



# Transformational Collaborative Outcomes Management

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Managing the Business of Personal  
Change

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*Dedicated to:*

*Gerald Stephen Lyons and Joan Praed Lyons*

*Your unconditional love and support and, yes, I will now admit, your structure and discipline, has helped me become the person I am. Wherever you both may be, I hope that makes you at least a little bit proud. Love forever, your son.*

## PREFACE AND ACKNOWLEDGEMENTS

This book is the fourth in a series that has defined the primary work for my career. The first one, *'The Measurement and Management of Clinical Outcomes in Behavioral Health'*, represented the initial organization of my thinking about outcomes management. At that point, my thinking was quite traditional. The experiences in the years between that initial book and *'Redressing the Emperor: improving our children's public behavioral health system'* radicalized me into believing that traditional approaches were a fool's journey. That evolution continued with the publication of the *'Communimetrics: A communication based theory of measurement for human service enterprises'*. If you read Italian, you will find that *Partecipazione e Valutazione di Esito Nella Salute Mentale in Eta Evolutiva* is a precursor to the present text. My professional journey to date culminates with the present book.

Overall, this is my ninth book. Perhaps it will be my last; we shall see. Regardless, the moment gives me pause to think back across my life to identify all the people who have influenced my personal and professional development—the people who are reflected in the thinking behind the words on these pages. I think my work is defined in large part by the relationships that I have had over the years. There is no way I can do justice to the people who have inspired, guided, and challenged me along the way. Nevertheless, I will try.

Let me begin with my parents Gerald Stephen and Joan Praed Lyons to whom this book is dedicated. Although my views have evolved from theirs, they provided me with a loving and stable base and a worldview that valued hard work and humility that has served me well all these years. Do not expect to be given anything. Value only what you have earned. From my brothers and sister—Tom, Kathy, and Matt—I have learned a great deal. Tom, a scholar of entrepreneurship, was the first to expose me to the work of Gilmore and Pine that became the foundation of TCOM. Later in our careers, it has been fun to publish together. Kathy and Matt have taught me a great deal about resiliency, grace, and the value of a spiritual life.

Early teachers often do not get as much credit as they deserve. These educators certainly provide the foundation for learning for all of us. My grade school teachers were often my heroes. I remember Mrs. Hitchcock giving me a break on the question of whether I could tie my shoes in kindergarten. My high school teachers were often irritating Buddha's. That is on me, of course. I would not have traveled this road without the early pushing of Jim Simon, Grace Hines, and Coach Owensby. In college, Sally Bell Beck took up the torch and if she had not gotten in my grill, I would not be the person I am today. I certainly would not have chosen the path of clinical psychology without her somewhat tough love and the inspiration of who she was as a teacher, clinician, and person. My graduate studies were mentored and supported by Nancy Hirschberg Wiggins, Alexander Rosen, Leland Wilkinson, Rowell Huesmann, and Benjamin Kleinmuntz. They each assisted enormously in my intellectual and professional development and scholarship. During graduate school, my friends and colleagues—Richard McNally, Howard Garb, Debra Brief—provided both support and healthy competition. My postdoctoral fellowship with Donald Fiske and Benjamin Wright was inspiring and in many ways established the intellectual pursuit that has defined my career. Finally, Ken Howard, my early career mentor, guided me into my career as it stands today. My long-time friend and colleague Frits Huyse, M.D., has greatly influenced the course of my career and brought me many laughs and good times as well. I will always treasure the Fritsonian perspective.

During my career, I have had many colleagues who have influenced this work. Many are currently working in the TCOM field contributing and actively innovating. I am grateful to all and, frankly, worry about listing any to not slight to contributions of people who have made important contributions that I fail to mention. However, the contributions of some stand out so much that mention is required if I am to be honest with how much this text communicates the wisdom of others beyond the author. First among these is Lise Bisnaire, Ph.D. Lise first pushed me to develop a conceptual framework for the use of the measurement tools when I was writing *'Redressing the Emperor'*. She, along with Ken Howard, provided the encouragement I needed to differentiate the measurement approach into communimetrics.

She was the first to develop the TCOM grid of tactics. She was the first to describe the CANS as resulting from a conversation that arises out of the child and families story. Her role in the development of the TCOM conceptual framework cannot be overstated.

Gene Griffin, J.D., Ph.D. also has a central role in the development of TCOM. Gene's work in government provided the window to develop and test early version of the approach. First in the Mental Health Juvenile Justice Program and then at Illinois Department of Child and Family Services. Without this proving ground for the key experiences and concepts, it is unlikely that there would even be TCOM.

Nathaniel Israel, Ph.D., has contributed significantly to the intellectual foundation of the TCOM approach. More than anyone I know, Nathaniel's

commitment to effectively representing people in the process of care helps us move the model from the original Total Clinical to Transformational Collaborative Outcomes Management. His knowledge of systems theory and the critical role of collaboration was invaluable in evolving this work.

Over the past decade, but particularly in the past two years, April Fernando, Ph.D., an Associate Director at the Center for Innovation in Population Health (IPH), has taken over many of the activities that I have done for the past several decades. Her wisdom and perspective have been invaluable in advancing the work. Her embrace of TCOM and her ability to work with others to help them join our efforts have resulted in impressive growth in the reach of this work. In addition, she contributed most of the graphics in this book and was an invaluable editor of draft chapters both early and late. Thank you, April.

Mike Cull, Ph.D., the other IPH Center Associate Director, has contributed his calm wisdom, humility, and patient reserve to building an amazing collaborative of professionals committed to making work environments that are safe places to learn. His guidance and perspective are invaluable in building and expanding the work of the IPH Center and the TCOM collaborative.

The rest of the TCOM team at the IPH Center provides daily support and inspiration for the work. Michelle Fernando, the ‘boss of us all’, runs a tight ship that has created our opportunity to build a Center that can support the work broadly and effectively. The creativity of Josh Nellist, Mark Lardner, Diamond Darling, Brandon Howlett, and Zac Shoopman supports our reaching new audiences in innovative ways. The brilliance of Olga Vsevolozhskaya, Ph.D., and Elizabeth Riley, Ph.D., along with Kate Cordell, Ph.D., points to a bright future of using person-centered data to change how research is conducted and policy created in our field. Lynn Steiner and Lauren Schmidt Mergen both have been long-term supports at the very foundation of the work. The value of their dedicated efforts cannot be overstated. The same can be said for newer members of our team Elliot Bloomer, Michaela Voit, Joanne Trinkle, Cassandra Cooper, Laura Rogers, Nick Guerra, Tiffany Lindsey, Joy Dicus, Yahaira ‘Ya’ Yahuaca, Jordan Costantine, and Brian Turner.

Finally, there is the large and growing TCOM community. Betty Walton, Ph.D., was a founding member who has stayed central to the work over the past two decades. Patrick Gardner, J.D., is one of the smartest people I know and his commitment to seeing that governments do the right thing is unmatched. Thanks to Karen Bryant, Ken McGill, Barbara Dunn, Alison Krompf, Shahrukh Chishti, Scott Fairhurst, DeLacy Davis, Ph.D., Kim Hammock, Lisa Witchey, Paul Davis, Kristine Herman, Judy Howard, Candace Falsetti, Mark Zubaty, Elizabeth Kromrei, Richard Epstein, Ph.D., Purva Rawal, Ph.D., Scott Leon, Ph.D., Inger Burnett-Ziegler, Ph.D., John Vessey, Ph.D., Kristen Cerilli, Tim Fall, Karen Sik, Saw Han Quah, Antonella Costantino, MD, Stefano Benzoni, MD, Mark Kerr, Ph.D., among many others. A special thanks to Gertie Beaucage and Crystal Doolittle for patiently



teaching me about First Nations' culture and how to think about TCOM from a different cultural lens.

To all of these people and to the thousands of unnamed colleagues I offer you my profound thanks. Thank you for being a part of my life. Thank you for what you do on behalf of others. Thank you for working together to try to help make the world a little bit better place to live for people who ask for our help to change their lives in some way.

Lexington, USA

John S. Lyons

## ABOUT THIS BOOK

Transformational Collaborative Outcomes Management (TCOM) is a comprehensive, multi-level conceptual framework for system management and improvement. This book provides a comprehensive understanding of TCOM by using person-centered, collaborative processes for decision making.

The issue with current human services systems is that there is a lack of access to care and that the system is focused on providing services as cheaply as possible. TCOM focuses on helping the greatest number of people while maximizing effectiveness.

By fully understanding the nature of the business of helping, the author seeks to offer ways to create and sustain effective and positively evolving helping systems. He lays out a series of goal-directed social change processes which allow people at every level of a system to begin a shift towards transformational practice and the emergence of transformational systems.

Building on three decades of work in a large community of scholars and practitioners, this book will represent the first full description of the conceptual framework and will appeal to an interdisciplinary group of scholars across nonprofit management, healthcare management, and social work.

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## ABOUT THE AUTHOR

**John S. Lyons** is the founding Director of the Center for Innovation in Population Health and a Professor of Health Management and Policy in the College of Public Health at the University of Kentucky USA. He has dedicated his career to creating strategies that effectively represent under-represented populations in policy decision-making.

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# Understanding the Business of Personal Change

In the recent past, the sector dedicated to helping others has undergone significance turbulence. A series of circumstances has created an environment of rapid change. Factors ranging from increasing privatization to the explosion of knowledge to a focus on performance have all led to a dizzying array of system and program changes. Perhaps in no place have these pressures been more profound than in publicly funded helping systems.

Around the world, the public sector is comprised of compassionate and dedicated people who have made personal sacrifices for others. By choosing to help, they have likely passed on more potentially lucrative opportunities so that they can serve others. Many are individuals who are fully committed to doing everything in their power to help others. In addition, our knowledge with regard to what is and what is not helpful has grown exponentially. Striking progress over the past several decades has dramatically increased organizational effectiveness and systems improvement in a wide and diverse array of fields, including aviation (Cui & Li, 2015; Waikar & Nichols, 1997) automotive (Akamatsu et al., 2013), and package delivery (Dennis, 2011). Sadly, there is scant evidence of similar improvement in public helping systems (Pronovost et al., 2009). Systems such as community mental health and child welfare continue to report similar types and levels of challenges and shortcomings that were obvious decades ago (Gilbert et al., 2011). Many attribute this challenge to an overlapping set of problems including insufficient funding (Sciamanna & Ogletree, 2019), excessive regulatory and documentation requirements (Dragatsi et al., 2019), and challenges with workforce development (SAMHSA, 2020).

In this book, I propose that a central challenge of public sector human services has been that we have been managing the wrong business. Further,

by fully understanding and embracing the nature of the business of helping, it is possible to reconfigure our approach to create and sustain effective and positively adapting helping systems.

R. Spencer Darling, the founder of the Chicago Leadership Institute, is famously credited with saying, ‘All organizations (and systems) are designed, intentionally or unwittingly, to achieve precisely the results they get’. Therefore, if helping systems have remained stagnant at least in terms of their effectiveness, over the past few decades it suggests that there are characteristics in the design of these systems that perpetuate these unfortunate circumstances. Design flaws arise from a fundamental mismatch between the *process of helping* and the *business of helping*.

Dean Roger Martin (2004) argues that the moment calls for a shift in thinking. Rather than traditional industrial approaches to business management (i.e., people who need help are widgets who pass through a standardized process of helping), we need to learn and embrace *design* thinking. Design thinking involves an iterative process where we seek to understand the end user to identify alternative approaches and solutions that are not clearly understood currently. To achieve this shift, we move to the use of heuristics to guide thinking. Heuristics are a set of guidelines for solving problems (called ‘mysteries’ by Martin). He proposes three implications. First, design skills become merged with business skills. Second, a new model of business enterprise is required. Third, people managing business do not need to *understand* designers; they must *become* designers. This book embraces these three implications in rethinking the business of helping. The key skill of designers is to create tailored things that individual people want.

One of the most fundamental aspects of business management is that you must first understand the nature and purpose of the business. In other words, it is necessary first to understand what results the organization or system wishes to achieve (Blasé & Fixen, 2013). This understanding should serve as our foremost heuristic moving forward. For more than half a century, any entrepreneur starting a new business is told to define the goals of the business and then manage to those business objectives (Drucker, 1954). In order to manage successfully any enterprise, one would expect it to be an essential requirement that one understands the nature of that business.

If someone were to manage a restaurant as a way of employing their friends and family without paying attention to the quality, convenience, and price of the food, that restaurant is unlikely to be successful over the long term. The US auto industry almost destroyed itself by trying to manage the value of its stock when it should have been managing the quality and desirability of its automobiles (Murray & Schwartz, 2019).

This core principle has been given many labels—management by objective (Drucker, 1954), results-based management (Lawrie et al., 2005), performance-based management (Mettler & Rohner, 2009), and outcomes management (Lyons et al., 1997). There is nothing new or controversial about this statement. Business people have known it to be a fundamental truth of

business for centuries (c.f., Smith, 1776). In the creation of its approach to the management of the business of helping, shockingly the helping sector seems to have misunderstood its primary objective—*helping people to change their lives in some important way*. This misunderstanding has led to the helping sector managing the wrong business, thereby perpetuating helping systems that do not consistently and effectively help the people in need.

Given this premise, we must reformulate the foundational principles of how we manage the business of helping. We have made a fundamental error in terms of how we think about the management of this sector. We talk about human *services*. We talk about *services* for children and families. The list goes on and on—vocational services, housing services, educational services, mental health services, health services, and intensive community services. We organize and finance the systems that support these helping activities as if they were an array of services (Stroul et al., 2010). Many government and community agencies even have the word ‘services’ in their names. It is clear that the common perception is that the helping professions fall within the realm of what economists refer to as the human service sector. We think of it as part of the larger sector of our economy that we call the service industry. This is not true. Helping is not a service.

This definitional error applies to both how we talk about human services and how we manage the business of helping. Common definitions of human services all reference meeting needs of individuals and preventing undesirable things from happening (e.g., Wikipedia).

Despite this recognition, the majority of human services are managed by paying helpers to spend time with those that they are intending to help. Although there are trends to shift this reality through performance-based contracting and similar approaches (c.f., Martin, 2005), it is safe to say that the vast majority of the businesses we call human services involve a third party paying a helper to spend designated periods of time with the person or people they are attempting to help. Further, many of the current efforts at performance-based contracting define the parameters of performance within this same framework (e.g., length of stay or number of sessions as performance indicators).

The belief that helping people should be understood as a service is simply mistaken, and perpetuating this belief contributes to the undervaluing the work of helping. Helping people is not like any other service—a dry cleaner, or an auto mechanic, or a restaurant, for example. A service has been defined as a business in which you are paying someone to apply a product for you (Gilmore & Pine, 1999). For example, a dry cleaner will wash and iron your shirts and clean and press your skirt, dress, suit, or pants. Many people could do that for themselves, but sometimes people prefer to hire the dry cleaner because they perceive the professional as either being more effective or efficient in providing this service. Many people do those laundry tasks that they feel comfortable completing and reserve the use of dry cleaning to only the most complex cleaning challenges. An auto repair shop also provides a service.



Your car may be transformed but you are not. Most of us eat grains. We could grow and harvest the grain and make bread to eat. However, most of us do not subsist on what we grow ourselves. Instead, we hire the grocer to obtain and prepare food for us. It is more efficient; therefore, we happily purchase this service often without a second thought.

A restaurant is a clear model of a service. A restaurant seeks to make sure its customers get a satisfying meal at a price that the customer is willing to pay. The business theory is that those satisfied customers will return for additional meals and tell all their friends or contacts, by words of mouth or ratings and reviews on the Internet, about the restaurant. (Note: Of course, in tourist areas, the location of the restaurant may be more important than the quality of the food as return business is not a primary goal. In these circumstances, it is the location of the restaurant, and perhaps its 'aesthetic' or 'authenticity' to the local culture is what likely determines whether customers choose to dine.) Regardless of how customers are attracted, to be successful the restaurateur must figure out a way to create the meal at a cost that allows sufficient profit. The restaurateur has to understand how much customers are willing to pay and how many customers might choose to dine at that restaurant. That is, the restaurant owner will try to ensure that the cost of preparing and serving the meal is sufficiently less than the price that is charged for that meal to guarantee that the restaurant is profitable. The manager will try to make sure that the restaurant has enough tables for the busiest times and will try to keep those tables filled (e.g., through advertising, promotions, word of mouth, location, curb appeal). Of course, the restaurant owner does not want unused tables, as the costs of the space will reduce the profitability of this restaurant. Having too few tables is generally far less risk than having too many, although too few tables can lead to the opportunity cost of missed profits resulting from the inability to serve the full demand for that restaurant. That said some 'high end' restaurants use the difficulty patrons have in securing a reservation as evidence of the quality of the meal. The goal of the restaurateur is to make a profit on every table and to keep as many tables filled as quickly as possible. In this way, the restaurateur maximizes the marginal rate and frequency of return on their investment.

Sadly, this restaurant metaphor is precisely how we currently manage most human service enterprises most of the time. Though counts of persons served may be a metric of success for some programs that provide basic necessities (e.g., a soup kitchen, a shelter for homeless individuals), simple counts of persons served make little to no sense for other enterprises (e.g., an outpatient mental health clinic, a Head Start program, a substance abuse treatment program, a vocational rehabilitation program).

As an example, let us consider an outpatient mental health clinic. We staff our clinics to make sure there are enough therapists but not too many. Particularly in a fee-for-service environment, in which therapists are generally provided salaries with benefits by a community agency but paid (by a third party) only for the time they spend with clients, therapists engaging in other

activities, regardless of their clinical value, are seen as unproductive and can be a major burden on the clinic. This reality is why most clinics have productivity standards for hours of billable services provided. Otherwise, it is ultimately disastrous if the clinic pays its staff's salaries, but those employees do not generate sufficient revenue to cover the full costs of those salaries. Thus, we try to manage caseloads so that the therapists stay sufficiently busy with hours that are billable. Alternatively, clinics do not provide salary and benefits and only pay therapists based on the number of hours they spend in billable time with their clients.

Depending on precisely how the clinic is funded, that clinic may benefit from having a waiting list to document the value of their service (i.e., 'our service is so good that people are waiting to engage and receive it'). In many jurisdictions, for example, providers invariably point to their waiting lists as evidence for a need for new investment. In this current paradigm, the fact that you have a wait list and, potentially, the length of your wait list, becomes the metric of desirability. In such a scenario, if you do not have a wait list you may be at a competitive disadvantage. Your resources may be re-directed to address somebody else's wait list. For example, in the early 2000s spending on mental health services in one jurisdiction was cut to reduce the wait list for hip replacements (Davidson, 2010). In a meeting with a program manager, she described a parallel occurrence. When she was promoted to manage the program, everyone pointed to the wait list as a major problem. Over the first few months, she diligently worked to shorten the list, to the point of eliminating the wait for services altogether. Children and families could finally get the services they needed when they needed them, meeting the program's goal for access to care. Shortly after her wait list was eliminated, her supervisor re-assigned several of her staff to other programs for other purposes. When she protested, the supervisor responded that she obviously did not need the staff as badly as other programs who still had wait lists. Her response: 'I learned my lesson. I will always have a wait list'.

Service systems, when they are managed like restaurants often create dynamics that can undermine effective management and, in fact, have the potential to harm clients. We are left to wonder whether a single therapy session is equally effective over the course of a day of work. After already seeing six people, it is reasonable to wonder whether the seventh person was well served. The therapist may not even clearly remember one session to the next for an individual client if they provide 30 sessions in a week. Even if they could, are all clients the same and is it reasonable to wonder whether they benefit equally from the time, their therapists spend with them? When we first began to teach therapists in Alabama on our person-centered assessment approach, one well-established therapist said that this was fine but she had 320 clients and there is no way that she had sufficient time to do a complete assessment process. My response was twofold—first, she was not a 'therapist' because there is no way anyone can provide simultaneous psychotherapeutic interventions to that many people; she may have been doing something with

her clients but it was not therapy. And second, this circumstance is why she needed a comprehensive and holistic assessment and documentation process, because there is no way she could possibly remember the assessment details of that many people when she could clearly only see them once each month, at best.

When we began our work with the children's system in Illinois, I found a clinic provider in a particularly disadvantaged neighborhood who treated their mental health outpatient care exactly like a drop-in health clinic. If a person wanted to talk to someone, they had to come to the clinic that day and waited to talk to the next available therapist. If this was a return visit, it may or may not have been the same therapist that the person had seen on their prior visits. The reason the clinic implemented this model is that they had a high 'no show' rate and it was difficult for therapists to meet their productivity standards. By using the drop-in clinic model, therapists could maximize their billable hours. In this example, the successful business model fundamentally corrupted any known and reasonable clinical model for outpatient mental health care.

Most financial and regulatory aspects of each helping system and much of our current language reinforce the concept among the helping professions that it is a system intended to provide services. However, it is not. Actually, the vast majority of the system is engaged in the business of helping people change their lives in some important way.

The primary business objective of any helping system (and the entire helping sector writ large) is to engage in processes and interventions with the intention of helping people become healthier, more effective versions of themselves. Gilmore and Pine (1999) have called this type of business a *transformational offering*. The majority—although not all—of helping enterprises are intended to be transformational offerings. The distinction between a service and a transformational offering from a business management perspective is dramatic. The business objective shifts the focus from investing time with people to helping people change their lives in some important way. That shift in business objectives has far-reaching implications, both large and small, for the design and management of helping systems.

Let us return to the restaurant metaphor. As described above, the primary reason a restaurant exists is to sell profitable meals. All business decisions are intended to balance the different considerations with regard to how the restaurant seeks to achieve its primary goals of selling meals. Success is a simple result of that basic fact. If a restaurant sells a sufficient number of meals at a profit, that restaurant will be a successful restaurant. The same is not true of most helping enterprises. A successful doctor should not be the one who can do the most procedures or see the most patients in the shortest period. A successful family therapist certainly should not be the one who sees the largest number of couples, regardless of that therapist's impact on the health of those couples' relationships.

Historically, it has been argued that the goal of helping enterprises is also to get people to utilize available help and keep them engaged. This argument is

couched as a challenge of ‘access to care’. However, access is simply an initial goal, a first step to actually helping. Once access has been achieved and people are engaged, the primary goal of helping enterprises is to help people change their lives in some important way. There is no point in accessing something that has no value. It is not just selling time spent with people. Rather, the system is selling personal change processes: changes that have an impact on the person’s life—perhaps lower weight or blood pressure or reduced blood sugars, or less reliance on alcohol or drugs, or greater levels of well-being. These types of goals involving personal change are much more challenging to achieve than simply maximizing or optimizing the utilization of services. As such, interventions whose primary purpose is helping people change their lives are far more difficult to organize, finance, and manage. Perhaps as an unintended consequence of the difficulty of managing transformational offerings, we have drifted into the easier course of pretending that we are successful in changing people’s lives as long as they come initially and are happy to come again—just like a restaurant!

The implications of running the helping system as if it were a human service system are enormous. If systems designed to provide help to others are ever going to evolve into successful systems, the first step is to understand the full implications of the shift from a service system to one that focuses on personal change. The genesis of this book was stimulated by work that has evolved out of a brief article written by two economists, who organized a description of types of businesses into a list that was ordered by difficulty of their management. They called this list the ‘Hierarchy of Offerings’ (Gilmore & Pine, 1999). We have already discussed two of these offerings; however, for context, it is useful to review all possible types of businesses according to their conceptualization.

## THE HIERARCHY OF OFFERINGS

Gilmore and Pine (1999) described five basic types of businesses or ‘offerings’ to consumers. The authors ordered them in a hierarchy based on the challenges of managing these types of business (Fig. 1.1). The first business type describes the easiest marketplaces to manage and each successive business type becomes increasingly more difficult to manage.

They specify the hierarchy of offerings as follows:

### *Commodities*

This type of business is the marketplace of raw materials—crude oil, minerals, grain, livestock, fruits, and vegetables. Commodities are the foundation of every economy. People need energy to produce and to transport things that are produced to market. People need food to eat. The raw materials to serve these needs are the staple of many of the most powerful economies on earth. Although not necessarily simple, commodity-based businesses are relatively



**Fig. 1.1** The Hierarchy of Offerings from the most complex markets to manage (to the easiest. *Source* Praed Foundation, 2021)

simple operations compared to any other type of business, in that they only involve the extraction or harvesting of a raw material. While logistics of a commodities business can be complex, relative to other market offerings this business type is the most straightforward.

Clearly helping does not fit as a commodity marketplace. I have talked to people who describe people being treated as if they were commodities in some helping programs. For example, both day treatment programs and residential treatment centers have been accused of admitting and keeping individuals who are not benefitting from the care provided just to make the business model work. Hospitals who admit low-risk patients to ensure that they maintain a sufficiently high ‘bed census’ could be accused of treating some patients as commodities.

Luckily, this is a rare occurrence across the entire helping sector. However, consistent anecdotal evidence across years of experience suggests that it does happen. The perception that this can happen sours trust relationships between payors and providers in some sectors.

### *Products*

One can take a commodity and produce something that is intended for direct consumption. The output of this production process is called a product. Crude oil is a commodity; gasoline is a product. Rice is a commodity; Rice Krispies is a product. The multiple steps it takes to convert commodities into products complicate the management of product production. Not only do raw materials (i.e., commodities) have to be acquired, but also a product has to be designed. That design must be accomplished with consideration to a target market for the product. Once designed, the product must be produced and then marketed, transported, and sold to persons with varied willingness to use, or need for, the product. This set of complex contingencies makes product generation and product-focused businesses more difficult to manage than business focused on the extraction or harvesting of a commodity. The relationship between the cost of the commodity (its core value) and the price

people are willing to pay for the product (its perceived value) is influenced by many different intervening contingencies.

### *Services*

As discussed above, a service is defined as when you hire someone to apply a product for you. Common examples of services would be dry cleaners, salons and spas, retail stores, home repair, and, of course, restaurants. A service is an activity that we *could* do for ourselves. However, people who specialize in doing that activity become far more efficient and/or effective at it than anyone in the general population does. In this way, it becomes more efficient and/or effective to invest in the service rather than attempting to do the same activity for oneself. That is why services are sometimes seen as conveniences: not necessary, but desirable.

A subset of services might be commonly identified as necessary as our daily living grows increasingly complicated. Getting a driver's license, for example, is a service, but it is not something that one can do for oneself. Of course, you can drive an automobile without a driver's license but that would be illegal in most current cultures. A homeless shelter is another example of the types of services that have business characteristics of a service. Temporary housing supports are provided but there is often no effort to change the person's housing status permanently. If a homeless shelter program were to be extended to allow this focus on changing the homeless person's housing status in a permanent way, then it would no longer be a service.

### *Experiences*

These offerings refer to the sale of desired activities that become memories. They go beyond simply applying a product into creating a period of time that people remember as fun or meaningful. Going to a concert or the theater would be an experience.

Taking your children to a theme park would be an experience. These would all be examples of common experiences.

Interestingly, Pine and Gilmore (2011) recommend that some service providers should attempt to package and market themselves more as experiences. A high-end restaurant, for example, might be managed more as an experience than a service: the ambiance of the restaurant; the attentiveness of the wait staff; the taste of the food; and the selection of wines through consultation with a *sommelier*. All of these things are done to make the dining more than just a convenient way to get food. Dining then becomes a memorable experience. Some high-end retail stores might be run as experiences (e.g., personal shoppers in some clothing or interior design stores, the special room to watch TV or listen to speakers in an electronics store) rather than services. The idea of this business approach is that people will spend more on a product or a service if it is delivered in a way that is pleasant and memorable.

It is noteworthy that some experiences are so profound to the person that they can be transformational. This is the exception rather than the rule but an important exception to contemplate as we think about the business of personal change.

### *Transformations*

This final and most difficult type of business to manage involves efforts to help someone change their life in some fundamental way. In a transformational offering, the purpose of the business is to assist in personal change processes. This objective is quite different from the objective of either a service delivery or an experience, in that instead of convenience or savoring, the focus is on *becoming*. Common examples of transformational offerings would be weight loss programs, recovery programs, mindfulness programs, health and mental health care, and educational enterprises.

## UNDERSTANDING THE RELATIONSHIP AMONG BUSINESS TYPES

Here is a simple way of understanding the hierarchy of offerings in Figure 1.1:

- Fish (Commodity),
- Fish Sticks (Product),
- A fish restaurant (Service),
- A public aquarium (Experience),
- Teaching people how to fish (Transformation).

Table 1.1 compares these five types of offerings on a number of relevant economic and business characteristics. Review of this table demonstrates how transformational offerings are quite different enterprises from the other types of businesses. They share the most characteristics with services but diverge from service businesses predominantly in terms of the type of information needed to manage the business effectively. The next most similar business to transformational offerings would be experiences (i.e., selling a memory), at least in terms of shared business characteristics; however, experiences are rarely ever provided within a not-for-profit environment, while transformational offerings are commonly offered in this type of business environment. Using taxpayer dollars to create ‘experiences’ would generally be frowned upon by funding agencies and government authorities. Foundations often fund these potentially transformational experiences (e.g., Make a Wish). Many agencies that provide help to poor people through government-funded projects try to invest little in their physical plant because if some members of the public saw them working in nice facilities, they might think they were misusing taxpayer dollars.

**Table 1.1** Characteristics of the five types of marketplace

<i>Business considerations</i>	<i>Commodities</i>	<i>Products</i>	<i>Services</i>	<i>Experience</i>	<i>Transformations</i>
Demand	Uses of commodities in manufacturing	Use of product by consumers	Customers willing to purchase	Desirability of the experience	Desirability and feasibility of possible change
Supply	Availability, ease of access and distribution	Ease of manufacturing and distribution	Ease of access of location Availability of skilled labor	Ability to create desired experience	Ability to provide predictable and consistent change
Management objective	Secure commodity at a low cost and sell the commodity at a profit	Produce product at cost below what consumer will pay	Produce service at low enough cost without sacrificing quality to risk repeat business or referral	Create desired experience at low enough cost without sacrificing the quality of the experience to risk repeat business or referral	Obtain consistent change at a predictable cost that is low enough to be accessible to those purchasing change
Needed management information	<ul style="list-style-type: none"> <li>• Volume of commodity</li> <li>• Cost of commodity</li> <li>• Price of commodity</li> <li>• Purity</li> </ul>	<ul style="list-style-type: none"> <li>• Number of products produced</li> <li>• Cost per product</li> <li>• Price per product</li> <li>• Quality of product</li> </ul>	<ul style="list-style-type: none"> <li>• Units of service provided</li> <li>• Cost per unit</li> <li>• Price per unit</li> <li>• Quality of service</li> </ul>	<ul style="list-style-type: none"> <li>• Number of people</li> <li>• Cost of experience</li> <li>• Price of experience</li> <li>• Quality of experience</li> </ul>	<ul style="list-style-type: none"> <li>• Number of people</li> <li>• Cost of transformation</li> <li>• Price of transformation</li> <li>• Size and consistency of transformation</li> <li>• Satisfaction with change</li> </ul>
Definition of successful business	Profit margin by volume of commodity	Profit margin by volume of products sold	Profit margin by units of service provided	Profit margin by units of experience provided	Profit margin by units of transformations provided
Not for profit	Rare	Rare	Common	Rare	Common



While customer satisfaction is an important outcome, particularly for those who focus on recovery and wraparound-type models of helping, it seems untenable to claim that symptomatic, functional, or strength-building outcomes are not important. Consumer satisfaction has clear limitations as an outcome. For example, in her dissertation, Anderson (Anderson & Lewis, 2000) found that people living in a nursing home program were more satisfied if they had previously been in the state hospital than if they were admitted from a community setting. Her analysis suggested that the explanation was that despite the poor quality of the nursing home, the state hospital experience was such a bad experience that being discharged to the nursing home was experienced as a relative upgrade.

Any given business may have components of multiple types of offerings. A product-focused business might attempt to facilitate its ease of use in a fashion that nearly makes it a service (e.g., a frozen dinner). As mentioned above, a restaurant might choose to try to sell its food by making dining an experience. ‘Build a Bear’ is a business mentioned by Pine and Gilmore (2011) as a retailer who has created an experience as their primary business. Given these overlaps, there are potentially permeable boundaries in the characterizations of any particular business in this regard.

In their article, Gilmore and Pine (1999) list Transformational Offerings as the most complex of all currently existing offerings. Despite these challenges, social entrepreneurs tend to engage in providing transformational offerings more so than traditional entrepreneurs (Lichtenstein & Lyons, 2010) due to the potential positive social benefits of these types of businesses. Transformational offerings are complex; they also provide tremendous potential for empowering people and changing personal well-being.

## EXPERIENCE LEADING TO TRANSFORMATION

In their book, *The Experience Economy*, Pine and Gilmore (2011) provide some interesting ideas for those trying to develop and manage transformation offerings—the business of personal change. They propose that a successful transformation must first start with a powerful personal experience. In other words, the route to providing transformation begins with a positive and perhaps profound personal experience—a memorable event. These economists argue that the most important underlying method of providing such an experience within a business context is utilizing what they describe as *mass customization* rather than either mass production or individualization. An experience is optimal when it is personalized within the constraints of the experience. In other words, the more a person has an experience that they feel is unique to them, the more powerful that experience likely will be.

The case example they use is the company ‘Build a Bear’. In this business model, a selection of materials is provided to customizer (i.e., the ‘mass’) but each customer (child) is allowed to combine these materials in whatever



Fig. 1.2 Continuum of Production (*Source* Praed Foundation, 2021)

fashion they wish to build a personalized stuffed bear (i.e., the ‘customization’). The company does not just get a herd of sheep in a coral, provide shears, and tell children—‘OK now build your bear’. Rather, the store provides a large number of varied, immediately recognizable, and useable component parts. The child then chooses among these component parts in order to build a bear that, while not unique, is customized sufficiently so that the child feels like it is their bear.

One way to think about this is to understand the range of options from mass production to individualization (Fig. 1.2).

Applied to the helping sector, Mass Production means all new clients are treated the same. We are sure every reader has had the rather off-putting experience of initiating some transaction where the first person you meet has you fill out paperwork as the entry into that transaction. Sometimes it can be a large amount of paperwork. Mass production can help guarantee the collection of consistent information. While it is efficient for the provider of care, it is not likely the way to generate a powerful personal experience. When sensitive information of a personal nature is important, it is likely that mass production generates less accurate information. The disclosure of sensitive information requires trust in the person and organization to whom the information is disclosed. Mass production models even influence our traditional theories of measurement. According to normal science, the best way to get reliable valid information is to ask everyone EXACTLY the same set of questions in EXACTLY the same order. If you think about this measurement approach from a clinical perspective, very few people deem that is the optimal method to get an accurate understanding of someone. Mass production likely does not engender trust given its intentionally impersonal approach.

The other extreme on this continuum would be *Individualization*. In the extreme of this model, EVERYTHING that happens would be unique to the individual. In the helping professions, the best exemplars of attempts at complete individualization are some forms of Wraparound with the child-serving system (e.g., VanDenBerg & Grealish, 1996) and some forms of Recovery models (e.g., Hilton & Pilkonis, 2015) in the adult system. For example, some wraparound models emphasize that everything, including

documentation should use the family's words. The emphasis is on the fact that every family story is different.

Individualization has serious limitations in the helping sector. If every situation were, in fact, unique, there would be nothing we could do to help. Helping interventions are invariably designed based on things we have in common with others, not things that are unique to only one individual. We do not decide how to help based on how people are different. We decide how to help based on how they are the same. If everyone were truly always different, we would never learn from experience. There would be little to nothing that could be learned by helping one person that would have any relevance whatsoever with regard to helping the next. Individualization requires that we develop the process of helping over and over again, for each individual or family that we meet. The irony (perhaps oxymoron) of both Wraparound and Recovery models is that both have stringent criteria for 'how to' do to the approaches'. Where do those guidelines come from? How do the purveyors of these approaches know what will work? Further, how do these developers possibly believe that they will work for the next person or family coming for help? Individualization cannot work as a business model in the helping sector.

In some areas within the helping sector, the need for *mass customization* is enhanced by the presence of existing practice models, evidenced-based treatments, program development, and varied funding mechanisms. Flexibility and adaptability are required of any overarching approach to managing personal change in order to remain feasible in diverse setting and situations.

A focus on Mass Customization means that the helping programs should attempt to stay away from our traditional 'intake' processes that represent a mass production model—everybody fills out the same paperwork and answers the same questions in the same order in a somewhat de-personalized way before you can get to the business of helping. Instead, they should design processes that can get the required information in a manner that enhances the experience of the person seeking help rather than detracts from that experience.

Helping programs should design a 'welcome' process that is tailored to the individual who is sharing their story and their goals. As they hear these individual stories, they should listen for the common themes that are relevant to helping strategies. This mass customization approach is much more likely to potentiate a positive personal change by creating the optimal experience at the beginning of care while respecting the information needs of the helper and third parties involved in supporting the helping process. More information will follow about the implication of using mass customization processes through the Transformational Collaborative Outcomes Management (TCOM) approach, as it is a core strategy for engagement and successful implementation.

## UNDERSTANDING WHERE WE ARE IN PREPARATION FOR THE JOURNEY AHEAD

The fundamentals of managing transformations (i.e., the business of personal change) are quite different than managing any other business type. Often, subtle but profound differences exist at the customer level, the individual enterprise level, and the system (market) level between transformational offerings and other business types. Because nearly all of our financing and system management models are based on a service industry concept, many social entrepreneurs have built helping enterprises within this service industry framework, supported by funding structured for service industries. Change from this business model to one that actually supports managing transformation, therefore, will not be easy. It likely faces significant resistance from those who currently benefit from the existing financial and business management structures and processes. Given these circumstances, we will need very good reasons to pursue a quiet revolution towards transformational management. In all likelihood, just like with person change, system transformation progress will have to be incremental.

The fundamental misunderstanding of the core business has led to multiple challenges in mental health, justice, child welfare, and other socially oriented sectors. The following section is a careful comparison of the implications of rethinking services as transformations.

### *Engineering as the Model of Science to Practice*

Since we have been managing the helping system, as ‘human services’ there are a number of long-held management strategies that may have prevented us from advancing to more effective care. As an example, most system managers get regular reports on the number of people served in various programs, the number of units of service provided, and the costs of this care. However, few system managers get or use routine reporting on the impact of these programs on the lives of the people served. Further, as a standard management process, we sometimes have developed quality management procedures in which we create a series of process expectations (e.g., answer a phone in so many rings, schedule an appointment within one week, ‘engage’ a person in treatment by ensuring that they attend regularly). These management strategies are implemented despite the absence of clear evidence that those processes and procedures have direct impact on the lives of the people served. If we are to manage personal change processes effectively, we must rethink how our system is designed, financed, and managed in its entirety.

The design of interventions to help and strategies to deliver, organize, and finance them should be driven by information from the best available science. There is certainly value in the science to practice efforts that arise from traditional sciences in health care. Randomized Clinical Trials (RCTs) are required

to confirm an Evidence-Based Practice (EBP). However, most of the considerations necessary to manage complex systems do not allow for this type of methodological rigor. You cannot randomly assign people to having a gunshot wound or a head injury. You cannot randomly assign someone to being a gifted musician and you cannot train *just anyone* to have this type of talent. Even if you could pose every possible question as having a yes/no answer suitable for an RCT, we would never have the resources to run multiple trials managed by multiple independent research groups on every question.

The concept of translating science into practice in most fields does not involve taking traditional scientific methods and inserting them fully into practice settings. A physician does not take all the laboratory equipment of a biologist and place it in their clinic. The actual process of translating research into practice involves is a biomedical engineer taking the knowledge of the biologist regarding the measurement of specific information and creating a laboratory process that works in practice and balances accuracy, efficiency, and cost.

Consistent with the thinking above, we propose that the work of managing transformational enterprises has, at its foundation, the application of the principles of engineering. Dictionary.com has defined ‘engineering’ as:

The application of scientific and mathematical principles to practical ends such as the design, manufacture, and operation of efficient and economical structures, machines, processes, and systems. (Dictionary.com 2022)

Clearly, from this above definition, it is reasonable to describe the design of systems and processes as the work of engineers. In fact, it is reasonable to conceive of engineering as the approach of translating science and experience to practice. So, the question is—Can we successfully engineer personal change? Can we successfully engineer processes to support personal change? We believe that the answer to these questions is an enthusiastic ‘yes’. We need dynamic systems engineering approaches to facilitate the design, implementation, and maintenance of ongoing social, adaptive processes necessary for an effective helping system.

These processes must be evolutionary to direct improvements in the helping enterprises despite an ever-changing world.

The intention of this book is to first establish how managing transformational offerings is fundamentally different from managing human services. Then we can begin to envision what the business of managing personal change might be as we shift away from service system management into transformational management.

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## Managing Services vs Transformations

A service industry is clearly a different type of business than one whose primary purpose is to help people engage in some type of potentially profound personal change. The fact that these offerings are quite different can have a demonstrable impact on how each of these business types are organized, financed, and managed. Since we currently manage transformational offerings as if they were services, there are a host of resultant problems. Most of these problems are small, but some are substantial. Many of these challenges are obvious, but some are more subtle. The following chapter describes the most salient challenges that arise from service system thinking and how a transformational system would address each. I have somewhat arbitrarily divided the implications between financial, clinical, and operational. Of course, some challenges overlap across these three areas of impact.

### FINANCIAL IMPLICATIONS

#### *Find People to Engage Versus Find People You Can Help, Help Them and Transition*

Access to care in all its meanings is important whether you consider the system from a service or transformational perspective. However, after achieving access, the two perspectives quickly begin to diverge in very important ways.

Perhaps the most obvious implication of managing a service system is that utilization of the service is the most important characteristic of any service system. The questions of how many customers do you have and how much each customer spends are the two fundamental pieces of information used to manage any service. Whether or not someone is satisfied by the service is



potentially important if the business model requires return customers but can be secondary to the fact that the service was actually provided. The translation of this reality into the helping sector is represented by our standard reports of how many people are served and how many units of service are provided in a timeframe. Nearly every helping program and system reliably produces these basic service management statistics. The returning customer concern often is reframed as ‘engagement in treatment’ but it is identical in concept to the idea of whether a satisfied customer returns to utilize a service once more.

Anyone who has worked for any length of time in any helping context can recognize the widespread implications of this focus on access from a service business perspective. Both managed care firms and large agencies have ‘Utilization Management’ staff or even departments. The primary purpose of these individuals is to manage access to and use of the time of paid professionals (e.g., services). In these models, length of stay actually becomes a primary outcome to manage as do related phenomena like access indicators (e.g., wait time, penetration) and staff productivity.

The simple way to describe how a service works from a service management perspective is that system employees focus on ‘finding people and engaging them in care’... Within such a system, different partners work on these issues in opposite directions. Providers want to find enough people to fill existing slots, appointments, caseloads, or beds. Funders want to limit the number of people who engage, and when they do, funders then limit the amount of time and mandate the type of activities those individuals can accomplish with paid professionals. This tension is the essential dance of managed behavioral health care: providers want more services, while payers want fewer (and less expensive) services.

The focus on finding people and getting them to engage in care creates both subtle and profound problems over the long run. We completed a pilot of implementation of three evidence-based trauma treatments within the Illinois child welfare system (i.e., Trauma-Focused Cognitive Behavioral Therapy, Parent–Child Psychotherapy, and Structured Psychotherapy for Adolescents Responding to Chronic Stress) (SPARCS, Weiner et al., 2009). In order to manage the referrals to these treatments, we set up a simple eligibility requirement that referred children had to have at least one trauma experience and had to have an actionable need with regard to their adjustment to that trauma (Lyons, 2009; Weiner et al., 2009). This simple decision support model is not a very high standard for referral to treatments that are *specifically* designed to treat a child’s maladaptive response to a traumatic life event. However, the only mechanism the state agency had to fund this pilot was to provide agencies with dollars and then tell them that they had to serve 50 children in each of their programs. While some agencies had little problem finding traumatized children in the child welfare system, several agencies struggled to reach their quota of 50 children or youth. Those agencies then rather stridently complained to the state, demanding that they drop the requirement that the children had to have problems adjusting to trauma. From a business perspective, that makes

complete sense—the contract agency wanted to honor its contract so that there was no risk they would have to give money back. From an effectiveness perspective, however, this approach is dangerously short sighted. In other words, contract providers were demanding to provide trauma-informed care to non-traumatized children in order to be paid. Happily, this request was denied and the state stood by the simple access model. If the state had succumbed to the provider pressure to lower the eligibility standard the intervention would not have been effective, it would be looking for change in clinical outcome variables that were already low. The evaluation demonstrated the value of these treatments for children who were traumatized and the state went forward with system-wide implementations of trauma-informed treatment for children and youth (Weiner, et al., 2009). The state could have allowed providers to treat non-traumatized children with an intervention designed for those who were adversely affected by traumatic experiences.

If they had, it would have guaranteed the failure of the pilot; children who do not need trauma treatment to begin with do not get better when they receive it. In fact, they might get worse. The state administrators' wise decision to retain the entry decision model in the face of political pressure ensured that effective treatments were allowed to be used to facilitate transformations—to facilitate personal change in children's lives when personal change is exactly what is needed. The results of the pilot demonstrated good clinical and functional improvement in all three treatment groups, so the state decided to fund all three EBPs for statewide implementation (Weiner et al., 2009).

Re-imagining a system that manages transformational offerings should shift the business management emphasis away from a focus on *utilization* to a focus on *impact*. Access to care is important but counting the number of people served is not a program outcome. A housing program should result in stable housing for those who have received help in the program. A mental health program should result in improved functioning, enhanced resiliency, reduced risk, or perhaps reduced symptoms or increased resiliency. An educational intervention should result in increased knowledge and skills.

This distinction is simple but profound. For example, it is conceptually possible that managing effectiveness or impact might actually result in a funder eager for a longer treatment or, perhaps even more surprising, a provider might be interested in facilitating the same impact in as short a period as possible. The incentives of a transformational system would focus on finding people who can benefit, helping them, and then finding new people (once the benefit has been realized). No incentives would exist for keeping individuals in care beyond the point where the care provided was useful to them.

Stated differently, managing access is important in a service system. Managing both access and egress simultaneously is critical in a transformational system. Although managed care has been working to develop end of care strategies for several decades, these strategies are often seen as adversarial between the managed care entities and providers. Once a system has converted

entirely to manage personal change, no conflict would exist between providers and payers on this fundamental issue.

### *Billable Hours Versus just Enough Help*

Shifting from managing utilization to managing impact is just the first of many differences between a services approach and one focused on transformation. In a fee-for-service system, organizations often set expectations for a certain level of productivity for each staff member. A community mental health center might expect each of its therapists to provide 25 to 30 direct (billable) hours of care each week, sometimes even higher. Since agency income is directly determined by billable time spent by its staff, it is only reasonable to expect staff to spend a sufficient amount of time in providing what are inevitably referred to as 'billable services' in order to cover the full cost of their positions. Failure to do so would result in failure or bankruptcy for the agency or program. This productivity-based management approach, which is quite reasonable within a services philosophy, has a number of important consequences in the helping sector.

In our work with implementing common assessment strategies, a common complaint raised by professionals is that they often feel like they do not have enough time for one more thing to be added to their workload. When our assessment approach is introduced, it is often perceived as a task added on top of their already substantial documentation requirements and assisting the staff can sometimes be received like one more compliance ask to keep a third party (or external party) happy.

Although documentation is often experienced as an onerous task, almost every thoughtful professional will tell you that they are more effective when they first develop a comprehensive understanding of the person(s) they are attempting to help. Having the time to do this is critical. If the initial discovery process (e.g., intake, admission) is a 45-min hour then you cannot possibly do a full discovery process (i.e., comprehensive assessment). If reimbursement policy dictates that this initial contact is the only time it is possible to bill for 'assessment', then the business model of the outpatient clinic forces clinic staff to do a partial, incomplete assessment process because staff have to provide time that is billable. In this way, the system creates incentives for intervening in the absence of full knowledge—at least from a documentation perspective. This challenge is why it is so important to make the documentation process a part of the work rather than an addition to the work. In other words, the work and the documentation of the work should become the same thing. Many industries have already achieved this aspiration.

A second consequence of managing productivity is the recognition that for both programs and program staff it is substantially less work to maintain an existing client than it is initiate care for a new one. There is a substantial workload differential between understanding and developing or evolving a plan of

care with someone you are seeking to help versus continuing to implement an existing plan.

With experience, the amount of psychological and technical preparation one needs to do to successfully engage with and help the individual or family is often very modest. A routine has been established, and expectations are in place. There is a natural continuity from the previous meeting. All of these conditions make a unit of care (e.g., session, meeting, contact) earlier in an episode harder than the units of care later in that episode. As a result, when professionals are expected to spend a certain number of hours providing ‘services’, there is a natural inclination to hold on to those people who are already known rather than seeking a new person to help. When you add a substantial documentation process to end an episode of care to that required at the beginning, the incentives shift even more strongly towards sustaining care rather than managing access and egress together. In the broadest sense we all have aspects of our lives, which could be improved, and so one can easily argue that everyone always has something to ‘work on’. There is always some help needed. Therefore, endless treatment (or most other forms of helping) can be seen as easily justifiable from this broad clinical perspective. In behavioral health, this consequence can result into the clinician’s illusion as described by Vessey et al. (1994). These authors demonstrated that while the majority of clients in psychotherapy only come to a few sessions, after even a few months of practice the majority of time spent by therapists is with longer-term cases. For instance, if a clinician has ten clients, which they have been seeing, long term and they accept sixteen new clients a month, in that month they will see 26 people. It can be expected that about eight of the new cases will dropout in the first month. That therapist then only sees eight new people in the following month to maintain their caseload of 26.

Another four dropout in the second month but the remaining continue long term. By the fourth month, that therapist will have a full caseload and will be unable to accept new cases despite the reality that the majority of any new cases would still be short term. This experience leads therapists to believe that their work is long-term therapy because that is how they spend most of their time. Within a year most therapists will spend more than 80% of their time with clients who they have been seeing long term. From a client perspective, however, the work remains predominantly short term. Regardless of the therapist experience, it will always be the case that only 1 in 5 of their cases is likely to go long term even if the number of new cases they accept declines.

Recently, models have been developed (e.g., Choice and Partnership Approach, CAPA) that prescribe durations of care based on assessed need (Child and Adolescent Mental Health Services, 2022). These models are quite consistent with movement towards a TCOM approach. The key to the success of these models, of course, is ensuring that the impact results are consistent with the prescribed durations of care. The experiences with EBPs, however, provide a cautionary tale. Although most EBPs have a prescribed duration of

care, the actual pattern of utilization often does not match the theory of practice. For example, in the pilot study described above, we found that TF-CBT with highly traumatized children often required at least 18 months despite the fact that this manualized treatment was a 16-session model. The TCOM perspective is that clinical and functional status (in real time) is a far more meaningful way to manage utilization than a priori prescriptions for duration of care.

