big time, to the point that they even sabotaged my training. So, they told me it had been canceled when it hadn’t been canceled. So, I’m sitting at breakfast with my wife and I get this call, Where are you? I was told it was canceled. So I drove the fastest I’ve ever driven between Chicago and Madison was that particular morning. I got there, did the training but they didn’t really buy in. So down the road they weren’t engaged so as the state started looking at the data, it became clear that there was one particular county whose data looked off. This is called data mining, right?

Data mining is extremely powerful. Did you know that Target can tell which one of their customers is pregnant by just looking at the buying patterns? To the point that they have a famous story about the father of 15-year-old calling Target to complain about the fact that they were sending baby product advertisements to his 15-year-old daughter and the next day he called back to apologize because his daughter told him that she was, in fact, pregnant. So what that actually means is Target knew the girl was pregnant before her father. Data mining is powerful. So, Dane County is sitting out here like an outlier. So they call in federal auditors, which happened. The federal auditors reviewed, came and met with people, and…so Dane County folks saw this as our next opportunity to kill CANS, which there will be people in Texas who want to kill the CANS. That’s the nature of this kind of stuff.

And so they saw this as the next opportunity so they complained to the feds that we don’t like this, we know it’s tied to case rates and so forth. So we just decided what we want to when we fill this out because we know we have to do it but we don’t think it’s helpful blah blah blah. They thought the federal government would step in and say, oh, that’s unfortunate about the CANS, we need to help you find something that works. Well, the federal government actually knows that this works. The federal government actually said, actually Dane County you are engaged in systematic fraud. And the whole reaction, of course, is different. So they are lucky they just had to do corrective action to fix it. But that’s how this stuff works. In an information culture, things are transparent, right? So it becomes real clear that people aren’t using this stuff accurately over time.

We’re having this experience right now in New York. They just started in New York City using the CANS and so we’re comparing their rate of detected trauma to everybody else’s rates, and we’re finding that they’re actually not doing it. Which doesn’t reflect on the CANS; it reflects on the process of how they’re actually doing that work. You're using this information to guide practice, and that’s how you do it. It’s just…once it’s out there, once you have it in aggregate then you can say, OK, is this information real or is this problematic? And if it’s problematic, you go and fix the information. That’s always the first stage. Until you start doing that and people know that you’re looking, it changes everything, right? Transparency changes everything. I mean we’ve seen all these problems with police brutality. That’s not because it just happened. That’s because it’s transparent. The famous Chicago case just recently, that’s not new, unfortunately. It’s transparent, so now we have an opportunity to stop it. It’s not new; it’s horrible. So, that’s the idea.

Zero is no evidence, one is watchful waiting prevention, two is action, three is immediate or intensive action. So, this is taking that model and converting it into actual needs versus not. So, twos and threes versus zeros and ones. So that first column and this is about the Abramoff needs in this particular table. So this is about the 5,000-plus episodes of care in residential treatment. So notice that the first column is the percentage of youth admitted to residential treatment who have an actual need on each of those dimensions. So the number one actual behavior health in residential treatment in Illinois is anger.

Now I’ve been doing this for 35 years. It used to be oppositional, impulsive, and depression were the top three. Anger now trumps everything everywhere. I don’t know why, whether that’s a re-framing or we have an anger epidemic, which is what I think we actually do have an anger epidemic because you’ve seen it rise to the top everywhere, anger number one, sixty percent. Notice that psychosis not so common, 11 percent. Notice, just as a placeholder, adjustment to trauma 48.5 percent.

The next column is the percentage of youth who enter residential treatment with a two or a three who leave with a zero or ones. We call those resolved. They had an actual need coming in, it’s no longer actual going out. That’s a success on that particular need. So notice that anger, less than half, not great. Note that psychosis, on the other hand, actually pretty good. Seventy percent, that’s actually quite high. And that’s because of two things: there’s lots of kids who have complex trauma and it gets identified in their community as psychosis and when they get into a more intensive treatment that they discover actually that this is PTSD in an extreme form and not psychosis. And also good medication management.