### *Incentives to Fill Beds Versus Achieve Successful Transition*

There is one number that every CEO or Executive Director of every residential treatment program or hospital knows every day that they work and may very well be aware of even on days where they are not working: the census or occupancy rate. The percentage of beds filled is a critical factor in the business of any enterprise that charges a per diem rate based on occupancy. Successful hospitals or residential facilities must maintain an occupancy rate above 90%. It means that a hospital must be run a bit like a hotel with massively higher overhead costs. Occupancy rates in the 80% range will create some hardships for the organization. If occupancy rates sink below 80%, the organization is likely to begin to bleed their reserves or endowment and risks significant downsizing or even closure.

This census-based management strategy has proven to be very problematic for residential treatment providers, particularly in the child-serving system. Historically, clinical and functional outcomes from residential treatment over relatively large samples of children and youth have been flat, suggesting no effect of the intervention. In residential treatment, that what actually happens is that some children and youth get much better, some do not change, and others actually get worse (Lyons, 2015). When averaged, these diverse effects look like no effect. In unpublished research, we found that it appears that any harmful (i.e., iatrogenic) effect for residential treatment may be specific to low functioning youth who had not engaged in high-risk behavior (denDunnen & Lyons, 2009). When you put them in congregate care settings, they become the milieu ‘wannabes’ and begin to mirror the higher risk behavior of their higher functioning (often more charismatic) peers. By admitting low-risk children and youth in order to fill beds, residential treatment providers actually damage their outcomes and, in the end, demonstrate to funders that they are not helpful. That is unfortunate, because residential treatment can be beneficial—but only for the right youth. A focus on filling beds as a business model masks the true value of residential treatment for youth and ultimately risks the entire enterprise.

### *Inexpensive Versus Effective*

One of the most obvious results of managing transformations as if they were services is the funders’ and agency administrators’ focus on trying to contain

the costs of employees. In a restaurant, the owner tries to buy the food for meals as inexpensively as possible to ensure that the sale of a meal is profitable (within a price range that maintains the restaurant's target level of quality based on menu pricing, of course). In the US, restaurants often pay wait staff below the minimum wage and expect them to make their money through tips from satisfied customers. In helping enterprises, often the primary cost is that of human capital—salary and benefits for staff. Getting the least expensive staff to do the most work is a standard operating procedure in all helping service systems. In this model, it is common that the least experienced, lowest paid employees are the ones who spend the most time with clients who require help. If an agency receives a fixed amount for each hour of time spent with a client, then the difference between the receivable income and the cost of providing that hour is the key component to either profit or the resource that the agency can use to cover its administrative and other costs (i.e., in a not-for-profit environment). This basic management strategy, of course, has the potential to limit the transformational impact of services if the experience and skill level of the staff has any relationship to the effectiveness of the intervention. If an intervention requires a certain knowledge base or skill set in order to be effective (or even a certain type of person drawn to a higher paying job), then relegating the intervention to the lowest cost employees is not likely to result in an optimization of effectiveness.

### *Time as an Expense Versus Time as an Investment*

Often, but not always, services are reimbursed based on the amount of time direct care staff spend with the people they serve. The agencies that employ therapists and counselors are paid for direct service hours in a fee-for-service system. Other times, service hours are reported as a productivity indicator when providers are not reimbursed in this manner. For example, some contracts call for a certain number of people to be served or service hours and with a set payment... In these cases, providers use their reports of service hours to document that they are honoring their contract and actually serving the required number of people within the expected amount of time. This productivity management strategy is quite reasonable from a services perspective. It can be quite problematic from a transformational offering perspective because the impact of the hours spent simply does not matter.

If providers are paid for time spent then any one hour is valued at exactly the same rate as any other hour. The very first hour that a provider spends with someone is deemed to be of the same value as the 2nd hour or the 10th hour or even the 100th hour or 1000th hour. It does not matter where in the person's trajectory of recovery that the hour is provided just so long as that time is spent directly with a designated recipient of the service. As such, service providers are paid to share time and space with people. In this business model, there is little guidance on what must happen during that time or in that space; the event simply must occur. In fact, nothing much happening is a

good thing because in this financing model, the only other factor to consider would be if something bad were to happen. Bad events during the time and space spent together lead to professional sanctions and lawsuits and other such unfortunate or unsavory experiences. Therefore, in a service system, what is actually incentivized is spending time and space where just enough happens to convince the recipient to return to spend more time, but not enough happens to convince the individual that they are ready to leave services and most importantly, nothing ‘bad’ happens at all. I am not arguing that is how most direct staff practice care; I am simply describing how the current system is constructed.

Since most interventions are initiated when people are at their highest need, the first phase of any intervention is often more difficult than later phases. The discovery phase—where there is an effort to figure out what the issues are and what are the best strategies to support positive change—is likely more difficult than a maintenance phase where gains have been made and the work is about building on those gains or keeping those gains in place. In addition, the sooner people come to a full understanding of their circumstances and action options moving forward, the more efficient and effective the helping process can be. When all hours are valued as identical, two clear problems arise. First, there is no incentive to ‘front load’ an assessment or discovery process to facilitate efficient care. Second, it creates a clear incentive to extend episodes of care to long standing recipients because they require less work to generate the same amount of billable time.

Most trajectories of recovery that have been published (e.g., Lyons et al., 2009) demonstrate that getting better is not linear. The maximum benefit of most treatment is in the initial treatment phase. Over time, the relative benefits of additional intervention declines. It follows then that in a system that values personal change, the actual value of initial hours of contact are much higher than the value of hours spent later in the course of an episode of care. The same is true in residential and hospital care. The first few days are likely of much greater value (and require more effort) than treatment days later in the hospitalization or residential stay.

### *Managing Programs over Time: Efficiency versus Effectiveness*

States and other systems are notorious for creating programs with an initial investment in resources and then over subsequent years consistently reducing investments (or not keeping up with inflation, resulting in cuts) in that program. Agencies then attempt to provide the basic elements of the program with successively fewer resources. The new programs are often announced with public fanfare. The political bureaucracy uses these moments in an effort to communicate to the public that they have initiated some great new idea to address a specific need or create a legacy in the community. I met the Chief of Staff for a member of the US House of Representatives. He told me that his job often amounted to creating opportunities for his Representative to stand

on the front steps of some organization and be photographed handing over money to support some new initiative. What happens to that new initiative over time is not particularly important in the political process.

The fact that political appointees use new programs to guide their agency and define their time in charge places these very programs at risk whenever a change in administrations occurs and a new administration takes office. Of course, visible initiatives or legacies associated with previous administrations are not likely to be seen favorably by a new regime. In some cases, focused efforts to eliminate any footprint of previous administrations can be a priority. Further, new politically appointed bureaucrats will be looking for new programs to set their new agenda and establish their legacy. In a limited resource environment, the only available money is usually already committed, so unless new monies are forthcoming, the new regime's initiatives may have to be funded through reductions in the previous regime's favored programs. Sometimes, the greatest curse for a program is when current political leadership features it as a part of their contribution to governance. This very act increases the likelihood of '*programicide*' by subsequent administrations.

This basic political calculus is quite consistent with a service system approach. Once you have a service implemented, the management strategy is essentially determined by the answer to the following question: 'How can you do the same thing for less and less money?' If an intervention is conceptualized merely as spending time and space with a person, then figuring out how to do that for less money is a pre-eminently reasonable management strategy. Unfortunately, the politics of this situation are at stark odds with managing personal change processes. If the intervention were to be conceptualized as a transformation, then management decisions should be based on how the program continues to increase the impact of its intervention(s) on the lives of the people served. In fact, providing the intervention more cheaply might damage the effectiveness of an intervention over the long term. The key management question becomes "What do we need to do to maintain or increase the impact of our care?"

In a transformational system, there also would be a different political calculus. Transformation is a social process, which involves the ongoing collaboration of many groups of stakeholders (partners) to achieve commonly valued health and wellness outcomes. Successful transformation requires the work of an ever-expanding coalition of people. In a transformational system, politicians and their appointees come to realize that the work of this network is what allows them to appear to be successful at helping. Therefore, the more they engage with and support this network of persons involved in transformational work, the better they will look and the more positive impacts in their community will be able to be documented. They can claim credit for this impact rather than claiming credit for investments only. Politicians can come to realize that reversing the normal course of interaction (they seek out the network's favor as a collective, instead of individual members of the network seeking out their



favor) allows them the quickest and most consistent access to claiming positive and sustainable impact of their tenure in leadership. As a response, the network may re-title or re-brand initiatives for the politician, in order to serve the politician's interests while preserving or expanding effective care for individuals. The State of New Jersey's Children System of Care is a great example. In my opinion, the state currently has one of the best children's system in the United States (Manley, 2016). They achieved this success in part by simply renaming it for different governors from the initial name of the Children's Initiative, to names such as the Partnership for Children, the Department of Child Behavioral Health and the Children's System of Care. Across all these name changes, the state continues to approach care with the same essential model, only modifying the system based on databased experiences rather than political whimsy.

## CLINICAL IMPLICATIONS

### *Assessment to Justify Service Receipt Versus Decision-Making*

Anyone who has worked in the U.S. behavioral health system has heard people talking about the use of an assessment to 'justify services'. This statement means that in the system, the perceived value of a standard clinical assessment (at least one that is communicated outside of the client-helper relationship) is to provide information to a funder that will convince them to permit the helping provider to be paid for designated activities with the identified person to be helped. In other words, the assessment is predominantly a communication between a provider and a payer coming from the provider to convince the funding source to pay, and is intended for use with the primary metric of a service system—access to care. Ergo, 'justifying service receipt' as the reason for common assessments. This dynamic creates a number of unintended and challenging consequences.

First, when assessments are used to justify service receipt, all incentives for helping providers are aligned to encourage helpers to describe the individual to be helped in the worst possible way, or at least bad enough to guarantee access. The output of the assessment is used to ensure that the individual will be given access to care, or qualify for reimbursement for any help provided. As we developed the TCOM approach, one of the most controversial aspects of the measurement system was the use of the last 30 days as the basis for the ratings. (i.e., 'is it relevant in the last 30 days?') Many people advocated for using the past 90 days or six months or even the last year as the basis for the ratings because they were worried that their clients would not appear 'sick' enough to justify ongoing intervention.

The second problem is that justifying service receipt makes monitoring progress difficult. If providers feel like their recipients cannot get better or they will no longer be eligible for ongoing care, which creates an unhealthy

incentive for providers to demonstrate no client improvement. In the financial structure of a service system, improvement can be associated with a loss of resources or income. This dynamic puts helpers in the difficult (bordering unethical) predicament of having to demonstrate to funders that what they are doing to help is not really working in order to justify them continuing to try to help.

On multiple occasions, providers have asked for outcomes measures that can reliability call very small changes ‘statistically significant’ so that they can make this argument work—their clients are improving but not enough to matter in terms of egress from care. However, the only change that reflects an actual transformation are changes that matter in terms of what we need to do. Other, small changes are trivial because they do not *really* matter. It is like arguing that it is a meaningful outcome for a person to go from seriously self-injuring himself or herself 10 times a day to 7 times a day because over a large enough sample of people, this change is statistically significant. From a transformational perspective, they are still self-injuring and helpers still have to monitor them closely to ensure that they are safe. The small change is nice and certainly better than getting slightly worse but it simply should not be relevant from an outcomes management perspective. This issue will be discussed in detail later in this book.

### *Incentives to Serve the Least Challenging Versus the Most*

In any service-based helping enterprise, since the business is simply spending time and space with people, the incentives line up to support serving persons with the least challenging situations or presentations. If you were going to spend an hour with someone, who would you choose: An affable, attractive, insightful person or someone who is floridly psychotic? The incentive is clear. This phenomenon was described originally by Scofield (1964 [1986]) as the ‘YAVIS’ effect. YAVIS stands for Young, Attractive, Verbal, Intelligent, and Successful.

Today, one could argue that you could replace ‘intelligent’ with ‘insured’. Described in a different way, reports about the phenomenon of providers ‘cream skimming’, or providing care to only those clients that are easiest to manage towards a positive outcome, does occur (Crew & Kleindorfer, 1999). The YAVIS effect are natural consequences of a service system.

This phenomenon results in some people being denied care because they are too difficult to manage. For example, some psychiatric hospitals in the United States have reportedly denied admissions to people because they were ‘too dangerous’. This adverse selection problem can result in helping systems trying to help the lowest need people that are still eligible, leaving the most challenging, highest need people with less access to care.

Thinking from a transformational perspective, taking on more challenging circumstances offers greater opportunities for impact. If the goal of helping is

to help someone change, the greater the change needed the larger the opportunity for improvement. Transformational management, when done correctly, provides clear incentives to work with people who have greater challenges and needs. The incentive is flipped. If a program is looking for impact, they are incentivized to take on the greatest challenges. If they are looking to fill their caseloads, they will may be tempted to take on the least challenging. Of course, this potential selection bias can be managed somewhat by specifying the mandate of the program type or facility. The TCOM perspective recommends robust decision support mechanisms as discussed later in this book.

There is an important caveat to the circumstance described above, and it involves the definition of an impact. There are many traditional efforts to study outcomes of interventions by measuring the status at the end of care as an ‘outcome’. That is not an impact; it is not personal change. In fact, defining an outcome as a status at discharge actually incentivizes taking on less challenging work. This methodological approach actually replicates the problems with a service system (Donenberg et al., 1999). There is a large body of so called outcomes research that reports end of care status in this fashion (e.g., Morris et al., 2020). Be very careful reading and interpreting such misleading analyses. Transformation, by definition, describes a change in clinical and functional status, not a status at end of care. Beginning with Cook and Campbell’s (1979) classic text on quasi-experimentation, post-test only evaluation models are seen as invalid assessments of the impact of an intervention.

In Cronbach and Furby’s (1970) influential work on measuring change, the authors argued against the use of raw change metrics since they tend to multiply any unreliability in the measure. They advocated, instead, for the use of residual change scores. Following this logic, regression models are often used to predict status at discharge. These models work by removing variance from admission levels. Unfortunately, this application of the general linear model can make the same mistake albeit in much more ‘sophisticated’ statistical that often escapes detection.

Often this statistical approach is accompanied by a lecture about ‘regression to the mean’. The argument runs something like this: people with very high levels of needs are also more likely to ‘self-correct’ to a much lower level of need and thus estimating the actual effect of treatment should remove this ‘self-correction’ from the effects of the intervention. This is an extension of thinking in terms of psychometrics, which consistently references a normative distribution, and often views outlier scores in a distribution as likely to be accidents of circumstance and as unlikely to repeat. Applied to persons with high levels of needs, this thinking would label their current distress as at least in part a statistical fluke, unlikely to repeat, and the person experiencing them as likely to ‘auto-correct’ and to return to a lower level of distress. The ultimate effect of removing variance from persons with higher levels of need at entry to care (i.e., changing their scores so that they are closer to the arithmetic mean) is that providers must then show greater change in high need cases to

be seen as equivalent in scale to smaller changes in low need cases (Lyons, 2015). Much like the caseload number example, regressing follow-up scores on admission scores to study change treats all persons as similar in need and dis-incentivizes providers from providing services to persons with high levels of distress or complex needs. It is making the argument that ‘If everyone started at the same level of need...’ This premise is nonsensical at the outset. However, you see similar lax thinking with regression models that purport to ‘control for’ gender, age, and race. The premise is that if you find some genderless, ageless person with no racial identity, then your results would be... I have never met such a person and frankly could care less about the impact of any intervention on someone who does not and cannot exist. Disaggregation is the only reasonable way to understand differences potentially associated with these personal characteristics. Historically, loss of degrees of freedom was a primary reason people preferred to use regression models with covariates—the cells sizes rapidly shrink to zero. With the now available enormous data sets, this worry is historical and may be no longer relevant for many analyses in the zeitgeist of ‘big data’ and machine learning.

Similar problems haunt outcomes defined as percent reduction (e.g., Große et al., 2020). Small changes of lower need people are equivalent to much larger changes for people presenting with many more needs. If you have two needs and resolve one that 50% improvement, it is hard to imagine that reducing one need of two is equivalent to reducing 16 needs to eight.

### *Managing Through Supervision: Compliance Officer Versus Teacher*

If the business of human services is spending time and space with people, then it makes sense that the oversight of this work is to ensure that sharing time happens and is properly documented to ensure payment. The services business model only works if the service is delivered and documented in a manner that secures reimbursement. As such, it is easy to see how we can slide into an operation where staff with supervisory authority over the performance of direct care staff focus on the deliverables of that service. Given this circumstance, it is generally considered standard practice for supervisors to be responsible for monitoring and enforcing productivity targets for the staff they supervise. When those productivity targets are defined in terms of billable services, then it is only natural that supervisors evolve into enforcers of the targets. In this model, compliance with productivity and documentation become the role of the supervisor. It is not uncommon for this policing/controlling role to become their primary role. This allocation of supervisor time makes perfect sense from the lens of a service delivery model.

From a transformational perspective, the devolution of the supervisor role represents a significant lost opportunity. When persons with the greatest service expertise are relegated to enforcing compliance, the opportunity to model and teach good practice is largely lost. There is only so much time that can be spent in supervision; every minute spent on enforcement is one less

minute spent on teaching critical skills and approaches that could maximize the impact of the interventions.

The supervisor is perhaps the most important level of a transformational system. From this frame of reference, supervision is teaching. The supervisor is responsible for ensuring that supervisees have or develop the skill sets necessary to be as effective as possible. Problem-solving the challenges to a particular client's progress, and assessing and teaching clinical and case management skills, become the primary tasks of the supervisor. In a transformational system, the care provider and the supervisor should be empowered with regular, standardized feedback about a care provider's collaborative practices and their impact on the client's progress towards achieving their goals. This feedback is used to create an ongoing, constructive dialogue about whether current practice is or is not supporting persons being served. This feedback, over time, can also be used to identify whether the skills, which the care provider needs to develop, are best supported by their current supervisor or would be better developed with the support of another supervisor, outside training and expertise, or some combination of both.

### *Consumer Satisfaction versus Personal Change*

As mentioned earlier in this chapter, another manifestation of a service management mentality is the use of consumer satisfaction as an 'outcome' measure. In this way of thinking, the person being helped could be conceptualized as the customer. So long as these people like the provider, feel respected, and are happy with the process then that is a positive outcome. Martin Seligman (1995) advanced this perspective persuasively in his well-known Consumer Reports article. The article was so persuasive that shortly thereafter he used his fame to launch a successful bid to become president of the American Psychological Association.

The core of his argument was this: using the same metrics as any other service industry, we can demonstrate that psychological services lead to positive customer satisfaction outcomes. The survey results strongly supported this notion. The underlying corollary was that psychological services have now met the standard required to continue to sell these interventions to the public. Such thinking is very consistent with the notion that the mental health system is about finding people and getting them to engaged enough to stay committed to the ongoing receipt of the service (as previously described). The real question is whether they are doing better.

In a transformational environment, engagement and progress are more relevant than satisfaction. Engagement is about committing to and working through a process that leads to goal achievement. This includes transparency, cultural responsiveness, openness to disagreement, willingness to have difficult conversations, and a commitment to working through problems, which arise on the way to achieving goals. In fact, research has demonstrated that while consumer satisfaction has little to no relationship with functional outcomes,

measures of youth and caregiver engagement have a strong linear relationship to functional outcomes (e.g., Moore et al., 2006; Tsai et al., 2012).

## OPERATIONAL IMPLICATIONS

### *Caseload Versus Workload*

Consistent with the discussion above, service system thinking often results in the use of caseloads as an important productivity metric. An individual provider is expected to maintain a certain number of cases. If a case transitions, then a new case is referred. However, if no case is ‘discharged’ then the individual’s caseload remains static. The concept of ‘caseload’ has a number of unintended consequences that overlap with the problems previously described. The most troubling is that when a caseload is determined, an individual is incentivized to maintain a load of low effort cases while trying to avoid high effort cases. It is far easier to serve a set of clients with minimal needs as opposed to serving the same number of clients with very high needs.

The transformational equivalent metric to caseload is workload. In this productivity model, a single complex case is valued over even multiple simple cases. Individual providers are expected to maintain a certain overall level of complexity, which can be summed across cases, rather than being held to account for a specific number of cases. A large number of simple cases is likely similar in effort to a small number of complex cases. Simple case counts do not allow for this important nuance (or real difference).

### *Loyalty to the Agency Versus Loyalty to the People Served*

It is not uncommon for jurisdictions to create system-wide programs to address new initiatives. Whether the program is a new supported housing initiative, the funding of an evidence-based practice, or a specialized program to address the mental health needs of offenders, each year new initiatives are created and implemented. Many times, those initiatives are designed by the jurisdiction but funded in multiple agencies throughout the jurisdiction. Sometimes agencies are asked to compete for the new program through a request for proposal (RFP) process and sometimes agencies are simply picked for the new programs based on less formal processes.

Further, it is not uncommon for jurisdictions to design new programs to have a core set of standards and practices. It is reasonable that the funding source would have expectations regarding how persons are served and how the program is staffed and managed, but there can be substantial variation in precisely how specific the central authority chooses to be regarding establishing, communicating, and enforcing these program management parameters. Oftentimes, someone is appointed at the jurisdiction level to run the program across the different agencies. However, these are generally

lower level system administrators and high turnover in these assignments is common.

This multiple agency program design creates an interesting tension when the focus of the program is about service delivery. At each individual agency, program staff often experience tension between the priorities of the jurisdiction (based on jurisdiction-wide expectations) and the priorities of each agency (based on within agency culture and job expectations). It can be a challenge of dual loyalty as to whether program staff are loyal to the priorities and expectations of the program or to those of the agency that is their employer.

The Illinois Mental Health Juvenile Justice (MHJJ) Program in Illinois (Lyons et al., 2003) is a case in point. At the state level, this program charged the regional agencies to hire a liaison for the juvenile detention centers around the state who would identify youth offenders who had major mental health concerns (e.g., depression or psychosis). The program was designed from a transformational framework—focusing on the functional change experienced by the youth served—but was inserted into a mental health system that was all about service delivery. The MHJJ was run with quite a bit of system-level support and we met regularly with the liaisons employed by the 16 funded agencies. While this contract and the regular in-person meetings, in particular, created some loyalty to the statewide program, it also created some tensions with some of the participating agencies. For example, more than one agency had the person serving in the liaison position also providing billable treatment hours, so that they could make additional money on top of an already fully funded position. However, as you might anticipate, time spent providing treatment services (perceived as positive for the agency's bottom line) meant time away from the intent of the position: spending time helping youth coming out of detention to get into the appropriate care. Thus, the more the liaison responded to the agency imperative (to bill additional hours and dollars via treatment provision) the less they were able to fulfill the intent of their position and the transformational imperative (to ensure that all youth who needed behavioral health services were able to access those services). Repeatedly, we had to reign in this tendency to respond to the agency imperative and guide people back to serving the transformational imperative. In complex systems, sometimes professionals must stay in their lanes, and in that way, youth get the mental health treatment that the program was designed to guide them into receiving.

In the MHJJ program, flexible spending dollars were made available to facilitate a wraparound-type approach to assist in engaging youthful offenders with mental health needs in the existing community mental health system. When we first started the program, each agency was given a \$50,000 annual flexible fund budget to manage. Because of how the state regulations worked in Illinois, if the agency did not spend those dollars they would then be released to the agency's general fund for the next fiscal year. Liaisons had dual reporting to both the statewide program and their agency leadership structure. Agencies instructed the liaisons not to spend the flex dollars on the youth because the

agency needed those dollars for other purposes. In the first two years of the program, very little of the \$1.5 million annual set aside for flexible spending was actually spent on program youth. A transformational system-level change had to take place. The flexible fund dollars were then removed from agency budgets and were placed in a U.S. Charitable Foundation which had no ability to re-appropriate the dollars to agencies' general fund budgets. Over the next several years, nearly all the dollars were spent every year on the program youth.

As this program example clearly demonstrates, the program versus agency tension can nearly disappear when the focus is on managing transformation rather than managing services. No longer is it about how staff spend their time (that is a service industry concern) or how can dollars be shifted from one program to another (i.e., an agency director's concept of blended funding). The management focus shifts to ensuring that the transformational impact of the new program is optimized (and perhaps even maximized).

### *Compliance versus Aspirations*

Of course, there is a recognition that managing services has unintended consequences on the impact of those services. There are clear incentives to spend time with people who need help. There are fewer formal incentives to provide effective help, only disincentives. In order to address the unintended consequence of incentivizing time spent, there has been a great deal of effort to design expected practice and program policy requirements in an effort to ensure more effective care. These strategies include everything from Medicaid compliance standards on documenting medical necessity and progress, to measures of fidelity, to evidence-based practices and all manner of policies in-between. When helpers are found not in compliance with these mandated practice indicators sometimes their payment for spending time with people is reduced.

However, if you ask people why they got into the helping professions almost no one says they are 'doing it for the money'. If a personal goal is optimizing personal wealth then a career in the public helping professions is likely not a good career choice. Instead, the vast majority of all people working in the helping sectors are doing it out of desire to be helpful. Despite the reality that personal motivations are complex and varied, nearly all formal incentives are financial. Few of the personal motivations, however, are financial. This disconnect is a major challenge in managing the business of helping. Addressing this challenge successfully is a focus of this book. As discussed later in this book, we believe that managing personal and professional aspirations is likely the path forward in creating sustainable transformational systems.

Aspirational management would replace compliance management across the levels of a system and impact would be seen as supporting personal change (with everyone) rather than productivity.



### *Moving Forward*

These are the circumstances in which we find ourselves. We have created a massive human services system in which employees, government contractors, and appointees are consistently rewarded for acting in ways that are not always in the best interests of the people that the system is expected to help. I believe that it is the underlying dynamics of this business model that must be changed if the helping system is going to demonstrate the type of progress seen in other industries over the last few decades. The remainder of this book lays out a series of goal-directed social change processes that allow people at every level of a system to begin a shift towards transformational practices and the emergence of transformational systems. It begins with learning to work collaboratively.

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## Helping as a Complex System

In the first two chapters, we discussed the need to shift to a system that embraces the concept that helping is the business of personal change. That is why the ‘T’ in TCOM stands for Transformational. The second letter in TCOM is a C that stands for Collaboration. According to Merriam Webster’s online dictionary, ‘collaborate’ is a verb with the following definitions:

1. to work jointly with others or together especially in an intellectual endeavor. An international team of scientists *collaborated* on the study.
2. to cooperate with or willingly assist an enemy of one’s country and especially an occupying force suspected of *collaborating* with the enemy
3. to cooperate with an agency or instrumentality with which one is not immediately connected. The two schools *collaborate* on library services.

The first definition is the key to understanding the concept of collaboration within our context. However, as we move from direct care to programs, agencies, and systems, the third definition of collaboration becomes relevant. (The second definition is not relevant for our purposes.) Among individuals, collaboration is a direct act of working together on a joint endeavor. At levels away from the actual helping relationship, parties work together while not immediately connected. Clearly, collaboration requires two or more people. No upper limit exists on the number of people who might collaborate with each other. One could argue that in a democracy, the entire country is engaged in a collaborative enterprise. TCOM’s focus on collaboration comes from two separate historical threads: person-centered care and the evolution of systems theories, specifically our emerging conceptualization of complex adaptive systems.

## PATIENT-CENTERED CARE

In its landmark publication, *Crossing the Quality Chasm*, the Institute of Medicine (2001) inventoried many of the challenges of the healthcare system. Among the solutions to these problems, that they proposed was an approach that they called ‘person-centered care’.

Person-centered care is a strategy of providing health care that sees the people using health and social services as equal partners in all of the processes of planning, developing, and monitoring care to ensure that the care meets their needs. The two words ‘equal partners’ is fundamental to this definition. Equal partnership requires ongoing collaboration: Collaboration on understanding the circumstances. Collaboration on deciding the intervention approach. Collaboration on monitoring the impact of efforts to help and adjusting those efforts accordingly. Finally, collaboration on deciding when enough has been accomplished. However, as soon as we move beyond the person-helper interaction, the concept of person-centered care becomes complex.

The idea that health care should fully involve the person is not new. A considerable number of prior initiatives have existed over the past decades that are similar in their focus. Many have talked of ‘patient engagement’, ‘family focused’, or ‘person-driven’. All of them sound appealing. The very idea that health care should be about anything other than the healthcare needs of the individual seeking care is unacceptable.

Unfortunately, despite our attempts at changing language and strategies, decision-making about health care has not been consistently centered with the person seeking care. Healthcare providers weigh in on what they think the problem(s) are and what actions are in the best interest of the people they serve. Often providers advocate for increased access to care rather than increased impact of care. Insurance companies and government funding authorities develop decision rules that are intended to balance the interests of the people served with the larger interests of all citizens or at least government agencies or employers, particularly in terms of the investments in the helping sector. Drug companies try to influence physician recommendations and decision-making and try to limit third parties’ ability to affect the costs of drugs. Of course, politicians on both sides of the aisle, representing constituencies with strongly held moral or religious convictions or strong financial interests, sometimes insert themselves into the healthcare decision-making process as well.

Person-centered care offers some hope of actually being different from the myriad of ‘patient-first’ type strategies that have been espoused in our lifetimes. There are two main reasons for hope. First, the approach is openly collaborative. Instead of naïve approaches that claim to put the person at the center of care, the person-centered approach explicitly makes the person serve as an *equal partner*. As discussed in detail below, this collaborative stance is very consistent with what we have learned about managing complex ‘soft’

systems. Second, the rapid development of the information culture allows for the democratization of information, and hence empowered collaboration, in ways that were not previously possible. However, person-centered care will suffer the same fate as many other good ideas unless we figure a way to embed it into the practice of care. Without a model to engineer people as full partners in their care, without social processes and strategies that place the principles of person-centered care formally into the day-to-day decisions made in the healthcare marketplace, it will simply be another nice idea left in the dustbin of history. Transformational Collaborative Outcomes Management (TCOM) offers a pathway to take person-centered philosophy to scale. TCOM is a systems engineering approach to facilitate the broad absorption of person-centered care into complex systems.

### COMPLEX ADAPTIVE SYSTEMS

Anything that requires more than one component part is a system. It is in the nature of systems that our idea of collaboration is understood. One characteristic of all effective systems is that the component parts work well together in concert; in dysfunctional systems, generally one or more component parts are not operating in concert with the others. Collaboration (working together) underlies system effectiveness.

Currently, the science of systems theory makes an important distinction between two fundamentally distinct types of systems: complicated systems and complex systems (Grabowski & Strzalka, 2008; Poli, 2013). Complicated systems are systems in which the components are 100% predictable. For example, an automobile is a complicated system. Complex systems are those in which the component parts are not as predictable. Often, systems are complex because they involve human beings. Human beings are not as predictable as a car part. Over the past several decades, science and engineering have made enormous progress in both modeling and managing complicated systems; evolving complex systems to the same degree is perhaps a work in progress.

It is important to consider the similarities and critical differences between these two types of systems. Both complicated and complex systems have many moving parts. With both types of systems, the only way to get the system to function optimally is for those moving parts to be fully coordinated with each other through continuous, simultaneous, perfect communication. This form of collaboration is true of both complicated and complex systems. In both types of systems, the component parts must ‘collaborate’ for the system to function.

While there are many similarities, the distinctions between complicated and complex systems are critical to understanding the important role of collaboration. Complicated systems are far easier to integrate because the component

parts are mechanical and, therefore, as described above, predictable. ‘Collaboration’ in these terms is a mechanical or electronic solution. Traditional engineering approaches work exceedingly well to optimize complicated systems. Telephones are wireless and have shrunk in size while dramatically increasing in functionality. Many mobile telephones now have the storage capacity and computing power of desktop computers from just a few years before and of mainframe computers from the end of the last century. Enormous rockets routinely blast off to help resupply astronauts in an orbiting space station; these same rockets have landed safely on floating sea-borne platforms to be re-used. Each of these successes is attributable to engineering solutions that successfully use breakthroughs in science to support solutions that integrate and/or coordinate an enormous number of component parts into a well-functioning whole. The successful operation of a complicated system requires the full integration of all the components so that all of the parts are working towards the common objective of the system.

A classic example of a complicated system is an airplane. Airplanes now have the capacity to fly themselves. The only way an airplane can safely land itself is if the engine, the wing flaps, the gyro, and the land gears are all in perfect simultaneous communication. They have to communicate with each other by sharing data and adjusting accordingly to ensure that the plane remains in the position and altitude required for a safe landing. Any failure of communication between these component parts will result in a catastrophic failure of the system (i.e., the plane will crash). Since complicated systems are fully predictable, it is 100% possible to predict the behavior and functioning of each component within the complicated system by deconstructing interactions into their component parts. Complicated systems, therefore, can be fully engineered.

As introduced in the first chapter, the ‘components’ of human-serving systems are people rather than mechanical parts. People, with their shifting perceptions of situations and goals, introduce a source of unpredictability that is uncharacteristic of machine parts. Wing flaps do not have bad days. Gyros do not have trauma triggers. Because of greater challenge in predicting human behavior, traditional engineering solutions cannot be directly applied to complex (human) systems. While we can learn a great deal from the success of engineering solutions with machines, there is a strong argument that organizations of people are not fully understood when thought of from a machine perspective (Stacey, 2001). While Artificial Intelligence (AI) can conceivably replace humans in many functions and activities, human cannot conceivably replace AI. Though an engineering metaphor may be useful for some binary behaviors of persons in well-controlled circumstances, complex systems largely defy the hierarchical order and linear progress which the term ‘engineering’ often implies (e.g., Kurtz & Snowden, 2003). In complex systems, it is not possible to predict the behavior of the component parts invariably. The presence of human beings as the primary components of a system introduces an important level of unpredictability to these systems.

The central implication of the relative unpredictability of human behavior is that while complicated systems can be simulated with close to 100% accuracy, complex systems always have a degree of uncertainty. This uncertainty is directly attributable to human factors. The decisions and behaviors of humans are influenced by such a multitude of possible causes—both intrinsic and extrinsic to person and their circumstances—so that it is currently impossible to predict our behavior with certainty.

Given the lack of predictability regarding human decisions and behaviors, recent work in a number of scientific fields have shifted to an analysis of complexity to bring a scientific lens to large, diverse organizations comprised of many people. The diversity of actions and functions that exist within such systems underscore their complexity. The more people, the more complexity, as every person has at least some decision-making authority in every human organization. In addition, complex systems are generally not linear in either their actions or effects. The behaviors of persons in large-scale human organizations are subject to a myriad of influences both immediately present and existing in each person's past experiences. These include social influence, bounded rationality, conflicting directives, and the ability to see outside of the local context (Kurtz & Snowden, 2003). Further, people in complex systems adapt and learn from their experiences in the system (Darling, 2018). Unlike a complicated system, complex systems incorporate feedback from the experience of people in the system and are in a perpetual state of adaptation based on that feedback. This iterative process of adaptation provides a large number of non-linear loops in causal chains within the organization. Though complex, these adaptive processes provide a window into the opportunities to assist these systems to evolve into more efficient and effective organizations.

Will Allen (2016) has used child-raising as an example of complexity in action. A parent can apply expertise garnered from reading the latest book on child-raising practices to their child's behavior, but there is no guarantee that the expert solution will work with a particular child in a particular context. Much trial and error is necessary in the process of learning how to raise any given child. Even then, some of that learning likely will not apply to a different child.

Anyone who has raised two or more children in the same family environment knows that what 'works' with one child often does not 'work' with another. While experts influence many, most parents also attempt to learn from their own mistakes and adjust their child-raising practices based on interactive feedback with their child. Therefore, raising children is an enterprise with unpredictable effects, marked by trial and error, changing over time, and proceeding based on the feedback (outcomes) of trying specific practices in particular contexts. Parents will try one strategy for encouraging positive behavior with their child; if that does not work, they will try another approach. Alternatively, a parent might be talking to a friend with a same age child and pick up a strategy to try from that parent. However, different children respond

**Table 3.1** Effective Management differences between a Complicated versus Complex System (adapted from Allen, 2016)

<i>Complicated systems</i>	<i>Complex systems</i>
Role clarity	Relationship building
Hierarchical decision making (top down)	Collective interpretation (collaborative)
Tight structure	Loose coupling
Knowing (evidence-based practice)	Learning (practice-based practice)
Staying the course (compliance to process)	Innovation and evolution

differently to the same circumstances. Child rearing is an exercise in managing a complex system.

The reality of the lack of perfect predictability in complex systems does not mean that it is impossible to improve the functioning of a complex system. It does mean that the approaches to effectively managing and problem-solving in that system will be notably different from the effective strategies for managing and problem-solving in a complicated system. Table 3.1 compares some basic differences between the management of complicated and complex systems. We must consider these differences in conceptualizing how to manage a complex human system.

Table 3.1 makes it clear that complicated systems are top-down systems in which there is an established truth; understanding and managing towards that truth creates a more effective system. There is a set strategy for designing and building an airplane. Although design teams in aeronautical engineering are useful to ensure a thorough consideration of options, you do not build a plane by committee. Complex system often cannot use the same approach, although they often try. Complex systems require constant feedback and adjustment based on learned experiences in an environment that is never fully predictable. Benjamin Franklin famously said, ‘Tell me and I forget. Teach me and I remember. Involve me and I learn’. Put simply, rather than telling people what to do, engaging people in the ongoing solution is the central task of the management of complex systems.

Although human decisions and behavior can be predicted with some accuracy, human beings are not preprogrammed to behave in precisely the same way across persons, time, and circumstance. Although this is a reasonably well-accepted reality in the science of complex adaptive systems, it is nowhere near the reality in terms of how many helping systems are currently organized. We still have many helping systems which are managed primarily through regulatory mandates with intensive compliance monitoring—a management process best fitted to complicated, not complex, systems. The TCOM goal of managing human systems is to increase the reliability of decision-making to reduce the impact of human factors on ineffective and inefficient system functioning.



It is instructive to consider the work involved in any helping system. At the most basic level of the system, there is a required exchange between one person (e.g., client, patient) and another person (e.g., provider). The field refers to the people in a complex system as ‘agents’. Both of these agents bring different perspectives to the exchange. These different perspectives are a main source of the complexity in the system. We cannot know, *a priori*, to what extent the person looking for help and the person helping will agree on the scope or type of concern to be addressed, much less the best ways to address it. There is research in the outpatient mental health field that suggests that the greater the size and importance of differences between the helping professional and the person seeking help, the less likely that helping is to be successful (Jennissen et al., 2020). That stands to reason: it is hard to help if there is no agreement on what challenges must be addressed or what help might look like. Thus, even in considering only one set of interactions to manage (between a person seeking help and a person providing help), human-serving systems are replete with complexity.

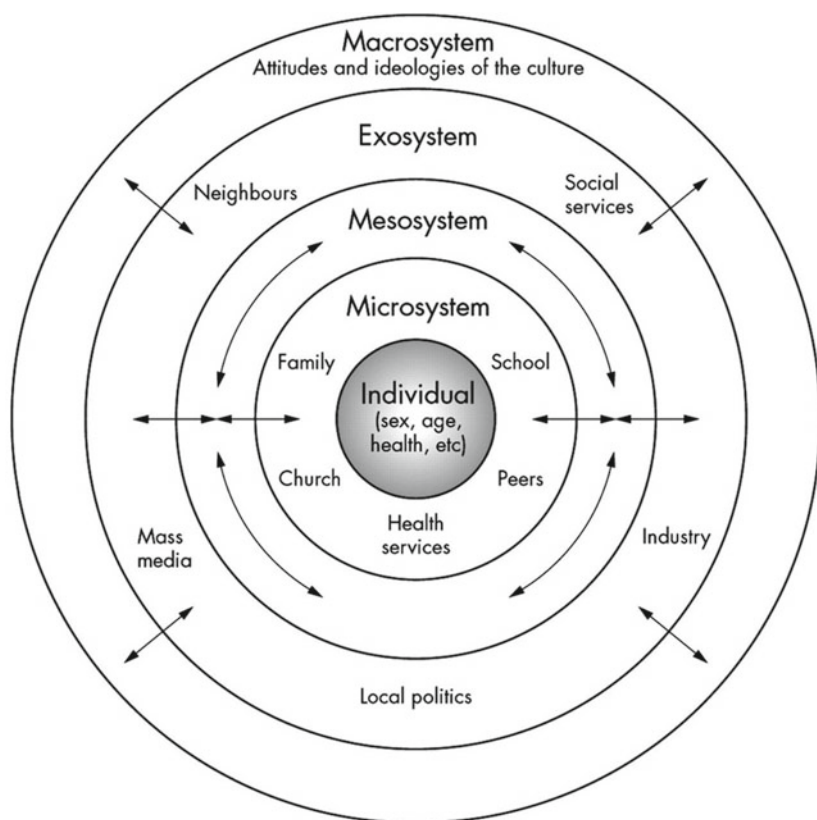
Over the past fifty years, there has been a great deal of good work on how to address this aspect of complexity, including everything from the work on therapeutic alliance (e.g., Zack et al., 2007), to innovative intervention approaches, to building motivation for collaboration such as motivational interviewing (Miller & Rollnick, 2013). Chapter 4 will elaborate on important aspects of this body of work. However, for the present purposes, the common thread of this work is that by creating a common purpose and vision, the person seeking help and the person seeking to help can make shared decisions that are experienced by the person being helped as in their (long- or short-term) best interests. The creation of a shared vision/common purpose in helping exchanges requires the sharing of information that supports the formation of a consensus understanding. At the level of a single, trusting interaction between these two agents, information is exchanged and used to support this shared decision-making. This is collaboration. This is person-centered care. In this initial exchange, the help-seeking agents describe their experiences that led them to the helper. The helping agent provides them with a larger context based on what they have learned from the experiences of many other help-seeking agents with whom they have interacted.

The complexity in the helping relationship expands past the help-seeking and helping agents in most settings, as these settings often involve multiple people in the helping enterprise. For example, family members, multiple professionals, representatives of funding authorities, and others are additional agents who influence the helping transactions. Even at the person level, helping settings can become quite complex due to the multiple agents involved in the transaction. There is substantial research documenting the challenges that occur when multiple helpers are not working in an integrated or coordinated fashion (Rosen et al., 2018). Much like in simple two-agent transactions, there is also a body of research documenting strategies to attempt to manage these challenges in diverse settings such as with a multidisciplinary team in a

hospital (Fleissig et al., 2006), or with a child and family team in a community behavioral health clinic (Burns & Goldman, 1999). Collaboration and open communication matter a great deal in creating optimal helping systems (Mayo & Woolley, 2016).

Bronfenbrenner's (1974; Bronfenbrenner & Ceci, 1994) Ecology Systems Theory is a useful model to organize the complexity of the child-serving system. Much of this logic applies to any helping system. In Bronfenbrenner's model (Fig. 3.1), there are five levels of the system:

- *Microsystem*: This level of system refers to those actors that have a direct and immediate impact on a child. Parents, teachers, and peers are all a part of a child's microsystem.



**Fig. 3.1** Bronfenbrenner's ecological model (Source Developmental Standards <https://intascprinciple2.weebly.com/bronfenbrenners-quos-ecological-systems-model.html>)

- *Mesosystem*: This level refers to the relationships among the actors in a child's microsystem. Parental collaboration, or a lack thereof, can influence a child's experience of each of their parents and parenting in general. The relationship between parents and teachers can also influence a child's experience at both school and home.
- *Exosystem*: This level of the system provides a social context for the child. For children, home, school, and the community represent three different social environments in which the child may have very different or very similar experiences.
- *Macrosystem*: This level of the system integrates cultural considerations into the understanding of that system. All micro- and mesosystems are embedded in a larger cultural context that influences how things are understood.
- *Chronosystem*: This level of the system adds the dimension of time. For example, different traumatic experiences can have unfolding impact over a person's life and development. Childhood sexual abuse might not manifest sequelae until the onset of puberty. The impact of loss might be greatest early and then slowly diminish over time.

Rapidly compounding the complexity observed at the person level, in helping systems there are additional agents who interact differently with agents operating at the person level. Perhaps three-dimensional chess is a reasonable metaphor for these interactions and their effects. Regular chess with its complex rules and strategies is a difficult game to master, but it is played in only two dimensions. Three-dimensional chess adds moving up and down in addition to right and left. In three-dimensional chess, the player has to be aware of relationships both at their level of influence and at multiple other levels of influence. Many adults are involved in the care of any given child. The more diverse the needs, the more adults that are involved.

A supervisor, for example, has only an indirect and unbalanced relationship with the primary exchange in a helping system. A person seeking help generally only interacts with the helper. It would be a rare event for the helper's supervisor to have direct contact with the person receiving the help. However, the supervisor has a direct and hierarchical relationship with the helper. Further, while the supervisor can have an impact through supervision on the direct care provider's approach with the person seeking help, the help-seeker has no opportunity to provide feedback to the supervisor. The relationship is inherently unbalanced. These additional multi-agent relationships add disproportionate complexity to the essential helping transaction. A program director may have relationships with supervisors and with agency leadership, but not directly with helpers. However, that program director may have an additional relationship with the funder's representative of the program that is different from that program director's relationship with the program's agency leadership (Lyons et al., 2004). Of course, funders often have direct relationships with agency leadership and little or no relationship to any of the employees

of the agency except to provide procedural dictates that the agencies must find a way to implement often without any relational context. In other words, the agency director will say 'This is how we must do it'. Staff might ask why. The agency director might answer by saying 'This is how our funder wants it done'. It is not unlike the dynamic of a parent explaining a decision to a child by saying 'Because I said so'. Perhaps not surprisingly, these strategies have parallel low probabilities of success.

The example of the child welfare system is illustrative. With an individual child, there are many people directly involved in interacting with the child. These frequently include parents, siblings, and other relatives. For children removed from their home, there are also foster parents and caseworkers. In some circumstances, the child will also have a psychiatrist or therapist; increasingly, child welfare systems make sure that a child has a pediatrician who the child sees for check-ups. If they are of school age, they will have a teacher or teachers with whom they directly interact. The number of significant people involved in the life of any one child in the child welfare system quite quickly increases into double figures.

As you move above the child level hierarchically in the system, each caseworker has a supervisor, as do most of the other professionals who may be involved. Some professionals will be representing specific programs that have their own policies and procedures. These may be consistent across agencies or they may be different depending on the agency that houses the program. It is quite likely that each involved agency will have different policies and procedures in addition to those of the program. As you move up to the system level, you have representatives of the three branches of government—executive, legislative, and judicial. All have some say in the definition and implementation of policies that impact decisions made at the child level.

Each of these people or agents in the system represent different perspectives and likely see the same circumstance through a somewhat different lens. A therapist may emphasize the freedom of a youth make their own mistakes and learn. A probation officer may emphasize the safety of the community when a youth makes a mistake. A caseworker may emphasize the inclusion of a child in a classroom. The teacher may emphasize the overall functioning of the classroom. Each of these agents have different relationships with other agents. For example, administrators in a child welfare system might decide that they want to implement a specific evidence-based practice (EBP). They reach out and form a contractual relationship with an EBP developer. In order to be successful, that EBP developer must form a different relationship with direct care workers and, if they are smart, they will form positive relationships with those workers' supervisors. Sometimes the transaction in the relationship between the EBP developer and the direct care helper might work at cross-purposes to the relationship between the workers and their agencies. For example, if the EBP involves some work that is not directly billable under current regulatory guidelines, the agency may actually discourage or even prohibit the direct care worker from engaging in that unpaid activity.

Alternatively, if training in a specific EPB makes a therapist more employable, an agency might have workforce losses that result from training their staff in an EBP. Thus, the implementing agency may undercut the desire of the EBP developer in order for their agency to stay in operation. These types of paradoxical directives are common in helping systems.

Sometimes an EBP implementation might create other circumstances that conflict with the priorities of the system administrators. These conflicts are common when the leadership of a helping system changes and the new leadership feels compelled to establish their vision and to practice in ways that are different from the prior administration. Given that in the United States, the state directors of child welfare stay in their roles for an average of less than two years (Bell et al., 2009), these leadership changes have the potential to create enormous complexity due to the implications of near-constant ‘regime change’. Real systemic change takes time—years and sometimes even more than a decade. The commonly brief tenure of state directors can work against the need for a long-term perspective on system change.

It is helpful to put some dimensionality to complex systems in order to consider how to approach management. Within complex systems, a set of relational factors are useful to consider—multiplicity, alignment, and power balance. The risk of multiple, misaligned, and unbalanced relationships are the type of phenomena that require management strategies to avoid the creation of intransigent and ineffective systems.

### *Multiplicity*

The more partners involved in each system transaction, the greater the multiplicity of the system. Health care involves at minimum three agents—people seeking help, people providing help, and organizations paying for help. This multiplicity increases when we consider the input of families of those seeking help, organizations of providers, and multiple payer organizations with overlapping mandates.

The child-helping system is perhaps the system with the greatest level of multiplicity. Parent, relatives, teachers and other school personnel, physicians, therapists, case managers, caseworkers, foster parents, parole officers, and community residents all sometimes take a significant role in the lives of children. Most of these individual partners are members of different organizations and agencies that add more partners through supervisory relationships.

### *Alignment*

It is almost given that systems involving more than two parties struggle with alignment of priorities, policies, and procedures. For example, the biological parents may see their behaviors and the behavior of their child differently than the foster parents see those same behaviors. The foster parents likely see their goals and define appropriate behaviors differently from the caseworker, and

so forth throughout the system. At the program level, statewide programs may have their own policies and procedures that are universal across agencies, but agencies might have somewhat different perspectives on these policies and procedures within the context of their specific agency. At the system level, the child welfare state agency likely has a different agenda from the Medicaid agency that funds many of the interventions used within child welfare. These different perspectives create misaligned systems, and as a result, they create the opportunity for conflict. Such conflicts can influence the behavior of the people in the system in ways that work against the overall effectiveness of the system (Lyons, 2004). Each perspective develops an agenda, but not all agendas match. Competing agendas create problems that interfere with the effectiveness of the system.

### *Power Balance*

The nature of ‘power’ in relationships is multifaceted and can depend on money, status, or even personality styles (Essabbar et al., 2016). When power imbalances exist, collaboration is only possible when the individual(s) with the most power make the intentional effort to empower less powerful partners in the collaborative activity. In the absence of that intentional effort, existing power imbalances can damage productivity and system effectiveness (Lam & Xu, 2018). In these situations, external pressures sometimes are needed to create better balance.

Power imbalances can come from a variety of factors. Oftentimes the person who controls the money has more power in the collaborative process compared to others participating in the collaboration. For centuries, people have said (often destructively from a TCOM perspective) that ‘Knowledge is Power’ (Bacon, 1597). There are two interpretations of this saying. The first is that if you know about your circumstances you have greater power over them. That interpretation is good and foundational for person-centered care. The destructive interpretation of this saying is that if you know something that others do not know, you have power over them. This way of thinking often contributes to difficult power imbalances.

Charismatic and persuasive people often assert more power in relationship decision-making based on their social engineering skills. People who pride themselves on being experts likewise can claim power in relationships. While those skills and knowledge can be useful to those who possess them, they also can interfere with effective collaboration unless they are shared. We have found that in TCOM implementations, early resistance comes from vocal and successful advocates because the approach builds in advocacy for *everyone*. Person-centered care ‘levels the playing field’ so that even people with no one advocating for them are given voice and advocacy by the approach. This strategy reduces the impact of individual advocates.

Regardless of the reason for any power imbalance, only two solutions exist to rebalance the relational context within a collaboration. Either the people

with the greater level of power choose to share power with their partners as a component of effective work, OR some external entity mandates processes that rebalance power even in situations where that is not the favored choice of people in the partnership who currently hold power. We will discuss these options in detail later in the book.

### *Embracing Complexity*

Complexity offers a lens by which to describe and understand systems and the behavior of the partners that define the elements of any system. This complexity lens allows emergent, new behaviors and prompts us to ask meaningful questions about both consistent behaviors within a system and their evolving impact on the functioning of the system. Monitoring the system's complexity can lead us to a shared understanding of both short- and long-term outcomes of the system's functioning and the behavior of individual partners within that system. This understanding allows us to act on that behavior in a more unified, outcome-focused manner. Elements of this lens follow from the characteristics of complex systems. Key concepts that can serve as a starting point for systematic inquiry into system complexity include behaviors and their ranges, factors that increase and decrease the behaviors, knowledge creation and communication, short- and long-term effects of these behaviors on individual partners, and the overall functioning of the system and subsystems.

### *Defining Behaviors and Their Ranges*

A key component of system modeling is to establish clear definitions of the behaviors and the boundaries for the behaviors for each of the partners in the system. Simple examples of these definitions might include whether specific interventions can be provided only in an office or may be provided at home, or how many hours of treatment time is allowed before the funder wants to see some evidence of the value of the intervention. Of course, there are thousands of possible examples of how complex systems define behavior and their ranges. Some jurisdictions work to implement specific evidence-based treatment approaches and sometimes even limit providers' engagement in treatment approaches that are not evidence-based. Some jurisdictions limit the number of different services provided on any given day. Some jurisdictions only allow the provision of certain services (e.g., respite) for people served in specific programs, service packages, or levels of care.

### *Identifying Factors that Increase and Decrease Behaviors*

A number of factors can influence the likelihood of any specific behavior in a complex system. In many natural complex systems, food and water are primary influences. The presence or absence of either of these life-sustaining entities

will increase or decrease specific behaviors of most partners in the system. In the helping systems, funding and regulations are thought to be the primary influences on behavior. In addition, the personal and social meaning of the work can be a major behavioral influence. As discussed in Chapter 1, people do not become helpers because it is the most lucrative sector of the economy. We argue that a service system sets influences to encourage helping to spend time with people. In a transformational system, we would hope to work to create influences that provide clear incentives to understand people fully, intervene with people based on that understanding of personalized care, and have a positive impact on helping the people change their lives in some important way.

### *Knowledge Creation*

A fundamental concept of a complex adaptive system is that learning occurs as an organic aspect of the system's process of adaptation. The key to effective systems is that the learning that does occur guides the system to greater positive impact, perhaps at a lower societal cost.

There has been a great deal of attention paid to evidence-based practices (EBP); however, these approaches have obvious limitations in complex systems. The concept of an EBP is that, independent of the system, a specific treatment approach is developed and tested. When scientific evidence exists that it is effective, it is then transported into and implemented in the helping system. EBPs are intentionally designed relatively independently from the systems themselves and are then (often) summarily forced into the system, with generally mixed results. Regardless of the use of well-established EPBs, the reality is that it is always necessary to learn about performance of any intervention within the particular context of the helping system itself. For this reason, practice-based evidence or application of what has been increasingly called Knowledge Creation (Brix, 2017) might be a more reasonable way to develop the concept of knowledge within an effective complex system.

If, in fact, learning in systems must be primarily organic within that system, it is necessary for helping systems to develop and evolve strategy for knowledge creation based on experience in practice. This knowledge ideally should be focused on knowledge about what types of interventions work for which types of people using what types of investment of resources.

### *Communication*

Work on the dissemination of knowledge within and between systems has been building for decades (Ackerley, 2017; Barwick et al., 2020). Technological breakthroughs have dramatically changed the manner in which knowledge can be shared. Understanding how 'to get the word out' is a critical process in all complex systems. Moreover, it is critical to have a 'system brain' that decides what the 'word' that needs to get out should be. Because each partner has a



different perspective on the system and may have goals independent from or contrary to the stated goals of the system, knowledge transmission is neither linear nor precise. Instead, knowledge transmission processes that are effective are likely to comprise multiple components that might vary by partner and level of the system.

These include having partners in the network actively interpreting knowledge for its implications in their context. Stakeholders must then be provided with opportunities to study and test the impact of behavior changes based on specific interpretations of communications of knowledge. Ongoing feedback about those behaviors is needed to validate or re-form an interpretation of the information. This cyclical information transmission process is the foundation of most models of quality improvement.

Ideally, activating communication across systems with similar characteristics (such as frontline providers in different agencies) allows for people with similar decision-making powers to see how different interpretations of information, or different actions taken to respond to similar data, lead to different effects. In this way, knowledge transmission across networks allows for better identification of the behavioral strategies which may most efficiently result in desired outcomes among persons responding to similar behavioral attractors (such as the same regulatory regime, or the same funding source). However, if a number of systemic barriers exist which prevent such knowledge sharing, it is important to understand and lower these barrier for effective system adaptation.

### *Monitoring and Interpreting Short- and Long-Term Effects of Behaviors*

This aspect of complex system management is outcomes management in complex helping systems. In order to create and communicate knowledge about effectiveness, it is necessary to measure things that can be used to generate such knowledge. You cannot manage what you do not measure. In a transformational system, the focus should be on creating and transmitting knowledge regarding the impact of the behavior of specific partners on the health and well-being (i.e., needs and strengths) of the people served.

### *Describing Multi-Level Effects of Behaviors*

Complex systems can be influenced by behaviors and conditions at multiple interacting levels of a system. Across these levels, behaviors taken by partners will lead to both short- and long-term effects. Of course, these effects may even differ by time scale at different levels of the system. A funding shortfall or delay at the system level may only have effects when agencies run out of their cash reserves and credit lines at the end of a fiscal year rather than at the time of the shortfall. A delay at one level (the system level) may appear to have little to no effect at the agency level until agency resources are exhausted. Then, at both the agency and system level, it appears as if a collapse occurs.

Suddenly workers go unpaid, agencies close, and nobody seeking care is able to get help. Further, the effects of a policy change or resource change may vary substantially across the levels of a system and the periods studied.

Because behaviors are situated within contexts, it is often just as important to assess the impact of a policy or funding change on personal change outcomes as it is to assess the impact of an individual intervention. These different outcome relationships require different methodologies, but they are all dependent on the collection of meaningful information about the status of the people helped over some period. However, the measurement of the impact can be the same at all levels.

## MANAGING COMPLEXITY

While our understanding of complex systems has grown along with an appreciation of the implications of their complexity, in many ways our understanding of how to managing complexity remains relatively straightforward. Essentially, two fundamental strategies have been identified that offer us the potential to manage complex systems successfully—hierarchical and collaborative.

### *Hierarchical Solutions*

The military is an excellent example of the value and effectiveness of the hierarchical approach to managing complexity. When soldiers are enlisted, one of their first training experiences involves learning to follow orders. Oftentimes the training on this fundamental aspect of military service is over-trained with experiences in doing things that are extremely difficult, sometimes quite dangerous and sometimes even nonsensical. The reason why following orders is a primary training goal of military service is because the military is a complex system that is managed successfully using a hierarchical solution. Following orders is what can help keep a soldier alive during a battle. The army that keeps the most soldiers alive usually wins. Therefore, it is in generally in everyone's best interest for as many soldiers as possible to survive any battle. (Note: There are exceptions to this rule, of course, where some soldiers are essentially sacrificed for the greater good of the entire army).

Battles are organized hierarchically. People at the top of the chain of command make decisions and soldiers execute their activities based on those decisions. By following orders, commanders are in a far superior position to understand their troop's current position and circumstances, which is important information in the overall management of the battle.

Hierarchical management of complexity is appealing in that it creates a single locus for all decisions. This process simplifies and streamlines decision-making. It sometimes complicates knowledge creation and communication because all knowledge has to traverse the highest level of the system so that it can inform decisions made at lower levels of the system. It can also interfere with decisions at the lowest levels because individuals are hesitant to act

without authority from the top of the hierarchy. It is also nearly impossible to use a hierarchical approach to support anything other than a mass production strategy where everyone is treated the same. Mass customization is challenging to managing hierarchically.

Good or bad, the only way a hierarchical solution to complexity can work is if there is a single line of authority and runs from the top of the system all the way to the bottom. Therefore, even if it were desirable, hierarchical solutions in complex helping systems *will never* work. There are simply no circumstances in which helping systems have a single line of authority.

### *Collaborative Strategies*

The only other strategy for effectively managing complex adaptive systems is collaboration. While hierarchical strategies can be both efficient and effective if there is a single line of authority and accountability, in systems where natural hierarchies do not exist, forced hierarchies often are neither efficient nor effective. All helping systems fall into this latter form of organization. We can use health care as an example. In the United States, there are two basic strategies—public and private—with many variations within these more global strategies. In private sector health care, insurance companies offer their products to employers as a benefit to employees. The insurance company is beholden to the employer to sell their products while the employee is beholden to the insurance company to receive access to or payment for health care. The physician or other healthcare professional is responsible to the employee to identify and provide needed care but is at least partially beholden to the insurance company to be paid for that care. If the insurance company refuses to pay, then the physician must collect whatever other monies they demand from the employee in order to achieve their business objectives within the healthcare transaction. Clearly, there is no single line of authority in this model.

In the public sector, the government provides money for healthcare funding through an entity as a code agency of that government. That code agency is beholden to the executive branch of the government for policy but is also beholden to the legislative branch for continued funding. The citizen is beholden to the code agency for access to care but is beholden to the physician or healthcare provider for receiving care. That provider is beholden to the government to receive payment for that care. Given that access to public help is generally means-tested, it tends to be reserved for the people with the lowest incomes. Therefore, there are seldom options for the provider to seek money from citizens to make up for an additional amount of money that the provider views as necessary to provide the care. Again, there is still no single line of authority.

Collaboration is the only viable strategy to manage the complex helping systems that are the focus of this book. We will define and discuss the process of collaboration in detail later in this book. For now, it is important to understand that creating collaborative relationships and processes is an important

part of successfully operating a complex system. Of course, not everyone can collaborate with everyone else on everything all of the time. In addition, ultimately only a limited number of people will have final decision authority in many circumstances. These realities put real work limits on our approach to collaboration to manage complexity.

In complex systems, the idea of collaboration is a duality of a linked process and a shared aspirational process. The linking process of collaborative relationships is embedded in the structural hierarchy of the system. Direct helpers form collaborative relationships with the people they intend to help and possibly their families. Supervisors form collaborative relationships with direct helpers. Simultaneously supervisors form collaborative relationships with program directors. Similarly, program directors have dual collaborations with supervisors and agency leadership. However, overarching all of these personal collaborative relationships (i.e., the first definition of collaboration), there must be a system-wide shared aspiration of everyone working together in the best interests of the people to be helped (i.e., the third definition). A fully functional complex system operating in a TCOM framework would have both of these approaches to collaboration as fundamental components on how to work in the system is conceptualized.

As first noted in Chapter 1, Transformational Collaborative Outcomes Management (TCOM) is a comprehensive, multi-level conceptual framework for managing complex helping systems by focusing on using person-centered, collaborative processes to support effective, person-centered decision-making at all levels of the system simultaneously. By using a consensus-based assessment process as the foundation of the approach, decisions made at any level can always be informed by the best interests of the people served. Thus no matter where a decision-maker is located within the helping system, the same person-centered information can support the decisions that fall within their purview and portfolio. By establishing a collaborative assessment and planning process at the individual level, information about the needs and strengths of the people seeking help is used as part of every decision made within the system.

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## Transformational Collaborative Outcomes Management

While the aspiration of TCOM is an ambitious goal, the solution is not conceptually difficult. In fact, perhaps it is obvious. If we go back to the nature of the helping business, it is clear that the business should focus on the personal change of the people served. This simplifies our challenge dramatically by creating a simple organizing focus: helping systems should be always focused on the process of people successfully being helped. Helping is the business of personal change or a transformational offering as described by Gilmore and Pine (1999). The challenge then becomes how to create, maintain, and, in fact, engineer this focus while still respecting, and at times incorporating, all the other competing pressures and agendas that have historically influenced helping systems. The challenge of TCOM is operational and socio-political, not conceptual (e.g., Fixsen et al., 2009, 2015).

This is the challenge first identified by the Institute of Medicine (2001) in their important report ‘Crossing the Quality Chasm’. After providing an inventory of a large number of shortcomings of the existing healthcare system in the United States, this report called for ‘person-centered care’ as a crucial component to a comprehensive solution to the identified challenges. In this report, person-centered care was defined as making the person ‘*an equal partner*’ in all healthcare decision-making. The concept of person-centered care is thus directly in line with the management of complex systems as outlined in the previous chapter. In this chapter, we will begin to discuss how the TCOM framework guides operational solutions to the challenges outlined in the first two chapters. We will also begin to discuss the socio-political challenges within the existing system and present strategies for addressing them. In this way, TCOM is proposed as a comprehensive strategy to realize the vision of person-centered care.

To understand TCOM operational considerations, it is important to re-orient towards the conceptual framework. This starts with defining and communicating the core values and guiding and operating principles of TCOM.

### CORE VALUES

1. Human-serving systems and enterprises have a primary mandate of facilitating and supporting personal change (i.e., transformation).
2. Human-serving systems and enterprises are inherently complex as a result of the number of humans involved. This diversity of aims and perspectives can only be managed through meaningful integration. Integration among people is best managed through collaborative processes.
3. All partners in human-serving systems and enterprises have the responsibility for collecting, managing, and using accurate, relevant, and respectful information about the people served.

### GUIDING PRINCIPLES

1. People have voice, choice with regard to participating in, and completing any assessments and interventions.
2. All assessments and interventions are culturally responsive and respectful.
3. All interventions should be personalized, respectful, and have demonstrable value to the people they serve.
4. Collaborative processes, respecting real-world limitations that are inclusive of individuals and families should be used for all decisions at all levels of the system.
5. Consensus on action is the primary outcome of collaborative processes.
6. Information about the people served and their personal change should always inform decision-making at all levels of the system.

### OPERATING PRINCIPLES

1. Person-centered assessments should be completed at the beginning and end of all episodes of helping and intermittently throughout extended episodes. These assessments should become the common language of the system to support a focus on the best interests of the people to be helped.
2. Everyone in the system using person-centered assessment information should be trained in the approach to ensure fluency across the system in the common language.
3. Business rules and information systems should be designed to reduce redundancy of information with the goal of making the work and the documentation of the work one and the same.



4. The findings of these assessments should be integrated into the operations of the helping system including planning, supervising, evaluating, and managing.

These values and principles provide the conceptual, philosophical, and aspirational underpinning of the TCOM framework and provide direction regarding how to think about implementation. The next stage of understanding TCOM requires deconstructing the acronym to review the intended meaning of the component words.

## TRANSFORMATIONAL

The focus of TCOM is on personal change, the extent to which people change from admission to later points in their journey or from program entry to transition or program exit (and beyond). As discussed in Chapter 1, TCOM proposes that the human-serving systems are not services; they are *transformational offerings*. As such, the focus is not on spending time with people but rather on helping people change their lives. As partially addressed in Chapter 2, there are a number of important implications from this shift in understanding. First, spending time with people in the helping process (and then documenting it) is the primary driver of the costs of helping, but it is secondary to the actual process of helping. Second, a person's change over in clinical and functional status over time is far more important than their status at the end of care. Thus, status at discharge outcomes are misleading—except for transition planning—since one could achieve a good status at discharge by selecting people to serve who have a good status at enrollment. A focus on status at discharge may be logical in a service system, but it can be counter-indicated in a transformational system; success in a transformational system is defined in terms of the extent to which people *change* from entry to time two or exit. Thus ‘creaming’ people (e.g., adverse selection, Akerlof, 1970) who are well when they enter treatment and equally well when they exit treatment would be counterproductive in transformational work. Instead, transformational systems can be incentivized to help persons who could experience the greatest amount of personal change, i.e., those with the greatest needs.

TCOM's shift of focus removes the conflict of interest of the adverse selection inherent in service systems whereby the most challenging people sometimes do not get help because they may be seen as less desirable by some in meeting the goal of ‘filling caseloads’ or meeting productivity standards, or even achieving ‘discharge status’ or service delivery (e.g., readmission) outcomes. Often, in fact, these challenging situations have the best transformational outcomes because they simply have more room for positive change.

Of course, the type of change that is relevant in a helping system is personal—often, but not always, clinical or functional. Changes in receipt of

‘services’ do not reflect the focus of a transformational perspective, although they might be relevant to certain aspects of managing a transformational system. Utilization of care is generally more relevant to the cost of care than its impact on the lives of people helped. While reducing psychiatric hospitalizations or out-of-home placements may be desirable for certain system partners, these changes do not reflect the focus of TCOM unless those are consistent indicators of personal well-being. In fact, one could imagine that a strategic use of a hospitalization or even a residential treatment stay may be in the long-term best interests of a person depending on their specific needs and circumstances. That said, there is substantial evidence that TCOM often has long-term benefits of reducing intensive interventions (e.g., Manley, 2016), but this impact would be considered a secondary (indirect) effect of focusing on changes experienced by the people served within the system.

### COLLABORATIVE

TCOM works to support the development and management of a shared vision and consensus on action. As first introduced in Chapter 3, collaboration is considered effective or successful when everyone in the collaboration gets what they need. By succeeding together, everyone succeeds individually. The principle of joint action as the optimal management strategy in complex helping systems is the second fundamental of the TCOM approach.

Collaboration at the individual level is sometimes called engagement. The first stage of effective helping is to form a strong collaboration between the helper and the helped to ensure a personalized plan to help the person change. Collaboration at the program level can be called teaming. Over the past three decades, substantial research and commentary exist on the importance of establishing organizational cultures whereby all professionals, regardless of discipline, work together for a common purpose (e.g., Martin et al., 2014; Senge, 1990). System integration is collaboration at the system level. As discussed in Chapter 3, the past decade has witnessed a dramatic increase in the number of efforts to determine how to best integrate complex systems (e.g., Latzman et al., 2019; Vogel et al., 2017). Despite different labels across the levels of a system, all of the concepts of collaboration share the same basic values. Collaborations require a shared vision that translates into shared objectives and, ultimately, shared action. In TCOM, this shared vision is the best interests of the people served. The shared objective is to work together to help people who are seeking to change their lives in some important way. By acting collectively with the people served in that system, it becomes possible to consistently reach important, consensus health and wellness goals for those served. Ultimately, this collaborative approach should allow us to design and manage optimal helping systems from a person-centered perspective. Such an approach would represent a fundamental shift from our current and historical approach of system design that relies predominantly on the use of service receipt information.

As described in the previous chapter, collaboration is really the only known strategy to manage complex system that do not have a singular, clear line of authority. Although authoritarian organizations can often be quite efficient (e.g., decision-making is streamlined), their values and perspectives are completely dependent on the vision of the authoritarian leader and thus, they cannot represent a consensus perspective. Helping systems invariably have multi-party authority and, at the end of the day, in nearly all helping systems, the people served are responsible for their own choices regardless of the input of others. Therefore, it is always up to the person seeking help to decide whether they fully engage with helpers to achieve a personal transformation. Given this fundamental reality, ensuring full collaboration with the person receiving help is a fundamental component to any effective helping system.

It is important to note that while recognizing the primary importance of people seeking help in guiding their own change experiences and trajectories, this does not abdicate professionals from responsibility for supporting positive change. There is an old joke that goes: 'How many psychologists does it take to change a lightbulb? One, but the lightbulb has to want to change'. Some traditional thinking leads to blaming people for not changing. This is not helpful. In TCOM, professionals have the responsibility to help people by communicating:

1. an understanding of the value of making changes;
2. an appreciation of what changes can be made;
3. identification of a pathway(s) to make these changes;
4. assistance in assessing and developing a readiness to change;
5. assistance in helping the person navigate their journey of change;
6. help to determine when stable change has occurred and celebrate that success.

In a collaborative model of helping, change efforts are a shared responsibility and positive change becomes a shared success.

Effective collaboration requires compromise and transparency. Competing agendas and interests must be exposed, discussed or debated, and resolved. These processes take time. However, the anecdotal evidence within the TCOM community is that by slowing down to ensure that collaborative processes are in place at all levels of the system, the helping system becomes more effective. Collaboration is a means of slowing down *reflexive* decision-making (to make it more *reflective*) in order to speed up effective action, and to prevent ineffective action.

As discussed previously, collaboration is a key process in managing complex systems where people are the primary components of the system. As such, developing and maintaining collaborative environments is a fundamental implementation and management process. The TCOM model of collaboration considers this challenge in terms of Values, Interactional Components,

and Structural Components (Fig. 4.1). Values represent the shared beliefs about how we all should approach our common work. Values tend to be entirely aspirational in that it is never possible to achieve perfection in any of these values; they are simply intended to guide us in our approach as we strive to be the best we can be. Interactional components are interpersonal behaviors of individuals involved in collaborative processes. These characteristics are the standards by which we are expected to behave towards each other in collaborative environments. Structural components are the processes put in place to allow collaboration to occur. Interactional components are measurable and malleable but tend to be fluid over time and context, while structural components are the more static components of how a system is designed and built. These components are also malleable but not so much in real time and the impact of changes in structural components is likely not immediate. The subcomponents of each component include:

i. Values

*Conscientious*—All partners work to make decisions based on the best interest of the people served. Given this value, it is necessary to have both an understanding of an agreed upon definition of ‘best interests’ and information about the best interests available to all partners.

*Judicious*—All decisions should be approached thoughtfully with timely information and perspectives used to guide these decisions. Available information guides decisions rather than politics or personal preferences or beliefs. In this context, sometimes it is necessary to slow down in order to speed up. Giving partners proper time to think through

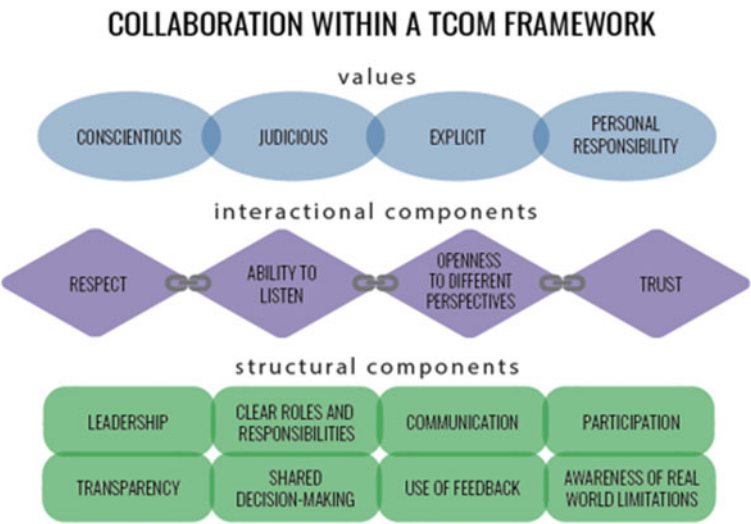


Fig. 4.1 TCOM Model of Collaboration

options and clear information to support a choice of options encourages judicious decision-making.

*Explicit*—All communications should be direct and clear. All expectations and goals should be clearly designed and communicated. By ensuring that everything is explicit, opportunities for confusion and misunderstanding are minimized.

*Personal Responsibility*—All partners take responsibility for those things that are under their control and jurisdiction. No partner seeks to shame or blame another or to shift responsibility for bad outcomes. All partners openly accept accountability. Matrix accountability (Lyons, 2004) is used to define accountability in a non-linear manner so that there are mechanisms for each partner in a system to be explicitly accountable to the other partners.

## ii. **Interactional Components**

*Respect*—Merriam-Webster's online dictionary defines respect as 'due regard for the feelings, wishes, rights, or traditions of others'. Basic respect among potential collaborators is a necessary component. Challenges with respect sometimes occur when different parties in a collaborative process have different credentials or relative power. Challenges with respect also can result from personality differences or similarities or personal experiences. Regardless of factors that can be divisive, it is incumbent upon people entering into potentially collaborative relationships to put aside these differences and treat others as equal partners in the process.

*Ability to Listen*—In order to create collaborative processes, all participants need to be able to listen to others. Each partner needs to be sure to structure time so that they have the time to listen. Challenges can result from problems with talking over, talking too much, or multi-tasking. Sometimes people feel like they are too busy to listen.

Experienced helpers sometimes have heard particular 'stories' so often that they can fill in the blanks and feel like they do not need to listen once they get the template of a person's story. Of course, arrogance is the great challenge to listening: some people believe that they already know everything and have nothing further to understand.

*Openness to Different Perspectives*—One of the hardest things for some people is to be open to hearing the viewpoints of people who see the world from very different perspectives. Cultural humility is an important concept here (e.g., Foronda et al., 2015). For example, some political processes have been devolving into simply following only the news that reinforces an existing position. Any information that diverges from the pre-existing belief system is seen as either inaccurate or biased. I once had a psychometrician colleague who was angry about communications' implications for psychometrics blurt out 'I see it when I believe it'. Some political and religious perspectives view those who do not hold their beliefs to be less worthy as humans. Many less extreme examples

also exist. We tend to believe what we believe and sometimes it is difficult to hear anything that could threaten our beliefs. However, to build a collaborative process, it is necessary for participants to put aside the fact that they may disagree with others on fundamental issues to allow for an open discussion of perspectives and maintain a focus on the best interests of those we all serve.

It is in this characteristic of collaboration that cultural humility and responsiveness (Kumagai & Lybson, 2009; Yeager & Bauer-Wu, 2013) are deeply embedded. Understanding the cultural lens of fellow collaborators is important to both the development of consensus and the long-term success of the collaborative effort.

*Trust*—The ability to create a safe space where disagreement and discussion are allowed and multiple perspectives are appreciated requires trust. We foster trust by respecting differences while believing that all humans share some core values and have at least some core standards for how to treat each other. Consistency, clarity, and honesty are key to establishing and maintaining trust. These values generally transcend cultural and experiential boundaries.

### iii. **Structural Components**

*Leadership*—All organizations require leadership, and while there are many types of leadership and, in fact, people at all levels should demonstrate some aspects of leadership, the reality is that in all systems and at all levels of every system, someone must be having authority. However, to implement TCOM effectively, this managerial leadership must embrace or at minimum be able to allow and support collaborative decision-making and processes. Implementation science has demonstrated the importance of leadership drivers in developing sustainable change (Fixsen et al., 2015). *Clear Roles and Responsibilities*—not all decisions are collaborative since often one person will have ultimate decision responsibilities. Having clearly established roles and responsibilities help partners to understand the reasonable limits of collaboration. It is good to establish roles and responsibilities clearly at the beginning of a collaborative relationship. In complex systems, where membership in collaborative processes changes often over time, strategies to maintain role clarity with changing people is an important component of maintaining a collaborative approach. The average tenure of a case manager is often much shorter than the average duration of a case. The average tenure of a child welfare director in the United States is about 18 months.

*Communication*—Consistent, accurate, and timely communication is required among partners in any collaboration. Sharing power requires sharing information.

Withholding information either intentionally for political consideration or unintentionally because of faulty communication pathways can damage or destroy collaborative processes. Creating and maintaining mechanisms that allow real-time communication is important. In TCOM, every measurement strategy is pursued from a communication perspective.

*Participation*—Sometimes you just have to show up. Collaboration will only work if partners are available to collaborate, of course. Time and other pressures can work against full participation, thereby reducing collaboration. All collaborations must find a balance between having partners commit to being present (in whatever that may mean for specific activities) and respecting pacing to allow busy partners time to schedule.

Every reader has been involved in a project that started out as a collaboration but, over time, the original partners either dropped out or started to participate less in the process. Responsible students often fear team projects where less responsible students slack off on their participation, leaving the responsible students with most of the work in order to finish the product effectively and on time.

In complex systems, schedules and workloads often compete with collaborative processes and limit collaboration. If we learned anything from the COVID-19 pandemic, it is clear that technology can replace travel to enhance participation (Riley et al., 2022). We have had substantial success with virtual child and family teams, for example (McClarín et al., 2020; Nellist & Wexler, 2021) which makes it easier for everyone to participate, including the youth, family, and natural supports.

*Transparency*—In transparent processes, all goals and objectives must be on the table. Hidden agendas derail collaborative processes. The ‘need to know basis’ information-sharing mantra that can be common in some organizational structures works at cross purposes to collaborative process where everyone has a need to understand. Of course, transparency interacts with communication to ensure that aspirations of being transparent are realized in practice.

The calls for transparency in the workplace are common (e.g., Mauer, 2016) as are calls for transparency in government (e.g., Pollack, 2011) and public health (Gottlieb, 2018). Little research exists specifically, which considers the concept of transparency. Not everyone agrees that it is ideal (Han, 2020). An emerging compromise position may be the concept of Collaborative Advantage (Vangen & Huxham, 2013) which attempts to accept the ongoing reality of competing and often hidden agendas with periodic strategic collaborative (and transparent) processes. To these authors, collaboration and transparency are too exhausting to do always. They recommend picking your battles. While we agree that collaboration can be a challenging process, we also believe that transparent collaborative processes can become habit that gets easier with practice.

*Shared Decision-Making (SDM)*—Veatch (1972) first promoted the idea of shared decision-making in health care. It has continued to influence practice in health, public health (Hoving et al., 2010), and human services. In models of SDM, the practice is to allow collaborative decisions to the extent possible based on and often limited by roles and responsibilities. Consensus-based decision-making is ideal when feasible. Allowing input from all partners prior to a decision actually being made is the basic standard. At minimum, allowing multiple partners to weigh in on decision-making processes with thoughts, perspectives, and decision preferences is necessary to the collaborative process.

There are two arguments made in favor of SDM: ethical and reliability (Stiggelbout et al., 2015). The ethical argument is essentially the argument for informed consent: people have a right to participate in decision about their bodies and their lives (Elwyn et al., 2013). The second argument is based on the observation that SDM can result in more consistent decision-making (Wenneberg, 2014). Since reliability of decision-making is a desired goal of efficient helping systems, using aspects of SDM to achieve that consistency is appealing. In TCOM, we make that argument as a means of addressing cultural bias and problems of equity.

*Use of Feedback*—The concept that feedback on performance enhances future performance is implicit in the concept of outcomes management generally and TCOM specifically (DeNisi & Murphy, 2017). Openness to performance feedback is the foundation of learning. Learning to be collaborative also requires this feedback for partners to grow their collaborative skills. In the context of TCOM, the feedback involves performance. Specifically, how are people doing who are seeking to change their lives in some important way? At the level of the person being helped, this would reflect feedback on their clinical and functional status and well-being, perhaps relative to people like them. For direct care staff, feedback is about the outcomes of their cases across their caseload. Clinical supervision is a critical component for successfully implementing TCOM. Programs, agencies, and systems would have similar feedback foci and processes but always at a different level of aggregation. The activities involving aggregation of information would likely rest in evaluation or quality units but the responsibility for understanding and acting on information should be agency/system-wide.

*Awareness of Real World Limitations*—As mentioned previously, not all decisions can be made collaboratively. Transparent recognition and discussion of natural limits is required to ensure the ability to maintain a collaborative environment and avoid the ‘illusion of inclusion’ experience that can damage or destroy collaborative efforts over time.



A focus on collaboration can create some interesting and potentially challenging tensions around the diffusion of innovation (Rogers, 2003). It is reasonable to propose that there is collective wisdom—there are things that we universally accept as true. Science, while not the only strategy, is perhaps the most common strategy currently available to generate universal shared knowledge. A rigorous application of the scientific method with replication by multiple scientists is thought to represent an important mechanism for generating a shared understanding of our world. Thus, translating science into practice can be thought of as the process of moving collective wisdom into a shared understanding in real-world applications.

Evidence-based practices (EBPs) are one example of this science-to-practice process. Of course, it is now well-known that effective practices must be informed by actual practice experiences beyond the original science that might have been used to both create and confirm the practice as efficacious (DuBois, 2020; Grissom & Lyons, 2006a, b). Therefore, the best process for creating EBPs are inherently collaborative. In addition, implementation experiences reveal that a collaborative approach to implementing EBPs is more effective than a hierarchical approach (Clarke, 2013; Olswang & Goldstein, 2017). It is not likely to be effective to come into a new jurisdiction and mandate that everyone must do EBP ‘X’. In these situations, system leadership is sure to experience the ‘Rose Reversal Syndrome’ (Lyons, 2004, see Chapter 11). A rose by any other name smells as sweet; but calling a dandelion, a rose does not make it so. Providers may say they are doing EBP ‘X’, but fidelity monitoring will demonstrate that many of them are not—they are simply relabeling what they already have been doing (Effland et al., 2011). As Rogers (2003) points out, education is seldom enough to facilitate the implementation of change. As such, collaborative processes should include strategies to identify agreed upon ‘truths’ so that each new collaborative relationship is not always re-inventing everything. Ultimately, it may be necessary to embed these truths into the educational, supervision, quality-monitoring system to ensure that all know these common understandings.

## OUTCOMES

In TCOM, outcomes refer to the health and wellness goals of the person or family served. Across the literature, the word ‘outcomes’ has been used for a large variety of constructs, some of which have little or nothing to do with the well-being of people served. In TCOM, we intentionally restrict the meaning of the word so that it focuses on the shared purpose of all helping systems. The term is used specifically to refer to the clinical, functional, and/or well-being status of individuals served. There is variability on the specific definition of an outcome across helping sectors. The operationalization of an outcome is based on an understanding of the goals of those served. No system can possibly work to achieve *all possible goals*; therefore, systems must define for themselves the ranges of personal goals applicable to their helping system. In

other words, personal goals are not individualized but rather mass customized based on what the person or family can or is currently willing to pursue within the context of common goals available within a helping system.

There are at least two common tensions that can influence the ability to form and maintain collaborative relationships. The first tension can arise when a person's goals or willingness to pursue goals conflict with what is optimally helpful or useful to them from the helping provider's perspective. For example, a person with a severe substance use disorder might simply wish for a harm reduction approach while their helping provider is focused on abstinence. This divergence of vision may result in a struggle with forming a collaborative approach to personal change.

The second tension can arise when that individual sees the prescribed goals of the system in which a person is being helped as coercive or unhelpful. Obvious examples exist such as involuntary hospitalization, or a community mental health center being unable to provide needed housing for homeless people with serious mental illness. However, this tension can also be quite subtle and nuanced. For example, several wraparound-based programs I have worked with report that some families are hesitant or even resistant to transition to less intensive community care when they feel that still need respite care. When respite care is *ONLY* available for people in a wraparound-based program, then families that feel they need that type of care will linger in these programs even if they do not need or perhaps even want some of the more intensive interventions that are also a component of these programs. The family perceives referral to a less intensive program as counter to the needs of the family despite it being in the best interests of both the program and the system. If people feel stigmatized by the identification of a mental health need, they may decline a referral for that reason alone even if the available treatment could help them. Even the best-intentioned goals may be perceived as paternalistic, culturally inappropriate, contextually inappropriate, poorly prioritized, or even irrelevant.

Outcomes, in TCOM, refer to the primary outcome person-centered goals of a system—that is, as they are prioritized and individualized by a person or family and their helpers. This focus on more clinical and functional outcomes differs from broader approaches to outcomes management that include utilization and cost considerations. In TCOM, those considerations are placed in the management aspects of the approach. The focus of management decisions, then, is twofold: to create a collaborative process in which people recognize and individualize subjective personal goals which are also relevant to the system, and to improve the ability of system partners to help people achieve these goals.

The collaborative processes indicated by the 'C' in TCOM set the stage to allow measurement of true transformational outcomes. A traditional research perspective mistrusts 'subjective' information and favors 'objective' measurement. However, the measurement of personal change often, although not always, requires the measurement of a subjective state. Personal health

outcomes such as weight and blood pressure are notable exceptions as is legal permanence and perhaps housing stability; however, most needs and strengths relevant to helping systems are subjective in their nature. Further, the consensus-based measurement process often requires a level of subjectivity to allow for agreement among multiple perspectives. It is quite likely that a shared vision or a shared goal will be subjective in the traditional meaning of the term—judgment is involved. We will discuss these issues in much greater detail in the chapter on the communimetric theory of measurement.

Given the simultaneous focus of TCOM on both transformation and collaboration, the definitions of what constitutes important personal change should be a consensus. The design of the measurement strategy to capture these personal changes likewise would be pursued in a collaborative, consensus-based manner. Off the shelf or plug-and-play outcome measurement systems based on research methodologies can seem desirable based on their ease and seeming simplicity: just take a measure of an important construct that has been developed as reliable and valid in research and insert it before and after a treatment experience and *le voilà*—you have an outcome. Unfortunately, if these approaches don't honor the basic tenets of collaborative assessment and personal change, then their selection will limit or even prevent the successful implementation of the TCOM model. So, while multiple measurement frameworks can be made to work within a TCOM framework, many of these frameworks have assumptions or methodologies associated with them that are counter to the TCOM philosophy. We will discuss measurement considerations in far greater detail in Chapter 5.

## MANAGEMENT

The management aspect of TCOM represents the greatest opportunity and challenge of the framework: using information about personal change to guide and support most, if not all, key decisions made in a system. Key decisions are made at all levels of the system simultaneously. A management structure and strategy is necessary. In TCOM, effective management is essentially effective decision-making. TCOM proposes that by using information about the needs and strengths of the people served and their experiences of personal change, it is possible for helping systems to make more effective decisions resulting in more effective management, thereby resulting in more effective systems. Therefore, it follows that using information about the change status of people helped directly for decision support is a critical component of the TCOM approach. This information must be obtained using a collaborative discovery (i.e., assessment) process. And, once collected, information about the people served should guide all key decisions in the system. Included in these decisions are those made at the person level (e.g., treatment planning, placement, level of care), decisions made at the program level (e.g., eligibility, program design), and those made at the system level (e.g., right-sizing, geographic investments).

An alternate way to think about the decision-making process is through the flow of people being helped within the design of most helping systems. Figure 4.2 outlines the common key decision points in most helping systems. Access refers to the decision to enter the system and must be mutual between the person considering seeking help and the criteria the system uses to define who is allowed and/or prioritized to receive help. Once in the system, the next decision involves engaging in the helping process. Engagement is not an either/or decision as there are degrees of engagement from all out to all in with nuanced differences in between. This is the decision that requires helpers to understand the stories of the people sometimes even through the lens of multiple and divergent storytellers. This decision stage is not static in that the level of engagement likely varies over an episode of care. Appropriateness is the decision point that allows the matching of helping strategies, including treatment and other interventions, to the specific needs and strengths of the individual seeking help.

While this decision can be static at the time an original plan is developed, it also can change. Changes are often based on decision-making at the next stage—Effectiveness. Monitoring the impact of a plan is a critical process to inform decisions on whether or not the plan should be sustained, modified, or ended. The effectiveness decision is more of a decision process than a decision point. The final decision point is called ‘transition’. The transition is the point at which the decision is whether sufficient personal change has occurred to warrant ending the plan. Transition can also be informed by evidence that the type of help offered in a program is not the type of help that benefits the help-seeker. In this second model, there is no point in continuing a plan that is not working—as some might say, there is no point putting good money after bad.

In TCOM, key decisions should be informed primarily by characteristics of the person and measured using consensus approaches in order to allow person-centered care. In order to achieve that goal, however, strategies are necessary. Specific collaborative assessment processes have been developed to be used within the TCOM philosophy. These include the Child and Adolescent Needs and Strengths (CANS), Family Advocacy and Support Tool (FAST), Adult Needs and Strengths Assessment (ANSA), the Crisis Assessment Tool (CAT), the Readiness Inventory for Successful Entrepreneurship (RISE), and the Geriatric Assessment for Transition Experiences (GATE). Each measure is used to understand an individual and (if relevant) family’s needs and strengths



Fig. 4.2 Common key decision points in most helping systems

in a consistent, communicable manner. These commonly used measures are strategies that fit the philosophy of TCOM and then allow us all to use an understanding of the people we serve to guide us in all decisions. The use of such standardized, collaboratively completed measures means that a common and family-driven understanding of needs and strengths can be communicated for decision support at all levels of a service system. Key decisions can be understood based on the common decision points in helping systems.

## ACCESS

Concerns regarding access can vary depending on perspective. Consideration of access requires understanding challenges to it, including social determinants, cultural differences, affordability, stigma, etc. For people seeking help, access involves believing that help is available and knowing where to look or at least knowing who to ask for assistance in finding help. Ease of entry is often the key characteristic from the perspective of the individual seeking help. People providing help and those who fund the help have overlapping perspectives. Both want clarity and agreement on who is eligible for help. However, generally, providers tend to favor a more open door with broader or lower thresholds for entry than do payers.

Entry into any helping system is usually managed by establishing eligibility criteria. Making those criteria clear is important to all parties, including successfully communicating these criteria to those seeking help so that they don't bother trying to get help where none would be provided.

Eligibility criteria are generally established based on the essential needs that a helping system is designed to ameliorate. Housing programs have eligibility based on the need for housing. Mental health clinics often require evidence of mental health needs in order to meet eligibility requirements. Often, but not always, financial characteristics are used for publicly funded help, particularly in the United States. Called 'means testing', poverty or low-income criteria for eligibility is often seen as helping to define the 'safety net' approach to government programs. Often financial eligibility criteria is a first-level characteristic followed by specific eligibility criteria that are intended to be more related to the person characteristics posited to be the core outcomes of the program to which eligibility is to be determined. For example, general Medicaid eligibility is determined by income; however, once an individual is Medicaid eligible, their eligibility for specific forms of treatment likely will depend on medical necessity criteria.

In TCOM, eligibility is seen as establishing clear referral guidelines based on simple decision support models that identify those individuals most likely to benefit (i.e., experience personal change) from participation in the target program. Ideally, a short version of the same measurement process used for impact (i.e., outcomes) management within the program is the basis of this referral model. The idea of building on the same measurement process is to reflect the storytelling nature of receiving care.

In terms of people's experience with the system, their stories begin at the point of access but oftentimes we force people to repeatedly tell their stories as they move through the system. As an example, imagine what it is like for a child and their parent when the child is having behavioral problems at school:

1. The school calls in the parents to discuss the bad behavior of their child. If it is 'bad enough', they refer to a mental health clinic.
2. The parents call the mental health clinic and set up an 'intake' appointment. They all meet with the intake worker to discuss the bad behavior of their child. If it is 'bad enough', they are referred to a therapist.
3. The parents meet with the therapist and discuss the bad behavior of their child to initiate treatment.

These three steps are standard regardless of the reason for referral. The full entry to some systems is even more complicated as multiple helpers all need the person to repeat their stories. Child welfare and both adult and juvenile justice systems are examples of these additionally complex access processes. This multi-stage, multi-partner process means that someone seeking help generally has to discuss their most intimate problems with at least three different people before any effort is made to help them. Particularly, when problems are related to a traumatic experience, repeatedly being forced to discuss them may actually be re-traumatizing. If care isn't taken to minimize the redundant and possibly traumatizing aspects of access, the process of seeking help likely will impede the process of getting help.

Understanding and facilitating ease-of-access even in discovery (i.e., assessment) processes is a tenant of the TCOM philosophy. Smoothing the access process to make it as fluid as possible is a priority with TCOM as it is with most other models of system improvement. The shift with TCOM is to ensure that the approach remains person-centered. In other words, access should be guided by the needs (and strengths) of people rather than by other factors. One strategy that can be helpful is to ensure that the documentation builds over the access process so that people don't have to ask questions to know the answer. In other words, allow people to build their story over the course of the experience in the system.

Access barriers, a staple of cost containment in many private insurance models should never be used to manage access; this is the assumption, used for approaches like rebates, that if someone 'really needs something' they will work through barriers, so making it more difficult helps sort those who need from those who don't. This approach simply does not work for populations with the greatest needs as these individuals often have the most difficult time overcoming barriers. This model of creating access barriers was the original form of managed behavioral health care ('just say no') in the United States (Freidlin, 2002).

## ENGAGEMENT

As discussed earlier, Pine and Gilmore (2011) recommend what they labeled ‘mass customization’ to create a business model that provides an opportunity for a positive personal experience. Mass customization offers a fulcrum which balance the poles of this tension (i.e., individualization versus mass production). In contrast to mass production that involves applying identical procedures across all individuals, mass customization allows the creation of a personal experience whereby the individual is able to see that they are treated as individuals. This customization, in turn, fosters better engagement in the process of helping. One example used in Pine and Gilmore’s text references the ‘Build a Bear’ product. Auto manufactures also have moved to mass customization by allowing customers to select their car from a range of options.

Publicly funded programs intended to help often use mass production approaches such as intake processes that involve routine and standard questioning to establish eligibility and complete required paperwork. This approach works at cross purposes in creating a transformational environment. If a powerful personal experience potentiates the effectiveness of a transformational offering, then attention to how a person is welcomed and how the discovery experience seems relevant to them is likely an important program component.

Consider the standard intake process where a person seeking help is required to go through a welcome process that involves them answering the same questions in the same order as anyone else who seeks entry into the program. It could be argued that the help provider is essentially communicating to the person seeking help, ‘Hey, we know you have a problem but before we can do anything to help you with your problem you have to help me take care of all this paperwork’. Mass production models clearly make the process ‘about the program’ and not about the person seeking help. That is not likely to be a successful engagement process.

Standard psychometric measurement approaches, which are commonly advocated by other approaches to outcomes management, require people to answer questions in a standard pre-determined order that can be seen as off-putting to an effective engagement process if not properly explained and contextualized within a personal approach. Traditional measurement is clearly conceived from a mass production lens.

In a TCOM approach, the initiation of care is seen as a process of welcoming and discovery.

As discussed in the section on access, we do not recommend using a standardized assessment process but rather building on a story that begins with the information provided in the referral. Measurement is required but the process of measurement should not define the interaction. We should allow people seeking help to start the process by telling their stories to first responders or updating their stories if they have prior experience with the system.

The idea of building on a story for people who have prior experiences likely requires some elaboration. In our work with children and families, it has become clear that, in the existing system, they are required to repeatedly tell their stories over and over. This redundancy is perhaps the most common complaint from both youth and parents. Helpers sometimes treat them as if they have no prior history and force them to retell their stories completely. In TCOM, the idea is to use prior information as the starting point of the process of re-entry into care. In this way, people are simply updating their story rather than being forced to start from the beginning again (and again).

### APPROPRIATENESS

One thing that we clearly know is that different people respond differently to the same effort to help. And different people benefit most from different things. Without a doubt, effective helping invariably will require the matching of interventions and activities to the needs, strengths, and possibly other characteristics of the person to be helped; we refer to this as appropriateness. At the individual level, this matching process is generally referred to as some form of planning—treatment planning, care planning, ‘service’ planning, individual education planning, permanency planning, etc. At the program level, appropriateness is increasingly defined using decision support approaches. Sometimes, these decision support approaches are applied at the point of access if that point of access leads directly into a specific type of action or intervention. At the system level, appropriateness is generally most usefully thought of as a quality improvement activity.

Appropriateness is an area of development that can inform the feedback loops inherent to a TCOM implementation. Most current decision-making with regard to what actions are best suited for which needs is informed by either clinical judgment, consumer preference, or some combination of the two. A goal of TCOM is to develop more advanced knowledge of what works for whom so that systems are better positioned to design optimal decision support strategies for this phase of the helping experience.

### EFFECTIVENESS

Sometimes called ‘impact’, developing the capacity to determine whether and when a helping intervention or action was effective is a core element of any outcome management approach. That emphasis is no different with TCOM. Identifying effective forms of help, matched to the need and strength characteristics of those helped, is a fundamental goal. It is also a goal to determine how to identify when an intervention has been optimally effective. Cost-benefit/cost-effectiveness determination are required for understanding how to match investment with impact. In public sector helping systems, the determination of ‘how much is enough’ is nearly always a fundamental question as jurisdictions struggle with optimizing inherently limited investments. Since



TCOM balances managing both access and egress simultaneously, a focus on sufficiency of impact is critical.

## CARE COORDINATION

The more complex the population served, the more likely that multiple professionals will be involved in the care. Effective care coordination should be based on the match between the individuals' needs and the skills, abilities, and focus on the available helping professionals. Effective care coordination shares much in common with effective project management. The key elements are up-to-date information about the status of people helped and strong communication among the team recruited to help them. The design of communimetric measures are ideal for this purpose, as will be discussed in Chapter 5.

## TRANSITIONS

Transitions is the word used in TCOM to describe egress from an intervention, program, or system. As discussed in Chapter 2, a major difference between a service system and a transformational system is that while a service system tends to focus on access to care, a transformational system attempts to simultaneously value access and egress. The front and the back door are equally important to good system management.

Particularly in multi-party systems where a third party takes financial responsibility for the management of the system (e.g., Medicaid or Medicare) or any system that uses pooled dollars across many people (e.g., insurance pools), ethics require that resources are spent judiciously. For this reason, the concept of sufficiency is important in terms of defining positive outcomes. The determination of how sufficient change is defined is an important consideration.

## HISTORY OF TCOM

TCOM was originally published by Lyons (2004) in the book *Redressing the Emperor: Improving our children's public mental health system*. At the time, the approach was called Total Clinical Outcomes Management. TCOM was framed as the strategy to address the many identified tensions and syndromes that tended to diminish the effectiveness of systems of care. The reason for the name choice was that during the early millennium, the debate in health care was between quality management (i.e., managing processes of care) and outcomes management. Since TCOM was the first theory of outcomes management, it was so named to distinguish it from Total Quality Management or Continual Quality Improvement methodologies which generally focused on monitoring and managing processes without a clear focus on their resultant impact. However, over the next decade, more and more attention was

paid to how processes do and do not link to outcomes. Nearly, everyone began to agree that it did not make a lot of sense to look exclusively at processes without at least some attention to the impact of those processes. The effect of these incremental changes was a shift in approach within the field of quality management towards adapting process based on its real-world outcomes.