The third column, now the interesting thing about the CANS is all change is clinically significant. It’s totally…it’s a non-arbitrary tool. Everything has meaning, so moving from a three to a two is also a success, right? You’re moving from an immediate or intensive, dangerous or disabling to actual. That’s a success. So every change is a success. So what you can think about the CANS does is it defines statewide the criteria for meaningful change in youth. That’s what it does, right? So an improvement is any better. The fourth column is completely different for the CANS than any other measure. Have you ever had the experience where you met young people and then over time you discovered things about them that you didn’t know? Every other metric forces you to call them getting worse. They may not be getting worse. You may be just understanding them more completely, right?

So, this metric is young people who enter residential treatment with zero or one who then leave with a two or a three and we call that identified. Because it’s possible that it’s just being identified. So just to give you a sense of that, the adjustment to trauma 48.5 percent. If you look at these same data, five years ago, it was 24 percent, or five years before this slide was made. Why? What happened? Did we actually traumatize kids more successfully in Illinois? What happened is we did a statewide trauma initiative where we trained all foster parents, all community providers on trauma informed. As soon as you do that, you know what happens? You do a better job detecting trauma, right? You see it. We think the actual number is going to end up 80 percent. Notice the identified rate is still 22 percent for trauma, that’s why we think it’s actually going to be higher. We’re still learning about this…Notice that psychosis has a very low identifying rate. People know about it before, not particularly surprising. Now some of those youth who start with a zero and end with a two or a three might actually be getting worse, right? They might be being identified but they might actually be…bad things happen in residential treatment. So how do you tell the difference?

The way you tell the difference is in the next metric, which is called worsening. So that’s kids who enter with a two and leave as a three. You already know it’s a need when they come in and they leave and it’s dangerous or disabling, that’s just bad, right? There’s no other explanation than that’s got worse. Notice that anger actually has a pretty high rate whereas anxiety does not. Depression and anxiety – kids don’t get more depressed they don’t get more anxious but they get more angry. So there is some evidence that actually anger can beiatrogenic to… if you start to break it out by sites, you begin to some create more anger than others. Some are good at managing and resolving anger and some actually create angrier kids, which is probably not a very good idea. Alright, see that high rate of identification for depression and the low rate of worsening? You know who those kids are? Those kids are predominately African-American boys. Because what we’re learning is that there is a filter on the detection of depression and that there’s a cultural bias actually that if you’re working with somebody who’s different from you culturally you’re more likely to label irritability as oppositionality or disruptive behavior kind of problem. And so as you get to know kids better, you see…that’s irritability, that’s depression, so we have a problem with the detection of depression that’s culture bound actual. So kids in the minority are overlabled as having disruptive behavior disorders and that’s because they’re underlabled as having depression.

You treat depression completely differently than you treat oppositional. So that’s why you have a high rate of success with conduct disorder. It’s the same kid because what we now know is you treat depression for kids who have disruptive behavior. The first thing that changes is the disruptive behavior. The depression often ends up an ongoing need that they need to be aware of and needs addressing ongoing . But the behavioral manifestations of the depression go away. The last column is transitioning, that’s the percentage that leave with a two or a three. That gives you what your post-residential treatment plan needs to look like. And then the very last column is not a child-specific number, it’s a needs-specific number. That’s just a net gain; it’s a bang for the buck, so it’s the first column minus the last column divided by the first column, so of the kids presenting what percentage resolved. So that’s basically what that metric suggests. So, you see you’re not particularly overwhelmed with the power of residential treatment for resolving behavior health.

The role of an effective residential treatment sector is taking very high risk kids and stabilizing that risk and then moving them back into the community fairly rapidly to address their ongoing behavior health needs. If you look at decision-support algorithms with this approach, it’s designed to support that what we know to be an effective practice. So you never put kids who are low functioning in residential treatment because those kids actually get worse. They become wannabes hanging out with higher functioning, higher risk kids and they pick up those behaviors and they actually end up leaving higher risk than they came in because that’s how it works. So, that’s why you manage who you send and you end up with better, more effective residential treatment that way.