Since the argument for the importance of outcomes was essentially won, TCOM was renamed at the 10th annual TCOM Conference in Chicago (Israel & Lyons, 2014) to reflect how this model of outcomes management is different from other approaches—with its emphasis on personal change as the outcome of interest and its use of collaborative, information-based decision-making as a primary process strategy for complex system management. This renaming has served to be quite clarifying as we continue to evolve the approach across the many implementations worldwide.

### THE RATIONALE FOR FEEDBACK: THE ROLE OF EXPERIENCE IN THE DEVELOPMENT OF EXPERTISE

In his book *Outliers*, Malcolm Gladwell (2008) introduced the concept of the ‘10,000 hour rule’ to the broader public. This rule states that it takes at least 10,000 hours with feedback for a person to develop expertise in anything. Practice may not always make perfect but it certainly makes pianists better. But practice must be done with feedback. You often learn more from your mistakes than from your successes. A person cannot simply sit down at a piano and expect to be a virtuoso in the following months without practice. However, simple repetition is not the same as the development of expertise. A critical aspect of the 10,000 hour rule that often gets less attention is what Gladwell referred to as ‘deep practice’. K. Anders Ericsson, the psychologist whose research identified the 10,000 hour rule (and apparently hated that it was called that [Epstein, 2020]), describes this component of the development of expertise as ‘feedback’ (Ericsson et al., 1993). According to Ericsson’s extensive research, it requires 10,000 hours with direct feedback on performance and the implementation of feedback-based adjustments in order to achieve expertise. Tennis and golf professionals use scores and coaches for this feedback. Musicians have instructors. Without feedback-based adjustments to actions taken, experience does not result in improved practice. Whether ten thousand hours is some sort of key volume to experience with feedback or not is up for debate.

However, the notion that experience paired with feedback is a key to the development of expertise is widely accepted.

In an interview with National Public Radio (November 28, 2016), Ericsson explained the following research finding. In his research, the only medical specialty in which experience was found to be directly related to effectiveness was surgery. In every other medical specialization, he was unable to find any identifiable relationship between experience (i.e., time working in the field)

and effectiveness. So why do surgeons appear to learn from their experience while internists and psychiatrists don't?

Ericsson attributes this phenomenon to the fact that surgeons get immediate and visceral feedback on the results of their surgeries. Both on the surgical table and in the required immediate post-surgical follow-up visits, surgeons can quickly and repeatedly see the success or failure of what they have done. For other medical specialties, the relationship of their practice decisions to their ability to get direct feedback on these decisions is more removed, decreasing the likelihood that these physicians receive consistent feedback on their performance.

We can expand this thinking more broadly to all of the helping professions. Despite folklore to the contrary, there is no scientific evidence that experience matters much in behavioral health (Stein & Lambert, 1984). Leon et al. (2007) found small improvements in outcomes when similar cases occurred close together in a therapist's experience, but beyond that type of impact, there is no evidence that the longer a therapist works the more effective that therapist becomes. Often therapists and other helpers do not even see people that they have helped after the helping encounter. For example, in a systematic review of attrition studies, roughly two-thirds of all outpatient mental health episodes of care ended with the client stopping treatment (Barrett et al., 2008). Clinic observations of the proportion of clients who 'complete' therapy often range from 10 to 15% (Lyons, 2004). Leaving therapy does not necessarily represent a therapeutic encounter that had no value to the client. In fact, there is some evidence that people end personal therapy when they feel liked they received 'enough' benefit and the client's definition of enough is generally less than the therapist's definition (Jeb Brown, personal communication, 1998). Regardless of the client's reasoning, often the only feedback the therapist has is that the client stopped coming. That decision may have resulted from dissatisfaction, or it may have resulted from satisfaction that a sufficient amount of improvement had been achieved and the client not wanting to have to defend their decision to stop. If therapists have an open-ended concept of therapy, clients might suspect the therapist will want them to continue. In fact, outcomes research suggests that a significant portion of these 'treatment dropouts' had therapeutic benefit before ending their treatment (Howard et al., 1986).

Behavioral health providers often only get feedback on either the people who stay in treatment for a long time or those who end treatment, fail, and return. This is a biased sample for learning and perhaps is part of the reason for the phenomenon called the 'Clinician Illusion' (Vessey, et al., 1994).

This group's research demonstrated that while most people receive a short episode of outpatient treatment, most therapists say that they provide long-term treatment because caseloads quickly fill up with people who stay longer. Crisis workers and hotline call staff often never see the outcome of their efforts and decisions except when interventions fail and the person experiences another crisis. Under these circumstances, it is nearly impossible for

practitioners to develop true expertise. Therefore, the creation of real-time, representative feedback loops between helping practitioners' practices and their outcomes with clients is critical for the development of real expertise in the system.

## ARTIFICIAL INTELLIGENCE, PREDICTIVE ANALYTICS, AND TCOM

In lieu of developing expertise, an increasing number of options are being developed that simply replace expertise. Two of the most exciting innovations coming out of the emerging field of information science are predictive analytics and artificial intelligence. Predictive analytics is a statistical approach to taking data, making assumptions, and predicting a future event or outcome. Human interaction is required; models must be tested iteratively with new data to ensure the most up-to-date predictions. Artificial intelligence (AI) automates this aspect of learning from experience to allow the machine to learn and adopt the model based on new data. While there are important differences between these two innovations and some believe that predictive analytics is a subset of AI (Parker, 2021), both share the essential concept that, rather than improving human decision-making, it is more effective and efficient to simply replace it with decisions based on vast amounts of information available through information age breakthroughs in our world. Most of us benefit on a daily basis from these information science innovations. Many of us are also likely annoyed when our phones try to tell us what to do.

Aspects of these approaches will be discussed in later sections of this book, but in practice, the TCOM perspective supports a decision-support approach to the use of information. TCOM strives to develop expertise in all people across a helping system. However, it does not seek to simply replace expertise with decision algorithms that are opaque or obtuse to most end users. The goal of our approach is to help people become smarter and more effective in their decision-making. This emphasis is grounded in the idea that helping is an inherently relational concept. Relationships between the helpers and the helped and among helpers and among helped in support of each other are fundamental to transformational change. Relationships are the fuel of the engines of change. Replacing relationships with selfless decision algorithms that require no human contact are proposed to have limited impact on truly helping people change their lives from the TCOM perspective. Instead, we seek caring people, armed with the best information and strategies to be working with others to help them change their lives in meaningful ways. Said differently, we cannot develop Artificial Intelligence (AI) until we have developed Human Intelligence (HI). TCOM focuses on the development of HI.

## RISK ASSESSMENT AND PREDICTION

While TCOM fully embraces the concept of predictive analytics in learning how to manage a person-centered system of care effectively, there are some significant concerns regarding how these analytics have been developed, described, and utilized. Perhaps the most glaring difference between TCOM and other approaches to system management has to do with risk assessment and risk prediction. From a TCOM perspective, the concept of risk prediction is problematic. The problem lies primarily in the language and the implications that the concept of ‘risk’ has on system policy and functioning.

The essential problem with risk assessment is that if a risk assessment is proven to be valid, it is evidence of a failed system. If based on an assessment at Time 1 we are able to predict the likelihood of bad outcomes at Time 2, we are documenting that we have failed that person. We knew this individual would have challenges at T2 and yet nothing was accomplished to prevent this prediction from being accurate. Therefore, the only truly valid risk assessment process should demonstrate zero relationship to bad outcomes because that would mean it is being effectively used to prevent those bad outcomes. The reality is that when people are experiencing some of the factors that populate the inputs of risk prediction models, we try to help them. Sometimes we are more successful than other times.

We could argue, of course, that there are no perfect systems, and therefore an imperfect relationship in predicting bad outcomes could be sufficient evidence of validity. But the issue should be clear: the validity of a risk assessment is not strictly a function of the individual; it is also a function of the system. Making judgments about individuals based on how the system has failed them (or is likely to fail them) seems inherently unfair and inconsistent with principles of social justice. Since it is not uncommon for people who live in disadvantaged communities to have lower quality, less accessible and less effective help, then these individuals are further disadvantaged by a risk assessment and prediction approach to system management.

The solution is actually a simple one. Instead of focusing precision analytics on the likely of bad outcomes, a simple shift to predicting good outcomes facilitates the needed shift in thinking. As an example, in justice and corrections sectors—in which criminogenic risk prediction models are commonplace—one would shift to ‘citizenogenic’ models of prediction. Criminogenic models attempt to identify factors that will lead individuals to commit future crimes. A citizenogenic model would attempt to identify factors that would lead individuals to decide not to commit future crimes.

In lieu of abandoning risk assessment and prediction entirely, it is possible within a TCOM framework to accomplish this work with reduced institutional bias. Most risk approaches to predictive analytics use any available data. Often that means service receipt, demographics, and other static indicators are used to develop the predictive models. This strategy risks institutionalizing all

sort of biases including racial and gender biases or any other bias that influences service receipt in existing systems. Predictive models that include these (already biased) indicators as inputs simply risk further institutionalizing and normalizing these biases.

In TCOM, predictive models always include **ONLY** person-centered information. Demographic or service receipt can be used to stratify models but should not be included in the models. In other words, one could develop separate models for boys and girls or men and women so that the models could be used and applied within the context of a person's sex, but that variable should not be included in the models because gender bias is often an interaction and not a main effect. That said, these cultural indicators can also be used to monitor and address disparities and disproportionalities in programs and systems as will be discussed in greater detail later in this book.

### CONSIDERING CULTURE WITHIN A TCOM FRAMEWORK

Cultural considerations are both important and sensitive. They can also be controversial and trigger many and diverse emotional responses depending on one's perspective and life experiences. Most cultures, including the United States, have long histories of cultural insensitivity ranging from biases to the extreme of genocide. In the United States, one could argue that the 'melting pot' philosophy is a subtle form of cultural genocide. While not killing people of a different culture, the process of encouraging all newcomers to shed their old ways and acculturate to the US common culture slowly kills the original cultural roots of immigrants. Culture when limited to race and ethnicity can be quite complicated. As we expand the definition even more broadly, it becomes quite complex. Factoring culture into decision-making without perpetuating bias is an important consideration in the management of the business of personal change. As such, cultural considerations factor prominently in the TCOM conceptual framework.

To understand the TCOM perspective to culture, it is necessary to first return to a primary premise of all efforts to help. That is, we decide how to help not based on how people are different but rather on how people are the same. As discussed previously, if everyone were completely different, then there would be nothing we can learn by helping one person that would have any meaning whatsoever for helping another person. We know that statement is patently false. Human beings have a long and substantial history of finding commonalities that guide us to become more effective in helping. In times of crisis, we have sought to find commonalities based on things that challenge us. It is a common political strategy to pull people together by finding a common enemy. This primary premise of helping—looking for commonalities—can be challenged with the notion that different people from different cultural backgrounds are different from each other.

When attempting to communicate, it is always useful to start with a definition of terms. Merriam-Webster's online dictionary (March 25, 2022) provides the many definitions of *culture*, in the following

- a. the customary beliefs, social forms, and material traits of a racial, religious, or social group *also*: the characteristic features of everyday existence (such as diversions or a way of life) shared by people in a place or time
- b. the set of shared attitudes, values, goals, and practices that characterizes an institution or organization
- c. the set of values, conventions, or social practices associated with a particular field, activity, or societal characteristic
- d. the integrated pattern of human knowledge, belief, and behavior that depends upon the capacity for learning and transmitting knowledge to succeeding generations

Within this understanding of culture, it becomes clear that there is substantial 'cultural customization' that must flavor how we understand the cultural experiences of any one person. From a TCOM perspective, the degree to which a person embraces a specific cultural identity as defined above can be understood as the degree to which they formally accept the commonalities among other people who have defined themselves within that culture. Under these circumstances, culturally specific approaches make very good sense. However, different people with similar general cultural identities may not necessarily embrace all of the commonalities of that culture. I have many Jewish friends. My friends vary dramatically in the degree to which they embrace the religious aspects of being Jewish but nearly all of them embrace at least some ethnic aspects of being Jewish and all will proudly tell you that they are Jews. So what does 'being Jewish' mean to someone who self-identifies as a Jew? Clearly it can be quite variable from family to family and person to person even within that cultural group. The same can be said for any identifiable cultural group. Similarly, I have multiple female friends who identify themselves as Muslim. Some wear the traditional hijab and some do not. Some have worn the hijab for part of their lives and have not worn it at other times. So, what does it mean when a person self-identifies as a Muslim woman? Again, there is no simple single answer. I was talking to an African American minister in Indianapolis and he said to me, 'Anyone not in your skin is in a different culture'. Therefore, there is the rub. Culture is, in practice, a highly individualized concept but it can have important meaning in terms of commonalities when people fully or partially self-identify themselves with primary cultural commonalities.

## QUALITY IMPROVEMENT WITHIN THE TCOM FRAMEWORK

The manner in which we use person-centered information to guide decision-making varies by level of the system. At the individual level, the focus is to glean key information from people's stories to understand them within the context of what we know about helping people who share commonalities with them. This same information can be tracked over time to determine whether our actions and efforts to help are resulting in meaningful changes in the lives of the people who are seeking help. Once we move past the individual level of the system, however, it becomes necessary to have strategies for combining multiple stories. In some ways, the storytelling changes. While the information that we use at the individual level tracks that individual's story, once we aggregate across a case manager's cases, we are now telling the story of that case manager's work. When we aggregate across a program, we are telling the story of that program. When we aggregate across an entire system, we are attempting to tell the story of that system. However, each of these stories—case manager, program, and system—are told from the perspective of their impact on the lives of the people who seek their help.

Collaborative inquiry has taken this idea to develop a conversational approach to quality improvement that fits ideally into the TCOM theory of change (e.g., Bell et al., 2009; Chan & Pow, 2020). Facilitated Collaborative Inquiry (FCI, Shimshock, 2017) is a quality improvement process aimed at engaging a group, through data and stories, in identifying the key patterns that could benefit most from the group's attention, innovative thinking, and ultimately their data-informed collective action.

- **Facilitated:** FCI aims to shift the traditional role of the analyst—whether that is a researcher or an evaluator or a quality improvement director—into one of 'facilitator'. Often, individuals without a research or evaluation background need help to understand both the meaning and limitations of data and analyses.
- **Collaborative:** FCI is a collaborative process that draws on the expertise and insights from all involved. Analysis, sense making, recommendations, and so on come from the collaborative group. Data are not used to answer questions but to stimulate conversations and insights among all participants. All activities in TCOM are intended to be collaborative; so should be the interpretation of data and the development of next steps from lessons learned.

**Inquiry:** FCI is an inquiry process that aims to empower participants in making sense of their data and taking informed action. The focus of activity is the use of data from transformational processes and person-centered assessments.



FCI is built on the tradition of the Shewert or the Plan-Do-Study-Act cycle (Tague, 2005) which has evolved into a standard way of describing continuous quality improvement (CQI) efforts. Although some efforts to engage all parties in CQI efforts have been a part of traditional approaches, FCI takes a more explicit stance on the involvement of affected parties. Much like consensus-based assessment and planning are used to engage people seeking help to facilitate changes in their behavior, the engagement of supervisors and direct care providers is optimal if the goal of the CQI effort is to inform a change in *their* (direct care and supervisor) behavior. Just like when working with individuals, the goal of CQI is changing individual behaviors that influence our ability to help people change. To develop personal expertise, we all need feedback. That feedback must be given in a manner that allows people to absorb it and use it to guide changes in behavior. This is the reality of system change, program improvement, workforce development, and personal change among the people who seek help. All that changes is that the ‘personal’ behavior change must become increasingly collective as we move through the system from the individual level to higher levels of aggregation of feedback.

In order to create a collaborative process that provides professionals working in programs or system with the feedback they need to plan personal and collective change, FCI re-envision the PDSA cycle as more conversational and collaborative approach for developing a consensus understanding of the story of a professional, a program, and/or a system of care. Specifically, the modified cycle is shown in Fig. 4.3.

Specifics of this approach and related TCOM strategies regarding understanding the appropriateness of matching actions to needs and strengths will be discussed in future chapters organized by the level of the system. However, it is important to note that, in TCOM, system-level accountability strategies move away from traditional compliance indicators (e.g., Did you complete the required assessment document?) to standards that reflect the use of person-centered strategies in all key decision points (e.g., Did you fully integrate the identified needs and strengths of the individual into their treatment plan?; Does funding follow the programs with the greatest impact or support change in programs that under-perform?). As will be discussed later in this book, the shift in audit focus is central to effectively encourage the evolution away from traditional service system thinking with its focus on compliance with specific actions to a TCOM system focused on collaborative helping.

Implementation science demonstrates that all implementations benefit from organization and project management (Fixsen et al., 2015). Helping people find common values, goals, and actions requires collaborative planning. Attention is required to ensure that business models are developed and policies and procedures support effective helping. Old habits must be identified and new habits established. Since TCOM tools and strategies have been widely implemented in multiple helping sectors, it is useful to review lessons learned within the context with the science of implementation.

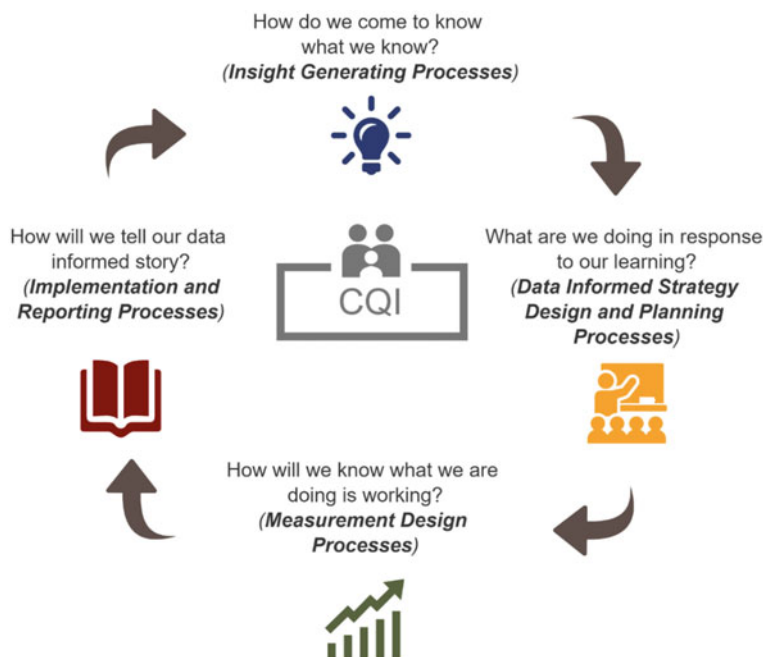


Fig. 4.3 Facilitated collaborative inquiry cycle

## KEY COMPONENTS OF A FULL TCOM IMPLEMENTATION

Before beginning a discussion of the process of implementing TCOM, it is important to state two realities that must be considered. First, no two implementations are the same: if you have seen one implementation of TCOM, you have seen one implementation. Therefore, it is important to remember that while steps and stages of implementation can be discussed, there is no single linear path to a full implementation of the principles of the TCOM approach. Second, the word implementation itself is a bit of a misnomer. Implementation is often considered a process of getting started doing something new. However, with an approach like TCOM, implementation never ends. In that sense, a discussion of the implementation of TCOM is really more of a discussion of how to do TCOM rather than how to start doing TCOM.

## IMPLEMENTATION SCIENCE AND TCOM

The National Implementation Research Network defines implementation as ‘*a specified set of activities designed to put into practice an activity or program of known dimensions*’, and distinguishes the set of activities being put in place to change practice from the intended practice model itself (e.g., Fixen et al.,

2015). Implementation strategies, then, are purposeful, are aimed at changing practice, and must be observable and measurable in presence and in strength (Powell et al., 2012).

Like any practice change in a people-serving system, the implementation of TCOM is a complex process. Change must be managed collaboratively across all levels of service systems. Service providers, supervisors, and leaders must change peoples' focus and behavior. Systems must be redesigned to support these changes. Ongoing supports to sustain and expand behavior change must be embedded across the system intended to be transformed. Implementation of TCOM takes time and focus, and requires organizational intention, vision, and resources.

An emerging body of literature from diverse human service, health care, manufacturing, and engineering fields suggests that implementation is not a static process (Fixsen et al., 2015). Instead, it is a multi-level, ongoing, dynamic journey. Implementation involves distinct but interacting and influencing processes at each level of a system (e.g., client, provider, team, program, provider organization, regulatory system, State and Federal policymakers). Successful and sustained practice change requires regular monitoring and readjusting of action plans as the 'moving parts' (Ghate, 2018b) of complex helping systems respond to the implementation process.

Additionally, the diffusion of innovative practice through implementation is a social endeavor as much as it is a technological endeavor, particularly in people-serving systems (Hemmelgarn et al., 2006). The 'invisible infrastructure' (Ghate, 2018b) of an organization is comprised of its policies, procedures, habits, *and* its social context, and all must be assessed and addressed for sustainable practice change to succeed. Organizational culture is composed of the shared norms, beliefs, and expectations among members of the organization (Ouchi & Wilkins, 1985). This culture guides the decision-making of the organization's membership and can support or undermine implementation of practice change. Organizational climate is discussed in Chapter 5. TCOM builds its approach to culture from the work in safety science (Cull et al., 2013). An organization's climate can support or undermine the success of implementation. Organizations, then, must examine and align organizational values and expectations, messaging of those values and expectations, and workplace conditions to the goals of implementation as part of any successful implementation strategy.

As mentioned previously, implementation science has begun to reveal that successful, sustainable implementation occurs in stages (e.g., Fixsen et al., 2013; Livet et al., 2018). These stages structure and support the intentional effort to change the system. Chapter 10 will provide a detailed discussion of our suggested phases of the implementation of key components of the TCOM approach. Stages include goal-setting and readiness assessment, workflow and infrastructure changes, training, practice change, and monitoring/sustaining of the innovation. Sustained practice change can take multiple years to achieve,

as people at all levels move through phases of experiences and the organization evolves a new practice culture (e.g., Kelly et al., 2009; National Center for Health and Clinical Excellence, 2007).

## THE TCOM MANAGEMENT APPROACH—SUPPORTING COLLABORATION AND ACCOUNTABILITY

Typically, system management approaches are designed *using a punishment/reward framework*.

Systems identify the desired behavior of agents in the system, monitor those behaviors, and then provide rewards or punishments based on the agent's compliance with the desired behaviors. These compliance models are standard approaches to system management in the vast majority (if not all) of helping systems (at least in North America and Europe). These system-level compliance standards get translated by provider organizations to the expected behavior of direct care staff and the compliance standard is replicated. A system might create a documentation standard and if an agency fails to comply, they are punished with a lack of payment for activities already completed. Therefore, the agency creates expectations for staff to comply with these documentation standards and staff who fail to do so are subject to disciplinary action by the agency. The most common carrot and stick that systems use for agencies is money. Typically, that incentive (or punishment) is not translated by the agencies to be the primary motivational tool for direct care staff. Rather, job approval, promotion, and other desired rewards or job sanctions or even termination and similar punishment are used by agencies to motivate.

Over the past several decades, a large body of research and discussion has evolved on aspirational leadership. Leaders who are able to inspire us to be better versions of ourselves or to join a cause are respected and even idolized. Some of the most influential people in history were seen as aspirational leaders, often for good but sometimes even for bad. While we have spent a good deal of time on the nature of inspiring leadership, less time has been spent on translating this vision to management. It may be that aspirational management processes can be created that do not necessarily require an aspiration leader to be the manager.

In 2016, Forbes identified the following nine differences between a leader and a manager

1. Leaders create a vision; managers create goals
2. Leaders are change agents; managers maintain the status quo
3. Leaders are unique; managers copy
4. Leaders take risks; managers control risk

5. Leaders are in it for the long haul; managers think short term
6. Leaders grow personally; managers rely on existing, proven skills
7. Leaders build relationships; managers build systems and processes
8. Leaders coach; managers direct
9. Leaders create fans; managers have employees <https://www.forbes.com/sites/williamarruda/2016/11/15/9-differences-between-being-a-leader-and-a-manager/#ac2f0af46096>.

At the end of the day, the helping sector needs both leaders and managers. Any vision that might be created or articulated ultimately must find its way into the policies and procedures used to ensure that investments in helping result in people being efficiently helped.

In general, our public helping systems are managed from a compliance perspective. Business rules and policies are established by funders and regulatory bodies and these rules and policies are enforced through a variety of compliance-based strategies. The underlying premise of a compliance-based approach to systems management is that people will not do the right thing unless the proper rewards or punishments are put in place. This way of thinking about management arises from traditional behavioral theories of human behavior (Skinner, 1971). The basic idea is that rewards and punishment control human behavior. You often hear it said that, ‘People do what they are paid to do’. There is, of course, some fundamental truth to this observation. However, money is not always a primary motivator of people in all situations. Further, the basic premise that, unless controlled, people will behave badly does not hold in many situations; there are innumerable examples of people doing altruistic acts that are clearly not in the best interests of the individual actor. We should consider the behavior of heroes both big and small. People see a person in need and reach out to help. This happens every second of every day all over the world. Having watched B.F. Skinner stump students trying to defeat his theory, the trick is that the definition of ‘reinforcement’ is tautological. A reinforcement increases the likelihood of a behavior. How do you know that it is a reinforcement? Because it increases the likelihood of the behavior. In this way, simple concepts of behavior management are stretched to explain this phenomenon. Somehow people find it ‘reinforcing’ to help others. This logic of course is circular—the only way we ‘know’ that it must be ‘reinforcing’ to help is that they actually engage in helping behavior because we have already established that people only do that which is reinforcing.

There are alternate ways of thinking about managing other people’s behavior that moves away from the rewards and punishments that are fundamental components of our compliance-based system. Particularly in professions where employees choose to take career trajectories that guarantee a lower fixed income ceiling than other professions, one wonders whether compliance approaches can really be effective. We know that some students and young

people select a career path knowing that the highest financial reward they will achieve will be demonstrably lower than the highest financial rewards achieved by their friends and classmates who pursued careers in higher paying professions. It is not likely that some sort of Darwinian sorting procedure is at work where the best students go into high paying jobs and only the less skilled end up in lower paying careers. Rather issues of conscience and meaning influence career choices. The behaviorist view that people do only what they are reinforced to do does not adequately understand the role that doing the 'right' or meaningful thing. Economic punishment models of compliance are simplistic and even insulting when seen from that lens.

In my work training helping professionals, I have often asked trainees to describe why they got into the field of helping. I have never heard anyone say that they were doing it for the money. A few have had other reasons but the vast majority of people have said that their personal journey into the field began because they wanted to help others. The desire to help often comes from profound personal experiences early in life. Public sector helping attracts people who aspire to help. If this is what brings them to the work, perhaps we should design systems that build off this aspiration, rather than a system that expects people to behave badly unless they are either coerced or seduced into good behavior. Our existing strategies that emphasize compliance make the implicit assumption that unless monitored and controlled, people will behave badly.

People come to help in large part because they aspire to create a better version of themselves.

If you consider the fundamental premise of TCOM that all relationships in a helping system are replications of this helping dynamic, the direct care workers seek supervision to aspire to become a better version of their professional selves. Program managers aspire to create programs that are better versions of themselves by supporting the program staff in all becoming better versions of their professional selves. Fundamentally, system managers seek to become better versions of their professional selves so that they can support programs and agencies to become better versions of themselves. One can then propose that public helping systems are layer upon layer of the same process of helping others to meet their own aspirations.

In Taoism, it is often said that until you find beauty, you cannot know what its absence is. The same is true with anything. Until you know social justice, you cannot know what social injustice is. You cannot know a lie until you know the truth. Thus, the absence cannot be understood until the attribute is discovered. In systems management, you cannot know where there is low quality care until you know where there is excellence. In supervision, you cannot help a supervisee become outstanding at their job until you know what being outstanding entails.

I recently helped to facilitate a planning meeting for a rapidly expanding community agency. As is often the case in these types of meetings, the convened leadership group was tasked with identifying the agency's goals.

The initial conversation was focused on being what might be described as 'good enough'. I made the comment that planning should be aspirational. They quickly shifted to adopt a goal of being the best and you could feel the mood of the group lift. I have never heard a coach working with their team, motivate the team by exhorting them to play for a tie. In all athletic endeavors, the one common goal is always excellence. The same should be true across the helping sector.

An aspirational focus to our work is particularly important as a strategy to strive to be transformational despite all of the unintended consequences of the stark reality that the system does not provide any incentives to be excellent. Nearly all of the most common incentives are directed towards compliance and adequacy. No therapist has to accomplish anything in a 50-minute hour in order to be paid; they just have to put in the time and be physically present. No residential program needs to provide a transformational experience for a resident in order to be paid; in most cases, they just need to provide a bed, three meals, and keep the person safe. Going beyond the required (i.e., compliance) can be a key component of helping people make real changes in their lives. This type of heroic action happens every hour of every day in all of our public helping systems. The motivation to do so is not financial. In all likelihood, it can never be.

The idea of aspirational management is that whomever is in the role of change agent (e.g., direct care worker, supervisor, program director, agency director, system manager) must integrate the individual aspirations of the people for whom they are responsible with common aspirations. This task is a mass customization process as described earlier in this text. Individual aspirations represent the individualism side of the continuum while common goals represent the mass production side. Making individual goals congruent with common goals is a key component of aspirational management.

## KINDNESS AND ASPIRATIONAL MANAGEMENT

Although being kind is a different concept from aspirational management, in practice these concepts are certainly overlapping. In general, supporting someone in their aspirations will be experienced as kind. Even teachers or coaches who are hard on their protégés to help them achieve goals and even dreams are in retrospect often seen as truly caring about the person they were teaching or coaching. Not always, of course, but often. Parents who may sometimes be strict with their children are often later experienced by their adult children as being guided by a love. Sometimes 'misguided' of course, but guided by love nonetheless. The key to the experience of kindness within an aspirational frame is the person in the position of authority (e.g., parent, teacher, coach, manager) taking the time to understand and embrace the person's aspirations rather than just projecting their own aspirations onto the person. The coach that wants to win for their own glory is experienced

differently than the coach who wants the players on their team to win, even though both coaches want to win.

In his book *The Five Side Effects of Kindness*, David Hamilton (2017) discusses how being kind to others is actually good for an individual's health and well-being. Spreading kindness can be seen as a health promotion activity within the workplace and to the people that helpers are intending to help.

One way to be kind is to recognize the aspirations of others and support them in their efforts to achieve their personal aspirations. I am sure some who read this are thinking something like, '*That sounds all well and good but kind of utopian. I am really busy and I don't have time for that type of touchy-feely nonsense*'. I think at the end of the day, it actually takes less time. Sometimes we need to slow down to speed up.

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## Communimetrics—Measurement in TCOM

As introduced in the initial chapters and elaborated in the rest of this book, the theory of TCOM requires the discovery and communication of the stories of the people served. The measurement demands of TCOM are often unique. In this chapter, I describe a measurement theory developed specifically within the context of outcomes management in the helping sector. While measurement of service utilization does not require a theory of measurement, the measurement of the key outcomes in a transformational system—personal change—are often constructs whose measurement is unobservable and subjective and, therefore, more complex to measure (Lyons, 2009).

Traditional theories of measurement for these ‘soft’ or subjective constructs, generally called psychometric theory, are grounded in research methodology for measuring subjective states and emphasize building on century-old research traditions and logical positivist assumptions regarding measurement (Nash, 1990). Traditional measurement approaches simply do not adequately meet the needs of person-centered care generally and the TCOM theory, specifically.

Within the history of science, the measurement of unobservable or subjective phenomenon has a relatively brief history—just over one century—and can be traced back to Stephen Cattell and Sir Francis Galton at the Cavendish Physics Laboratory beginning in 1887. With their measurements of reaction times and sensory perception, they first introduced the concept of psychometrics. The concept became a field unto its own with the publication of seminal texts by Joy Guilford (1936) and then Jum Nunnally (1976) on Classical Test Theory. The field expanded into two competing psychometric theories beginning in the 1940’s in Europe (Rasch, 1960) and then the United States (e.g., Wright & Stone, 1979) with the introduction of Item Response Theory.

Although work within these two theories has continued to evolve, the basic premises of the measurement field have a whole has been relatively unchanged since the early 1980s.

With the emergence of the information culture, demands on measurement have shifted in fundamental ways. The democratization of data requires flexible and creative ways of thinking about how to capture and describe things. Within scientific enterprises, the field of psychology claimed the mantel as the field of subjective measurement given the non-observable status of many important psychological constructs (c.f., Stanger, 2014). Hence, the term *psychometrics*—is the measurement of psychological constructs.

As mentioned above, psychometric theories of measurement have their intellectual roots in the philosophy of science of the time, logical positivism, often called empiricism (Nash, 1990). Psychometric theory originally was influenced by the intellectual giants of the time—Darwin, Locke, and Hume. Of course, philosophies of science have evolved past logical positivism as a basis for our current understanding of science. Perhaps it should be not surprising that psychometric measures, which have remained largely unchanged in their philosophical underpinnings, have often struggled to remain current (except in the field of psychology where the tenets of psychometric theory are often held with a near ‘religious’ commitment). These shortcomings are increasingly obvious in our emerging information society.

From my perspective, the solution to this challenge lies in returning to the existential reason for measurement—to describe phenomenon in a fashion that allows the communication between variables and among scientists (Nunnally, 1976). By expanding this idea of communication beyond scientists to a broader audience, we can conceive an alternative that reconsiders measurement from a communication perspective. Similarly, to how we think about language, we can consider measurement in a manner that is simultaneously more inclusive and relevant to everyday applications. This measurement theory is called *communimetrics* (Lyons, 2009).

As mentioned previously, the practice and theory of measurement have always had an important focus within the field of Psychology. The advent of the information culture has begun to open access to information and perhaps has even begun to alter what we broadly consider measurement. From a historical perspective, a far greater proportion of the population routinely attempts to use data to help inform decisions. This activity is no longer strictly the purview of science and that broadened use influences a wide variety of activities from choosing a restaurant to directing advertising strategies to guiding surgical procedures. Social behavior is being informed by much faster information cycle than considered by the procedures exemplified in traditional measurement theory. Approaches to measurement, such as psychometric ones, which assume generally static population characteristics (i.e., norms) and rely on asymmetric access to development, testing, and scoring information may be increasingly vulnerable to misuse, misapplication, and ultimate irrelevance. The idea of an unchanging measure, once validated, is inconsistent with our

emerging information culture that is quite fluid and iterative. All you have to do is to read a newspaper from 50 to 100 years ago to get the clear idea that how we communicate with each other changes over time, sometimes dramatically.

In their rigid focus on logical positivist and operations philosophy, psychometric theories have disregarded Werner Heisenberg's first notation in 1927 of the 'observer effect' (c.f., Furuta, 2012; Heisenberg, 1930). The evolution of measurement in psychology has remained relatively insulated from the dramatic shifts in philosophy of science of the past century. The substance of these shifts was foreshadowed in Ludwig Wittgenstein's own shift from the logical positivism of his early works (*Tractatus Philosophicus*) to his growing understanding of the critical importance of defining 'reality' in terms of our shared communication of mutually defined and actionable statements. This shift has been applied to the framing of science in diverse ways, including in social constructionist thinking (Gergen, 1985; Kuhn, 1962) and more recently in native naturalism (Laudan, 1990) as well as in other efforts to merge the relationship between some objective reality and our perceptions of that reality (Parnas et al., 2013). As such, psychometric theories have remained unchanged in their epistemological roots in logical positivism that is no longer considered as fully reflecting the increasingly diverse views of the scientific process.

For our purposes, it is useful to review each of these foundational psychometric theories briefly. This allows us to discuss re-imaging measurement from a broader communication perspective consistent with the use of measurement in the Information Age.

### *Classical Test Theory*

The basic concept of classical test theory is that, at least conceptually, there exists a universe of all possible items that could be included in a measure—a population of possible items from which to sample. This theory posits that the degree to which one can adequately sample items from this population is the degree to which a measure will adequately measure a construct. If you can develop a population of all possible items to measure depression, then you can randomly sample from that population of items to develop a measure of depression. Of course, it is impossible to elaborate fully on this population of potential items. Therefore, in order to evaluate this sampling process correlations among items are used to assess possible membership in the population. Selected items should be identified and studied. A total score is created by combining items into a linear combination of items (i.e., a sum). Evaluation of items then is done by studying the correlation of individual items with all other items and with the total score. Nunnally (1976) recommended that good items have inter-item and item to total scale score correlations in the 0.30 to 0.60 range indicating that the item is measuring a similar construct but is not fully redundant with other items. Logically with Classical Test Theory, the more items included, the more likely the measure will adequately sample a

population of all possible items. Research suggests that about 30 items are sufficient to measure a construct well. Ten items are often identified as a minimum standard of effective sampling of the population of items (Nunnally, 1976).

### *Item Response Theory*

The core concept of item response theory (IRT) is that measurement is conceptualized as locating an individual relative to all other individuals on an unseen (latent) continuum. Thus, the population of possible items are thought to exist at different levels of ‘severity’ or intensity’ along this continuum. The sampling of items is based on the degree to which items effectively represent this continuum. A good measure adequately samples across all relevant levels of intensity or difficulty. Thus, the goal of effective measurement is to identify and select items that are sensitive at different degrees of intensity or severity along this latent continuum (trait). The classic example of IRT is math mastery. A simple item, which is sensitive on the low range of a math skills continuum, would be simple addition. An item requiring multiplication would likely be more difficult and thus sensitive at a higher range of math abilities. An item requiring matrix algebra or the calculation of a derivative would be solvable only by a respondent with strong math skills and thus would only be sensitive at the highest ranges of the math skills continuum. In items response theory rather than inter-item correlations, the approach uses item difficulties to order items that fit along a latent trait. Of course, complex approaches to IRT can use many parameters taken from the statistical behavior of each item, but nearly all approaches use at least the difficulty parameter (Lord, 1980). While IRT also requires multiple items to measure a characteristic, it does have a logical minimum of two items (i.e., you cannot have a line without at least two points).

### *Common Characteristics of Psychometric Measures Across Specific Theories*

Whether one uses CTT or IRT to develop a psychometrically sound measure, the most important information used by the developer is the statistical relationship between and among items. The statistical ‘performance’ of the items informs the measurement developer regarding their decisions about item inclusion and fit. Moreover, in terms of at least some forms of reliability (i.e., internal consistency) these same metrics are used to help define the quality of the measure. CTT uses correlation coefficients and IRT uses difficulty metrics and other fit statistics (i.e., depending on the number of parameters in the model used). While sophisticated approaches to both theories support strategies like cognitive testing of items to ensure that some attention is paid to what respondents believe the item means, the final decisions regarding inclusion or exclusion of a specific item into a measure will be guided by the statistical characteristics of each item relative to the other items (c.f., Furr & Bacharach, 2013). There are notable implications of this common characteristic:



1. All psychometric measures require multiple items. CTT generally requires a minimum of 10 items but the ideal measure has at least 30 items (Nunnally, 1976). IRT has been reported to be functional with as few as two items; however, the ideal measure again has more items to ensure appropriate scale sensitivity across the continuum.
2. Decisions on test construction are based on the statistical relationship among items. While a number of theorists have suggested various methods of ensuring that, the actual linguistic content of the item should be studied to ensure that respondents understand the meaning of the item, there is little to no formal inclusion of these processes in the theories themselves.
3. The measure's total score that is almost invariably a sum of items always results in arbitrary metrics (Blanton & Jaccard, 2006). Latent continua have no obvious grounding in reality. Since individual items are thought to be insufficiently reliable, there is no pressure to make individual item rating scales non-arbitrary either.
4. The same total score of a measure can result from a variety of different scores on individual items. Therefore, two respondents with identical total scores on the measure might actually look quite different on closer inspection. In other words, on a measure of ten items that each uses a 4-point Likert Scale measure, 10 items rated a '2' would be equivalent in meaning to five items rated a '3' and five other items rated '1'. The more items on a measure, the more varied the possible profiles of ratings that can result from the same score. For this reason, translating a scale score back to an individual in a meaningful way is challenged. This problem is particularly acute for classically developed measure but may also be true within IRT. Although IRT establishes a clear latent continuum there is no clear relationship of any location on that continuum and actionable meaning.

## THE PROBLEMS WITH PSYCHOMETRIC MEASURES

In context of our work, measures arising from psychometric theories suffer practical shortcoming. Foremost among these shortcomings are challenges with meaning. Blanton and Jaccard (2006) have asserted that psychometric theories create arbitrary metrics that challenge their broad use. In other words, psychometric measures generate numbers that do not have immediate or clear meaning. What is the meaning of a difference between a 17 and a 13 on a Beck Depression Inventory (Beck et al., 1961)? Is that difference comparable to the differences between a 21 and a 17 or the difference between a seven and a three? No one really knows. No one can ever possibly 'know'. This arbitrary nature requires additional layers of interpretation (e.g., norms) before measurement results can be meaningful. In addition, even with norms, meaningful interpretation that translates into actionable information remains



challenging. In the world of the helping sector, information that is not actionable is not particularly useful. In a transformational system, information that is not clearly actionable is close to worthless.

A major reason that psychometric measures result in arbitrary metrics is their reliance on ratings of severity, frequency, or intensity using Likert scales proposed originally by Rensis Likert in 1932. All of us have been subjected to this method of scaling. We have received satisfaction surveys asking us to rate our experiences on a scale of that goes from very satisfied to not at all satisfied. Usually it is a 5-point scale, sometimes fewer, and sometimes more. Fewer of us likely have tried to interpret the meaning of these ratings in aggregate. Good luck with that. I would argue that although we have been acculturated to use them, Likert scales do not represent how people actually think. Do any of us wake up in the morning and say to ourselves: “On a scale of 1 to 5 with ‘5’ being ‘Absolutely yes’ and ‘1’ being ‘Absolutely no,’ how much do I need to go to the grocery store/market today?” What would we do if we rated ourselves a ‘3’—sounds like a day of dithering about a shopping trip to me. I suspect my experience is common. You wake up and look at what food you have at the moment and you make a calculation resulting in the selection from among these response options—‘No, I don’t need to go’; ‘I need to go, but not today, I can wait until tomorrow’ or ‘I must go today’. For me personally if I am out of coffee, I might add the option ‘I need to go immediately before I do anything else’. The Likert scale was brilliant not because it fits the human condition or maps into decision-making, but precisely because it fits the psychometric measurement theory to allow easier, more efficient statistical analysis. Everything we know about person-centered design and human factors engineering, tells us that is ultimately a bad idea.

A *major* initial advantage of psychometric theories was that they created metrics that naturally fit into a normal distribution. The development of the General Linear Model (GLM) that has been the standard analytic approach in psychology for most of the history of the field was potentiated by propositions of the Theory of Algebraic Invariants proposed in the 1800’s by brilliant mathematicians of that time including Gauss, Boyle, Cayley, and Sylvester (Wolfson, 2008). The statistical applications of this theory were developed with a clear eye towards computational convenience since all statistical analyses were done by hand and even a simple correlation could take days or even weeks to calculate. Computational convenience is what makes the normal distribution such an important breakthrough at the time in our common history. The normal distribution creates a population of observations that can be completely described using only two numbers—mean and variance. Psychometric measures generate numbers that fit the general linear model well. Linear combinations of numbers, particularly those on a uniform Likert scale, tend to distribute into a bell-shaped curve. That was a major breakthrough at the turn of the twentieth century. Now, of course, the widespread availability of powerful computers has led to the creation of an entire new range of options

for statistical analyses—dramatically diminishing the importance of parametric statistics generally and the GLM specifically.

More recent statistical models using machine-learning approaches (c.f., Athey & Imbens, 2019; Yarnold & Soltysik, 2005) do not make similar demands on measurement. These approaches can address computationally intensive, clinically complex classification and decision-making problems with relative ease (c.f. Cordell et al., 2016). Machine-learning approaches have been used increasingly used for a variety of applications within the helping sectors including within the TCOM framework (e.g., Troy et al., 2021). The utility of forcing all measurements into a normal distribution in search of computational convenience is now only a historical consideration. Given this circumstance, there is no longer any need for basing measurement development strictly on psychometric theory.

### *The Problem with Norms*

As mentioned above, individual items on measures developed from psychometric theories generally use Likert type scales of agreement, intensity/severity, or frequency although some applications use yes/no or true/false item level scaling. Neither classical test nor item response theories take a consistent position on an item level scaling choice except as it impacts the statistical behavior of the items relative to each other and the total scale score. While such rating strategies are not logically a requirement of the theories, there is a substantial amount of research over the past century on the best item designs within this basic logical framework (e.g., Schriesheim et al., 1993). IRT does differ from CTT in this regard, as IRT also supports mastery items (e.g., correct vs incorrect). Given this choice of item design, many psychometric measures guarantee their arbitrary nature even at the item level as there is substantial research demonstrating response sets with Likert ratings. In other words, response biases can influence ratings so that one person's rating of 'moderate' or 'somewhat agree' might be substantively different in either meaning or importance from another person's rating under the same circumstances. (e.g., Podsakoff et al., 2003; Reese et al., 2013).

The concept of norms defines individuals within a population based on their relationship to the average of that population. Deviations from this average are described in multiple ways (e.g., T scores, z scores). However, because of the logic of the approach and the language used, there is a significant risk that deviations from population averages are defined as 'deviant'. This natural semantic consequence of the theory of measurement creates challenges for cultural sensitivity and responsivity. When the population average is defined as 'normal' (i.e., it is after all the 'normal' distribution) then the natural implication of intervention is to move individuals who are deviant from that norm towards the population average (i.e., 'abnormal'). This is congruent with the notion of acculturation (i.e., the melting pot) that was the predominant cultural perspective of the first two centuries of the United States but

creates problems of cultural insensitivity and even racism. For example, in the 1984 case, *Larry P. versus Riles*, the United States Court of Appeals ruled that IQ could not be used as a decision input in the school system because its norm-based structure resulted in cultural insensitivity across racial groups.

Psychometric theories were developed in the scientific context of an early understanding of the potential applications of evolutionary theory to social processes. Proponents of the use of normed instruments in the United States sadly moved away from more enlightened perspectives on the use of norms. Binet's perspective (Binet & Simon, 1916) that normed tests of intelligence could be used primarily to help accelerate or ameliorate the learning of persons underperforming scholastically is no longer fashionable. Instead, norms can be used to 'bake-in' racial differences creating the possibility of systemic bias. Perhaps this should not be surprising given the reality that the original psychometric theory came from the same mind that gave the world the theory of eugenics (i.e., Francis Galton). Features of this basic approach are still in operation today, though the pejorative language used in the past for categorical designations has been somewhat softened. For example, many normed clinical instruments in use today label any scores which are at least two standard deviations above the mean as beyond the 'clinical cutoff' or 'in the clinical range' for determining a need to treat an underlying condition. Some go so far as to label this deviation as 'abnormal' (Strengths and Difficulties Questionnaire, Bourdan et al., 2005). Though this may appear at first glance to be an objective criterion for determining the presence of a case (e.g., diagnosis), it rests on the idea that there is a clear and categorical distinction in which labels should be used. Therefore, clinical actions should be taken based on scores with potentially small differences on an underlying continuum. For example, there is no evidence that a child with an IQ of 69 is functionally different in any way from a child with an IQ of 71 but regardless, scoring below 70 has been used to designate the presence first of mental retardation, then intellectual disabilities and now intellectual or learning challenges.

This approach ignores two important observations. First, most human characteristics are distributed on a continuum which does not have clear cutoffs (or 'joints' at which to be carved) but rather gradients which defy clear a priori categorizations of where one's standing on the characteristic is and is not harmful to a person or society (c.f., Anastasi & Urbina, 2010; Lilienfeld & Marino, 1995). Second, the import of a person's score on a characteristic is contextual. By contextual, I mean that the identical score on a characteristic can have very different meaning in terms of action based on a cultural or contextual interpretation of the construct, its usefulness or accommodation within a context, and its relationship to other within individual constructs. (c.f., Lilienfeld et al., 2013, among others). For example, being aggressive in a hospital setting may have very different contextual meaning than being aggressive when living in the community. In addition, being aggressive in one community setting maybe contextually dependent on that community and specific external factors surrounding the behavior. Further, depression and

trauma appear to have different symptomatic presentations depending on race and ethnicity (Bailey et al., 2019; Trespasso-Grullon, 2012).

Again, the complex feel of ‘intelligence’ offers a case in point (Gardner, 1993; Sternberg, 1988). Many would agree with the conceptualization of intelligence as a set of characteristics which allows persons to be more adaptive in a given context or series of contexts. In this view, intelligence underlies our ability to solve problems rapidly. The particular set of traits and skills which optimally predict success in a given environment has been consistently broadened over time as we have better conceptualized the dynamic demands that varying environments provide, further complicated by person-environment interactions. Most now agree that there are various kinds of ‘intelligence’ almost to the point of making the concept irrelevant.

Beyond measurement of intelligence, similar challenges confront measurement of other clinically relevant constructs. Our conceptions of ‘reality testing’, for example, are also co-constructed and contextual. The behavior of a religious member of a Pentecostal church (e.g., speaking in tongues) when observed in a psychiatric emergency room versus at a place of worship would result in two entirely different conceptualizations of that behavior. In our work, I have experienced multiple cases of Native American and First Nations individuals reporting that they talk to dead ancestors (a culturally normative experience in many tribes/nations) only to be misunderstood by mainstream mental health practitioners as behavior indicative of a psychotic traumatic grief response. These two examples illustrate the centrality of context in assessing constructs that have been central to the profession of psychology for over one hundred years. Even the constructs with which psychologists are most familiar as require a dynamic and contextual construction to be utilized in a way that minimizes the possibility of harm to the people we help and maximizes the potential for mutual understanding and growth.

### *Psychometrics and the Challenge of Triangulation*

Person-centered care, the goal of TCOM, requires a full and equal partnership between those who seek help and those who provide help. It is instructive to consider how traditional measurement views consensus. Due to its grounding in logical positivism as the underlying philosophy of science of psychometrics, the dominant method for measuring meaning has been pre-triangulation measurement (Obeid & Lyons, 2011). The focus in these theories of measurement is on the careful measurement of a single perspective. That then levels us with the challenge of how does one combine information from multiple perspectives. The traditional solution originates in astronomy—triangulation.

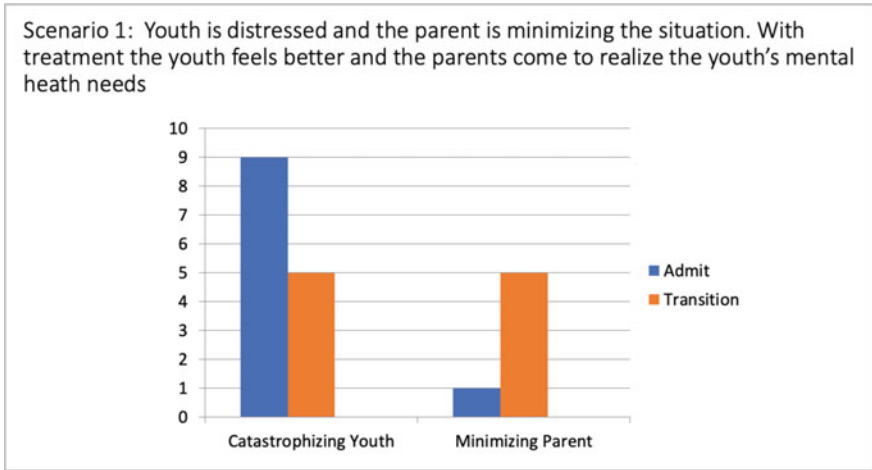
Triangulation is a very important methodological breakthrough in the history of science. The famous Danish astronomer, Tycho Brahe, revolutionized astronomy with its introduction at the end of the sixteenth century. Triangulation arose from work in astronomy and physics as a strategy to

measure the movement of objects from a distance. In astronomy, the movement of stars and planets can be understood based on the measurement of their location from different places and times. Combination of these measurements ('triangulation') allows precise distances to be calculated. In human measurement, Campbell and Fiske initially translated the concept of triangulation into multi-trait, multi- method approaches of taking different measures from different perspectives using different methods of measurement (Campbell & Fiske, 1959).

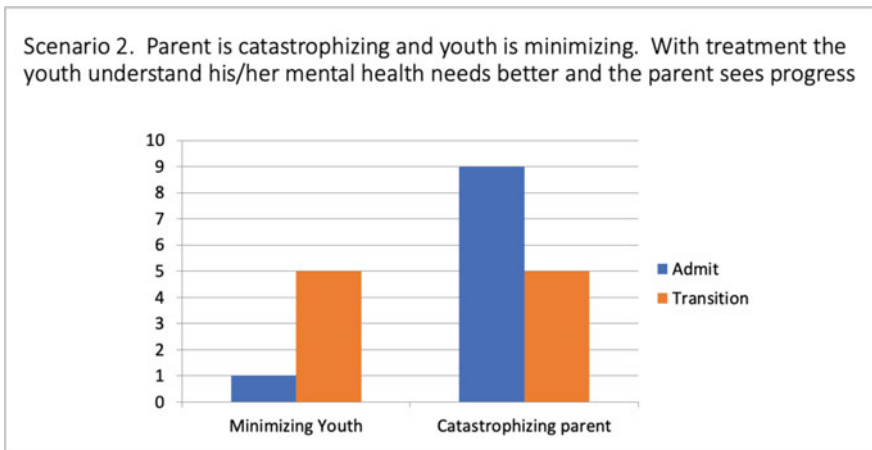
Unfortunately, in the helping sector, this approach to measurement triangulation has serious drawbacks. It has not been demonstrated that it is possible to combine the measurements of multiple human perspectives using any form of statistical procedures to create precise measures of a single personal attribute (e.g., achieving consensus). Researchers have tried averaging ratings across informants, which is an unsatisfying solution. Rather than providing more precise information, averaging perspectives threatens to remove the most important information—directional differences among individuals in their perceptions of what is actionable. Typically, measures remain representing the single perspectives. In outcomes work, this means the impact of interventions is often interpreted separately for different perspectives (e.g., client, therapist, family, etc.)

Perhaps a demonstration is useful in providing a window of the limitation of pre-triangulation measurement in assessing the impact of helping actions on personal change. Let us take, for example, two family presentations in the same program. In the first family, the youth is doing very well in school and socially but has some serious concerns about their internal mental state with feeling of anxiety, racing thoughts, and difficulty concentrating. However, they are smart enough to compensate for these internal challenges in school and social settings. The parents are blissfully unaware of their child's internal turmoil. The parents are aware that their child sometimes seems to 'catastrophize' things but are relatively unconcerned given their high functioning. The youth feels like everything could fall apart at any moment. Say, the youth asks to see someone. In this scenario as represented in Fig. 5.1, at the initial contact, the youth's self-report would be quite high (catastrophizing) while the parent report would be very low (minimizing). Successful treatment would move the youth's self-report ratings down and the parent's awareness of their child's needs would grow resulting in high scores at the end of care.

Here is a second familiar scenario. Say the youth is having all sorts of troubles but is in denial that there is anything wrong while the parents are growing increasingly concerned about their child's well-being. In this situation, as represented in Fig. 5.2, the minimizing youth would have a very low self-report at the initiation of the episode of care. The parent, on the other hand, would be rating their child quite high. In this second scenario, successful treatment would result in the parents feeling better about how their child is doing while the youth is becoming aware and ability to 'own' their challenges. The parents



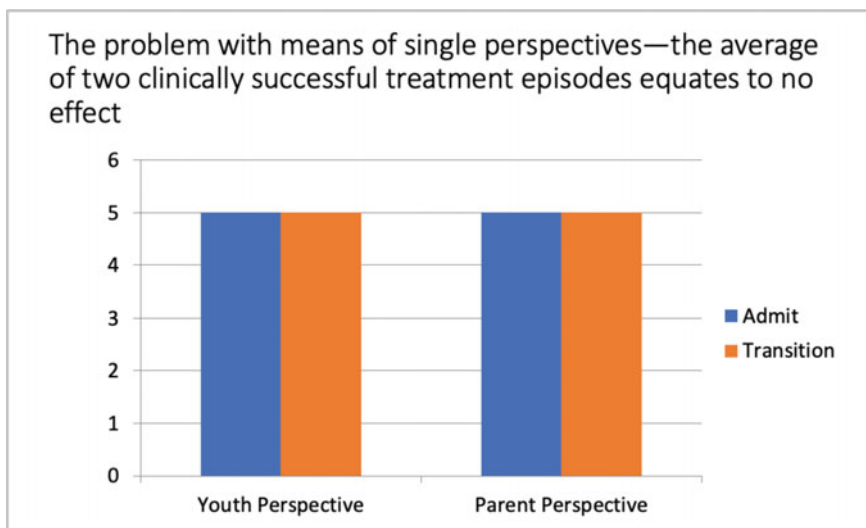
**Fig. 5.1** Clinical outcomes of catastrophizing youth and minimizing parent (*Source* Praed Foundation, 2020)



**Fig. 5.2** Clinical outcomes of a minimizing youth and a catastrophizing parent (*Source* Praed Foundation, 2020)

ratings would go down while the youth self-report ratings would rise over the course of the successful treatment.

Now let us look at what happens when we do a traditional program evaluation of this program. Everyone can likely see that these are two successful cases but when we average the pre-triangulation measures over time, we observe no effect of the program with either youth or parents. Given our reliance on pre-triangulation measurement, traditional measurement schemes can routinely



**Fig. 5.3** Standard program evaluation approach to clinical outcomes (Source Praed Foundation, 2020)

underestimate the impact of treatment in complex multi-perspective situations that are common in most helping sectors (Fig. 5.3).

In communimetrics, the proposition is that by first creating consensus among interested parties, it becomes possible to apply measurement to this shared vision while still honoring the importance of triangulation to the science of measurement. This creates an efficient and effective measurement strategy that captures the complexity of human measurement while supporting the development of rapidly useful measures, in other words post-triangulation measurement (Obeid & Lyons, 2011). The triangulation (gathering of the same information from multiple perspectives) occurs first, honoring this important tenet of science. The measurement then is applied after the triangulation has occurred. It is noteworthy that cliometrics also utilizes a form of post-triangulation measurement although a single observer is doing the triangulation (e.g., Goldin, 1995).

Given the focus on post-triangulation (i.e., consensus) measurement in communimetrics, it is necessary to create a shared vision to be measured. In other words, interested parties have to agree on the level of measurement of attributes. *Post-triangulation measurement is required for person-centered care.*

### ***In Summary: Why We Must Move Beyond Psychometric Theories***

Based on the reasoning expressed above, there are a set of reasons to reject psychometric theory as a workable conceptual framework to facilitate the required measurement within outcomes management of person-centered care

framework. First, as first discussed by Blanton and Jaccard (2006), psychometric theories create arbitrary metrics that challenge easy interpretation. In other words, psychometric measures generate numbers that do not have immediate or clear meaning. The arbitrary nature of psychometric measures then requires additional layers of interpretation (e.g., norms) before measurement results can be meaningful. Even then, meaning may not have clear implications for action. For instance, there is no discernible, scientifically valid difference in the actions one would take to treat someone who scores in the 97th percentile on a scale of anxiety versus someone scoring in the 96th or 95th, 94th, or 93rd percentile on that same scale. Well-normed psychometric instruments often provide a level of accuracy that belies meaningful gradations in the interventions needed to address the need or strength being measured by the instrument.

Second, despite the dramatic evolution of philosophy of science in the past century (c.f., Furuta, 2012), psychology has maintained its focus on theories of measurement arising from a Kantian logical positivist philosophy of science. Psychology as a field has pursued logical positivism without appearing to have made any discernible attempt to speak to the implications of century-old measurement paradoxes from physical sciences (such as the ability of quantum phenomenon to have multiple properties, or the paradox that if one measures phenomenon then it necessarily changes a characteristic) for the measurement of social phenomenon. The evolution of measurement in psychology has also remained largely insulated from insights available in both social constructionist thinking (c.f., Kuhn, 1962) and native naturalism (c.f., Laudan, 1990), as well as other efforts to reconcile the relationship between some objective reality and our subjective perceptions of that reality (e.g., Pawson & Tilley, 1997).

Third, Classical Test theory was developed prior to the advent of computers. Item response theory was developed prior to the advances in computing and big data applications in technology. The widespread availability of powerful computers is creating an entire new range of options for statistical analyses. The major advantages of the statistical innovations from the new machine-learning literature are often lost on psychometrics due to the construction of scales using Likert scales. While psychometric measures, of course, can be used in predictive analytics and other machine-learning approaches as can any measure, they create challenges with cut-points. As we will soon discuss, communimetric measures are designed to support binary decision points common in these analytic approaches. In addition, the interpretation of the models is far more straightforward when communimetric measurement is used.

Fourth, the advent of the information culture has begun to democratize access to information and perhaps has even begun to alter what we broadly consider measurement. The very nature of our definitions and use of the concepts of expertise are shifting towards being defined by recipients of service. It is now incumbent upon professionals to communicate information (data) reliably to non-professional audiences.



For these reasons, psychometric theories are simply inadequate to serve the measurement needs within TCOM. To serve more effectively the information needs within this outcomes management framework, we have developed an alternative measurement theory called ‘Communimetrics’ (Lyons, 2009).

## MEASUREMENT AS COMMUNICATION

Others have recognized the limitations of psychometric measurement in applied settings. Perhaps the most widely used alternative measurement theory has been clinimetrics (Feinstein, 1997). Virginia Apgar (1966) created the first clinimetric measure to assess the well-being of newborns during the early stages of delivery. The Apgar is still widely used today. The focus of clinimetric measurement has been the creation of a single item to capture relevant information for a clinician during the process of care. Relevance to the clinical process is the driving consideration in designing a clinimetric measure (Feinstein, 1997).

Over the past decade, we have been working on an alternative conceptualization of measurement that builds from this clinimetric innovation. In this work, we are not primarily considering measurement from a research perspective. We have concerned ourselves with understanding and acting on the measurement of psychological constructs as they are applied in helping enterprises. Specifically we have proposed a new measurement theory called Communimetrics. The shift in conceptualization comes from reconsidering the role of communication in measurement. Communimetrics considers measurement in applied settings to be a structured form of communication.

In Nunnally’s (1976) classic text, he lists communication as *one* of the priorities of measurement. He specifically identifies six important priorities of measurement:

- Objectivity. Through objectivity, another can verify a statement of fact made by one person.
- Quantification. Assigning numbers to observations has two advantages. First, it allows a finer detailed description than would be possible otherwise. Second, it allows different observations to be combined thus creating ability to aggregate experiences.
- Communication. ‘Science is a highly public enterprise in which efficient communication among scientists is essential’ (p. 7).
- Economy. Standardized measurement is generally less expensive than individualized assessments that often take longer and are less consistent.
- Scientific Generalization. Measurement allows us to move beyond a single set of observations to create an understanding of a broader range of experiences.

A careful read of this text reveals that the author considers communication *among scientists* as a primary consideration for measurement. In other words, communication in psychometric theory was seen as serving to support replication and extension of research by other scientists. Beyond the important focus on communication among scientists, no other role for communication has been directly addressed in psychometric theory. Perhaps much like the use of an electron microscope in microbiology, psychometrics is a measurement approach with an exclusive focus on scientific applications. That focus places a limit on the utility of scientific measurement in any public space involving non-scientists.

### *A Story Telling Perspective*

As we have discussed previously, helping requires understanding people's stories. Stories can often be complex with multiple storytellers able to describe some aspects of single person's story. To be effective, helpers must learn how to combine these multiple stories into a single story in collaboration with the person to be helped. This single agreed upon story can then guide decision-making during the process of care. In person-centered care, the person seeking help is to be a full and equal partner in their care. Therefore, person-centered care generally, and TCOM specifically, requires the measurement of consensus-based stories and shared decision-making.

To measure complex multi-perspective stories, the theory of measurement requires more flexible strategies that allow for the development and measurement of a consensus, 'shared vision' and the translation of that shared vision into rapidly useful information for various decision support applications. For this reason, TCOM emphasizes the surfacing of actionable information across sources. For example, identifying what an individual believes is a strength that they display, or a strength that they would like to build, requires information from this individual. It also requires information from others who can observe the strength in action in a natural environment. If observers agree that the individual has this strength in evidence, then a consensus rating is easily obtained. If observers indicate that the strength is in different levels of development than the informant believes or used differently in different environments, then a consensus-based educational process is needed across observers so that everyone can see how the strength either already exists or requires development. The goal is for all to agree on a rating that reflects the status of the strength. The creation of consensus around a rating is likely in and of itself a part of the therapeutic process. The literature on assessment indicates that the collaborative assessment process itself is associated with a modest positive treatment effect (e.g., Maramosh & Kivlighan, 2012). Person-centered care and therefore TCOM, require the measurement of a consensus, a shared vision as reflected in the measurement process. Clearly, from the above discussion, measurement that depends on a constructed, multi-perspective understanding of a person's story is logically far removed from the process

of simply averaging ratings across informants on a questionnaire. This process of consistently constructing and communicating a shared vision requires a theory-based approach to measurement that is different from existing theories of measurement.

Communimetrics is a measurement theory that arises from communication theory and is designed for applications of measurement in helping sectors, particularly as they apply to measuring the stories of people seeking help within these enterprises. First published in 2009, the communimetric theory proposes that the primary purpose of measurement in the information culture is to communicate (Lyons, 2009). As such, measures should be designed with their communication value and action applications as the overarching consideration.

## SIX KEY CHARACTERISTICS OF A COMMUNIMETRIC MEASURE

There are six key design principles that shape the construction of communimetric measures. Design principles have been defined as guidelines that represent the accumulated knowledge of practitioners and researchers. These principles are aimed at assisting future designers to identify strategies that can enhance usefulness, shape perception, increase appeal, and educate users (Lidwell et al., 2003). Each design principle is described and an example provided from its application in the creation and use of the Child and Adolescent Needs and Strengths (CANS), currently the most widely used communimetric measure. Each principle's implication for a fit between clinical practice demand characteristics, innovation features facilitating uptake, and dimensions of big data, is then described.

### *Principle 1: Each Item Is Selected Based on Clinical Meaning and Is Reliable on Its Own.*

In routine practice, helpers must have a comprehensive understanding of the people they serve. However, this information must be organized with efficiency in mind. Clinicians and other helpers routinely report pressing demands on time and attention that require efficient tools (e.g., Hatfield & Ogles, 2004). Items on the CANS (Lyons, 2009) are designed to communicate commonly understood constructs as concisely as possible while using relevant words to create a common language. Specifically, communimetric item banks have been developed through consultation and active engagement of family, advocacy, and professional partners. These collaborative efforts have resulted in the generation of items with face-valid names and easily understandable definitions.

The inclusion of input from multiple user groups facilitates both the understanding of items and ultimately their reliability when collaboratively rated. This item development strategy is most consistent with the concept of content validity, which includes elements of item relevance and representativeness (Lawshe, 1975). For example, different versions of the CANS included

different items selected based on their relevance to treatment planning and outcomes in different circumstances that require attention to different constructs being measured (Lyons, 2009). All the items are structured in a similar fashion creating consistency and interpretability.

Designing communimetric items with active user input and for perceived relevance across groups allows for rapid uptake in both initial implementation and scaling across systems. Because items are developed and selected as part of a collaborative process, persons engaged in the process may perceive ownership of the tool, lowering attitudinal barriers to initial use at the start of implementation. Furthermore, because the measure is designed from the perspective of multiple end users, its application is designed for robust generalizability across health care and human service settings. This provides an innovation uptake advantage in that the measure can readily be integrated into practice and communication workflows. In terms of information production, the use of relevant and reliable items is most likely to generate verifiable information. This allows people to trust and act on the voluminous data that they then encounter.

Put simply, a communication tool is designed to measure the common themes in people's stories. Effective clinical work requires listening to the personal stories of the people seeking help. While all stories are unique, the common themes of those stories are the constructs that clinicians use to guide decisions regarding intervention options. As noted previously, we do not decide how to help based on how people are different; we decide how to help based on how they are the same. The items of a communimetric tool should result in reliable measurement of each of the common themes (constructs) in a specific clinical process of care.

Given the reliance of communimetric measures on the meaningfulness of individual items, Item-level inter-rater reliability is critical for generating concise, meaningful measures of clinical and functional information. Consistent judgments across raters are facilitated by the use of items easily perceived as relevant to the underlying process of helping. To date research on the CANS has documented reliability at the item level supporting the first principle. Anderson et al. (2003) compared CANS that were completed by caseworkers and independently by two non-clinical researchers. Inter-rater reliability was sufficient at the individual item level and 0.81 overall and ranged from 0.72 for problem presentation to 0.85 for functioning on individual subscales. This item-level reliability has been replicated cross culturally (Carson et al., 2011; Liu et al., 2014) and with other communimetric measures (De Jonge et al., 2002). Communimetric measures have been developed for applications such as emergency room decision-making (Cappelli et al., 2012); medical/surgical patients (Huyse et al., 2001), obesity staging (Hadjiyannakis et al., 2016), entrepreneur skill development (Lyons et al., 2021), sickle cell anemia risk (Tanabe et al., 2010), and cochlear implants (Nuess et al., 2018). Communimetric theory has also been used to develop a measure of system pressures

related to child fatalities and other critical incidents in child welfare (Cull et al., 2022).

Further documenting reliability, Lyons et al. (2002) have reported good inter-rater reliability on field audits in a statewide implementation. Given this observed reliability, information at the item level can be used in applications and analyses. Communimetrics borrows this principle from clinimetrics (Feinstein, 1997). In published research with the CANS, individual items have been used both as predictor variables (e.g., Burnett-Zeigler & Lyons, 2009; Cordell et al., 2015) and outcomes (e.g., Ellis et al., 2011; Epstein et al., 2011).

### *The Importance of Meaning*

Rather than relying on statistics to make fundamental measurement decisions, communimetrics starts with meaning as the driving conceptual framework for item selection. An item should be included if it provides meaningful and actionable information to the decision-making process for a particular population. That has important consequences for both the design of measures and the ease of application of these measures.

As an example, in child welfare, fire setting is a rare challenge with less than one percent of children in custody engaging in this behavior. However, this is an extremely dangerous behavior that easily threatens the lives of the child and anyone else involved with that child. In terms of statistical performance, a fire-setting item would not scale well with either of the standard psychometric theories. It is too rare to be relevant from a statistical perspective. Psychometrics would generally not allow the inclusion of this item in a measure unless that measure was only applied to a subset of children at higher risk of fire-setting behavior than the general population of children in care. From a communimetric perspective, given the powerful action implication when that item is present, its inclusion to support effective decision-making is completely justified. Therefore, most child welfare applications of the Child and Adolescent Needs and Strengths (CANS) tool include a fire-setting item (Lyons & McClelland, 2010).

In fact, item selection is the characteristic that most dramatically distinguishes a communimetric measure from a psychometric one. In psychometrics, the definition of a 'good' item is ultimately in terms of that item's statistical relationship with other items. Item-to-item and item-to-total correlations are a key diagnostic in classical test theory. Item difficulty (e.g., endorsement rate) is the common item parameter used in nearly all measures developed using ITR. Items of a communimetric tool are selected based *exclusively* on their meaning. So unlike a psychometric measure which selects items based on the item's statistical performance relative to other items, communimetric tools select items based on whether or not a construct is a unique contribution to understanding the common characteristic among people. In a TCOM context, the items represent the common themes of people's stories. Although all stories are unique, they do have common themes. As mentioned previously, if people's stories were unique then we could never learn from each other and

there would be nothing that we could do to be helpful. We decide how to help based on how different people are the same, not based on how they are different. The items of a communimetric measure from a TCOM perspective represent the common themes to the stories of people seeking help. The use of meaning to select items guarantees immediate face validity and expedites what we have called the ‘utility validity’ of a measure.

The advantage of the meaning-based approach to measurement construction is quite relevant to TCOM applications because it creates a far more flexible approach to how information is collected and used. Traditional measurement theories will require either a separate measure for each construct to be measured or a multi-construct measure with a large number of items. Within this conceptualization of measurement, it is very hard to measure every piece of information which a good decision requires. Further, each separate measure stands alone and must be completed as it is designed. This rule can create very ‘unfriendly’ information gathering processes. Items may be included because they ‘hang together’ with a construct or predict an outcome of interest even if they have no obvious, face-valid connection to the construct of interest. Additionally, the psychometric requirement to measure a construct by using many modestly correlated items can mean that clients are repeatedly asked a series of similar-seeming items. This planned redundancy while creating evidence of ‘reliability’ can create great frustration from the respondent. This frustration can result in assessment processes that are experienced as necessary and important to researchers and statisticians but exasperating or even ridiculous by professionals using the tools and, more importantly, people being served.

Within TCOM, the definition of a good assessment process revolves around a simple guarantee. This guarantee is that the assessment and agreement among all partners result in the construction of the minimum standard of understanding needed to improve on the needs and build or use the strengths of persons being helped. The selection of measurement approaches is guided not by the statistical relationship among items but rather by the meaning of the items to inform good decisions within the context of supporting personal change processes.

***Principle 2: Each Level of Each Item Translates Immediately into Action Levels—Measurement Is Not Arbitrary***

Translation of assessment data into meaningful practice recommendations is facilitated by the use of inherently meaningful metrics. Unfortunately, many, if not most, clinical assessment tools make use of arbitrary metrics. Metrics are classified as arbitrary when:

...it is not known where a given score locates an individual on the underlying psychological dimension or how a one-unit change on the observed score

reflects the magnitude of change on the underlying dimension. (Blanton & Jaccard, 2006, p. 28)

To avoid arbitrary metrics, communimetrics employs a straightforward solution. The only reason for a helper to understand a person’s story is to figure out what might be done to be helpful. Translating the story into a plan of action is the essence of any helping enterprise. Therefore, in communimetrics the levels of all items should translate immediately into action priorities. All communimetric tools utilize scales indicating the level of action currently warranted to develop a strength, build a skill, or address a need. For instance, the CANS measure uses a four-point action rating scale. Although different groups using the measurement theory have developed a number of different action level strategies, the most commonly used action levels for both needs and strengths are provided in Table 5.1

As before, action implications are the key to differentiating levels of an item. Every one-unit change in a rating on a communimetric tool leads to a corresponding change in the type or intensity of action which would need to be taken to address the need or develop the strength. In this case, the action is the inclusion of the item in a strength-based planning formulation used to address needs and develop strengths.

Early on, some people have expressed a concern that simultaneously integrating the evaluation of the level of a characteristic and the priority of action into a single rating makes the rating scale into a tautology. However, judgments often are not a two-step process whereby one first establishes

**Table 5.1** Standard action levels for needs and strengths

<i>Basic design for rating needs</i>		
<i>Rating</i>	<i>Level of need</i>	<i>Appropriate action</i>
0	No evidence of need	No action needed
1	Significant history or possible need that is not interfering with functioning	Watchful waiting/prevention/additional assessment
2	Need interferes with functioning	Action/intervention required
3	Need is dangerous or disabling	Immediate action/Intensive action required
<i>Basic design for rating strengths</i>		
<i>Rating</i>	<i>Level of strength</i>	<i>Appropriate action</i>
0	Centerpiece strength	Central to planning
1	Strength present & accessible	Useful in planning/supports well-being
2	Identified strength	Build or develop strength
3	No strength identified	Strength creation or identification may be indicated

the level of a characteristic and then determines whether action is needed. Rather, clinical judgment is frequently an intuitive and simultaneous process of determining the level based on the perception of the need for action (c.f., Kahneman, 2011). Combining the two constructs into a single rating scale, both reflect how judgments are made and simplify the measurement process. Explicating the factors that require action facilitates rational decision-making (c.f. Kahneman, 2011), enhances the efficiency of consensus-based rational decision-making, and creates a transparent relationship between the measure and the action plan. This transparent relationship between the output of the discovery process and the plan improves communication with third parties (e.g., insurers, state agencies) not involved with the individual agents (i.e., help seeker and helper) directly involved in the helping transaction.

The use of a transparent, action-keyed scale can help engender trust across persons engaged in treatment. Persons involved in the assessment process can see the utility of the assessment process and how assessment leads to their desired intensity and type of supports. The direct applicability of item ratings to treatment planning processes eliminates the need for the use of standard scores or other normed scoring conversion processes. This reduction in complexity may also facilitate the initial uptake of the tool in practice, as it eliminates both the process of converting scores across metrics as well as the process of deciding how an arbitrary metric then translates into meaningful and consistent clinical action. Existing research indicates that ease of measurement is an important consideration in the adoption of measurement tools in front line practice (Morley et al., 2001).

Further, the use of actionable metrics may facilitate buy-in and ongoing use of the tool throughout treatment, as it becomes an extension and record of the impact of treatment on needs and strengths (Peh et al., 2021). Integration throughout the treatment process has become the norm in several large-scale implementations of the CANS, with the CANS routinely updated every 90 days by practitioners and persons served. Across a system, this leads to a very large volume of data. The action-planning scoring used allows for high-velocity data. By velocity, we mean that data can be produced, understood, and utilized quickly.

When paired with the output capability of an information management system, communimetric data can be used to generate individual and group-level decision support information in near real time in a fashion that anyone can interpret without statistical sophistication. Helpers and those to be helped can reach a consensus on status and monitor that status over time to assess the value of different interventions and reach an agreement about transitions. People can access decision-relevant information based on their scope of work in the system. For instance, a practitioner can look to see how many youth with early signs of psychosis that they are serving discharge early from care. A supervisor can look across practitioners' caseloads and identify whether the rate is higher or lower than that of other practitioners serving the same population. A program administrator can look to see if this rate is consistent across



all practitioners in the program, or if there are clusters of practitioners with markedly higher or lower rates of early discharge within this population. A system administrator can look to see how these rates vary across this entire sub-population being served, to identify whether there are policy changes which need to be considered. This means that clinically meaningful characteristics of the population can drive decision-making at policy, procedure, and practice levels simultaneously.

Use of the same person-centered clinical information by every decision-maker in a system can help align decision-making throughout the system around the best interests of persons in care (i.e., the needs and strengths of the people served should inform all decisions regardless of the level of the decision-maker within the system). Alignment of perspective and contingencies across multiple internal and external levels of service delivery contexts has been described as an important driver of adopting and sustaining effective practices (Aarons et al., 2011). This reduction in information and process complexity may facilitate the effective use of a measure, as reduction in complexity generally facilitates innovation uptake (Rogers, 2003).

Communimetric measures are developed to support real-time decision-making at the person level. The use of the action levels creates clear meaning that can readily be mapped into types of interventions and levels of care. When paired with an electronic record system, feedback can be provided which allows for very rapid, targeted use of person-centered information to plan and adapt care. Algorithms or decision support models have been developed and are in use that recommend specific intensities of care, as well as when it may be appropriate to use particular evidence-based treatment elements (e.g., Ebesutani et al., 2017; Chor et al., 2014). Such real-time use of person-centered information is readily achievable with communimetric tools, and consistent with a growing body of research indicating that routine outcome measurement is perceived as helpful by clinicians and clients when it is completed collaboratively and clearly facilitates care planning and progress tracking (e.g., Bickman et al., 2011; among others).

### *Principle 3: Each Item Describes the Person, Not the Person in Care*

A person's current functioning represents how they are adapting to their current environment's demands and supports. An individual who is depressed and suicidal and in a hospital environment with ongoing and frequent monitoring, access to immediate clinical intervention, and an absence of opportunity for self-harm may indeed be free of self-harming behaviors for as long as they are in that intensively monitored, highly supportive environment. Measures that only track whether or not the person has engaged in a particular behavior over a given period may be misinterpreted as indicating that a person does not require supports to maintain that status. Thus, using traditional approaches to measurement, a well-meaning assessor might indicate on a measure of self-harm behaviors that a person has not demonstrated

these behaviors for several months when the only reason such behavior has not been present is the 24-hour level of support provided in the hospital. When this information is provided to another care provider unaware of the person's clinical supports in place to prevent such behaviors, they may conflate the absence of troubling or endangering behaviors with a lack of need for care.

Communimetric measures are designed to incorporate information about the need for supports into the rating of the characteristic. For instance, if a person requires ongoing intensive monitoring to prevent the recurrence of self-harming behaviors, then the 'Self-harm' item is rated a '3', even though no self-harming behaviors may have occurred in the past thirty days. If the same individual who is hospitalized demonstrates in treatment that they have internalized coping strategies to deal with cues which trigger self-harm and is able to apply those strategies when exposed to such triggering cues, then the 'Self-harm' item could now be rated a '1'. This would indicate that a professional would monitor the individual for signs that self-harm required further intervention but would no longer actively treat it. In this case, discharge from hospitalization might be appropriate.

A clear example of the importance of this characteristic would be the use on insulin in the treatment of diabetes. Effective insulin management can keep blood sugars in the normal range and prevent the complications of diabetes. However, you would never argue that a person with diabetes no longer NEEDS insulin in these circumstances. They may perform better on other characteristics such as vascular or ocular functioning, but they still need to take their insulin.

At the macro-practice level, administration of resources in clinical treatment systems also requires the application of this logic in order appropriately make decisions about intensity and level of care effectively. Appropriate matching of supports to an individual's current intensity of need both optimizes fiscal resources and reduces the risk of providing harmful care. The iatrogenic effects of providing high-intensity care to persons with low levels of clinical need have been documented across multiple populations (Lyons, 2004).

Further, for large systems analysis of functional and clinical status, it is essential to decontextualize interventions in place in order to compare people across varying treatment settings. Only using this communimetric process can it be meaningful to compare the status of a person in a residential program or hospital setting with a person in the community. Without this decontextualization, the person in the hospital might be viewed as higher functioning and lower risk than a person in the community simply because of the protective environment of the treatment setting. The lack of consideration of treatment context makes ALL psychometric measures useless for studying outcomes beyond episodes of specific types of care. Movement across programs or levels of care becomes uninterpretable if you are only asking 'how is the person doing' rather than 'what are their needs'.

The communimetric design of the CANS means that a single measure can simultaneously provide decision support (Chor et al., 2014; Epstein et al.,

2015; Israel et al., 2015; Lardner, 2015), quality improvement (Lyons et al., 2004) and outcomes (Effland et al., 2011; Lyons et al., 2003; Weiner et al., 2009). For this reason, the implementation of the CANS has been associated with significant system improvements in multiple states (Lyons, Terry et al., 2001; Lyons, Mintzer et al., 1998; Manley, 2016).

***Principle 4: Culture and Development Are Considered Prior to the Application of an Action Level to an Item***

Contextualization of supports includes consideration of the roles of culture and development in the rating of a person's need for supports. These considerations are consistent with addressing both practitioners' and scientists' concerns about the dangers of normative approaches to determining pathology. The use of culturally responsive frames in the assessment process help persons come to a shared meaning regarding how behavior or emotions are manifesting. Such framing also helps people come to a shared understanding of the need for action in each of the individual's multiple contexts in order to be able to meet the demands of different contexts. A common language must be culturally neutral. The most efficient way to achieve a culturally neutral common language is to understand a person's cultural worldview first and then decide how to be helpful. For example, there are religious practices (e.g., speaking in tongues, conjuring spirits) that if witnessed out of context might be seen as psychotic. Understanding these practices within the appropriate cultural context, of course, they are not psychotic.

If we are to compare people across developmental trajectories, it is important to deconstruct the impact of development from the measurement process as well. Nearly every two-year old has 'anger management' issues. It is a meaningless construct at that age. However, a twelve-year old who acts like a two-year old in terms of anger management clearly has an actionable need on this dimension.

Using a communimetric measures as a decision support and quality improvement strategy in a mobile crisis program, we were able to demonstrate that use of these tools can both highlight important cultural differences and eliminate racial disparities (Rawal et al., 2008). An increasing number of states are using a lifetime approach whereby a core communimetric tool is used across all ages, but specific items turn on and off depending on age and development. Illinois Medicaid's approach is an example of this strategy.

***Principle 5: Items Maintain a Focus on Description, Not Explanation***

The fourth design principle is that items maintain a focus on description, not explanation. The clinical process of generating a shared explanatory model is the work of the collaborative helping process, not the responsibility of the tool. The tool provides a more neutral set of descriptors to which people can ascribe varying theories of change. For instance, a child may have both an impairing

level of anxiety and problems in school performance. A communimetric tool does not ascribe a direction of effects. The child's anxiety may be impairing their school performance. Conversely, their poor school performance may be generating anxiety. In this example, the work of the therapist is to work with the client to bring the most useful theory to bear.

Indeed, unwanted interpretations of conditions can be a source of disruption in the therapeutic alliance (Ackerman & Hilsenroth, 2003). The focus on description better allows for a collaborative understanding of the meaning of clinical information to develop as a process of shared dialogue throughout the course of the assessment. This process has been shown to be associated with a modest positive treatment effect in and of itself (Poston & Hanson, 2010). Shame and blame is in the 'why' not in the 'what'. Therefore, a focus on consensus in the discovery process helps promote consensus and collaboration.

### *Principle 6: Information Must Be Timely in Order to Be Relevant*

The third design principle used in the application of communimetric tools is that the information collected must be timely. Timeliness is about relevance and refers to information about the person's status. This does not mean that a contributor to functioning has to be recent; for instance, a traumatic event that occurred several years ago meets the timeliness criteria only if it affects a person's current or recent functioning (e.g., Adjustment to Trauma). The CANS uses a 30-day rating period in which the rating is based on the relevance of the need or strength in the past thirty days. Other approaches use different time frames based on relevance to the constructs measured. For example, some crisis versions use a 24-hour time since acute status is relevant crisis decision-making.

Timely information facilitates appropriate clinical action. Psychiatric symptoms are more likely to wax and wane over time than to reflect chronic conditions (Kessler et al., 2012). The use of timely information also helps people involved in care experience assessment and treatment planning as relevant to their current situation. Numerous studies have indicated the importance of using timely information in treatment planning and treatment delivery, as psychiatric symptom and syndrome persistence are typically due to recurrence rather than chronicity (e.g., Kessler et al., 2016; Lyons, Mintzer et al., 1998). Because behavioral health disorders are complex biopsychosocial phenomena, changes in aspects of a person's nervous or hormonal systems, perceptions of themselves and others in the world, and environmental stressors and resources may each or together affect a person's behavioral health (Borrell-Carrio et al., 2004). These dynamic factors underline the importance of ongoing attention to multiple dimensions of a person's life context in calibrating care.

The use of timely information also provides an implementation advantage to instruments which have this characteristic. The extant literature indicates that symptom expression in most major psychiatric disorders is fluid across

time (Brent et al., 2009). Further, if an instrument is intended to be sensitive to clinical change, but if the collection of clinical information is not timely, then it is less likely that the intervention will be able to reliably detect an effect as symptoms may have changed before an intervention was provided. Finally, a standard of learning is that feedback should be provided close to the behavior, so using clinical feedback to improve clinician performance requires timeliness.

Timely information requires relatively frequent assessment. Relatively frequent assessment provides continuously updated, high-volume data on the characteristics of persons in care. Large data volume is a prerequisite for ‘big data’ and machine-learning analytic approaches which require large volumes of data to detect optimal and generalizable decision-making patterns. This high-volume data collection’s burden on the clinician is moderated by its usefulness in practice. When data are integrated into the ongoing flow of clinical decision-making, then they can become an asset to practice as opposed to being seen as a liability (Bickman et al., 2011). In this way, the use of the tool in clinical practice and the generation of large data sets for advanced analytics are convergent practices rather than being in tension with each other.

Ironically, the use of standard 30-day rating periods on the original communimetric tools was met with substantial resistance early on. When we first started implementing the CANS and ANSA people kept insisting that we should be using 90-day, six month, or even one year as the rating periods. The rationale for a longer rating period came directly from the pressure to ‘justify service receipt’ as discussed previously. The irony comes from the reality that extending the rating period makes it more difficult to observe change. So in order to ‘prove’ the need for continued care, service providers felt compelled to demonstrate that their care was not working. This circumstance led to some people advocating for the CANS and ANSA as ‘service planning tools’ but not ‘outcome measurement tools’. Justify service receipt with one tool that stays high need. Demonstrate some significant change (but not enough to justify ending care) with a different tool. That rationale is questionable at best.

### *Understanding Time in the Assessment Process*

The use of time frames in assessment processes is important because they recognize the reality that things change in people’s lives. Documenting personal change is fundamental to managing transformational offerings. The point of helping enterprise is to facilitate these changes in the stories of the people helped. Further, just because a person engaged in a particular behavior at one point in their lives does not mean that they will continue to engage in that behavior for their entire lives. The notion that timeframes are critical in defining a person’s status is particularly important within the TCOM framework. If the entire focus of the approach is about defining, measuring, and using information on personal change, then it is critical that the assessment approaches actually have the capacity to document when and on what dimensions change occurs. Traditionally we have understood time in measurement

as defining whether something happened during a specific period. How many days in the past week did you wake up early? How often did you cough in the last 24 hours? This approach to measurement is a challenging when applied to the helping system.

- Sometimes things are happening now that are simply suppressing the expression of a need. For example, a child could be in a 1 to 1 special education classroom because of behavioral problems. Having the 1 to 1 attention controls the child's behavior; however, if they were return to a regular classroom design (or perhaps even a 1 to 5 classroom, their behavior problems would be expected to return.
- Sometimes active interventions are in place to manage the need but have to stay in place otherwise the need interferes with functioning. A person who has major mental illness with psychotic symptoms might be successfully treated using medications. However, if they were to stop taking their medication, the symptoms of psychosis would return.
- Sometimes a person is in an environment that does not allow the expression of a need but they are planning to leave that environment in the near future. A person who is incarcerated may have trouble accessing substances and therefore does not uses illegal drugs will in jail. However, what will happen when this person.

These all are circumstances that commonly happen in helping systems that make traditional measurement solution inaccurate. As discussed earlier, the focus of traditional measurement on a person's status regardless of circumstances can be misleading. The complex interaction between a person and an intervention or treatment context is the reason for the principle 'about the person, not the person in care'. This contextual issue can also affect how we must think about time.

Communimetric measures define time based on the concept of whether it is 'relevant' during the time frame (e.g., 30-days, 24-hours depending on the tool). Thus, the tool expresses whether a need is 'actionable' or a strength 'useful' currently by understanding the current relevance of information about that need or strength. Communimetric measurement focuses on whether a characteristic is relevant in the designated time frame, not whether it happened during that time frame. That is an important contextual characteristic that allows for a more nuance representation of people's stories as the related to what are otherwise arbitrary time frames that exist strictly for the measure and not the purpose of accurately communicating a potentially complex story.

As an example, a man completed suicide at age 35 on May 20th. Years later his eldest son also completed suicide on May 20th, during his 35th year. One might reasonably suppose that if the goal was to prevent suicide in the grandson, we would pay far more attention during the second half of May, particularly in the year in which he turns 35 than we might during a different

month like August or November or even a different year. Alternatively, a serious family history of substance dependence might not be particularly relevant when a child is five but may become relevant when they are 15. Perhaps the simplest example, if a man is using drugs and is arrested and incarcerated for 30 days would any one argue that since he did not use drugs in the past 30 days, would be relevant to his substance use recovery? Of course not. Communimetrics builds in this level of flexible understanding.

Psychometric theories do not.

## MEASUREMENT AND MASS CUSTOMIZATION

Traditional measurement theory has always resulted in a mass production approach to understanding. In other words, a psychometric measure was developed of a specified length and order of the items. Maintaining the same items in the same order is seen as sacrosanct to the reliability and validity of these measures (Nunnally, 1976). The application of this method dictates that you always use the same items and always use the same item order. Failure to follow this protocol would be understood to threaten the reliability and validity of the measure. In this way, consistency of application is considered important and any flexibility would be problematic. Pine and Gilmore (2011) among others would argue that this type of one-size fits all approach actually works at odds with potentiating a transformational experience. One could imagine that someone might have a profound personal experience filling out a standard assessment measure, but it stretches credulity that most people would have such an ‘experience’ for something that was created clearly without them in mind.

It is certainly possible to embed a psychometric measure into a process that could be experienced as individualized. It is also possible to use the results of a psychometric measure to customize the understanding of the person’s needs and strengths. However, the actual process of getting to understanding the person’s or family’s story is best done outside this method of measurement—it requires a conversation. In that conversation, it is important to comprehend what the person understands and how that reflects on how they talk about their challenges and vision for themselves. Traditional measurement strategies simply do not allow the measurement of a story, rather the story must be pulled from the measures. A communimetric measure is designed to be the measure of the story. Communimetrics allows the combination of multiple story tellers into a single story.

Most helping interventions have the following process. A person arrives seeking help. The helper listens to their story. The helper may use specific strategies to discover certain aspects of the story (e.g., questionnaire, lab tests, observation). Often once a person seeks help, other story tellers (besides the person) are identified. Almost invariably, the multiple story tellers tell somewhat different stories. It is the job of the helper to put all of these story lines into a single story. It is that single story that guides any plan to help.

Further, that helper needs to ensure that the person helped agrees with the full understanding of the story. It is their story, after all.

Given its focus on the measurement of stories, communimetrics could be thought about as a measurement application grounded in qualitative research. Qualitative research takes narrative information and then identifies categories of meaning and creates ratings of those categories. People with experience in listening to these narratives and making decisions based on common themes of the stories are used to identify the common themes. Conceptually it might be possible to take a large number of clinical narratives and feed them into a content analyzing software. However, that is likely less satisfying to system partners than becoming personally involved in identifying themes (items).

### AN EXAMPLE: THE CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)

Currently, the most widely used Communimetric measure is the Child and Adolescent Needs and Strengths (CANS, Lyons, 2009). At this writing, there are statewide implementations in at least one sector (e.g., behavioral health, child welfare, justice, education) in 41 states with multiple states having multi-sector statewide implementations (see Fig. 5.4). Upwards of 10 million children and families are described with the CANS each year making it the most commonly used measure in the child-serving system in the United States, and likely, the world. There are applications of the CANS on every continent

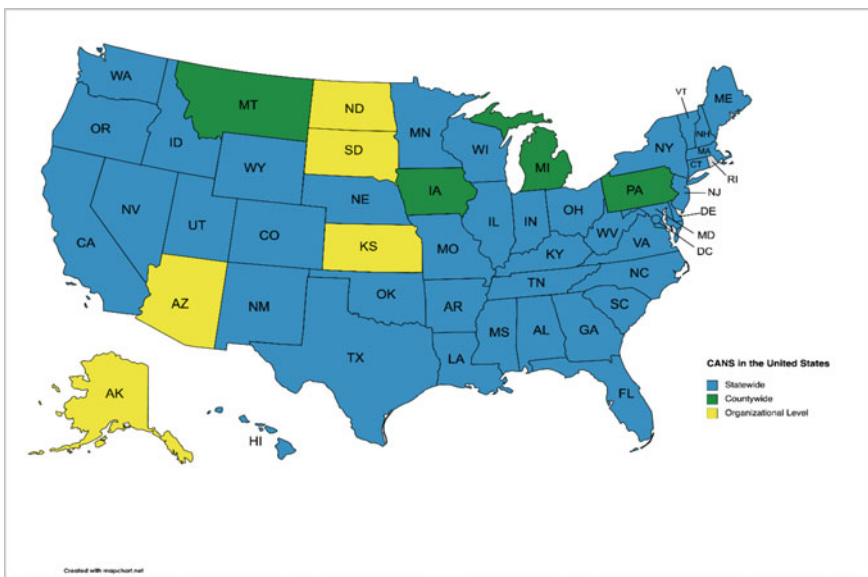


Fig. 5.4 CANS utilization in the United States in 2022



except Antarctica. As the name implies, the CANS is designed to communicate about the needs and strengths of children and families as follows.

### *Defining a Need*

A *need* is a characteristic of a person in the environment that describes a situation in which external assistance could improve that person's well-being. It is the interaction of the person and environment that is key to understanding the presence of a need.

Let's take the example of hunger. The experience of hunger is a personal characteristic. The availability of food is an environmental characteristic. Sometimes I am hungry. When I am hungry, I need to eat. When I then eat, I am no longer hungry. So, I have successfully addressed my hunger by accessing an available resource in my immediate environment. In my life, I am lucky to have both the wherewithal and the means to address my hunger when it arises, therefore I do not have a need when it comes to hunger. If I did not have the ability to feed myself or had no understanding of food preparation, I would go hungry and I would have a need for assistance from another. If I had the wherewithal to feed myself but did not have the means to secure food or food was simply unavailable, then I would go hungry and need assistance from another.

Despite the importance of needs in good decision-making within all helping systems, an understanding of needs alone is often insufficient. Besides understanding the challenges a person is facing within their environmental and cultural context, it is sometimes as important, or even more important, to understand the assets that they bring to their personal journey of change (transformation). We referred to these characteristics as 'Strengths'. Again, with the person-in-environment perspective of TCOM, it is necessary to understand a person's strengths within their unique environmental and cultural context. Given this circumstance, we utilize the following definition of strengths.

### *Defining a Strength*

A *strength* is a characteristic of a person in the environment that describes a situation that promotes meaning and well-being in that person's life. While some strengths are personal characteristics (e.g., musical talent) and other strengths are characteristics of the environment (e.g., family), it is generally the case that it is the interaction of the person and environment that is key to understanding the presence of a strength.

Let us take musical talent as an example. A young person may have the underlying proclivities needed to be a gifted musician. But if those proclivities have not been recognized either by the youth or others, then that gift cannot really assist in creating meaning or well-being for that youth. If the

young person's musical gifts are recognized and supported in their environment (e.g., musical instruments, lessons, opportunities to perform), then it becomes possible for the expression of that strength. As the youth becomes more involved with music the value of that gift to them increases. But without that involvement, the musical gift has no value to the youth.

### *Mass Customization of the CANS*

As discussed earlier, TCOM embraces the concept of mass customization in an effort to create initial measurement experiences for people that support a movement towards personal change (i.e., transformation). This concept then must also be translated into the theory of measurement. In order to address the many possible definitions of the 'minimum standard of understanding' inherent in communimetric item selections, there are many versions of the CANS, each tailored to a consensus understanding of the common themes in different programs or applications. In other words, unlike traditional measurement, there does not have to be a single, rigidly applied version of the tool. A helper is less likely to engage a person in a process of positive change if they start by essentially saying, 'I know you don't care about some of these questions, but I'm required to ask you these series of questions in exactly the same order. After you meet my measurement needs we can talk about you'. Of course, nobody says that but the use of a standard assessment battery of always asking the same questions in the same order communicates that sentiment. One of my most fundamental measurement experiences in this vein involved a study I did with James Strain, MD and evaluating the impact of a psychiatric liaison intervention (Strain et al., 1991). In this NIMH funded study, elderly hip fracture patients were the tracer patients to evaluate the impact of a psychiatric liaison on an orthopedic unit. We used standard measures of course and one was the Geriatric Depression Inventory (Lyons et al., 1989). One of the questions on this measure was, 'Do you feel particularly helpless the way you are now?' You can only imagine how enraged some bedbound hip fracture patients in severe pain following surgery became in response to this question. Always asking everyone the same question is nonsense if the goal is creating a helping relationship. Ideally, a helper should facilitate a conversation in which people feel that they have been heard and then organize the information from their stories in a uniform manner to allow comparison. That is mass customization in the process of measuring.

Taking the concept of mass customization further, in different situations, different information must be gleaned from people's stories. At the same time, we need to optimize the ability to compare across sites and ensure robust reliability and validity of individual items within versions.

In the spirit of mass customization, versions of the CANS have been designed for behavioral health, child welfare, trauma, children/youth with developmental challenges, commercially sexually exploited minors. Cross

sectoral versions have been developed that create a common language framework across sectors so that the idea of one child-one story can be realized even in complex situations.

Despite all the variations in item selection, there are a core set of common themes that we have identified that appear to be consistent across nearly all applications of the CANS. They are described in Table 5.2.

The customization then involves adding additional items that are relevant in a specific context. The Trauma version of the CANS includes items for trauma exposure and traumatic stress symptoms. The Autism Profile version adds items for Restrictive Interests and Repetitive Behavior along with additional Speech and Language items. While the common 50 has Delinquent Behavior as an item, if someone works in a juvenile justice environment, they likely need more information including information on compliance with court orders, peer and parental Influences, and seriousness and frequency of the behavior. Since a communimetric tool is designed to be reliable and valid at the

**Table 5.2** Common items on nearly all versions of the Child and Adolescent Needs and Strengths (CANS)

<i>Behavioral/emotional needs</i>	<i>Life domain functioning</i>	<i>Risk behaviors</i>
Psychosis	Family functioning	Suicide risk
Impulsivity/hyperactivity	Living situation	Non-suicidal self-injurious behavior
Depression	Social functioning	Other self-harm (Recklessness)
Anxiety	Developmental/Intellectual	Danger to others
Oppositional behavior	Decision-making	Sexual aggression
Conduct	School behavior	Delinquent behavior
Substance use	School achievement	Runaway
Adjustment to trauma	School attendance	Intentional misbehavior
	Medical/physical	
	Sexual development	
	Sleep	
<i>Cultural factors</i>	<i>Strengths</i>	<i>Caregiver needs and resources</i>
Language	Family strengths	Supervision
Traditions and cultural rituals	Interpersonal	Involvement with care
Cultural stress	Educational setting	Knowledge
	Talents and interests	Social resources
	Spiritual/religious	Residential stability
	Cultural identity	Medical/physical
	Community life	Mental health
	Natural supports	Substance use
	Resiliency	Developmental
		Safety

individual item level it becomes possible to customize versions without sacrificing the reliability and validity of the overall approach. This is very different from a psychometric tool that requires the perpetual use of exactly the same selection of items presented to the respondent in exactly the same order for every implementation of the measure in any context. In psychometric theory, failure to do so threatens the reliability and validity of the measure. That logic is simply not relevant for a communimetric tool. The inclusion of an item is related to its meaning, not to its statistical relationship with other items.

### Summary

The development of the communimetric theory of measurement was fundamental to the development of TCOM as a theory of system change. By creating an action-oriented methodology to integrate multiple perspective into a single assessment, communimetrics provides a measurement framework for the philosophy of person-center care and the strategies embedded in a TCOM approach to helping. Communimetric measurement is critical for taking person-centered care to scale at the levels of supervision, program, and system management as will be discussed in the chapters that follow.

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## Setting the Stage: Establishing and Maintaining a TCOM Organizational

The renowned business consultant Peter Drucker is often quoted as having said, ‘Culture eats strategy for lunch’. Success requires an organizational culture that allows it to happen. For this reason, it is essential to consider organizational factors that should be in place to support the TCOM conceptual framework. Knowledge of implementation drivers are fundamental of any new approach (National Implementation Research Network, NIRN, 2022). NIRN distinguishes among three types of drivers—competency, organization, and leadership. We will discuss competency drivers when we discuss training and support processes. This chapter will focus on organization and leadership drivers.

Over the last several decades, the important role of organizational factors in that organization’s accomplishments has been established and further understood (e.g., Robertson et al., 2002; Wilson et al., 2006). In health care, Donabedian (1988) divided organizational factors into structure, process, and outcome in his important contributions on understanding quality. Structural factors refer to static characteristics of an organization including organizational hierarchies and defined roles and responsibilities. Process factors can be less static and harder to observe as these characteristics relate to how the work is accomplished. Since this early research on organizations, over the past several decades the concepts of organizational culture and climate have been added to allow a more complex and nuanced understanding of how organizations function (e.g., Kurnaedi et al., 2020 among others). While each of these three characteristics can be discussed as stand-alone concepts, they are, of course, interactive. Donabedian’s model continues to be influential in providing a general framework for understand healthcare systems (e.g., Moore

et al., 2015). Before we discuss how these three sets of organization factors pertain to the TCOM, a clear definition of each is required.

## ORGANIZATIONAL STRUCTURE

Organization structure is often represented by an organizational chart that is intended to describe reporting relationships among all employees. In hierarchically organized enterprises, the organizational structure also defines how information is transmitted (i.e., only one layer of the organization at a time) and how decision-making is handled, although it may be unclear from the structure precisely who in the organization has decision authority in what specific area. Organizational structure describes the planned operational nodes or locations for decision-making and accountability. Recent organizational management strategies suggest efficient organizations work to minimize the levels of an organization (e.g., LEAN processes) but there is also pressure to make sure no one person has too many direct reports. Generally speaking, at the top of an organizational chart, no one person should have more than five direct reports. This number sometimes rises at lower levels of an organizational chart with supervisors often responsible for more than ten direct reports from direct care staff. Of course, the higher the number of direct reports, the lower the ability of the direct supervisor to exert direct influence with their supervisees.

In general, it is within the organizational structure that the NIRN organizational driver referred to a ‘Decision Support Data System’ is located. Deciding where information services fits within an organization and integrating the person-centered data products into the day-to-day operations and decision-making of the organization is fundamental to a successful TCOM implementation.

Organizations that structure information services strictly for billing and reporting out data for purposes of compliance will likely struggle in a shift to a TCOM organization.

### *Organizational Process*

Organizational process refers to the actual flow of information and decisions. While the structure of an organization provides a putative way of doing business, the actual act of engaging in the business is all subject processes by which information is communicated across the structure and decisions are made within the structure. While in theory, structure should provide significant guidance for how processes occur, they are often somewhat independent of each other. Process is different from structure. While two organizational charts may highlight the same decision-making role of a supervisor, one supervisor might approach decision-making with supervisees more collaboratively than another.

The NIRN organization driver called ‘Facilitative Administration’ (NIRN, 2022). This driver serves to create policies and processes to support implementation. These drivers also set the tone for organizational climate and culture as described below.

### *Organizational Outcomes*

The traditional use of the word outcomes in this context applies to a very broad set of constructs that may result from various organizational structures and processes. TCOM dramatically narrows the definition of what is considered an outcome to personal change among those who are proposed to be helped by the activities of the organization. The traditional broad definition of outcomes could include organization finances, workforce training and retention and any number of other performance indicators that may or may not be related to the impact of the organizations work on the people seeking help.

Defining outcomes from a person-centered perspective is important for an organization’s journey from a traditional way of management towards a TCOM organization. Understandably, many organizations currently focus on financially focused outcome metrics. Sometimes the focus includes numbers of people served. Only more recently have organizations explicitly shifted their definition of outcomes for focus on personal change. Even those organizations suffer from significant definitional problems with measuring personal change (Lyons, 2015).

## ORGANIZATIONAL CULTURE AND CLIMATE

There are two concepts related to organizational process that have received a great deal of research attention in the past decade (e.g., Ehrhart et al., 2014). However, Kurt Lewin (1939), the famous theorist instrumental in the development of system theory approaches, originally suggested these concepts. Both organizational culture and climate will invariably influence organizational processes by changing the nature of relationships within an organization often despite or because of organization structure considerations.

**Organizational culture** includes an organization’s expectations, experiences, philosophy, as well as the values that guide member behavior, and is expressed in member self-image, inner workings, interactions with the outside world, and future expectations. Culture is based on shared attitudes, beliefs, customs, and written and unwritten rules that have been developed over time and are considered valid. (The Business Dictionary, pg. X)

Simply stated, organizational culture is ‘the way things are done around here’ (Deal & Kennedy, 2000). Alternatively, Edgar Schein (2016) defines culture as

A pattern of **shared basic assumptions** that was learned by a group as it **solved its problems** of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be **taught to new members** as the correct way you perceive, think, and feel in relation to those problems.

Schein's definition is particularly congruent with a TCOM perspective in that it highlights that learning occurs in the context of decision-making with feedback. The key distinction is that TCOM carefully defines the desired feedback—effectiveness supporting personal change. In this conceptualization, if you want to evolve or influence organizational culture then you would work to impact decision-making processes within the organization to make them more person-centered.

As mentioned above, the legendary business consultant Peter Drucker has been attributed by Mark Fields (2006) among others, with saying 'Culture eats strategy for lunch'. This famous quote is used to make the point that while strategy is important, without establishing an organizational culture that supports the strategy, it simply will not be a success. A strong organizational culture is a necessary but insufficient condition for organizational effectiveness.

On the other hand, *organizational climate* is often defined as the recurring patterns of attitudes, emotions, and behaviors that characterize life in the organization. Idalberto Chiavenato (2014) has defined organizational climate as

A set of measurable properties of the perceived work environment, directly or indirectly, created by individuals who live and work in this environment and that influences the motivation and behavior of these people.

Being a bit more stable, organizational culture is likely more tightly aligned with organizational structure and formal policy considerations. Organizational climate, however, is more volatile and often tied to the attitudes, emotions, and feelings of people in the organization. One loud and aggressive 'complainer' or bully in an office can render that office's climate toxic and unworkable. Similarly one charismatic and committed employee can go a long way to establishing a positive and effective climate in an organization. Clearly, leadership has a potentially greater influence over all on organizational climate; however, every member of an organization has some influence on the climate of any workspace. As Derek Sivers (2010) cleverly illustrates in his well-known TED talk, first followers are critical for defining leadership and the direction of climate. A complainer with no follower often falls silent with time. However, given the energy of followers, complaining can dominate the climate of any organization. Since organizational climate is a perception, an individual employee, of course, has the greatest amount of control over their own experience of the climate of their workplace.

**Diversity, Equity, and Inclusion.** I hesitate to make this topic a separate section because these concepts should be embedded in all aspects of everything we do as people. I hope that it is clear that the person-centered, consensus-based approach of TCOM is by its very nature intended to support diverse, equitable and inclusive processes, programs, and organizations. However, given the progress we have made and the substantial work still to be done, it is useful to talk specifically about these concepts together as they influence organization culture and climate.

There is a body of research demonstrating that a diverse workforce promotes organizational performance (e.g., McKinsey & Company, 2018). Further, in public helping sectors, the people to be helped often present with substantial diversity. Having a workforce that reflects the diversity of the population served is likely helpful for both understanding and engaging people in a transformational journey. As is often discussed in this book, the nature of collaboration creates equality of voice while appreciating differences in role and perspective—we are all ‘experts’ in different ways. These values are ideal for supporting equity. Inclusion requires us to have open doors, open minds, and open hearts for all people regardless of the ways in which they might be different from us. Inclusion is the heart of collaboration.

## ESTABLISHING A COLLABORATION ORGANIZATION

As presented in Chapter 4, TCOM has a model of collaboration. From this perspective, the recommendation is for organizations to develop and maintain a collaborative work environment. Review of the TCOM collaboration model (Fig. 6.1) allows us to map these concepts into the current ways of thinking about organizations. The structural components of collaboration fit into how you would create an organizational structure that supports collaboration. The interactional components reflect considerations for building a collaborative organizational culture. The values reflect considerations for a collaborative organizational climate.

Creating a collaborative organizational structure. Eight characteristics could be considered aspects of organizational structure although some also bleed into organization process considerations. Entirely flat organizations are only feasible with very small organizations—economies of scale work against the long-term effectiveness of these non-hierarchical organizations and severely limit growth. Once an organization reaches a particular size, leadership designations are required and clear roles and responsibilities must be defined. These basics are also true of any collaborative organization. However, in a TCOM organization, the expectations are that the leadership role requires the facilitation of collaborative relationship both within that leader’s organization branch and across different branches of the organization chart. Leaders are also charged to define, evolve and maintain an aspirational focus for the organization. Collaboration works best in situation where everyone wins when anyone wins. That is why identifying common aspirations is critical to

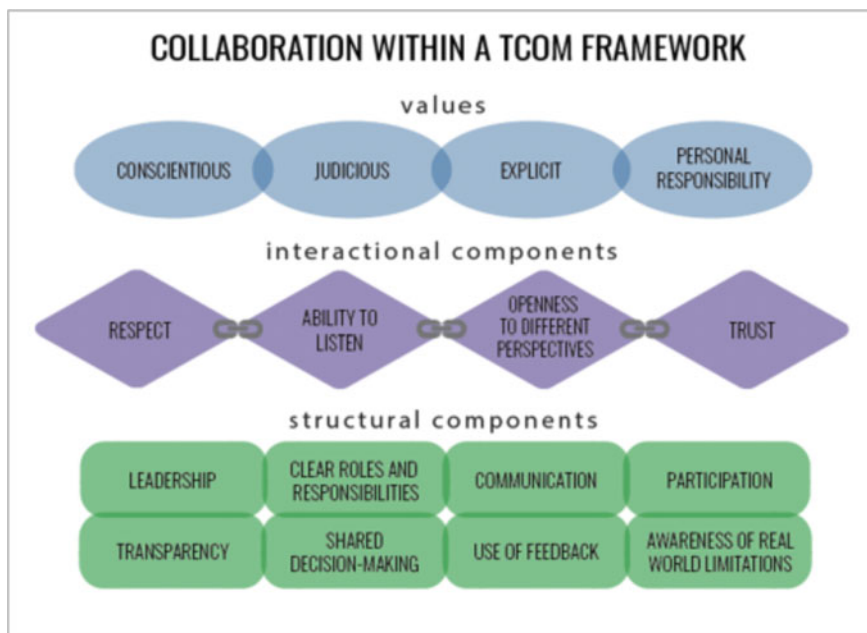


Fig. 6.1 TCOM model of collaboration

sustaining ongoing collaborative relationships. Effective collaboration requires a common purpose and shared aspirations clarify that purpose within a TCOM organization.

Expectations regarding implementing and maintaining collaborative processes should be written into job descriptions. Whether managers and staff behave collaboratively should be included in performance reviews. Feedback loops for information must be built and managed to ensure that they optimize communication about core aspirations. The key to maintaining a collaborative organization is to have the shared vision (aspiration) in the forefront of every activity while simultaneously recognizing and aligning any individual aspirations for each member of the organization.

**Collaborative Organizational Culture.** The key to creating a strong collaborative culture in any organization is inevitably based in the relationships within that organization. Since our focus is on organizations involved in the helping sectors, I have found it useful to remember that all relationships are transformational. Our relationships change everyone in the relationship. The goals are to make these relationships 'therapeutic'. If you think about the type of relationship a professional helper wants to create with anyone they are attempting to help, those same relational dynamics translate to every other relational dyad in our work. We should all be seeking to establish relationships that support others becoming better versions of themselves. That is certainly true of the therapist-client relationship. However, it is also true of the

supervisor–supervisee relationship. In addition, it is equally true in both directions in every relationship. This concept fits in nicely with the ideas of matrix accountability (Lyons, 2004). We are all accountable to each other, simply in different ways. In TCOM that accountability focuses on helping each other be better versions of ourselves in our roles that overlap with each other. The key interactional components of the TCOM model of collaborative are all features of a good therapeutic relationship which is simply to say features of a good relationship period—Trust, Respect, Openness to Different Perspectives, and Ability to Listen.

**Collaborative Organizational Climate** The values of TCOM’s model of collaboration represent the underlying vision for the attitudes and emotions that would be the hallmark of a collaborative organization. People talking ownership and stewardship of their roles and responsibilities. Everyone should work to remain conscientious in their efforts to pursue the common cause of the organization. All decisions should be made in a judicious manner. All communications should be explicit—clear and understandable with follow-up efforts to identify and resolve any miscommunications.

## ORGANIZATIONAL DECISION-MAKING

A core principle of the TCOM framework is that the work of helping involves a series of decisions. The better the decisions, the more effective the help. As discussed previously, unlike an airplane where component parts are integrated with perfect simultaneous communication, helping systems are connections of people. The key ‘components’ of the system over which we have the ability to exert some level of control are the decisions that are made across the system. Understanding and improving these decisions require an approach that embraces the very human nature of helping.

Therefore, it is useful for us to consider what makes good decision-making. We will start with a brief review of factors that consistently lead us to make poor decisions.

## COGNITIVE BIAS AND ORGANIZATIONAL DECISION-MAKING

The important work of Tversky and Kahneman (1974) on heuristics and biases is a great way to understand decision-making in real-world applications. These researchers focused on heuristics that lead to bias in decision-making.

**Fundamental Attribution Error.** Sometimes called the over-attribution error or correspondence bias, the fundamental attribution error is the tendency of people to attribute the behavior of others as due to personality traits while failing to notice situational effects. Anyone who has driven a car and likely had the experience of interacting with someone else’s bad driving (e.g., cutting you off or running a light in front of you) and you likely said or thought ‘What a jerk!’ (or perhaps a somewhat worse characterization). Yet when you engage in the same behavior you readily attribute it to the circumstances of the driving



(e.g., you were rush, had to move over quickly to avoid something else). The challenge of this cognitive distortion is that when mistakes are made in organizations there is a natural tendency to attribute to bad bosses, careless or stupid employees and other just non-helpful dispositional characteristics of the organization's workforce. Such a proclivity interferes in identifying situational causes of mistakes that can then be prevented in the future.

**Confirmation Bias.** This distortion has also been called the 'evaluator's dilemma'. Confirmation bias is the tendency for people to see all new evidence as confirming existing opinions and theories. In a meeting during the early days of implementing communimetric tools, I was describing the approach to a psychologist colleague who has trained in psychometrics. As she grew increasingly agitated in our conversation she first said, 'You just made that up' (somewhat true—I did make it up but not 'just') and then she blurted out 'I'll see it when I believe it'. That is the confirmation bias.

This bias makes change challenging because new evidence tends to be 'spun' to fit the status quo. Confirmation bias in program evaluation refers to the problem that are 'sold' to system partners by convincing them that the program will work. If an evaluator can demonstrate that, yes, the program works the reaction can be 'well of course, we already knew that'. If the evaluation demonstrates that the program does not work like expected then there is often a belief that the evaluation itself was flawed. That is the evaluator's dilemma. Moreover, in worst cases, the confirmation bias then triggers the fundamental attribution error ('that evaluator is a jerk!').

**Selective Attention.** This cognitive distortion refers to the challenge of focus. When we are focused on one set of situational circumstances, we have a tendency to miss or be unaware of other factors that are outside of our immediate attentional focus. If I am working at home and focused on a task, my spouse might say something that I simply do not 'hear'. Having done that more than once, she began to think I had a hearing problem (the fundamental attribution error). We were both surprised when my hearing was tested as normal. Now I need to figure out how to stay aware while focused on work while at home if there is a chance that she will speak to me.

This distortion leads to missing hypotheses for situational factors that contribute to organizational effectiveness. One could consider that the over-used term 'thinking out of the box' is an informal effort to confront selective attention bias. Staying 'in the box' ensures selective attention bias.

**Hindsight Bias.** This bias is also sometimes called creeping determinism or 'knew-it-all-along' bias. Hindsight bias is when people perceive past events as more predictable than they actually were. The 'they should have seen that coming' bias. This bias creates the impression that everyone should also be able to control everything all of the time (thus creeping determinism). Such thinking of course is nonsense but it is easy for the bias to filter into analyses of organization mistakes. Real-time decision support helps moderate this bias by providing a structure for what was known at the time of the decision.

**Severity Bias** This bias generally refers to the tendency to rate employees consistently worse on performance. It is considered the flip side of the leniency bias of always rating employees better. Managers often have a bias in this regard one way or the other. However, perhaps a more important application of this bias is the tendency for organizations that when bad things happen managers will decide to punish behavior that historically had been over-looked. When bad outcomes occur, the standards of behavior sometimes become more severe. It is not just that the behavior was ‘missed’ in real time leading to the bad outcome, it is that the behavior was accepted and sanctioned previously and then when the bad outcome occurs the ‘rules’ suddenly change. This bias makes collaboration in a hierarchical organization very difficult.

**Justification Bias.** This bias was not one of Kahneman and Tversky’s original biases; however, it has been identified in disability employment research (Black et al., 2017) and in my experience, it is a common challenge in helping organizations. This bias is the tendency to create explanatory models that justify prior behavior. In disability research, this phenomenon refers to the tendency of disability recipients to over-estimate their functional impairments in order to justify lower work productivity. However, this bias extends well past the disability field. Many researchers have had the experience of seeing the results of a study and developing a nice theoretical explanation of these results only to discover a flaw in the analysis that leads to the opposite findings. It is remarkably easy to spin an alternative, equally attractive theoretical explanation for the opposite result. That is not true of all research but it happens. In life and at work, when we engage in a specific behavior that results in a bad outcome, the natural tendency is to explain that behavior in a way that ‘justifies’ it to others. The ‘if you were in my shoes you could have done exactly the same thing’ model of explanation.

These biases must be understood, identified, and addressed in any workplace that is committed to continual improvement. Each bias on its own and often these biases on combination create challenges for problem-solving. The primary challenge is that each bias serves to close the mind of individual member of the organization to understand possible factors that impede the performance of the organization. To offset these natural processes, a comprehensive strategy is needed to create an organizational culture and climate that supports learning. For this purpose, safety science represents an emerging field evolving out of high-risk enterprises that has shown considerable promise to facilitate the development of a learning culture (Cull, 2020).

## POSITIVE HEURISTICS

While the original work on heuristics focused on common ways of thinking that create bias, in our TCOM work, we have been developing ‘positive’ heuristics that are designed to support effective decision-making. Rather than focusing on bias and resultant bad decisions, our efforts are to identify easy

to remember ways of thinking that will support effective decision-making in helping enterprises.

The following are examples of heuristics that we have used to facilitate positive decision-making consistent with TCOM.

*You can't manage what you can't measure.*

*Strengths are not opposite of needs.*

*Sometimes you have to slow down to speed up.*

*You can ask almost any question if you do it from a caring perspective.*

*Collaboration manages complexity.*

These are examples of easy to remember ideas that can help guide decisions when working from a TCOM perspective. In order to communicate these heuristics to the TCOM community, we have created videos of these and others to post on 'The TCOM Channel' on YouTube.

## A TCOM TO CULTURE AND CLIMATE—SAFE SYSTEMS

Michael Cull, Ph.D. and the Safe Systems team at the University of Kentucky, Center for Innovation in Population Health (IPH Center) have translated principles of safety science into organization approaches for use in public helping sectors such as child welfare and public behavioral health. One of the key concepts of his Safe Systems approach is reconsidering resilience as a characteristic of an organization or system rather than a characteristic of people in the organization.

Resilience is a concept that has generated considerable interest in the past decade. Dictionary definitions generally include either (1) the ability of an object to reform its original shape after deformation, or (2) the ability to overcome adverse events. Of course, the second definition is the one most often applied in the helping sector. However, on the TCOM tools, we have come to define resilience as the ability to recognize and marshal one's strength to promote health and well-being. In helping fields, the challenge of using the survival definition of resilience is that it sometimes forces us into thinking that the worse the circumstance someone overcame, the more resilient that person. As in 'you have suffered a lot, therefore you are resilient. Which leaves us in the unsatisfying position with someone who needs to build resilience... "You haven't suffered enough. Go out and have bad thing happen to you and you will be resilient". As if, you only have to go through experiencing adverse events to build resilience. "What does not kill you makes you stronger", so to speak. The problem, of course is that sometimes 'it' kills you. Wanting to avoid such dramatic failure is an aspiration of all helpers. As such, we recognize that the standard deviation of resilience is missing a key step between the adverse experience and the ability to thrive despite that experience. Therefore, we use a definition in which resilience is represented as a cognitive and

emotional stance in which one is fully aware of one's assets and it able to call on them when needed to solve problems and continue to move forward.

## RESILIENCE AS A CHARACTERISTIC OF AN ORGANIZATION

When thinking about organizations, similar logic has been applies to professionals and other employees in the helping sector. Building employee resilience has been identified as an organizational priority (e.g., Lawrence, 2018; McFadden et al., 2014). However, in Safe Systems work we consider the ability of the organization to handle adverse experience more than the sum of the resilience of individuals within that organization. This reconceptualization fundamentally changes how we consider building resilience. Instead of placing the responsibility to be resilient and 'tough it out' on individual employees, the idea is that the responsibility for being resilient lies with the organization.

Organizational structures and processes must be created and maintained that help that organization and its employees learn from and adapt to adverse experiences while creating a work environment for employees to thrive. We work to achieve organizational resilience by adapting the work in high-risk industries described as safety science (e.g., Aven, 2014).

### *Creating a Safe Organizational Processes, Culture, and Climate*

Creating a resilient organization requires understanding the complex relationships among the constraints that invariably challenge workplace effectiveness, the importance of identifying the safe boundaries of behavior, and the impact of stress on employees and their decision-making in day-to-day functioning. Figure 6.2 lays out a graphic representation of these complex relationships.

A number of key principles organizations must be understood and adopted in order to create a safe organization that promotes collaboration and learning. Some of these principles can be written into structural considerations, others can be written policies as a part of organizational processes.

However, an organizational commitment from leadership on down to honor these key principles is often required to create the time of sustainable safe organization climate. NIRN (2022) describes the role of leadership in implementation has requiring the ability to use strategies to overcome technical challenges and adaptive strategies. These strategies should be employed to create a safe working culture.

Building off the recommendations of the Agency for Healthcare Research and Quality, Cull (2020) identifies the following are characteristics of a safety culture in an organization.

An organizational culture that:

1. Acknowledges the **high-risk nature of an organization's** activities and the determination to achieve **consistently safe operations**

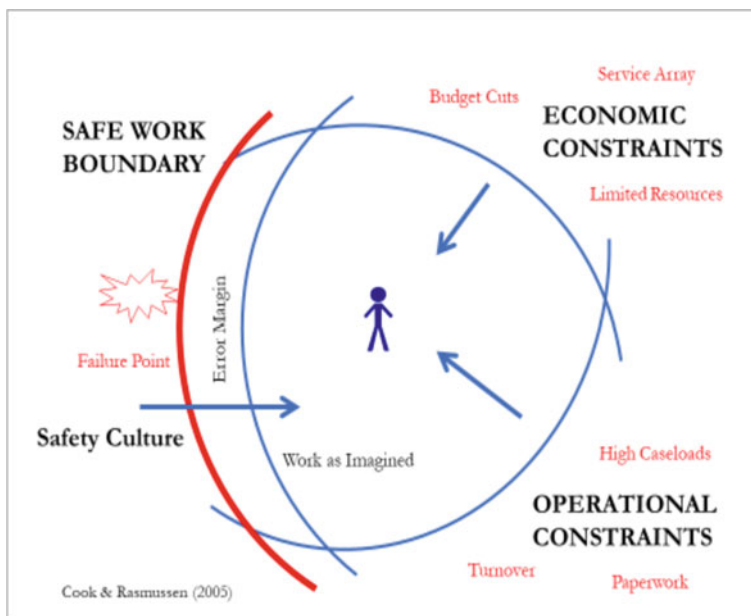


Fig. 6.2 Stress work place safety (Source Cull, 2020)

2. Promotes a **blame-free environment** where individuals are able to report errors or near misses without fear of reprimand or punishment
3. Encourages **collaboration across ranks and disciplines** to seek solutions to problems
4. Commits **resources** to safety concerns

Leadership. There are three key principles for organizational leaders to follow. This includes leadership at all levels of the system from the executive director (ED) to vice presidents (VP), in larger organizations, managers in smaller organizations, to program directors and supervisors.

1. Strive to balance systems and individual accountability.
2. Value open communication, transparency, and continuous learning and improvement.
3. Promote a blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment.

In my book *Redressing the Emperor* (Lyons, 2004), I discussed the concept of matrix accountability. In this way of thinking about accountability, everyone is accountable to every other person in an organization and its clients, albeit in different ways. In an outpatient mental health clinic, the therapist is clearly accountable to their supervisor and their clients. The therapist

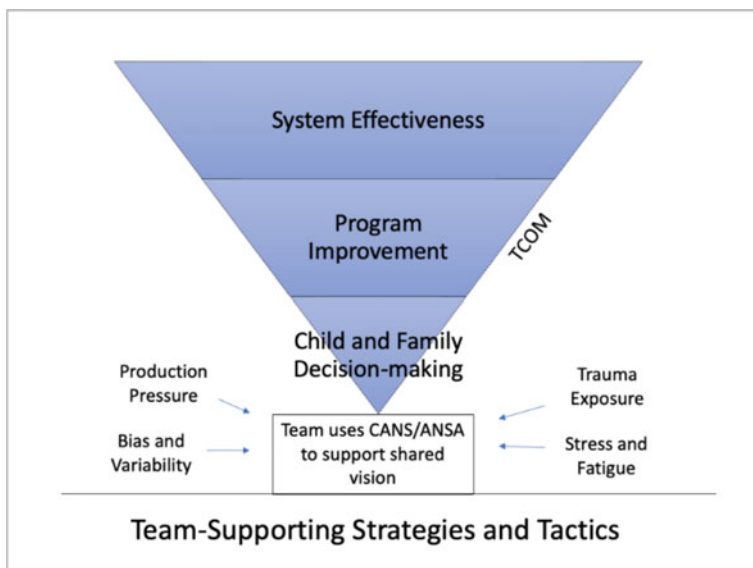
is also indirectly accountable to everyone else in the mental health center since they represent that center and are part of the team. The supervisor is of course responsible to the program director. In addition, the supervisor is also responsible to the therapists to provide effective supervision and to those therapists' clients to ensure effective treatment is provided. All supervisors are also members of the center team and represent that center and, therefore, are accountable to every other employee and client. The program director is likewise accountable as are the VPs and ED. All of these accountability relationships should be managed with respect, transparency, and personal responsibility. Creating mechanisms to support matrix accountability creates organizational processes that support a safe organizational climate. I believe that the best achieve this complex goal is through a focus on aligning aspirations across the organization.

Research in both human and animal learning have clearly and consistently demonstrated that punishment is the least effective strategy for learning (e.g., MacCleod, 2018). There are not too many other finds in the field of learning that are more clear and consistent. Despite this truth, we continue to attempt to use a variety of forms of punishment to enforce compliance to laws, regulations, and organizational policies. We often have little control over how laws and regulations are enforced unless we are elected officials or law enforcement professionals; however, organizations have complete control over their choices regarding using punitive measures to attempt to 'teach people a lesson'.

There are assorted problems with sanctions and other punitive methods to encourage good behavior. First, this approach endorses the severity bias cognitive distortion described above. Clearly, a punishment is only justified if the behavior punished is the problem and that problem is the result of an individual who must be punished. In addition, this feeds the fundamental attribution error. Other people mistakes are attributable to their flaws although our mistakes very well may be explainable by situational factors. Second, instead of suppressing the behaviors that resulted in the punishment, it also tends to suppress the *reporting* of those behaviors. It is difficult to impossible to create a culture with matrix accountability if key behaviors are not reported unless 'caught' by another member of the organization. These strategies create what is often reported in the law enforcement of a 'buddy culture' within partners (e.g., the blue wall of silence) where suppression of mistakes is seen as a means of building trust within the partner dyad. That type of climate eliminates the possibilities of a safe and effective organization Teams also have a responsibility for establishing the organization culture and climate that promotes safety and improvement as shown in Fig. 6.3.

Among the things teams in any organization should emphasize include

1. Monitor themselves, their colleagues, and their system for stress; and
2. Anticipate and respond to unexpected events as a unit. The entire team is responsible for response



**Fig. 6.3** Team-supporting strategies and tactics (*Source* Praed Foundation, 2020)

3. Ensure that any leadership of a team respects all perspectives and ideas offered within the team. Heuristics such as ‘the squeaky wheel gets the grease’ and ‘still waters run deep’ and ‘chain is only as strong as its weakest link’ are each worth remembering in a team context. Open, respectful and transparent communication within the team and between the team and other aspects of the organization are important values of teaming.

Teams can be like families. You may not even like all of your family members but they are still family. Figuring out how to work together in team environments is a skill that comes quicker to some people than others. Just like with a family, the team needs to trust each other both within the team and in each team members’ external communications with others. Others in the organization must be able to trust the team to honor the shared aspirations of the organization. None of this is easy to establish or maintain, particularly with shifting people over time resulting from turnover and promotions. That is why it is so important to ensure that everyone’s individual aspirations remain aligned with the organizational and team aspirations. In addition, that team aspirations align with organizational aspirations. In the absence of such alignments, unintended consequences can result that contribute to failed communication and ineffective operations.

## SUPPORTING A SAFE SYSTEMS CULTURE

The IPH Center's Safe Systems team and collaborators within the National Partnership for Child Safety (NPCS) have developed a set of related strategies to support the development of a Safe Systems culture (Cull et al., 2013; Vogus et al., 2016). Most of the initial work with these tools and strategies has focused on the child welfare sector, which is a particularly high-risk enterprise. However, the approaches could apply, with some modifications to all helping systems. That expansion is ongoing at the writing of this book.

As mentioned previously, leadership has a strong role in the development and maintenance of organizational climate. Leadership who are committed to a safe culture. As discussed by Vogus et al. (2016) leaders can establish an appropriate climate by prioritizing safety above other goals (e.g., productivity) and encouraging workers to speak up and take interpersonal risk (i.e., if you see something, say something as John Lewis famously said). By leaders taking care of organizational employees, those employees are free to take care of the people we help.

## SYSTEMS ORIENTED CRITICAL INCIDENT REVIEW

A TCOM Safe Systems approach to critical incident review looks to shift how an organization thinks about its worst outcomes. Just like with person-centered care, the goal of this review process is to help people move away from traditional ways of thinking about documenting things into developing learning-teaching moments that improve future decision-making. Three major shifts in thinking promote a safety culture.

First, bad events are never considered random events. An attitude that 'Sh#\$! Happens' is not conducive to organization learning. When bad things occur, the event is understood as an emergent property from the system. This way of thinking shifts us away from a mindset that writes off bad outcomes to bad luck into a mindset of curiosity where the goal becomes to figure out what malleable aspects of the organization and situation facilitated the bad outcome.

Second, as with other TCOM approaches, the safety culture perspective remains always forward facing. Unlike a psychological autopsy, which generally focuses on the history of events, a critical incident review is only done to facilitate future decision-making—the focus is always on identifying actionable organizational changes, not assigning responsibility or blame. The review is the *beginning* of the process not the end.

Third, human error is not seen as a cause—it is a symptom. The outcome of a critical incident review should never be to ascribe the mistake to human error. Since all helping organizations are staffed with human beings, ascribing bad outcomes to people making mistakes gets us precisely nowhere. Rather human error is seen as a symptom of the confluence of organizational and situation factors that can be understood and controlled in the future.



Creating a standard way of learning from obvious bad outcomes serves multiple purposes. First, openly using bad situations encourages ongoing transparency even in difficult circumstances. This transparency builds trust and cohesiveness within the organization. Cover-ups are often the biggest threats to transparency and trust. In a safety culture, there is never a need to cover anything up—‘You win some and you learn some’ as the song by Jason Mraz goes. The steps of a critical review are as follows

1. Review the Record—identify possible Key Findings
2. Contextualize—debrief professionals, explore Local Rationality, learn the system factors affecting the case
3. Standardize the output for communication—how will you tell the system’s story?

The key to the TCOM approach to safety culture is through the use of a consensus-based person-centered assessment called the Safe Systems Improvement Tool (SSIT, Cull et al., 2022). Since critical incidents are rare in nature, systematically assessing and measuring the characteristics of these events and sharing those experiences widely in a collaborative format is the key strategy for optimizing learning that can come from particularly bad outcomes.

The SSIT (Cull et al., 2022) is a structured communimetric measure that allows to an output from a consensus-based review of an identified event (Lyons, 2009). Since the SSIT is designed as a system review tool, the key principles have been modified as follows:

### SIX KEY PRINCIPLES OF THE SSIT

1. It is designed at the item level. Each item may inform the development of a plan. Each item is individually reliable and valid.
2. Each item uses a 4-level rating system. Those levels are designed to translate immediately into action levels. For a description of these action levels please see below.
3. The ratings are made for the opportunity for improvement independent of current interventions. So, if interventions are in place that are masking a need/opportunity, the underlying need/opportunity is described, not its status as a result of the intervention. For example, if a work-around has been created to overcome an equipment failure, the underlying equipment failure should be rated.
4. Culture and development are considered before the action levels are applied to account for implicit and explicit bias in decision-making. This characteristic is the mechanism to make a common language culturally sensitive and developmentally informed.
5. Ratings use the influences’ proximity to the incident as an organizing principle to support communication. If there was closeness in time,

distance, or relationship, relevant to the incident and it is reasonable to believe the item had an impact on the incident, a rating of ‘proximal’ is appropriate.

6. It’s about the ‘what’ not the ‘why’. Items are agnostic as to etiology. Items are designed to be descriptive and avoid the controversy that can arise from cause-effect assumptions.

Similarly, the action levels must be redesigned somewhat to capture the intent of the review process. For the SSIT, the action levels are used as shown in Table 6.1.

The use of the concept of proximity in assessing potential system influences is important to this application. Proximal influences must be addressed more rapidly than non-proximal influences so proximity replaces ‘dangerous or disabling’ concept for moving to immediate action with this tool.

The tool consists of 16 items on four dimensions: Professional, Team, Environment, and Problem Statement. In addition, nine items from the FAST/CANS are included to provide specific case context for the review process. This structure allows the SSIT to describe the event simultaneously in terms of the individual(s) involved and the team process in place while contextualizing the describe through environmental considerations. The Professional dimension has six items (Table 6.2), the Team dimension has for (Table 6.3), and the Environment dimension has four items (Table 6.4).

The final scale consists of only on item called *Organizational Recurrence*. This rating captures the likelihood of recurrence of the reviewed event in the context of existing organizational constructs that could mitigate against its recurrence.

**Table 6.1** Action levels for the safe systems improvement tool

<i>Rating</i>	<i>Observation</i>	<i>Appropriate action</i>
0	No evidence	No action needed
1	Latent Factor	Watchful waiting/prevention
2	Influence to Improvement Opportunity (IO) without proximity to the outcome	QI action may be needed to promote best practices in casework. IOs should be tracked over time and/or compared with other quality date before being considered for system-level improvement projects
3	Influence to Improvement Opportunity with proximity to the outcome	QI action to protect against recurrent of critical incidents may be needed. Response could include: providing case level or system-wide education or forming and ad hoc QI team

**Table 6.2** Professional domain of the safe systems improvement tool

<i>Item</i>	<i>Description</i>
Bias	A faulty understanding of a situation due to inherent bias (es) (e.g., confirmation bias, cognitive fixation, focusing effect, transference)
Stress	Unsafe work practices influenced by a psychological strain or tension resulting from adverse or demanding circumstances
Fatigue	Unsafe work practices influenced by extreme tiredness
Knowledge Base	An absence of knowledge or difficulty activating knowledge (i.e., putting knowledge into practice)
Documentation	Absent or ineffective official records
Evidence	Difficulties in obtaining and synthesizing (i.e., summarizing; combining multiple pieces of information into a coherent holistic assessment) externally sourced information (e.g., medical records, criminal records, statements from key members, formal assessments)

**Table 6.3** Team dimension of the safe systems improvement tool

<i>Item</i>	<i>Description</i>
Teamwork/ Coordination	Ineffective collaboration between two or more internal and/or external entities (e.g., agencies, people, and teams)
Supervisory Support	Supervisor provides ineffective support, communication, teamwork, and/or is unavailable
Supervisory Knowledge Transfer	Case direction from supervisor was inconsistent with best practice
Production Pressure	Demands on professionals to increase efficiency

**Table 6.4** Environment dimension of the safe systems improvement tool

<i>Item</i>	<i>Description</i>
Demand/Resource Mismatch	A lack of internal resources or programs (e.g., inadequate staffing, limited access to drug testing supplies, insufficient funding for services) to carry out safe work practices
Equipment/ Technology	An absence or deficiency in the equipment and technology (e.g., communication devices, electronics, and protective safety materials like gloves, vehicles, operability and usability of electronic records management system) used to carry out work practices
Policies	The absence, poor clarity, or ineffectiveness of a written practice or procedure
Training	The absence, poor clarity, or ineffectiveness of formal instruction
Service Array	The unavailability or ineffectiveness of a particular external and/or community-based service to support safe, healthy outcomes for clients (e.g., children and families) or staff

## ORGANIZATIONAL ASSESSMENT

Of course the first priority of TCOM is to support good decision-making at the individual and family level; however, as we have discussed in this chapter, it is also necessary to create and maintaining a work environment that facilitates good decision-making. Since you cannot manage what you do not measure and you cannot measure what you cannot define, it is important to define and measure organizational well-being. The Safe Systems team has developed an organizational assessment for this purpose.

The core of the Safe Systems organizational assessment consists of 19 items assessing three dimensions using a standard psychometric measurement approach. The dimensions are mindful organizing (e.g., Vogus & Sutcliffe, 2007), Emotional Exhaustion (Maslach & Jackson, 1981), and Psychological Safety (e.g., Edmondson, 1999). The core items are found in Table 6.5.

Additional scales have been developed that can be used optionally to create mass customization options for systems and jurisdictions while still honoring

**Table 6.5** Safe systems organizational assessment

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### *Mindful organizing*

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1. When giving a report to another employee, we usually discuss what to look out for
2. My team spends time identifying activities we do not want to go wrong
3. My team discusses alternatives to improve how we go about our normal work activities
4. My team has a good understanding of each other's skills and talents
5. We discuss our unique skills with each other so we know who has relevant specialized skills and knowledge
6. My team talks about mistakes and ways to learn from them
7. When errors happen, my team discusses how we could have prevented them
8. When we attempt to solve a problem in my team, we take advantage of the unique skills of our colleagues
9. When a child and/or family-related problem occurs in my team, we all get together to figure out the solution
  - a. When a problem occurs in my team, we all get together to figure out the solution. (*This question is provided to participants who do not work directly with children and families*)

### **Emotional exhaustion**

1. I feel burned out from my work
2. I dread getting up in the morning and having to face another day on the job
3. I feel emotionally drained from my work
4. I feel used up at the end of the workday

### **Psychological safety**

1. If you make a mistake in our team, it is often held against you
  2. The people on my team value each other's unique skills and talents
  3. Members of my team are able to bring up problems and tough issues
  4. It is safe to take an interpersonal risk in our team
  5. On this team, people are sometimes rejected for having different ideas
  6. It is difficult to ask other members of this team for help
-

the primary measurement considerations of a psychometric measure. These optional scales include: Stress Recognition (i.e., the ability of a respondent to recognize their personal symptoms of stress, Sexton et al., 2006), Safety Climate (i.e., the perceived degree to which leadership pays attention to and values safety), Personal Safety Decision-Making (i.e., a dimension that combines the impact of prior unsafe experiences with the worker's personal thresholds at feeling safe/unsafe). Also, Workplace Connectedness (i.e., the degree to which the respondent feels connected to their team), Workplace Safety (i.e., the respondent's perceived feelings of safety at work) and Intent to Remain Working in Child Welfare (i.e., a behavioral intent scale). At the time of this writing, a Racial Justice dimension is under development. Vogus et al. (2016) report on the reliability and validity of this assessment in a large sample across the child welfare system in Tennessee.

## TOOLS FOR TEAMS

In TCOM, the work of helping begins with the person seeking help as the form a relationship with those who intend to be helpful. Similarly, the work of creating a safe and effective workplace begins with managing the teaming process. For this reason, the Safe Systems team has developed a document to function as a set of 'tools for teams'. They highlight the six habits presented in Table 5.2. Safe and effective teams...

**Spend time identifying what could go wrong.** Teams should always work to plan forward. A primary strategy that is widely used to reinforce this habit is huddles. Small groups of people who are all involved in project, an activity or a short meeting should gather and discuss the event a priori in order to make sure every in on the same page in terms of expectations and desired outcomes. Huddles can be very brief, lasting only minutes but checking in with each other is an important way to sustaining coordinated effort and reducing the impact of potentially conflicting agendas or simple misunderstandings. The literature on huddles suggests that it is best to stand (not sit), keep it under 15 min and starts and ends on time to respect people's time (Cull & Lindsay, 2019). Cull and Lindsay provide a handy pneumonic exists for huddle management:

**PREP**=Prepare, Review and anticipate, Enact, Promote resilience

*Prepare.* Ensure team members have what they need to prioritize case activities (e.g., referrals assigned, case logs, overdue reports). Organize the materials the team needs (e.g., case assignments, family contact logs, overdues, information on any incident reports/new referrals on open cases, etc.)

*Review and anticipate* State the purpose: to update and anticipate o Provide team-level update (e.g., case closures, caseload data, overdue #s) For example, in child welfare, all professionals assigned to work with a family gather before heading into court to summarize the family's status, verbalize concerns,

and project plans for what likely happens next. Huddles also occur before important meetings where the child and family will be present.

*Enact.* Mobilize resources to remove barriers. Expect team members will experience challenges throughout the day. Build individual resilience and team shared meaning with an eliciting/evoking style and closed loop communications.

*Promote resilience.* Close each huddle with a statement that reinforces Safety Culture and promotes resilience.

In addition to huddles, another strategy used for this purpose is sometimes called ‘pre-mortem’ planning. Although there are some very unfortunate aspects of this term as a label for a process, it does dramatically highlight the stakes of thinking through situations and anticipate different outcomes based on varied circumstances. This can be accomplished by imagining the future state (e.g., youth has returned home, person has been hired for a first job, individual has secured independent housing) and then think through different scenarios. Interestingly, the field of dramaturgy, invented by Gottfried Ephraim Lessing in the first century uses a similar process to pre-mortem planning. Dramaturgy is the science of storytelling and understanding the story telling process can help people learn how to do imagine different futures (e.g. Cardullo, 2005). People who write novels and screenplays oftentimes must anticipate future states and imagine pathways to different outcomes before finalizing the plot lines or storyboards that finalize the story of the book, play, opera or movie.

Another excellent strategy to support this stage of create a safe organizational system is using checklists. Although an unnecessary checklist can be experienced as a needless burden, a well-designed checklist can be a very useful strategy particularly in situations with a relative high risk of bad outcomes. Examples of where checklists are useful would be in dispensing medication, moving a child with Type 1 diabetes, welcome a new admission to a hospital or residential unit.

Checklists for safety-critical tasks are crucial, especially in building strong casework practices and remembering relevant details during infrequently conducted, safety-centered tasks.

*Readily Accessible*—if a worker has to go looking for it, it will not be used

*Clear*—no ambiguity in interpreting items on the list

*Concise*—no more words than necessary

*Relevant*—should be only key items placed in an order consistent with the work process

*Easy to Use*—does not require special training or technology

Figure 6.4 presents an easy to remember rubric for creating mindful organizing in any organizational culture. In addition to spending time, teams are encouraged to talk openly and try to learn from mistakes. Similarly, to quality improvement strategies, teams should test out solutions that are proposed.



**Fig. 6.4** Six habit for mindful organizing and psychological safety (Source Cull, 2020)

Although it might sound obvious, establishing good communication and role clarity is often one of the biggest challenges for teams on an ongoing basis. Taking the time to acknowledge and appreciate the contributions of team members individually and collectively is important. Finally, respectful but frank communication is more desirable than trying to ‘be nice’ and not upset anyone. Everyone should know where everyone else stands on any issue of importance to the team.

Although organizational readiness facilitates success in the implementation of nearly everything, it is important that perfect should not become the enemy of the possible. No one can be fully ‘ready’ nor can any organization. Often-times, it is useful to implement person-centered TCOM strategies with the people the system or organization serves and work backwards towards creating a resilient organization. The relationships are not linear. Attention to creating a resilient workplace through organizational strategies is an important aspiration of systems that choose to embrace the TCOM approach to system improvement.

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## TCOM at the Level of the Individual or Family

I spent six years on the faculty of Psychology at the University of Ottawa, a bilingual university. The University's motto was *ce parte dici*, which in English means 'It starts here'. In TCOM, it 'starts' with the individual or family seeking help. In order for the TCOM approach to engineer person-centered care, the full system's attention must be able to have consistent information on the best interests of the individual people served within the system. To have meaningful data at the system level, the information has to be meaningful to every individual person who is directly engaged in the helping process. Direct care helpers and the people they help will only fully and accurately participate in gathering information that they feel is also helpful to them. To honor this reality, TCOM starts with working to make the work and the documentation of the work precisely the same thing.

### OUTCOMES AS ASPIRATIONS AT THE INDIVIDUAL LEVEL

One of the greatest ongoing challenges in the fields of outcomes, performance, and quality management is the definition of these terms. Work on outcomes, in particular, has been fraught with definitional challenges. The term 'outcome' has been applied to access to care (e.g., Feinglass et al., 2014), service utilization and costs (e.g., Jennings et al., 2018; Chaves et al., 2019), mortality (Pietilainen et al., 2022), clinical and functional status (e.g., Sánchez et al., 2014), and consumer satisfaction (e.g., Hudak et al., 2003) among other definitions. Of course, in TCOM our choice is to define outcomes of helping exclusively in terms of personal change (i.e., transformation) that occurs as a putative result of receiving some form of help. Further, we

propose that personal change is best measured using person-centered assessment processes that encourage agreement among multiple partners involved in the helping encounter (i.e., communimetrics). That clear focus still begs the question about what type of personal change in what context should be the focus on our efforts within the TCOM conceptual framework. Significant complexities of outcomes management is that not all interventions anticipate the same impact, so generic measures oftentimes risk underestimating the impact of specific interventions, particularly at an individual level.

Generally, direct care helpers are intuitively and intentionally aspirational in their approach. They ask for, listen to, and understand the goals and objectives of the people they seek to help. They work to respect those individual preferences. Of course, the most effective helpers often try to encourage the people they seek to help to understand and embrace common aspirations as well—health, well-being, not engaging in criminal behavior, and so forth. A number of specific intervention approaches focus on the alignment of individual and common aspirations. Understanding people's aspirations is fundamentally the same as creating outcome expectations or goals on any helping process. In complex circumstances such as justice and child welfare of course, individual level helping requires finding shared aspirations or at least multiple congruent aspirations.

Motivational interviewing can be conceptualized as an effective method of integrating individual aspirations with common or professional goals/aspirations (Lundahl et al., 2010). While motivational interviewing is presented as an intervention to potentiate effective helping, it might reasonably be considered an aspirational management strategy useful in all relationships. The view of helping from an aspirational perspective is not new. Goal attainment scaling was one of the first broad efforts at establishing outcomes in community mental health (Cyntrynbaum et al., 2014; Kiresuk et al., 2014). Wraparound philosophy can be considered aspirational in that youth and families are encouraged to identify their personal goals (Luesse, & Luesse, 2019). Missing in some recent versions of wraparound, though, is the effort to include common goals into the aspirational framework. When John Vandenberg first evolved wraparound into an approach borrowed from Inuit culture in Alaska, the original focus was on strength-based integration of multiple perspectives (VanDenBerg, 1998). That is aspirational management as we conceptualize it within TCOM.

Useful examples of aspirational management in direct care can be found in many sectors. For example, in a program designed to help individuals re-integrate into the community after release from prison would ideally identify each individual's life goals but integrate those goals with the common goal of no getting re-arrested. The aspiration of staying out of prison should be true of all individuals served by the program. The convergence of individual and common goals (aspirations) is likely fundamental to the success of this program. To provide an obvious example, if a person is institutionalized to prison life and actually prefers to return then a post release diversion program

is unlikely to be helpful to that person. The same fundamental dynamic is likely true of all forms of helping.

I once evaluated a ‘Safe Haven’ program that was designed to provide stable housing options for individuals who have proven difficult to serve in traditional housing programs. Mostly these challenges involved the individual not following program rules. The program manager told me a story of a resident who particularly liked the hamburgers that a specific hospital served. This individual was very system savvy and knew what days the hospital would have the hamburgers on its rotating menu (i.e., Tuesdays). The night before, this individual would arrive at the hospital’s emergency department presenting as acutely suicidal in order to be admitted and enjoy the burger. Once learning of this aspiration, the Safe Haven program simply told the person that they would periodically purchase the hospital’s hamburger for him thereby aligning the individual’s goal (i.e., having a favorite hamburger) with one of the common program goals (i.e., preventing hospitalization). While this is a somewhat silly example (although very real if you work in community mental health) that is not possible in many helping programs, it vividly captures the idea the integration (mass customization) of aspirations. Most programs become rule bound and limit the flexibility of intervention to a narrow range of options become increasingly less likely to individual aspirations as the options constrict.

## INDIVIDUAL LEVEL PERSON-CENTERED DECISION-MAKING

To improve customization in programs that become mass production through the ‘routinization’ of practice and policy, person-centered care has been suggested (IOM, 2001). Person-centered care—making people full partners—is facilitated by the concept of meeting people where they are. The TCOM approach provides opportunities to support person-center decision-making at all levels of the system simultaneously. These decision can be organized in the pathway described earlier (Fig. 7.1). The common key decisions points allow us to organize how we think about person-centered decision-making all along a pathway of helping. Thus being person-centered facilitates customization of the work—which some have called ‘precision medicine’ in the healthcare sector (Bresnick, 2018). While these decision points are common across levels of the system, the TCOM approach suggests different strategies to address the



Fig. 7.1 Common decision points on the pathway of helping

common decision points depending on the level. Said differently, supporting effective access decisions is different for an individual than for a program or a system. In the next three chapters, we will review TCOM strategies that have been successfully used within the TCOM collaborative. The present chapter will focus on strategies at the individual level. Subsequent chapters will focus on TCOM strategies at the program/agency, and system level. Each chapter will be organized using the common decision points in Fig. 7.1. In the present chapter, we begin with a discussion of TCOM considerations at the individual (or family level). We start here because this is the foundation of the TCOM theory of change.

## ACCESS

Access to care is the entry point for anyone seeking help. In many helping sectors, the decision here is sometimes driven by the person or family seeking help but in a number of public helping sectors it is also influenced or even controlled by external parties (e.g., justice, child welfare). There are dramatic differences in access processes between helping approaches, programs, and sectors based on the person driving the original decision to seek or refer for help. Regardless, in all helping sectors where public funds are used (and in most where any ‘third party’ funds are used) to pay for help, a regulatory agency provides oversight regarding who is allowed to access the helping system. In most situations, not everyone can access public mental health services, people generally have to meet some basic income or medical necessity criteria. Of course, not every family will access the child welfare system and not every youth will have a probation officer.

The TCOM philosophy when applied to concepts of access focuses on the principles of finding the right intervention for the right person(s) at the right time and in the right amount. This statement is very easy to write. It is easy to say aloud. In it actually quite difficult to engineer these simple decision concepts into an effectively operational helping system. In order to facilitate a feasible operational process, TCOM focuses on easing bureaucratic and administrative burdens and encouraging collaborative decision-making processes. These aspirations are central to addressing the challenges of access to help. As such, there are two essential stages of access that must be considered—person identification and easy of entry.

The first challenge of access at the individual level is person identification. Referrals into different helping options often involve the possibility of either self-identification or identification by some interested helping system partner. Oftentimes, identification is a joint responsibility and expectation. The use of brief screening assessment to identify key themes of people’s story without requiring the entire story is the goal at this phase.

**Building Self-Identification.** Given that self-identification is generally an important access pathway for many helping systems, building awareness between helping options and people who might benefit is a valuable aspect

of access. This awareness could be built in numerous ways. Use of media, both conventional and social are an option to consider for reaching people who may benefit from a particular form of assistance (Farsi, 2021). Traditional ‘word of mouth’ pathways are often the most common whereby people who have been helped by a particular program meet others with similar needs and help build self-awareness. This ‘satisfied customer’ access pathway is commonplace in the private adult mental health system in the United States (Goers, 2018). Embedding strategies to increase awareness and lower stigma in educational settings can be another strategy to enhance self-identification (Levitt et al., 2007). Of course, most medical students that they sometimes experience symptoms of diseases they are studying. What is required to actualize a good self-identification process is a tailored self-assessment strategy followed by professional consultation to determine whether the self-assessment supported the proper personal triage decision. Many community agencies use a phone triage approach where it becomes possible to do a brief interview to reach a person-centered approach to referral. Brief communimetric tools have been designed for this purpose.

When a brief conversation is not possible to guide access, decision support strategies to support enhanced self-identification generally take the form of self-report surveys (e.g., Levitt et al., 2007). The person can answer the questions of the survey at their convenience. A simply scoring approach is provided along with a suggested action depending on the score. The key principles of this approach are that the tool should be clear, concise, actionable, and very easy to use with limited opportunity for respondents to be confused or misled by the language in the survey. Since there is often little to no control exerted on who can complete to survey it needs to be designed for what might be called the ‘lowest common denominator’—everyone should be able to successful use it without becoming confused or misled. The sensitivity/specificity trade off should be weighted based on the risk of the condition to be identified and the potential damage done by a false positive identification of a need that is not real. Face validity is essential because these surveys are best understood as a teaching device to help people understand when a particular type of help might be useful for them.

Recently, Todd Johnson (Johnson et al., 2021) from Washington State worked with us to develop a self-identification strategy based on the CANS for use with school-age youth (Table 7.1). Notice that we modified the action levels to increase clarity for the responding youth. The statements while representing key dimensions and items on the CANS are written in a way that it easier to understand and apply without training or a background in behavioral health. Those principles are keys to successfully supporting self-identification processes.

**Building Other-Identification Processes.** For many helping systems, the process of identification is the responsibility of people other than the person in need of assistance. In most of these cases, the responsible identification agent is a system partner representing a different albeit potentially overlapping

Table 7.1 A simple self-identification tool for school

SCANS  
FOR YOUTH

Date:  
School:  
Student Name:

0 This is not an issue for me.

1 I sometimes worry about this but I don't think I need to do anything at the moment.

2 I think I need to do something about this.

3 I need some help in doing something about this.

My mood getting in the way of my school work.

0 1 2 3

My relationship with classmates and others at my school.

0 1 2 3

My relationship with my teachers.

0 1 2 3

My behavior getting in the way of my schoolwork.

0 1 2 3

My grades.

0 1 2 3

Things at home interfering with my school work.

0 1 2 3

Difficult or bad things happening in my life.

0 1 2 3

0 This is something I'm really on top of. I consider it a strength.

1 This is something that is useful to me at this time.

2 I'm interested in developing this.

3 I'm not really interested in this.

MY STRENGTHS

0 1 2 3

Extracurricular activities

0 1 2 3

Student body leadership

0 1 2 3

Talents/Interests/Hobbies

0 1 2 3

Positive friendships at school or home

0 1 2 3

A career plan


0 1 2 3

Involvement in spirituality or religion

0 1 2 3

Having a positive view of my life

0 1 2 3



helping system or a traditional service system professional. For example, pediatric health care is a common referral pathway into behavioral health treatment for children. In these situations, formal identification processes and referral protocols can support identification.

Ideally, a person should not have to form multiple sequential relationships in order to receive a helping intervention. Recipients of help often describe a process of great frustration from access processes that require multiple re-telling of their story. Sometimes, however, it is simply impossible to have a single agent access process. For example, a school counselor might meet with a youth and discover that the young person has emotional needs that surpass the counselor's abilities to address effectively. While the counselor is the first point of access, final access would be achieved after referral to a mental health specialist requiring the youth to tell their story at least twice to two different people. A family doctor might share the same limitation relative to referral to a specialist. That counselor or physician should make an effective referral to the proper professional, which requires at least a two-agent access process. As another example, if large agencies that serve people with varied presentations of needs, it likely is necessary to have some sort of triage process from the person's initiation of contact to the initiation of help. For example, some community mental health centers use a central intake process with referral to

a program or therapist based on the patterns of needs identified during an intake assessment process. So although the agency has a single point of access, the triage from that ‘one door’ likely requires meeting multiple agents of the helping agency.

One strategy in TCOM implementations sometimes is to create a process that builds out the full assessment process over time by starting with a small number of items during a screening/triage call or referral and working towards a full assessment using the identical documentation process over time.

The communimetric assessment process starts with a few items relevant to decision-making at the initiation of contact and then additional items are added to build the story as the person passes through different stages of the access process. Training involves encouraging initial access agents to understand that they do not have to require people to tell their entire stories—just enough of the story to help the access agent make the appropriate referral. Agents later in the process can review the assessment documentation to get a strong start on understanding the person’s story before they initiate care.

The first use of this approach was in New Jersey’s system of care (originally called the Partnership for Children). In this model, a brief version of the CANS was used for referral from any referral source to the Care Management Organization that was a geographically defined case management/service broker entity. That brief version was exclusively describing needs with no attention to strengths because referral into the system was based on the presence or absence of needs given the use of Medicaid funding. This ‘Needs Assessment’ (NA) was 42 items. Upon referral to the CMO, a care coordinator was assigned who was tasked with organizing a child/family team meeting. One of the first tasks of this group was to complete a full assessment process resulting in the Completion of the CANS, called the Strengths and Needs Assessment (SNA) in New Jersey. This full assessment was 65 items plus specialty modules with some additional items used when relevant based on the endorsement (rating of 1 or higher) on a set of core items (e.g., Developmental item would trigger a module if there was any level of action required). The 65 core items on the SNA all were also included on the NA. Thus although multiple system partners were involved in the process of accessing care, families were not required to completely re-tell their stories with each new professional that they encountered. Rather, the system was designed to build the family’s story over time where the output of one professional’s effort was the input of the next professional’s conversations with the family.

**Regulatory Control of Access Processes.** Because of our sad history of using inaccurate clinical information to advocate for access to services, funding authorities have increasingly required third party processes to verify eligibility and allow access to various forms of help. For example, the Family First Prevention Services Act (FFPSA) was enacted February 9, 2018, as part of the Bipartisan Budget Act. This groundbreaking legislation was an attempt to shift the child welfare focus from foster care to prevention. One of the proposed strategies involves shifting the federal reimbursement away from higher tiers



of foster care and towards secondary and tertiary prevention. Specifically, the legislation makes an effort to de-scale the use of congregate care. One mechanism they use is the requirement of a third party assessment of the need for a placement in a Qualified Residential Treatment Program (QRTP).

The Act (FFPSA) requires the use of an assessment by a ‘qualified individual’ (QI) for determining the appropriateness of youth’s placement in a QRTP. The QI is a clinician who, in collaboration with the agency and family team, conducts an independent assessment of the youth’s clinical functioning (e.g., needs and strengths) in order to determine the appropriateness of placement in QRTP. This assessment must take place within 30 days of the child’s placement in a QRTP setting, preferably before the youth has been placed in the QRTP setting. The Act also specifies the use of teaming to support placement decisions, the connection between assessments and planning, and the measurement of progress on youth needs while placed in congregate care.

Given its widespread use, the CANS is a common assessment strategy that has been embedded in QI processes in many states. The ideal model is for the CANS to be used in the state’s system writ large. When a possible referral to residential treatment is contemplated, the child’s CANS can be sent to the QI to be verified. A referral decision is made and if the CANS has been adjusted in this process, it can be forwarded to the youth’s next place of care to inform the treatment planning process and facilitate person-centered system communication. It is not recommended for the QI to ‘redo’ the CANS. Children and families already have to tell their stories far too many times to far too many disinterested parties. Efficiency in sharing and building our understanding of a person’s (and family’s) evolving story is fundamental to TCOM.

## ENGAGEMENT

Once a person(s) has initiated care, the next step is to get that individual or family fully involved in the process of care. This process has often been referred to as ‘engagement’. Several processes have been clearly shown to be related to an effective engagement process. Among the most important if these from a TCOM perspective is the use of a consensus-based, collaborative assessment process. The process of coming to an agreement about what needs to be worked on and how those efforts will proceed is fundamental to effective engagement.

As discussed in Chapter 5, the TCOM assessment approach is designed from a storytelling perspective. Conceptualizing problems as separate from people is an important aspect of a storytelling and in narrative therapy approaches. *The person is not the problem. The problem is the problem*, as narrative therapists often say (White, 1988–1989; Epston, 1993). By externalizing problems from people, people’s stories become less blame and guilt ridden and less restrictive (Combs & Freedman, 2012). People can be seen as people and not only their problems but also the possibilities for changing their story or for transformational change is more likely.

Miciak and colleagues (2018) completed an in-depth qualitative study of the factors that are required to establish a therapeutic relationship with a physiotherapist. These authors identified the following four conditions as required: present, receptive, genuine, and committed. I would be willing to argue that these conditions are likely requirements for engagement in any effective relation with a transformational helper.

*Being present* as someone tasked with helping others means that the helper is fully attending to the circumstances of the encounter. No distractions. No checking the phone. Paperwork when done during initial encounters can interfere with people feeling like their helper is ‘present’. However, helpers are generally quite busy and paperwork requirements are enormous. Engaging the person or family in a collaborative documentation process (e.g., DiCarlo & Garcia, 2016) whereby they fully participate in a transparent completion of paperwork together with the helper is one strategy to maintain being present while attending to some of the more mundane requirements of helping.

*Receptive* means open to hearing from the people seeking help. This requires asking difficult questions without anticipating or judging answers. Encourage helping professionals to be receptive is one of the reasons the communimetric measurement theory focuses NOT on how information is gathered, rather on how gathered information is organized. Professionals should be unfettered to gather information about people stories in a conversational manner where people are encouraged to disclose at their own pace in sequence.

*Genuine and committed* are characteristics of a helping relationship that helpers can achieve by consistent focus on the best interests of the people that are attempting to help. Getting overly rule or protocol based can interfere with a genuine relationship style. Commitment comes from a communication of a prioritization of the person’s transformational journey rather than a message that the helper is ‘just doing their job’ (and nothing more). Explaining why the helper asks what they ask or does what they do facilitates both of these relational aspirations so helpers need to be very clear in their understanding on the ‘whys’ of their roles in any helping process.

## APPROPRIATENESS

Once care is initiated and the individual or family is engaged in the process of care, the next key decision is matching the help to the needs and strengths of the person(s) served. We call this decision point ‘appropriateness’ to reflect that the task is to personalize care in order to make it sure that the help is appropriate to the specific circumstance. As discussed earlier, the structured TCOM assessment process provides a structure to personalize care while also creating a reviewable documentation process. The structured output of the assessment process using a communimetric measure allows for an equity approach to fairness rather than the traditional equality approach that is the ethical guideline of many programs. The two major decision types within

appropriateness are treatment planning and intensity of care. Although these are overlapping concepts each requires a somewhat different application of information and metrics and, therefore, will be discussed separately.

### INTERVENTION APPROPRIATENESS—TREATMENT PLANNING

In TCOM, using person specific information to generate a personalized plan is how the appropriateness of interventions can be conceptualized. Whether you call it a treatment plan, care plan, action plan, individual education plan, crisis plan, or plan of care (please do not call it a service plan if the intention is transformational), this plan is informed by relevant information about the person's and or family's story. A good plan is by its very nature personalized (not individualized). Personalization allow treatment planning to function within the natural constraints of program structures.

The communimetric person-centered measure is used to establish a consensus understanding of the person's story. However, you cannot move directly from a description of the story into a plan because it is necessary to first develop a theory of change before you can translate the person's story into a plan of action. Said differently, the assessment stage of helping is about the 'what' of people's stories. The intervention stage must be driven by a hypothesis about the 'why' of people's stories. It is best to attempt to intervene on the causes of a person's challenges—not the effects. If depression leads to drinking—treat depression. If drinking leads to depressions—treat the drinking.

The selection of items included in a version of the CANS (or any other Communimetric tool), and the basic structure of the action levels of the CANS are designed to allow it to serve as the output of any assessment process and the input to the creation of the plan—and support building a clear theory of change. As discussed earlier in this book, the selection of items should reflect the information needed to be effective. Therefore, given the design considerations in communimetric measurement, it should be possible to generate a theory of change for millions of possible theories and there would be few possible theories that could not be captured with the items of the correct version.

The action level structure of items allow you to determine whether to include an item in the plan. For needs, any item with a rating of '2' or '3' (referred to as 'actionable' needs) should be considered for attention. Any strength with a rating of a '0' or '1' (referred to as 'useful' strengths) should be considered for strength-based planning. Strengths with ratings of '2' or '3' should be considered for strength-building activities.

A TCOM framework recommends a collaborative process to develop any plan of care. The idea is to use the planning process as a learning-teaching moment between the helper and the helped. The helping professional learns

the person's theory of cause-and-effect and identifies their goals. The professional then uses their training and experience to inform the person about alternative theories of change (i.e., cause-effect). In addition, as mentioned earlier, general aspirations might be included into the plan after the professional's input (e.g., going to school, not using corporal punishment, etc.).

For some needs there sometimes a very clear relationship between what is actionable and what is recommended. For most mental health needs, there are evidence-based and promising practices that should be considered when specific actionable needs are identified. For instance, a rating of '3' on Residential Stability would indicate homelessness and a housing intervention would be a priority for that person in all likelihood. Alternatively, a rating of '2' or '3' on depression would generally suggest that an evidenced-based treatment of depression would be optimal. A number of places provide links between these types of actionable needs and either specific evidence-based practices or the core components model of evidence-informed practice (e.g., Practice-wise which is sometimes known as the Chorpita model) (Ebesutani et al, 2017). That is not always the case. Sometimes things are more complex than they seem in terms of the putative cause-effect relationship among needs and strengths.

In a simple example, suppose a person comes to a housing assistance program because they are homeless. The housing assistance program provides them housing and although they move in and live there for a period, they ultimately lose that housing because the person has a substance use problem that was leading to their housing instability in the first place. On further assessment, it is revealed that the person is using substances to self-medicate symptoms of severe trauma (Pope et al., 2020). By failing to either identify or address the root cause of the homelessness (traumatic stress), the housing assistance program was unable to achieve a positive housing outcome for this individual.

As another simple example, suppose two different people present to a clinic with symptoms of severe depression and loss of employment. Perhaps Person A become very depressed and lost their job while Person B lost their job and as a result became depressed. Should we simply treat depression in both persons A and B or should we treat depression in person A but help person B find another job understanding to do so would resolve their symptoms of depression?

Risk behaviors also often suggest specific theories of change but that theory might be phased depending on the specific action level of the risk. An individual presenting with a '2' on depression and a '3' on Suicide might be effectively treated with Cognitive Behavior Therapy for the depression and a specific safety plan for the suicidality. The safety plan would be used to move the person from a '3' to a '2' on Suicide but the treatment of depression would be proposed to help transform the individual to a '1' or even a '0' on suicide if the CBT is effective on the depression.

Oftentimes a person will present with a number of actionable needs. In these circumstances, it is necessary to organize your understanding of the

needs (and possibly strengths) to inform the target of treatment. Put bluntly, if someone presents with 15 actionable needs, then it is rather unreasonable to assume you could create an action plan simultaneously and individually addressing each of these needs. That would be overwhelming not only to the provider but also to the person(s) seeking help.

Historically, we have attempted to simplify such situations using strategies such as picking ‘a primary diagnosis’ or identifying the top three needs. These types of approaches invariably sacrifice an understanding of the complexity of a situation to achieve an efficiency to the intervention. That is not likely a winning strategy. The development of a theory of change helps organize even complex situations into a manageable plan. A theory of change is created by addressing four fundamental questions as shown in Fig. 7.2.

In this approach, the development of the theory starts with a description of what is happening and then an explanatory model can be created to explain why this is happening. In TCOM, we propose that this explanatory model be considered a ‘working hypothesis’. There are no known causes for most of the problems that the helping sectors attempt to address. For example, there is no known cause for any diagnosis in DSM-V so it is hard to answer the ‘why is this happening’ question with any certainty. It is more constructive to consider this answer as our best collective guess given our current knowledge. The consensus-based process of generating these working hypotheses also engages people in their own transformational journey. Of course, the process of trying to help based on this initial theory will give everyone involved important information about whether the explanation of the ‘why’ is accurate.

Perhaps a simple example would help. I had a sex therapy case during my clinical training. After diagnosing the challenges of sexual intimacy between the married couple, standard and effective sex therapy was initiated. It did not work. On exploration of why sex therapy did not work, I discovered that



Fig. 7.2 Developing a Theory of change

one member of the couple was drinking an excessive amount of alcohol on a daily basis. For males, alcohol inhibits performance and that was the actual explanation of the sexual intimacy problem with the couple. As he sought treatment for alcohol abuse and reduced his intake, his sexual performance returned to baseline (Fig. 7.3).

Proposing any theory of change as a working hypothesis sets up the helper and the helped in a mutual shared exploration into the possible causes. An expert model where the helper announces to the helped that expert's theory sets up the expert for failure if the initial theory proves to be incorrect. Given how little we know about cause-and-effect in most complex helping situations, humility about the theory of change is powerful in keeping people engaged even if initial efforts fail.

We have found that it is helpful to address two other questions in establishing the theory of change—what are our goals, and how do we achieve them? The goals and the route to achieving them often help clarify the explanatory model and provide some insights into potential helping strategies. These components also provide the outcome context to defining when and how we know a helping plan has been sufficiently successful.



Fig. 7.3 Example of an individual level progress report using the CANS in a TCOM framework. Care Coordination

Once an explanatory theory has been generated, it is generally possible to fit together actionable needs into a causal explanation of the individual's circumstances that guide treatment choice. For example, if a youth presented with actionable ratings on Adjustment to Trauma, Anxiety and Self Injurious Behavior, it might be reasonable to propose that the Trauma led to the Anxiety, which led to the Self Injury as an attempt to self-regulate the anxiety. Treatment then would be focused on the Adjustment to Trauma with the idea that successfully addressing these issues would reduce anxiety and the consequent self-injurious behavior. Although If the Self Injurious behavior was particularly dangerous and the Anxiety high (i.e., both rated '3') then the initial plan might focus on controlling the anxiety to reduce self-injury. Once stabilized, the plan can shift to addressing the underlying traumatic stress as the sustaining cause.

In this puzzle-like strategy for using the CANS, it becomes useful to conceptualize actionable needs as either *background/contextual needs*, treatment target needs, or anticipated outcomes. Background needs are needs that are not currently addressable but may shift the pathway down which treatment is provided (Table 7.2).

For example, ADHD might be a treatment target while School Behavior and Achievement would be the Functional Outcomes. In other words, a young boy might have severe ADHD that results in both severe behavioral problems at school and academic problems. Treating his ADHD as a Treatment Target would be anticipated to have a positive effect on both School Behavior and School Achievement. Here is a different pattern of needs placed into this approach (Table 7.3).

In the situation depicted in Table 7.3, the history of sexual abuse and low intellectual functioning set the stage for the treatment approach (trauma informed but consistent with the individual's learning style), The treatment target needs are high levels of Anxiety, problems with Adjustment to Trauma,

**Table 7.2** Understanding needs: Background, treatment target needs and anticipated outcomes

BACKGROUND NEEDS	TREATMENT TARGET NEEDS	ANTICIPATED OUTCOMES
An intellectual impairment of significant trauma experience would often be a background need. Alternatively, if someone has no interest or ability to address a particular need it could be placed in the background.	Needs that are the focus of intervention. These are the putative causes in the theory of change that must be developed for effective planning. <i>Ex: If anxiety is leading to problems with school attendance, anxiety should be the target of treatment.</i>	Needs that would be expected to respond as a result of effectively targeting the treatment needs. These needs are the effects of the theory of change. <i>Ex: Anxiety is treated to address school attendance. If successful in treating anxiety, child should return to going to school.</i>

**Table 7.3** Example using background needs, treatment target needs and anticipated outcomes

<div><div>BACKGROUND NEEDS</div><div><ul style="list-style-type: none"><li>• Sexual Abuse</li><li>• Developmental/Intellectual</li></ul></div></div>	<div><div>TREATMENT TARGET NEEDS</div><div><ul style="list-style-type: none"><li>• Anxiety</li><li>• Adjustment to Trauma</li></ul></div></div>	<div><div>ANTICIPATED OUTCOMES</div><div><ul style="list-style-type: none"><li>• School Attendance</li><li>• Social Functioning</li><li>• Non-Suicidal Self-Injurious Behavior</li></ul></div></div>
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Both of these needs would have treatment components directly addressing them. If treatment was successful one would then expect the reduction of needs involving improved School Attendance and Social Functioning, and reduced Self Injury.

For Strengths, the approach is somewhat different because there are action implications at all four levels of the ratings. Given the structure of these action levels, strengths can be divided into two classes—*strengths to use* and *strengths to build* (Table 7.4).

Here is a straightforward case example provided d by a certified CANS trainer as a part of their process of learning the approach (Table 7.5).

In this example, the developing trainer conceptualized the following organization found in Table 7.6.

In the treatment plan, the clinician would address Dad’s understanding of his son by using Mom to help with the anticipation that successfully educating

**Table 7.4** Strengths to use and strengths to build

<div><div>STRENGTHS TO USE</div><div><p>Strengths that might inform a strength-based approach.</p><p><i>Ex: Using a child or youth’s involvement with a religious organization to help address social functioning issues.</i></p></div></div>	<div><div>STRENGTHS TO BUILD</div><div><p>Identified where no useful strength currently exists (or no evidence or identified as ‘2’ or ‘3’) and the plan is to work with the individual to develop a strength in that area.</p><p><i>Ex: A youth has no identified talents or interests. A discovery process might be recommended to identify and develop an area of interest.</i></p></div></div>
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Table 7.5 Example: Miguel’s story

<p style="text-align: center;">“Miguel”</p> <p>Miguel is a 7-year-old boy with a diagnosis of Autism Spectrum Disorder (ASD). Miguel and his parents Esmerelda and Hector immigrated to the United States 2 years ago. In Mexico Hector was an engineer but he has struggled to obtain employment in his field. He is currently working three jobs including car detailing and food delivery. Hector works everyday two shifts but is off on Saturdays.</p> <p>Esmerelda was a schoolteacher in Mexico. She is currently not working but she has gotten Miguel into a special education program, and it is reportedly going well for Miguel. She has also established strong routines for Miguel both before and after school. Miguel actually does well every day except on Saturday. On Saturday when he is off work, Hector wants to do things with Miguel. However, Dad’s desired activities disrupt Miguel’s routine, and he becomes very agitated and aggressive. When highly stressed Miguel engages in repetitive behaviors that worry the parents. He will also become aggressive and strike out and anyone who he feels threatened by.</p> <p>Dad is experiencing his son as oppositional, which is what has brought the family in for help at the local mental health clinic. Esmerelda and Hector have a strong marriage and are committed to the well-being of their only child. They plan to wait for other children until they feel Miguel has ‘outgrown’ his current challenges. Hector’s brother and his wife live in the area, which is why the family selected this community.</p>
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Table 7.6 Needs and strengths for Miguel

BACGROUND NEEDS	TREATMENT TARGET NEEDS	ANTICIPATED OUTCOMES	STRENGTHS TO USE
<ul style="list-style-type: none"><li>• Developmental/ Intellectual – Miguel’s ASD</li></ul>	<ul style="list-style-type: none"><li>• Caregiver Knowledge – Hector’s understanding of Miguel</li></ul>	<ul style="list-style-type: none"><li>• Oppositional Behavior – Hector’s experience of Miguel as non-compliant</li></ul>	<ul style="list-style-type: none"><li>• Family Strengths – Esmerelda’s clear understanding of how to work with Miguel</li></ul>

Dad would result in his son no longer being oppositional. There is no expectation in this episode of care that anything changes on Miguel’s ASD—that is the school focus. You can see that you can pull the metrics through directly into the plan without sacrificing either specificity or clinical sophistication.

To demonstrate the flexibility of the approach—consider the additional complexity that in a different scenario, Hector is unwilling to accept his son’s diagnosis of ASD and for cultural or individual reasons believes that his son just needs to be ‘set straight’. The clinician can easily shift the treatment plan so that the Treatment Target would be Miguel’s oppositional behavior and through an indirect route she would teach Hector how to manage Miguel’s behavior addressing the Caregiver Knowledge need becomes reframed as Hector not yet knowing how best to manage his son’s behavior. Resolution

of Caregiver Knowledge would be the indirect effect (Anticipated outcome). Perhaps the therapist would use the principles of Applied Behavior Analysis (ABA) to help Hector. Since ABA is used for behavioral management for children on the autism spectrum, the therapist would actually be teaching Hector the proper approach but in a frame of meaning consistent with Hector's perspective.

A slightly more complex example with more actionable needs that required a more sophisticated theory of change can be found in Table 7.7.

If we were to apply the CANS-Comprehensive to Mike's story (Table 7.2), the following Needs would be identified for Mike (ratings of '2' or '3' or in the case of Trauma Experiences the rating of a '1') (Table 7.8).

**Table 7.7** Example: Mike' story

"MIKE"
<p>Mike is a 15-year-old boy who is currently living with his grandparents. He is not in contact with his mother who has a serious substance dependence disorder. The identity of his father is not known. His last contact with his mother was more than five years ago. Over the past three months, Mike has grown increasingly argumentative and disruptive at home and school. He has been suspended one day two weeks ago for fighting. This has involved heated arguing and swearing at several other youth. In one fight, he was seen pushing the youth he with whom he was arguing. Teachers report that his grades have slipped considerably. He has gone from being a B/C student to getting mostly failing his courses this school year. Mike is not in special education. His IQ was recently estimated to be 96.</p> <p>At home, grandmother reports that he starts arguments with her, ignores curfew and sometimes stays out with friends until two or three in the morning. There is no evidence that he has engaged in any criminal behavior. Mike's problems appear to have started after his grandfather had a stroke. Grandfather is better but was left with a partial paralysis that forced him to retire early. Grandmother works at an area grocery store. No other children or adults live in the house, although Mike's aunt, who has five children lives in the neighborhood. Mike is reportedly close to his cousins and spends a lot of time at their house. Mike has expressed interest in moving in with aunt but she is unwilling to take on the added responsibility. Grandparents are currently feeling like they are no longer able to handle Mike's behavior and are asking about foster care or residential treatment options. Grandparents report that they do not understand why Mike is so ungrateful to them for taking him in. Mike expresses worries about the Grandfather's health and resentment about all the restrictions they have tried to place on this behavior.</p> <p>Mike has lived with his grandparents since he was an infant. At that time, child welfare had taken him from his mother due to allegations of neglect. She would leave him alone for long periods and failed to address his basic needs. As an infant, he was significantly underweight. He now is healthy and active. Grandparents are not active in a church and neither they nor Mike have ever attended religious services.</p> <p>Mike reports that he has a girlfriend but has never been sexually active. Mike reports he has been seeing this girl for about 8 weeks. He has a number of male friends at school. His friends have been supportive of him when he has had problems.</p> <p>At the assessment, Mike seemed to be a generally sullen and non-responsive young man. His was dressed in baggy shirt and jeans and listened to a portable cd player until the assessor asked him to turn it off. He answered questions but did not elaborate even when pressed. He reports no suicidal or homicidal ideation. When the conversation turned to talking about Mike's girlfriend his mood brightened notably and he smiled and talked openly.</p>

**Table 7.8** Mikes actionable needs and useful strengths

TRAUMA EXPERIENCES	ACTIONABLE NEEDS	STRENGTHS
<ul style="list-style-type: none"><li>• Neglect, Disruptions in Caregiving/ Attachment Losses</li></ul>	<ul style="list-style-type: none"><li>• Behavioral/Emotional Needs: Oppositional, Anger Control, Adjustment to Trauma</li><li>• Functioning: Family Functioning, Living Situation, Social Functioning, School Behavior, School Achievement</li><li>• Caregiver Needs (Grandparents): Physical, Supervision, Knowledge, Involvement in Care, Family Stress</li></ul>	<ul style="list-style-type: none"><li>• Family Strengths. Interpersonal, Community Life, Natural Supports, Relationship Permanence</li></ul>

These needs and strengths can then be allocated into the five categories described above based on our theory of change for Mike. In this conceptualization, Mike’s history of neglect in combination with his abandonment from by his mother and now his Grandfather’s stroke has created an adjustment to this trauma that is characterized by Anger. Mike’s challenges managing his anger has led to functioning difficulties at home and school. The grandparents have misunderstood Mike’s anger and feel that he is not grateful for all that they have done. They now feel like they might be unable to finish raising Mike. Clearly, a reasonable goal of this family would be keeping them together at least until Mike finishes school and can live independently. Addressing Mike’s anger within the context of his trauma history would be proposed to address his functioning problems. Simultaneously, it would be important to help the grandparents understand Mike’s angry trauma response so that they do not take it personally. They might also benefit from learning some advanced strategies for managing teenage behavior.

Table 7.9 provides a basic treatment plan for Mike based on the theory of change described above. Review of the treatment plan for Mikes demonstrates how you can take 12 actionable needs and two trauma experiences and focus the treatment plan on only four while maintaining an understanding of the complexity of Mike’s situation. In Mike’s case the strength-based approach would be to work to maintain his existing strengths, which all appear to be link to his living with his Grandparents (or possibly aunt) and rebuilding his Family Strengths as a centerpiece, as the Grandparents have lost confidence in their ability to serve in this role for Mike.

INTERVENTION APPROPRIATENESS—LEVEL OF CARE

Decision support models (or algorithms) for level or intensity of care will be discussed fully in the next chapter since most of these approaches are best understand from a program eligibility perspective. However, when these program level models are applied to individuals some considerations must be discussed to optimize the effectiveness of decisions.

**Table 7.9** Treatment Planning Example for Mike

Background Needs	Target Needs	Activities/Interventions	Anticipated Outcomes	Objectives
Mike: Neglect, Disruptions in Caregiving/Attachment Losses Grandfather: Medical/Physical	Mike: Anger Control, Adjustment to Trauma	Mike: Trauma Informed Therapy	Mike: Family Functioning, Living Situation	Mike follows his grandparents' rules at home. Mike does not fight at school
			Mike: School Behavior, School Achievement	Mike identified at least two possible activities or hobbies.
	Grandparents: Knowledge, Supervision	Grandparents: Parent education	Mike: Oppositional Behavior Caregiver: Involvement with Care	Grandparents commit to Mike living with them for one more year.
Useful Strengths	Activities	Strengths to Build	Activities	
Family Strengths Relationship Permanence Interpersonal Natural Supports Community Life Resiliency	Keep Mike with grandparents	Family Strengths Talents and Interests	Positive family activities Interest inventory	

While the TCOM approach to the creation and implementation of decision support models has been demonstrated to be reliable, valid, and effective (e.g., Chor et al., 2014; Lardner, 2015), consideration of the ecological fallacy is important in individual applications of these techniques. In other words, just because overall using TCOM decision models are more effective than not using them, which does not mean that for any given individual we are better off with the decision model. You can infer group statistics to the individual.

The decision models create recommended level or intensity of care referrals and many jurisdiction use these recommendations to guide and monitor decisions in this regard. For example, Indiana's behavioral health system has used algorithms successfully in both the children and adults' system for more than a decade. However, these models always should be considered decision support models, not expert systems. While on average, the application of these models is associated with improved effectiveness, it is important to allow for exceptionality of circumstances when applied to individuals. Rather than having the models decide the referral, we recommend that the model suggests the referral and some other agent makes the final decision while allowing the right of appeal if anyone believes the wrong decision was made. Within the TCOM collaborative, nearly all jurisdictions who use this approach allow appeals and in general between 2 and 5% of cases result in an appeal.

One of the concerns with integrating a common assessment with level of care, placement or intensity of case management, is that this creates an incentive (in a service system) for providers to misrepresent people. While in my experience the great majority of people are honest and try to do their best, there have been situations where that is exactly what happens. We have had situations where a provider enters CANS or ANSA data is given a computer-generated level of care and then they immediately re-enter the case with a changed assessment. It appears they are attempting to complete the assessment

to get a desired level of care rather than understanding the person and drawing resources based on the person's identified needs. While these situations are the exception rather than the rule, when system administrators witness them, they become 'vivid' experiences and in a culture of policy based on intuition and anecdote, these vivid observations sometimes trigger draconian policies that can further decimate the trust within the system. In Chapter 10, we will details a series of strategies that can be used to both mitigate against these circumstances and manage them when they occur.

## INTERVENTION EFFECTIVENESS

Individual level outcomes are substantively quite different from outcomes understood in aggregate. Historically most attempts at reporting individual level outcomes have used the same essential metric with the individual that are used with groups or even systems. From a TCOM perspective, this is both counter-indicated and unnecessary. With of communimetric action levels, it becomes possible to report quantitative outcomes without the process of sacrificing information that is required when information is aggregated over people.

Figure 7.3 demonstrates the types of individual level reports that can be used within a TCOM framework to provide guidance to practitioners on the progress of individual clients. It should be understood that the goal of helping is often not resolving the needs for which people seek help but rather address the functional implications of these needs and develop strengths or assets so that the person is able to learn to live effectively live their best lives despite their ongoing need(s).

One of the first applications of communimetric measures to get significant implementation uptake was its use a case management or care coordination tool. Comprehensive, actionable informant generated by a consensus process, is in fact, a large part of the work of care coordination. Using comprehensive versions of communimetric tools allow case coordinators to keep track of what needs should be address on an ongoing (and updatable) basis. Care coordination is like project management—keeping track of what needs to be done and when it can be removed from the 'to do' list is the job. Using TCOM tools for this purpose always makes the job of the care coordinator easier and more efficient.

When Child Family Teams (CFT, e.g., California Department of Social Services, 2022) or other form of teaming are a component of the care coordination model, the TCOM assessment should be done as an output of the teaming process. It is common practice for a trained professional to meet with a family prior to a CFT and then accompany that family to the CFT and lead a discussion about the CANS or FAST identified needs and strengths. The team then confirms or adjusts the ratings based on their perspective and experiences and reaches a consensus on actionable needs and useful strength to inform the planning process. This provides both a summary of the points of consensus

and a useful post-triangulation measure of the status of the individual or child and family.

## TRANSITIONS/LINKAGES

As discussed beginning in the first chapter, one of the biggest practical difference between a service system and a transformational system in terms of individual level system design is that while, a service system focuses on access, a transformational system attempts to balance access with egress. The front door and back door are of equal importance. You have not completed a transformational process until you are able to say goodbye to the helper(s). In other words, a caring episode is not fully transformational until the episode has ended and the individual or family is able to live their best lives *without* any interventions in place. In TCOM, while engagement is of course still important, it is never an end unto itself.

While there has been a growing emphasis on transitions for the past several decades through concepts of hospitals beginning discharge planning at admission and other efforts to ensure effective linkages and transitions from episodes of care, TCOM adds to the emphasis by suggesting that person-centered information should drive decision-making and planning for the transition process.

Transitions become an increasingly important consideration when a third party (private or public) is the principal source to finance the helping system. If someone is paying for some type of help from their own resources, they should be free to purchase as much of the help over as long of a period as they choose. There are only two parties in these transactions—the helper and the help. Those two parties should be free to decide, barring concerns about ethical or legal constraints on the nature of the ‘help’. When a third party is involved in payment, it raises the complexity of the transaction significantly. We should never have complete control over spending other people’s money. Since duration of course influences costs of care nearly as much as access, managed care, and similar approaches have heightened our attention on transitions from care.

In TCOM the idea is to create an agreed upon consensus clinical and/or functional definition of transition status. If a consensus can be reached a priori on person-centered thresholds for transition and the ongoing assessments are completed with consistent consensus across participating partners, this decision model can generate recommendations for transition from care. The consensus-based approach has the additional advantage of creating positive buy-in and reducing some of the conflict of interest problems that can result when payment is associated with a clinical or functional assessment.

When decision support models are used, a transitional status is considered the same level at the referral status, just working in the opposite direction. For example, a youth and family who exceeded the recommended complexity level for wraparound/intensive community care using the CANS would be

considered ready for transition after they were rated below that threshold on a subsequent CANS—above the threshold to initiate care and below the threshold to transition from care.

Some jurisdictions and/or programs prefer a more cautious approach. In these models, it is required that the consensus assessment remains below the threshold for two consecutive assessments to ensure that gains realized were stable. The needed research has not yet been completed but it would be reasonable to propose that this stably below threshold criteria might be associated with program recidivism.

**Celebrations.** Since TCOM is interested in creating learning cultures, it is important to consider that people remember vivid experiences. Therefore it is important to make success as vivid as possible in order to enhance people's ability to learn from success (their own and others). With individuals and families, celebrations can serve two important purposes. First, they provide an opportunity for review and recognize notable progress that has been made during the episode of care. While the individual or family has lived through this progress, change is sometimes gradual and we all tend to live 'in the weeds' and sometimes lose track of a bigger picture. Taking time to review progress using a communimetric tool is a nice way to create a consensus sense of progress.

The other advantage of celebrations is they can be used to fortify any individual or family's confidence that they can be successful without the helper. Celebrations provide an opportunity to highlight ownership of personal change. 'Congratulations! You did it!' Institutional dependency on external helpers is a failed outcome from a TCOM perspective. Helping people realize that they can continue successfully without additional help is a great message.

Another aspect of celebrations using TCOM tools is also warrants discussion. It seldom the case that either individuals or families eliminate all needs and build all strengths to a centerpiece level. Few people in the world would ever score all '0' ratings on a communimetric measure. We all have needs and very few people have comprehensive and multi-faceted strengths. Celebrations can be used to remind people of the work left ahead for them and to provide an understanding of thresholds that might be used to support a decision to return for additional help or a booster if necessary.

Ensuring that a TCOM implementation works well at the individual level is a key ingredient of a successful overall implementation. The information that is collected in the helping transaction, should be the same information used at the program and system level. If that information has no value to the helpers and helped, over time, it will have no value to the program or system. That is why TCOM *ce part dici*. It starts with the individuals and families seeking help.

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## TCOM at the Program Level

As with the discussion of TCOM at the individual level, it is possible to understand program performance by using the general decision point analysis described in Chapter 7. As we move from considering the individual from a TCOM perspective to considering the program, all that really changes are the metrics that allow us to understanding whether a program is performing optimally at each decision point. At the program level, it becomes necessary to combine multiple people's stories to describe the story of the program.

Therefore, program level metrics are somewhat different from the metrics used for the individual level. However, to remain true to the fundamental premise of person-centered care, it is still the person characteristics, not the program characteristics, that should guide thinking about program performance parameters. Of course, it is also true that program considerations can flavor how specific person characteristics inform performance metrics. At every level, it is always important to create a collaborative environment of working together towards a common purpose. Aspirational management at the program levels shift from a treatment approach to a management strategy to help ensure that collaboration remains always possible.

### ASPIRATIONAL MANAGEMENT AT THE AGENCY LEVEL—SUPERVISION, PROGRAM, AND AGENCY MANAGEMENT

In TCOM, the role of the supervisor is to help the supervisee to become the best version of themselves in their job. Professional development aspects of supervision represent identifying and supporting the individual goals of the supervisee. An effective supervisor integrates these goals into the common goal

of providing effective help for those that the supervisee serves. The common aspiration remains the best interests of the people served by the supervisee. However, now the supervisor needs to understand and align the supervisee's personal aspirations with these common aspirations. The supervisor must also be aware of their own personal aspirations lest they compete or interfere with the aspirations of either the people serve or the supervisees.

The role of program managers is to guide the program to be the most effective program possible. Of course, from a TCOM perspective 'most effective' means the program maximizes its impact on the lives of people served by the program. Other metrics might figure into an overall definition of 'effective' including managing within budget parameters, increasing workforce retention, etc. Program level aspirational management begins to get complex when the program manager must work to align individual employee aspirations with the program aspirations. If the common aspiration of personal change among those served is maintained from supervisor to program manager, this duplication of aspirations facilitates program management. The program manager must also align program aspirations with agency and sometimes system aspirations.

The role of agency leadership is for executive to help the agency become the best version of itself as defined within the context of helping others. However, agency leadership has a significant challenge in terms of aligning aspirations. Alignment at this level is the most complex because, ideally, leadership must understand and align funder and regulator aspirations with agency aspirations and with individual staff aspirations. It is common for agency leadership to bail on this complex alignment and focus on aligning the agency with EITHER funders and regulators OR agency staff. Both of those strategies become problematic over time, of course, with either alienating staff resulting in potential turnover or alienating funder/regulators resulting in potential loss of revenue.

## PROGRAM LEVEL TCOM BY DECISION POINTS

We will seek to understand the TCOM perspective at the program level through the lens of the decision point analysis. People's journey of care begins with access.

### *Access*

Program evaluation from a traditional 'services' perspective has done a great deal of work on issues of access. Access is the most important program process in a service system because as described in Chapter 1 the focus of that system design is about finding people and getting them to show up for services. The big challenge of this essential model of access is that it does not really matter to the service provider whether or not the person accessing care (i.e., showing up) has needs corresponding to the design of the program. As long as caseloads are filled, a program providing 'services' is a winner. A TCOM

perspective on program level access, of course, is somewhat different. Access at the program level means getting the people to show up who are the most likely to benefit from help provided by that program. Filling caseloads is on a successful program from a TCOM perspective.

### *Decision Support Models for Program Referral/Eligibility*

One common application of communimetric tools is decision support models previously called algorithms. In 2021, we dropped the use of the term ‘algorithm’ because of its use by major technology companies to target advertising using predictive analytics. Since TCOM leaves the locus of the decision-making with people rather than statistically derived models, the term ‘decision support’ is more accurate. In other words, we approach the work from a precision analytics rather than a predictive analytics perspective. TCOM decision support strategies are designed to use person-centered information to guide decisions about level of care, intensity of case management, placement, care package, or type of intervention. There is a growing body of research on the validity of these models and to date that literatures demonstrate that using algorithms improves outcome by better matching people to treatment or intensity of treatment (e.g., Chor et al., 2013, 2014; Epstein et al., 2015; Lardner, 2015).

These findings should come as no surprise since it is well known for some time that making decision based on data consistently results in more accurate decisions than those based on clinical intuition or other factors (e.g., Dawes et al., 1989; Garb, 2005; Salisbury, 2014).

The design of decision models starts with a clarification of decision options. In New York State, we designed a decision model for health homes using the CANS that recommended into three different levels of case management intensity. In Indiana and Texas behavioral health, the CANS is used to map into service packages. In Wisconsin, it has been used to recommend intensity of placement or placement or supports. In Texas Child Welfare, the CANS has been used to recommend specific interventions from an array of possible options that are funded by the state. In Tennessee Child Welfare, models support safety, risk, and removal decisions prior to custody and level of care after. The number and range of examples continue to grow.

Ultimately, we want to build systems that take people into programs where there is a met threshold likelihood of a positive outcome. The evolution of machine learning with large datasets is ushering in a time in which such a vision is already theoretically possible and will soon be feasible within the next decade. We recently used machine-learning strategies to identify anomalous CANS assessments as a precursor to develop a targeted audit process to ensure the accuracy of assessments (Cordell et al., 2021). We also recently developed a model that predicted the likelihood of actionable substance use challenges at EXIT from child welfare using ONLY initial CANS assessments (Vsevolozhskaya et al., 2022). While these statistical approaches are exciting, they introduce a range of practical, ethical, and moral considerations that must

be resolved before any implementation. For now, we rely on clinical judgment as the foundation for building decision support models.

Most decision models are designed and implemented at the system level. For this reason, we will delay a full discussion with examples until the next chapter. Some agencies use agency-specific models to create a ‘one door for care’ admission process. In this approach, decision models help with the internal triage program. Similarly, the HEADS-ED is an acute psychiatric decision model for use in hospital emergency departments to triage hospital admissions (Capelli et al., 2012).

### *Engagement*

Engagement is the second key decision point in the TCOM conceptual framework. Pine and Gilmore (2011) argue that a transformational offering begins with a profound personal experience. The business of creating experiences is about honoring the concept of mass customization. Sadly, entry into many helping programs, particularly those that are publicly funded use a mass production approach. In other words, they create ‘intake’ processes that are standardized and staff are taught to take every new clients through the identical paperwork maze. Part of this approach has arisen from the massive (and at times ridiculous) documentation requirements of many publically funded programs. The other reason for this approach is simply the convenience of the helping provider. Considering the concept of mass customization, these standard intake processes are often not experienced as either personalized or welcoming. Therefore, the program is setting itself up from the start to weaken the possible transformational effects of the help provided later by failing to create a positive personal experience for those seeking help at entry into care. In a TCOM program, welcoming policies and processes are designed based on the best interest of the person or people seeking help. They are not designed for the convenience of the helping organization, rather to create a positive sense that the program cares about the person.

In most helping professions, we have thought of engagement as a primarily personal and often dyadic. A therapist engages a client in mental health treatment. A substance treatment provider engages a person in their process of recovery. A caseworker engages a child in child welfare. While there personal relationship is clearly powerful and important in potentiating transformational experiences, we also work in environments in which the professionals change frequently or in which multiple professionals work together in teams. In some public clinics therapists work one year until they are licensed and then move to more lucrative employment elsewhere. Turnover rates in child welfare caseworker positions have been reported between 20 and 40% annually (c.f., Boraggina-Ballard et al., 2021). The duration of person’s experience in the helping system is often far longer than the duration of employment of any of the people who are charged with ‘engaging’ that person. Current business models of seeking to pay direct care staff as little as possible so that more

people can be served work at cross-purposes with our conceptualization of engagement (see Chapter 1).

Absent a major new investment in workforce salaries, this problem is likely to be with us for the near future. So what can we do to facilitate engagement recognizing that personal relationships with professionals are often transient in the public system? One strategy is to broaden our conceptualization of engagement to include institutional engagement. In other words, we consider the relationship of people to be helped to programs and agencies rather than simply the professionals who work in those agencies. Forming a bond between a person and the program and/or agency that is attempting to help offers an additional route to effective engagement that may be less affected by high turnover. If a person feels a meaningful connection to a program or to an agency, then maybe they will keep working with different people in that program or agency.

Of all the agencies I have visited, perhaps the one that does this type of engagement the best is Boystown. Given its well-known history, Boystown, as an institution, has a reputation that transcends the current staff. In talking with youth served in various programs there, it is clear that while they talk about relationships with key staff, they also have a bond with the agency that goes beyond any personal relationships with individual professionals.

Numerous other agencies have similar historical footprints that allow this form of engagement. I was affiliated with the Children's Hospital of Eastern Ontario (CHEO) for six years. CHEO has a long history in the community in the Ottawa region of Ontario that has resulted in a stellar reputation as a caring institution. This reputation buffers against times when individual relationships between professionals and patients and their families are problematic. An organization connected to the community (and not one that just happens to have their office space located there) is likely seen as part of the community, accountable to the community, and is responsive to what happens in the community and members of the community. The staff not only understand the clients, but may live among them.

Of course, one way to help build 'brand loyalty' to a program or agency is through staff who are already committed to that program or agency. Staff who are engaged in their work and share the values and mission of their employer are much more likely to be successful engaging client/customer/patient in the process of personal change. Obviously, happy employees are better at 'branding' a program and agency than bitter or disgruntled employees. If a direct care helper complains to someone being helped about their employer, that likely damages all relationships in that encounter.

Another strategy for establishing what I will call 'institutional engagement' is a history of effective service to others. However, not all agencies have the advantage of long and distinguished histories of caring. What strategies can agency and program leadership use to increase engagement beyond ensuring engaged employees? It is likely useful to look at the research on establishing

brand loyalty as a framework for thinking through this type of engagement. Ryan Westwood writing in *Forbes* magazine provides the following three keys:

1. Your brand should inspire.
2. Your brand should be consistent.
3. Your brand should support your company's core values.

Making it clear that the agency or program is designed for the success of those who seek help and telling the story of that success is important. It is inspirational. Also, ensuring that every professional in the program or agency approaches the work in a similar fashion that is consistent with the values of the program or agency is also important. These three recommendations describe the Boystown approach quite well. It is worth noting that the Aspirational Management as described earlier would also be a mechanism for building brand loyalty. Also in *Forbes*, YEC Women recommends the following seven tips taken from 'The Little Black Book of Billionaire's secrets' (October 25, 2011):

- a. Keep quality high.
- b. Engage your customers.
- c. Solicit feedback from consumers.
- d. Give them a reason to come back.
- e. Stay relevant.
- f. Provide Value.
- g. Show your appreciation.

Perhaps it is clear from these recommendations, how the strategies in TCOM are designed in a fashion that allows a program or agency to address all seven of these recommendations as an essential structure of the core approach to the work of the program or agency. Consensus-based assessment processes to create a collaborative process immediately and stay relevant cover the first five recommendations. This initial consensus-based assessment process should then be followed by the use of personal status information to monitor and celebrate success, demonstrate value, and show appreciation for personal progress. These processes are core to TCOM and address the remaining two recommendations.

Even state agencies should consider this form of institutional engagement. For example, when a state employee decides that the state will make a better parent than the current parents, even if temporarily, the state has the immediate responsibility of engaging that child as their own. That is not simply the child's relationship with their caseworker and foster parent. It is also that child's relationship with the child welfare agency. Helping children and youth seeing child welfare involvement as an opportunity requires a system that is

inspirational and consistent in its application of clear core values. All children would like to be proud of their parents even if that ‘parent’ is a state agency.

As a further consideration of engagement at the program and agency, level is useful to revisit our discussion of mass customization (Pine & Gilmore, 2011). Falling on a continuum from mass production to individualization, mass customization offers a balanced perspective on creating a powerful individual experience—a foundation of engagement—and takes care of the information needs required for a thoughtful match between a persons’ needs and strengths, the helping options available.

### *Appropriateness*

Applications of TCOM principles for this decision generally involve various forms of decision models as discussed above. The previous chapter discussed the TCOM approach to care planning and the next chapter will discuss decision models in depth. The program level falls between these two and so the responsibility of agencies and program when they embrace TCOM is to ensure the full and appropriate implementation of these strategies. Quality improvement activities can be directed at helping people develop optimal plans of care and reviewing cases where decisions were made that we are not supported by the recommendations of decision models. In this way, programs are the locus of implementation of decision support activities and the use of data to improve decision-making over time. The TCOM team is actively working to develop a program level Continual Quality Improvement approach that stays true to the tenets of TCOM/person-centered care.

### *Effectiveness*

Of course, effectiveness from a transformation perspective requires change over time. That might lead us to propose that personal change should be defined based on where they start versus where they finish an episode of help. Yes and no. Conceptually, that definition of personal change is on point. The challenge arises from an understanding how helping encounters work in practice. In truth, helpers seldom get the full story of people’s needs and strengths at the initiation of the helping process. There are a number of reasons for this including (but not limited to):

1. The person was focused on the most salient needs that were leading them to seek help.
2. The person was embarrassed by the presence of a particular need or strength.
3. The person was simply unaware that something was a need or strength.



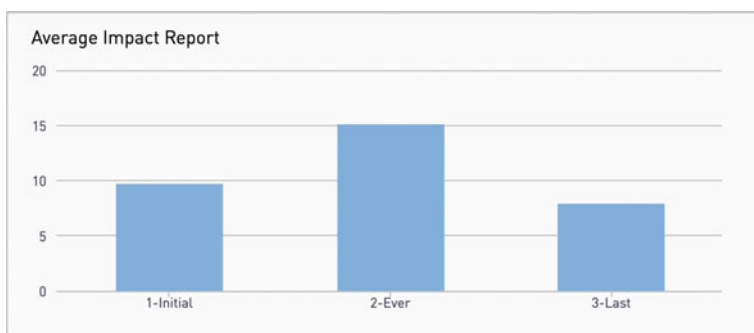
Since trust is not automatic, it builds over time in the relationship. Therefore, it often takes some time for the full story to come out. Since communimetrics do not pretend to divine the truth, it merely represents a consensus understanding of the story, oftentimes second or even third assessment document the presence of needs that were not recognized earlier. This reality does not mean that the person got worse (which is the only possible conclusion from a psychometric perspective).

Given the design of the approach, we recommend using the number of total actionable needs at initial, ever, and last to get a full understanding of the effectiveness of a program.

Strengths are handled differently. The idea of ‘ever’-actionable need is important. This metric is calculated by reviewing ALL assessments and seeing whether a need is ever rated a ‘2’ or ‘3’. Figure 8.1 presents program effectiveness from the ‘YES’ program in Idaho using this approach.

Notice in Fig. 8.1 for all the 10K+ youth who engage in the ‘YES’ program for at least nine months, the average number of actionable needs at enrollment into the ‘YES’ program is about 9. For this same cohort, however, over time an average of 15 needs is identified as actionable during their course of care. However, at end of care, the average for all youth is about seven actionable needs. A pre-post outcome comparison would reveal a 22% reduction in needs. However, a best estimate of the true impact of the ‘YES’ program would be a 53% reduction in need.

The outcome grid in Table 8.1 is a nuanced way for programs to understand the impact of their work at a level that can inform practice change. This is the data from a large residential treatment system for youth. Anger and Adjustment to Trauma appear to involve almost all youth while Psychosis is a relatively small subset. These percentages have implications for program design. Also, note the dramatic rise in identified (actionable) Anger Control and Adjustment to Trauma. When combined with the higher rates of ‘worsening’, this should lead the program to question whether iatrogenic effects are



**Fig. 8.1** Simple outcome report on ‘YES’ program in Idaho as presented on their publicly available dashboard, February 20, 2022

**Table 8.1** Outcomes on behavioral health needs using the CANS

<i>CANS item</i>	<i>% Presenting</i>	<i>% Ever</i>	<i>% Resolved</i>	<i>% Improved</i>	<i>% Worsened</i>	<i>% Transitioning</i>	<i>% Net gain</i>
Anger control	60.2	85.5	47.1	56.1	14.0	42.0	52.5
psychosis	10.9	15.9	70.5	74.7	10.8	7.6	52.2
Adj to Trauma	48.5	70.7	50.1	60.1	15.2	35.0	50.5
depression	48.0	64.5	52.0	55.9	5.3	35.8	44.5
Opposition	49.5	62.4	42.7	50.5	12.5	37.9	39.3
Conduct	29.6	46.3	59.3	66.1	14.6	23.8	48.6
Attention-impulse	49.7	69.7	46.7	55.1	9.1	40.1	42.5
Anxiety	29.5	48.5	50.9	54.1	6.0	25.1	48.2
Substance use	16.0	27.6	55.8	61.1	17.3	15.5	43.8

5248 Youth in a residential treatment episode of care

**Presenting:** The percentage of youth in the cohort that have an actionable need ('2' or '3') at the initial assessment

**Ever:** The percentage of youth who rated actionable at ANY assessment during their episode of care divided by the total number of youth

**Resolved:** The percentage of youth with an actionable rating at initial that is no longer actionable at reassessment

**Improved:** The percentage of youth with an actionable rating at initial that decreased by 1 rating point from initial to reassessment

**Worsened:** The percentage of youth that had a rating of '2' at initial that subsequently had '3' at reassessment

**Transitioning:** The percentage of youth that were rated actionable at initial and exited care with an actionable rating

**Net gain:** The percentage of youth who were ever rated actionable minus the percentage of youth who transitioned divided by the percentage of youth who were ever rated actionable

happening. Are youth becoming angrier during their admission? Have some youth been traumatized during their care?

Depression on the other hand appears to be recognized during residential episodes of care, but youth are less likely to become depressed. Perhaps the programs should work to identify depression earlier in the episode of care. These findings can be disaggregated by gender, age, and race to begin to understand possible disparities.

### *Care Coordination*

Consistent with the discussion above, TCOM tools can be used to help care coordination entities. A primary application is to document what quantity of care needs should be available in their networks and where that care should be located. Patterns of actionable needs are all that is required, although it is also possible to create decision models to further this understanding. For example, it is a common practice when we implement a decision model for residential treatment that we run the model on the existing system in order to check the

number of youth currently placed that may not require that level of care. By applying the same model for youth in community settings, it is possible to identify potential unmet need.

### *Transition*

As discussed previously, a key concept of TCOM is that systems should manage egress with the same intelligence and assertiveness that they manage access. In a transformational system, access and egress are equally important processes. Real transformation has not been achieved until the helper can say good-bye. There are varieties of strategies that can be useful in managing transitions.

**Defining enough change.** A common strategy to guide decision-making around transition from care at the program level is the application of the same decision model used for admission to monitor progress. When individuals fall below the threshold at either one or sequential assessment, transitions are recommended. As with decision support with access, the program level application is generally ensuring that models are implemented, used, and engaged in quality improvement activities around cases around the use of the model and its implementations for program effectiveness.

**Identifying post-episode options.** First, establishing a clear idea of ‘what’s next’ for the help-seeker is important. Oftentimes, the end of one episode of help leads to the person seeking help from a program that continues their journey towards well-being. For example, some form of outpatient care generally follows leaving a hospital. After an episode of residential care, intensive community-based programs are often recommended and so forth.

It is important to inventory and keep current a knowledge of these transition options so that seamless and supported transitions can occur.

## SUPERVISION

Supervision is important for every position in a helping organization. Supervision is a strategy to maintain accountability and support professional development. Many supervision models, strategies, and supports have been developed in the past few decades (e.g., O’Donaghue et al., 2017; Uys et al., 2005). These approaches share many commonalities. Where supervision within a TCOM framework might differ from many of the available alternatives, it is in its focus on teaching with data/information. As discussed earlier in this book, often in service system practice, supervision has devolved into a compliance-based activity. Instead, we propose that when the system is focused on being as effective as possible, then supervisors are in the best possible position to help teach their supervisees how to improve their effectiveness.

In this way, the role of the supervisor as teacher and mentor goes back to the original concept of the role, rather than the compliance and productivity officer who has evolved from decades of service system thinking.

Setting the Context. In order for a teaching approach to be successful, it is important that both supervisors and, particularly, supervisees feel safe. The only way for anyone to improve is to recognize where they are not being effective. Specifically, if you do not recognize what you are doing wrong, it will be difficult to learn to do it right. If supervisees feel like that cannot ‘own’ mistakes because they will be blamed, shamed, or fired, then it will be difficult for them to be open about discussing their challenges. Similarly, if supervisors feel like they must always say positive things and cannot provide feedback on mistakes or shortcomings, then it will be unlikely that supervisees will be able to receive useful feedback. Feedback on what we do well is simply praises and only serves to reinforce already effective practice. Feedback on what we do not do well stimulates learning. Feedback is most effective within the context of both shared and individual aspirations.

Particularly given that we are still operating within a service system design rather than a transformational one, it is necessary for programs and agencies to carve out time for their supervisors to shift from compliance officers to teachers. Anecdotal evidence suggests that the retention of supervisors is enhanced by this shift. Organizations still must engage in compliance activities. We recommend that technology solutions can be used for compliance and human resources can be used for teaching. Ensuring that existing electronic systems have the capacity to support both compliance and outcomes management is an important organizational priority.

Besides creating an environment in where everyone feels safe, it is necessary for supervisors to learn to use data to provide feedback to their supervisees. Data is a far more direct form of feedback than observations from the supervisor. It is seen as more objective and thus often easier to accept in the process of personal learning. A variety of different types of feedback reports can be generated for use in conversations between the supervisor and supervisee.

**Workload vs. Caseload.** Given our traditional business model of paying helpers to spend time with people, there are often few if any incentives in a traditional service system to say good-bye. Given this unintended consequence of service system thinking, it is often necessary to come up with new ways of incentivizing the egress process at the individual level.

One strategy that has gained some popularity has been a shift to workload management as an accompaniment if not an alternative to caseload management. Many experienced program managers have had talented staff, and due to the pressures of the work, they have had to ask these highly skilled employees to take on the most challenging cases. However, these workers burn out and leave for a different job or must be promoted quickly as a reward for their good work and as a manager is then left with the staff they have been working around when it comes to managing challenging cases. A major explanation of this phenomenon is that programs manage caseloads, consistent with service system thinking. For example, each case manager might be expected to maintain a caseload of 20 cases. New referrals will generally go to the case manager with the fewest cases to keep the caseloads equitable.

Unfortunately, although caseload management is easy and efficient, there is a problem with its fundamental logic. Not all cases are equally easy or challenging. Some cases take more time and emotional energy. Thus, pretending all cases are equivalent actually penalizes staff who are willing to take on the most challenging cases. This management strategy also provides a clear incentive for case managers to hold on to cases that could possibly be transitioned from the program. Typically, it is less work to hang on to a case with which you are familiar and is stable than to take on a new case.

Within a TCOM framework, this is straightforward problem to confront. Managing workload simultaneously to caseload provides a more equitable management strategy and rewards staff for both taking on challenging cases and transitioning those who are ready to finish their transformational experience within that program.

Workload = Total number of actionable needs summed over cases

With the action levels of the typical communimetric measure ('0' = no evidence, no need for action), ('1' = watchful waiting prevention), ('2' = action), and ('3' = immediate/intensive action), all that is required is a count of the number of '2' and '3' ratings on need items for each case. This number is summed over a worker's caseload resulting in a workload metric.

For example, you might have two staff, one with a caseload of 22 and the other with a caseload of 17 (Fig. 8.2).

A new case comes in, to who do you refer this person or family? Traditional caseload management would say Staff B of course gets the new case. However, what if you look at the workloads and see the following (Fig. 8.3):

Staff A has a workload of 44 and Staff B has a workload of 85. In this situation, Staff A's caseload has an average of two actionable needs per case while Staff B's caseload has an average of five actionable needs. It may make far more sense to refer the new case to Staff A. Of course, a precise threshold of when workload over-rides caseload in referral decisions requires program policies. Taking the average number of actionable needs for the program and using a cut-off of two or three times, this number might make sense. With experience, program managers can begin to get a sense of this type of decision support. Thus, the workload metric is one more tool for programs to use for effective management within the TCOM framework.

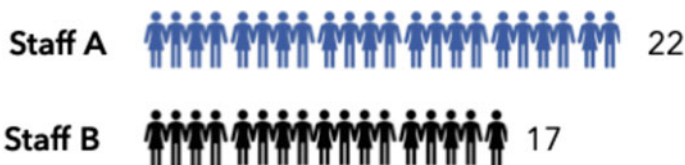
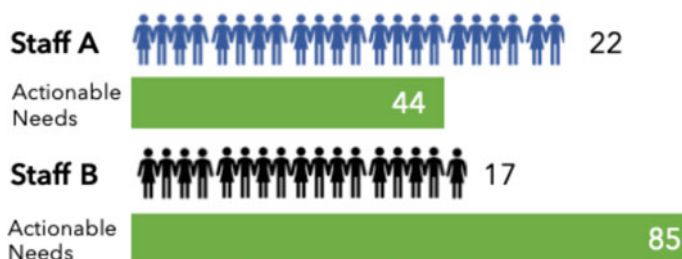


Fig. 8.2 Staff caseload example



**Fig. 8.3** Staff caseload and workload example

We have not established any clear guidelines for when a supervisor (or triage process) might shift case assignment based on workload differences, however, anecdotal experience suggests that if the workload of one helper is more than twice that of another helper, then there is little controversy with assigning the direct care staff with the much lower workload a new case. This is an example of equity-based program policy that promotes buy in from you most effective staff.

## WORKFORCE DEVELOPMENT

In order to use a TCOM assessment strategy, training and certification on the TCOM tool are required. We see this process as an essential workforce development strategy. The goal is to help helpers develop an understanding of a common language approach so that stories of those to be helped can be understood, organized, and communicated in a consistent manner. Since the design of these tools is based on a ‘minimum standard of understand’ approach fundamental to communimetrics, by definition, learning the vocabulary of the tool guarantees that all share this common minimum standard of understanding. For this reason, we see training and certification in person-centered assessment as a fundamental starting point to creating an effective workforce.

We also believe that training is not the same as learning. Anyone who is bi- or polylingual knows that learning a language only starts with building a vocabulary. Becoming bilingual requires immersion in the new language before learning is complete. Using a communimetric tool within the TCOM framework also requires immersion. For this reason, agency level workforce development goes beyond training and must rely on additional strategies to ensure that the common language frameworks initiated with the assessment tools become an effective language of communication within the daily work of all helpers. This type of thinking is a major departure from traditional views of measurement that essentially conceptualizes a measure as simply inserted as a neutral objective observer in an otherwise subjective process does. In this traditional view, the objectivity of measurement should not be ‘sullied’

by the reality of the day-to-day operation of helping. We hold this view to be naïve at best. More likely, the traditional view results in inaccurate measurement. In fact, even traditional measures are pulled into the complexity of helping systems. Worst of all these supposedly independent observations of the process of care becomes irrelevant to that process of care. Often they are not completed or when they are completed experienced as irrelevant burdens to the far more important process of helping. This is the reason why research tools when embedded into practice environments lose both reliability and validity compared to their applications in research projects (Lyons, 2004).

There are two strategies to promote workforce development within a TCOM framework—mentoring and coaching. Table 8.2 highlights the basic differences between these two roles. Clearly, mentoring is a greater investment in the long term than coaching and requires the long-term involvement of the mentor. Depending on the specific circumstances, coaching may be more feasible since coaches are generally less senior than mentors are and the time investment is over a more defined period. If the goal is specific skill development, then coaching is recommended. If the goal is professional development, mentoring is likely the superior pathway.

While mentoring is a broad professional development, strategy that has demonstrable effectiveness in helping develops an organization's employees. However, mentoring is more time intensive and expensive and therefore, often reserved for mid- to high-level leadership staff. Coaching, being more focused and time-limited, results in an efficient and less expensive approach for developing direct helpers. TCOM coaching is focused on one or more the following objectives:

**Table 8.2** Comparison of mentoring and coaching

<i>Mentoring</i>	<i>Coaching</i>
The relationship between the mentor and mentee is intended to be long term	The relationship between the coach and the staff has a planned duration until a skill(s) has been developed
Time spent is often unplanned and informal and can often be ad hoc when advice and guidance is needed or requested	Time spent is organized and formal with held on a regular schedule
Focus is more on professional and personal development	Focus on skill development
Mentor is generally more experienced and senior than the mentee	Coach has a specific skill(s) that the staff member does not possess but otherwise might be similar in age and overall experience
Agenda set by the mentee with the mentor responding to the mentee's needs and goals	Agenda set by the coach with the staff member responding to the coach's strategy of learning
Conversations more broad-based	Conversations narrowly focused

- Passing the certification test.
- Engaging clients and others in collaborative assessment processes.
- Treatment planning using communimetric measures.
- Monitoring change and completing helping episodes.
- Asking questions and understanding data in aggregates.

### *Executive Management*

Perhaps the roles at the program level that must make the greatest changes in thinking and behavior in our shift away from service system thinking into transformational management are people in executive management position in community agencies (Lyons, 2004). Often these individuals rose up the ranks by understanding how helping programs function effectively within the existing service system framework. A shift to transformational management, no matter how gentle, tends to force executives to think in new ways or to learn to think again as they used to think before they became institutionalized in service system thinking. The shift to TCOM may not be consistent with the strengths they have developed in their rise to leadership positions. I have often said publically that the executive leadership of provider agencies and organizations represents among the greatest obstacles to effective system change.

### *Learning to Use Data*

Once person-centered information about the status of people served in a program is routinely collected, it becomes possible, of course, to use that information for program planning and policy development. This use is a primary goal of TCOM. However, for a variety of reasons, the actual uptake of information within programs is not very straightforward.

There are a number of significant obstacles to consider:

1. There is very little tradition to the use of data in program management so news procedures, processes, and habit must be developed.
2. Many people who choose careers in the helping professions are not particularly math savvy. People with research and evaluation expertise likely have different questions about program performance than people who provide care within the program. Thus, externally developed reports might not ‘speak’ to people in the program.

A growing focus in the TCOM community (see Chapter 12) is the development of strategies to facilitate the uptake of information gleaned with data at both the program and system level. Helping program leadership and staff be conversant with data taken from communimetric tools is an important priority.



We believe that it truly is learning how to have a conversation with data so that people can come to a shared understanding of their work within the context of people served in the program. The key strategy is analyzing, reporting, and discussing findings using the tools within the program's organizational structure. Designing action steps based on the implications of findings facilitates everyone understanding the value and importance of the data collected.

### *Social Entrepreneurship*

Merriam Webster's online dictionary defines a social entrepreneur as 'a person who establishes an enterprise with the aim of solving social problems or effecting social change'. Given this definition, it becomes possible to conceptualize nearly all agencies founded to provide help as the product of social entrepreneurs. Since TCOM focuses the helping sector on the best interests of those we are intending to help, it is natural that within the framework we would consider social entrepreneurship as the optimal way to think about developing the business of helping.

There has been a great deal of work to understand entrepreneurship generally and social entrepreneurship specifically (Lyons et al., 2021). While, historically, models of entrepreneur development have involved helping the prospective entrepreneur write a business plan and obtain start-up capital, there has been a more recent shift to a skills based understanding of this process. Such a skill focus allows us to consider the development of TCOM-oriented enterprises using the same frame with which we think about any other form of helping. In other words, the process of supporting the evolution of businesses that design to help is conceptually the same as support people with other challenges who need help changing in some fashion (Lyons et al., 2021).

The existing research literature on social entrepreneurship has identified four basic areas of skill development that we have described as: Transformational, Relationship, Business, and Organizational Process. A single successful social entrepreneur must either achieve mastery in all four areas or assemble a leadership team that brings to bear all four of these skill areas with a sufficient level of sophistication in order to be successful.

### *Transformational Management Skills*

**Change is a constant in all business environments. The ability to manage change is a fundamental skill.** We have identified the following skills as comprising the key skills under the umbrella skill set of supporting change as it applies specifically to social entrepreneurship (Table 8.3, Lyons et al., 2021).

**Table 8.3** Transformational management skills

<i>Skill</i>	<i>Description</i>
Problem-solving	The ability to think strategically and play out multiple scenarios, understanding the potential consequences, to create possible solutions to obstacles, and then to efficiently select the best option
Moral compass	The individual's ability to promote, live, and work by the highest moral and ethical standards. Able to embed ethical practices into the enterprise's culture and processes. This skill is far more important for social entrepreneurship and perhaps irrelevant for a commercial entrepreneur
Moral judgement	The individual's drive to right something that is perceived as wrong. Pursuing efforts that are clearly stimulated and supported by a sense of moral responsibility
Empathic understanding	The individual having a clear empathic appreciation for a target social cause. The ability to feel another's pain
Persistence/Relentlessness	The individual's determination, once an objective is set, to do anything possible to succeed. The ability to use adversity as a resource, drawing motivation to work harder through challenges
Persona/Charisma	The individual's zealous drive towards a goal—the ability to compel and inspire others by one's personality and ability to communicate that goal
Flexibility/Adaptability to change	The individual's ability to assess changes in a situation and modify actions accordingly—resolving negative emotions and embracing differences
Knowledge as a resource	The individual's ability to harness the development and share knowledge as a core strategy to achieve a goal
Creativity	The individual's vision to use unique and alternative perspectives to create a new strategy or to progress in an existing situation—invention
Innovation	The individual's ability to produce creative ideas and then implement in strategic planning and actions, efficiently and effectively
Leadership skills	The individual's ability to lead their own team or peers effectively in pursuit of a goal or goals. Leadership is a multifaceted skill. There are variety of leadership styles that potentially be successful depending on specific circumstances and the people involved

(continued)

**Table 8.3** (continued)

<i>Skill</i>	<i>Description</i>
Resiliency	The individual’s capacity to recover quickly and effectively from obstacles or setbacks, developing and growing strengths from challenges to better themselves and the organization
Resourcefulness	The individual’s ability to identify and utilize external/environmental strengths to progress and better both themselves and their organization
Self-awareness	The individuals’ capability to recognize and identify their own strengths and weaknesses as well as resource and capability needs—an ongoing process of self-reflection and metacognition

*Relationship Management Skills*

Anyone leading agencies or programs has to be able to make and maintain professional relationship both internally and externally (Table 8.4). The need for ‘people skills’ is particularly strong in helping sectors.

**Table 8.4** Relationship management skills

<i>Skill</i>	<i>Description</i>
Networking capacity	The individual’s ability to build and maintain networks as a leader. Embedded in these skills is the ability to understand the relevant networks and build relationship with key people in that relationship. Networks are both powerful and sometimes difficult to be invited into for new leaders. The famous ‘old boys network’ depicts these challenges. While most helping sector networks are no longer ‘old boys’, the dynamics of favoritism and exclusion are human in these circumstances
Leveraging existing partnerships	The individual’s capacity to utilize one’s existing network and relationships as a resource, including peer, advocacy, and funder organizations, as well as individuals. The ability to attract long-term, mutually beneficial partnerships in order to develop and grow
Resource leveraging	The individual’s drive to right something that is perceived as wrong. Pursuing efforts that are clearly stimulated and supported by a sense of moral responsibility

(continued)

**Table 8.4** (continued)

<i>Skill</i>	<i>Description</i>
Building and maintaining a reputation	The individual's ability to cultivate respect as a leader and maintain a stellar reputation. The desire to share credit for success. A strong reputation for an organization can facilitate staff recruitment and retention and can even enhance the engagement process with those served
Community influence and involvement	The individual's development and creation of external, community-based working relationships. The ability to perceive the political environment and understand and utilize influence over community leaders is a valuable skill at a community- based agency
Accountability	The individual's ability to define and create accountability structures whereby all components of the business, including all people, have clearly articulated performance objectives that remain consistent to the organization's aspirations
Teaming	The individual's ability to structure teams and team-based approaches to the activities and processes of the organization. Effective teaming is an increasingly valued skill given the widespread use of teaming approaches in complex helping environments

### ***Business Management Skills***

In my experience, this is the least developed skill set among social entrepreneurs. In most cases, social entrepreneurs are not 'in it for the money' and so therefore do not focus on the development of core business skills, that is a required part of any profitable business (Table 8.5). Regardless, this skill set must be included in the executive leadership team.

### ***Organizational Process Management Skills***

The skill set of Organizational Process Management describes a set of skills for managing the organization as a complex system (Table 8.6). These skills are critical to running the business on an ongoing basis.

Very few, if any, social entrepreneurs have all of these skills. However, an effective community agency requires all of them. By assessing and understanding the skills sets of a leadership team, it becomes possible to ensure that an organization has all the required skills for success in the business of helping (Lyons et al., 2021).

In summary, TCOM at a program/agency level shares many common characteristics with TCOM at the individual level, but there are also notable

**Table 8.5** Business management skills

<i>Skill</i>	<i>Description</i>
Knowledge of field/Industry	The individual's understanding of the context surrounding the enterprise, with experience in the field itself. This skill is often the one possessed by the social entrepreneur
Knowledge of laws/Regulations	The individual's knowledge and understanding of the existing laws and regulations in the business environment of the organization that directly pertain to the functioning of that organization. This skill requires great attention to detail that is why it is often placed with a leadership team member rather than the Executive Director
Accounting/Bookkeeping	The individual's knowledge and understanding of accounting and bookkeeping principles and practices. This skill is similar which is often 'outsourced'
Finance	The individual's knowledge and understanding of financial management principles and practices. Some social entrepreneurs even struggle with the distinction between accounting and finance. Having a strong understanding of how to manage the financial structure of an organization is critical to long-term success. For example, developing endowments and other structures to manage cash flow can be important particularly in publicly funded enterprises in which states, counties, or the federal government are slow to contract and/or pay
Marketing/Communications	The individual's understanding of and experience with marketing, sales, and communication practices. This is a fast moving skill set in the information culture. Most currently, useful media strategies fall into what was originally called 'social media'. Agile community agencies must learn to meet people where they are, which is increasingly online
Operations management	The individual's knowledge and understanding of operations management practices. Creating processes that are fast, efficient, and effective is important. Having training or knowledge of developing fields of logistics and project management is invaluable
Technology-enabled business management	The individual's knowledge of the tools of technology-enabled business (e.g., social media, CRM, bookkeeping software, etc.) and their utility to the organization

differences. There is the same focus on the best interests of the people to be helped by the organization. There is use of the same information sources to allow this focus. However, the information is used differently and with different people. Information is generally aggregated and the aggregated stories are used to enhance performance. Rather than a focus on the helper-helped relationship, program/agency level TCOM focuses on program or agencies leadership working to help the helpers be increasingly helpful.

**Table 8.6** Organizational process management skills

<i>Skill</i>	<i>Description</i>
Internal communication	The individual's ability to express one's meaning to others in a clear, transparent, and positive way—the ability to utilize effective communication to lead an organization. In my experience, within organization communication is the skill that is often in deficit in many helping organizations. If the goal of organizational management is ensuring people continue working together towards the common cause, then it is critical to have ongoing efficient and effective communication. The absence of communication creates a void into which rumors flow. Organizational cultures with a strong rumor mill waste inordinate time on nonsense and conspiracy theories. I have found that personal contact with as many people as possible in the organization is a very useful strategy.
Process design	The individual's ability to work efficiently and effectively toward goals and objectives through processes that are robust, lean, well designed, consistently used, and widely accepted. Pre-pandemic, we might call that 'walking around management' (Senge, 1990). I use a regularly scheduled open zoom room that I call 'The Hallway' as a similar strategy.
Decision-making	The individual's ability to, first, make decisions and then to make them in a well-reasoned, informed, and timely way towards achieving individual and organizational goals. A part of this skill is to know which decisions to delegate, which decisions to do jointly, and which decisions to maintain at the highest levels of leadership. Confusion on the distinction among these types of decisions can lead to confusion and conflict within the organization.
Conflict management	The individual's ability to manage conflict in healthy and constructive ways—the ability to create an organizational culture that addresses conflict in this way. Conflict inevitably occurs when more than two people work in an organization. Conflict comes in many shapes and sizes. Simmering, passive aggressive conflict is often more harmful in the long term than emotional outbursts. Emotional outbursts, though, are more likely to result in job sanctions, at least in North American culture. It generally falls on leadership to deal with conflicts as they arise. Being timely and equitable is important. Letting all voices be heard but identifying the organizational solution without alienating any combatants and allowing any hurt feelings to heal are all part of this skill.

(continued)

**Table 8.6** (continued)

<i>Skill</i>	<i>Description</i>
Performance and disciplined action	The individual's focus on performance as an expected norm—self-discipline and the ability to encourage and reward high performance in others. Ultimately, in any business, the final indicator of success is performance. Staying focused on building performance over time and taking the necessary steps to achieve, maintain, or enhance performance is an important skill. This skill is one of the key reasons that leaders cannot be friends with people who work for them. The blurring of relationship lines creates pressure away from the goal of performance to a non-organizational goal of maintaining a friendship

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## Creating and Managing Systems *That* Care

In this chapter, we will take the TCOM conceptual approach to the system level. This level includes jurisdictional implementations within a sector and cross-sectoral implementations that have become increasingly common. Over the initial years of the use of TCOM-related tools and strategies, we have looked to create a blueprint of how a system can ‘do’ TCOM. We have come to realize that there is simply no one way to approach this process. The variation across systems in terms of components, regulatory and legal structures, and people are far too great to have a formula for how to create a system that cares. The starting premise is that the people currently in the system already do care. The idea is to find various ways to tap into that shared aspiration to advance the overall impact of the system on the lives of the people we serve. While exactly how any given system decides how to approach this challenge can vary dramatically, there are still lessons learned. Mass customization is as important at the system level as it is at both the individual and program/agency levels.

Metaphorically, it can be useful to think of TCOM system implementation a bit like rock climbing. There is no single path up the side of cliffs. Rather, the climber reaches and searches to find rocks to grasp and footholds. There might be a ledge on which to rest for a while before resuming the climb. At least in my limited understanding, rock climbing is less about strategically planning the route that might apply to all cliffs and more about ensuring that the climber understands their own skills and abilities, has the right gear and a knowledge of climbing, and can anticipate things that can go wrong and either prevent or correct these circumstances. Knowing how to tie a knot and which type of knot to use in which circumstance is important. Sometimes climbers fall but the good ones use ropes and harnesses to make sure it is a

short fall and they can easily recover. System-level TCOM is more like this way of thinking than creating an automated approach to running a system. With this in mind, this chapter will attempt to illustrate system-level applications of TCOM with stories and examples of different projects and processes that systems have undertaken using this philosophy. The goal is for system managers to have the tools they need to be successful in managing a system that cares about the well-being of the people to be helped.

### *The Origin Story*

The original intent in the development of the tools that now comprise the person-centered assessment strategies of TCOM was to provide information about the people served to inform policy. The history of the approach can be traced back to the final stages of my training. After completing my doctorate in clinical psychology and statistics in 1981, I became a postdoctoral fellow through a National Service Award from the National Institute of Mental Health (NIMH) to the University of Chicago. This postdoctoral fellowship was one of the first efforts of NIMH to build the field of mental health services research. As I started to explore the field at that early stage, it became clear that there actually was very little ‘mental health’ involved in mental health services research.

For context, this was the year that the Epidemiological Catchment Area study was first beginning to publish results (ECA; Eaton et al., 1981). The ECA remains to this day, the largest epidemiological study of psychiatric disorders making clear the scope and impact of mental health challenges. However, health services researchers, including those focused on mental health, were using large administrative datasets to study relevant policy questions (e.g., Penchansky & Thomas, 1981 among many others). These datasets usually had gender, age, race and one or more diagnoses and that was the only information routinely available about the people served. However, a substantial amount of information was included in administrative data about services received. In 1981, diagnoses found in charts and administrative datasets were routinely described as unreliable and therefore difficult to include in research. These concerns remain to this day (Davis et al., 2016). In this context, the available data to inform policy was the various things that the system did *with* people.

There simply was very little information about those people. Sadly, not a lot has changed in the subsequent four decades. We are now, however, on the cusp of having the ability to include robust and comprehensive information about health and well-being in our understanding of service system. Being able to understand patterns of service utilization within the context of a comprehensive understanding of the people helped might just change a lot about how we understand the system. That was the original goal of this body of work when I began my career journey forty years ago.

After the fellowship, I accepted a faculty position at Northwestern University’s Feinberg School of Medicine initially in the Department of Psychiatry

but eventually also in Medicine and Preventive Medicine. Initially, my research focused on consultation-liaison psychiatry and the role of addressing mental health needs of medical/surgical patients in managing outcomes and reducing costs of care (e.g., Fulop et al., 1989; Strain et al., 1991). By the end of this NIMH funded research, Diagnosis-Related Groups had become a focus on cost containment issues (Fetter et al., 1980), and it was clear that this prospective payment strategy simply would not work with psychiatric hospital care (English et al., 1986). After completing a study that demonstrated significant practice pattern variations as the driver of length of stay in psychiatric hospitalization (Lyons et al., 1991), I realized that psychiatric diagnosis was unrelated to decision-making about psychiatric hospitalization. It was not whether a person was diagnosed with Major Depression or Bipolar Disorder that determined hospital admission—it was whether they were dangerous to themselves or others or unable to take care of themselves. This recognition represented the key moment that ultimately led to the creation of TCOM and the ability to have large, clinically sophisticated administrative databases.

The idea of the original TCOM tool—the Severity of Psychiatry Illness (SPI; Lyons, 1998a)—was to create an easy to use measure that was clinically relevant to psychiatric crisis workers but related to factors that drive psychiatric hospital utilization. I had recently become familiar with Susan Horn’s great work with her Severity of Illness tool that was used to case-mix adjustment with medical surgical patients (Horn et al., 1984). This tool was modeled in the tradition of clinimetrics (Apgar, 1966; Feinstein, 1997) where a single item was used as an indicator of a specific relevant characteristic. A single item indicator solves multiple problems confronting and limiting psychometric measures. If you do not require a set of items that you combine into a score by allowing single item metrics, you can measure far more constructs easily and you can make the measure more palpable, interpretable, and meaningful for clinicians who complete it. From this initial work, with the contribution and collaboration of a very large number of people all over the work, Transformational Collaborative Outcomes Management evolved over the subsequent two decades.

## KEY CONCEPTS OF SYSTEM-LEVEL TCOM

The application of TCOM principles at the system level is designed to ensure the focus on person-centered care. In other words, system level TCOM creates opportunities for system manager and administrators to make their decisions based on what is in the best interest of the people helped within that system. This focus on clinical and functional information can be a dramatic shift for system administrators for whom the only data has been information on the number of people served in different programs, the number of sessions, new admissions, readmissions, and average length of stay. In the TCOM approach, system decisions should be informed by what policy or practice changes potentially will have the greatest positive impact on the people to which the system

has committed to provide help. Actualizing this principle at the system level is now feasible. Despite these new possibilities, this aspiration is no small task to achieve. One of the main challenges at the system level is that decision-makers are removed by several layers from the individuals to be helped. People working to make system management decisions often

- Have less (or less recent) experience with the people served.
- Must include consideration of many more people when defining the meaning of ‘best interests’ or ‘greatest positive impact’ or ‘consensus’.
- Must be aware of more individual, program, and agency aspirations that have a stake in the management of the system.
- Confront more competing agendas arising out of individual agendas that can distract attention away from the transformational impact of the system on the individuals to be helped.
- Must function in a political environment that often introduces competing agenda from outside the helping sector.

Together these five considerations make the complexity of systems management far greater than the complexity of direct care. Given this reality, both the importance and challenge of collaboration at the system level are even more pronounced. However, collaborative approaches offer the best opportunity to navigate this enhanced complexity successfully. The nature of collaboration expands the number of relationships that are necessary to work towards common interests. Yet, the value of system-level adoption of TCOM principles and approaches cannot be under-estimated. Leadership defines culture and climate. Rules provide guardrails for behavior. People will do what they are paid to do. Even the very best intentions of people working at the individual or program levels can be thwarted when the system forces work at cross-purposes and do not support effective helping.

As we discussed earlier, the TCOM approach considers many of the same issues that confront direct helping and program and agency management and adjusts these considerations to systems management. While you can see the consistencies that come with a person-centered focus throughout each of the levels, system level management does present unique challenges and opportunities.

### *Aspirational System Management*

Similar to considerations at both the individual and program levels, system managers are charged with helping systems become the best versions of themselves. When explaining this concept to clinicians, I often have said that in the helping sector all relationships should be considered ‘therapeutic’ or ‘transformational’. We are all doing what we can to help others become the best

version of themselves. What changes, of course, is how we consider definitions of ‘the best’ and what strategies are available to use to help others transform. At the system level, the opportunity to help others change must be reconsidered from the perspective of understanding the impact of systems and the system administrator’s decisions on the work of people who help people. System administrators do not have a direct role in the helping enterprise. Rather, they enable or disable, facilitate or encumber effective helping. They are primary creators of the work place in which help is provided. That said, how system administrators work to achieve this aspiration still requires them to understand the impact of the system on the lives of the people whom the system is mandated to help. Like program managers and to a lower degree supervisors, system managers now deal with aggregates-multiple stories understood together to create a story of the system. Of course, the number of stories to aggregate becomes geometrically larger across the system.

In addition, new aspirations come into play at the system level that may or may not be in alignment with the overall system aspiration of helping others. These aspirations must be understood, appreciated, and embraced when possible or addressed and blocked when they work at cross-purposes with the primary aspiration of the system. For example, often system directors (e.g., commissioners or directors of state code agencies) have strong aspirations for recognition for their good work. They work in a political environment and recognition is the ‘coin of the realm’ in those environments. That aspiration can be a very good thing if channeled into supporting an effective agency or program. Of course, if that recognition is seen as obtained strictly through friendships or social engineering, that aspiration can work against system-level TCOM goals of helping those in need.

System leaders should be aware of their own aspirations and the impact of their personal goal and desires on their work and the work of the system. Since political appointees lead most public helping systems, the tenure of these positions is seldom long. For every county administrator who stays in the role for more than a decade, there are likely twenty system administrators who stay less than two years. Typically, politically appointed system leaders are not in their positions for their career. Often they serve for several years and then move into a job as a consultant to other systems. For this reason, some system leaders prioritize establishing their ‘legacy’ during a relatively brief period of leadership.

Unfortunately, this often means dismantling the work of earlier administrations and rapid implementation of ‘splash’ programs and initiatives. The goal of these type of initiatives is to do something where the optics look good. The long-term impact can be of little interest or importance for short-term decision-making. It is important to note that not all politically appointed leaders are driven by these aspirations. However, it is important to recognize that some are and that it is important for systems to help their leaders meet personal aspirations while not compromising the system.

### *Rules and Regulations—Policy and Procedures*

Systems document, support, and sometimes enforce their vision of the system using policies and procedures—rules and regulations. Policy does not always translate into practice. In addition, sometimes the manner in which policy translates into practice is in stark contrast to the original intent of the policy—the problems that arise from policy are called unintended consequences. While this book is not intended to serve as a TCOM policy-writing guide, it is important to note the importance of written policy at the system level.

A major complexity for system managers is that although rules and regulations tend to be uniform across the system, the impact of programs can vary dramatically. In my experience, large systems often can be characterized by what I would describe as ‘pockets of excellence’ and ‘piles of crap’. In other words, there are invariably some outstanding people, programs, and agencies. Every system has its own ‘star’ performers. Often these outstanding performers are not the ones with the best reputations. In my experience, people, programs, and agencies with the best reputations are often the second ring of performance rankings. The ‘star’ performers are quiet risers who are going about the business of helping effectively and either do not engage (or have not yet engaged) in the schmoozing, marketing, or social engineering that builds a reputation (at least a reputation built in the absence of data). A second way to describe this phenomenon is the reputation is a lagging indicator to performance data, sometimes by a large amount. Really good programs get a good reputation but then leadership and staff change and the program declines, but it takes some time before the ‘glow’ of the initial positive reputation also declines. Similarly, it can take time for programs with a bad reputation to overcome their reputation even if they are currently doing good work. A journalist recently asked me to name some ‘really good’ residential programs for youth. I declined because as I told the journalist, being effective is not a permanent state of any program. It depends a great deal on stability of leadership, including both the executive and the supervisory levels. A good program six months ago may not be as good today, and a program struggling last year may have addressed its challenges and be providing effective help. Regardless of these complexities, in my experience, nearly all systems have a subset of outstanding performers. Most performers, of course, will fall in an average range of performance. Of course, in most systems, there are people, programs, and agencies that are poor performers.

Given the natural variation in expected performance, the concepts of mass customization are as relevant to the system level as they are at the individual and program levels of any system. However, mass customization becomes increasingly more difficult as we move from direct helping interventions to programs to agencies to systems. System managers have a tendency to take a mass production approach to their management. Many would argue that it is only ‘fair’ to treat all providers and programs the same. Most policies and

regulations are written from a mass production perspective, often for this very reason.

In our traditional approach to system management, we hear stories of the bad performers. These stories may come in the form of multiple complaints. In the worse cases, they end up as stories in the media. All systems have both formal and informal mechanisms in place to recognize very bad performance. When such poor performance is recognized, a typical process occurs generally started with an investigation. Often sanctions for the bad performer result. However, it also is common that in order to prevent future bad performance, the system managers create policies that are then applied to all performers, regardless of whether they are good, bad, or ugly (the equality doctrine of fairness once again). We then hold all performers into standards of compliance to these new policies. Such policies were designed originally to prevent failure, often a very specific type of failure. This process repeats itself in supervision, in program management, and in agencies. Invariably, it messages that leadership neither notices nor trusts good performers and treats everyone as if they might be a bad performer. I am sure that as you read this description you both recognize the pattern from your own experiences and as you reflect on it, know that it is not a good way to manage anything. There are alternative ways of thinking about system management but you must have outcomes and performance data.

Envision a system in which system managers are able to monitor the effectiveness of each individual, program, and agency. Once this data is readily available, system managers can identify and celebrate the effective performers. The majority of performers will be average which is certainly good enough but if they are made aware of the ‘star’ performers some might be motivated to aspire for such relative ‘greatness’. Healthy competition to achieve (particularly on something other than who has the most money or largest staff) is a great benefit for any system. In addition, identifying below average performers allows system managers to plan remedial actions to either bring these performers up to an average level of achievement or, if that fails, replace them with a more effective performer. Corrective actions can be much equitable and effective using ongoing outcomes and performance data.

### *Aspirational Management and Accountability*

As with the other levels of helping sectors, in TCOM it is desirable to shift away from traditional compliance-based models of accountability into ones that are more aspirational management approach. Of course, this shift does not eliminate the need for accountability. The evidence is quite clear that holding people accountable for their behavior is an important component of any effective system. The shift is not away from accountability; rather, it is a shift in the things for which people are held accountable. Table 9.1 provides some comparisons between accountability standards that are traditional compliance-based version aspirational performance standards.

**Table 9.1** Examples comparing compliance and aspirational accountability standards

<i>Traditional compliance</i>	<i>Aspirational accountability</i>
Was the CANS/ANSA completed within the first 30 days of care?	Were the CANS/ANSA identified needs and strengths integrated into the plan of care?
Were strengths assessed?	Was the plan created to either use or build strengths?
Were outcomes measured?	Were results of outcomes analysis incorporated into a quality improvement plan?
Were direct care staff provided individual level outcomes?	Is there evidence that direct care staff used individual level outcomes for professional development?
Were the needs of people served clearly identified?	Were identified needs used to monitor program offerings or develop training plans?

Many have called for and developed strategies to create and maintain systems *of* care (e.g., Stroul et al., 2008; Stroul & Friedman, 1996). TCOM strives to create and maintain systems *that* care. In other words, system integration is not sufficient. System integration must be accomplished within the context of bettering the lives of the people served by that system. Through a TCOM lens, no other form of integration is particularly meaningful. By having easy to analyze and interpret person-centered information in aggregate across large systems, it becomes possible for system administrators to make their policy and investment choices based on the best interests of the people served by that system. Thus, creating a collaborative process at each of the other levels first reduces the complexity that system administrators must manage in order to make informed decisions to improve system performance from a personal change perspective.

When everyone in a system uses the same (or overlapping) person-centered assessments and the information from people's experience in the system is accessible electronically across the system, it becomes possible to understand the entire system's functioning from a person-centered perspective. In other words, a primary goal of TCOM is to allow systems to support all their decisions based on the best interests of the people served within that system. We call that building systems *that* care. At least the system has the possibility to care. In most of our current systems, policymakers only have good information (i.e., information that systems' partners trust) about money and the activities of professionals (i.e., services, claims). With the possible exceptions of age, gender and race/ethnicity, many analysts continue to view person-specific information with suspicion. As discussed throughout this book, the



full implementation of TCOM allows the creation of reliable and valid person-centered information that is as or more rigorous than the traditional 'objective' measures that many analysts currently trust.

### THE ORIGINAL TCOM SYSTEM-LEVEL PROJECT

In the 1980s, I was involved in work on understanding the interface between health and mental health and building clinical models to predict and manage psychiatric hospital decision-making. This body of work set the stage. Nevertheless, the origins of TCOM can be traced to a community re-investment project in child welfare in Illinois in 1995. At that particular time, the Illinois Department of Children and Family Services (IDCFS) had 55,000 children in care and a budget of about \$1.5 billion. That is actually quite a bit of money in the mid-1990s. The problem was that nearly one-third of those dollars was tied up in expenditures on psychiatric hospitalization and long-term residential care. Worse than that, many of the existing community services were located where people wanted to work and not in the communities that had disproportionate representation among children removed from their parents. Therefore, children and youth in the system had to fail in the community, often resulting in psychiatric hospitalization. Once hospitalized (even if it might not have been necessary in a more effective system), these children and youth would then qualify for placement in residential treatment, by the very fact that they had been hospitalized. The newly appointed Director of IDCFS at the time, Jess McDonald, wanted to fix that problem.

Psychiatric hospitalization stays were paid for by Illinois Medicaid and without a Waiver from the federal government, that money was not discretionary to IDCFS administration. Residential Treatment, however, was in large part paid for by IDCFS. At the time, there were about 6,000 children and youth placed in various forms of congregate care. Therefore, Director McDonald's plan was to actively bring youth home from residential treatment centers and save some of these discretionary dollars. He got an agreement with the Governor and the Illinois Assembly to be able to use any initial savings in the first year for program development in future years. This agreement was a key condition for success. Otherwise, since the State operated on fiscal years, savings in one year could simply result in having less money available to serve children and youth in care in subsequent years.

The first strategy to achieve this community re-investment goal was to request that all residential providers review their current cases and identify youth who would be options for return to the community. Of course, the only way this plan could possibly work is if the residential providers nominated youth who could live in the community safety *without* intensive community services already in place. While this plan seemed reasonable on its face, it was disastrous. Unless otherwise held to account, all institutions function at the convenience of the institution. Instead of identifying optimal candidates for safe community living, residential providers tended to identify those youth

with whom they were currently unsuccessful. This practice identified precisely the wrong youth. In other words, they would say essentially things something like ‘Mary is doing great. Do not disrupt Mary’s treatment. Take Johnny. We are not helping Johnny, maybe you could help Johnny’. This plan was abandoned after a 16-year-old living in an out-of-state, hospital level residential facility was identified as a ‘step-down’ candidate. He was not doing well at this facility—running away and fighting. Unfortunately, he had grandparents who loved him—retired schoolteachers living in a small town in Central Illinois. Since no one else appeared to want this young man, his grandparents volunteered to try. A few weeks after he was moved to the community to live with his grandparents, he murdered both of them.

This tragic story is a classic example of how not to manage a system. This young man needed a structured treatment setting. The actual decision was based on whether a community placement was available when it should have been based on an understanding of this young man’s needs. However, the only way that would be possible would be if there were some clinical or functional standards that could be used to identify which youth would be the best candidates to live in the community safely.

It was at that time that Director McDonald invited me into the process. He had hired a consultant, Harry Shallcross, Ph.D., who was familiar with my work modeling psychiatric crisis decision-making in a managed care environment (Lyons et al., 1998) and asked if I could apply the same method to residential treatment for youth. Since psychiatric hospital decision-making at a bit more robust research literature, it had been possible to use the existing scientific literature to create the original clinical decision support tool, the Severity of Psychiatric Illness (SPI; Lyons et al., 1995). In the mid-1990s, no similar knowledge base existed for residential treatment for youth. To address this knowledge gap, we convened a number of focus groups representing key partners in the decision-making process including psychiatrists, psychologists, social workers, caseworkers, teachers, and parents.<sup>1</sup>

Each focus group lasted about 90 minutes. One of the fascinating components of these meetings was that it was invariably difficult to shift the conversation away from services and dollars in order to talk about children, youth, and families. All groups got to the topic at hand but it usually took 30 minutes or more of people saying we need this or that service or more money before we could talk about the youth. Once we got to youth, the observations were uniform across groups. People were seeing the decision about placement in residential treatment as informed by three potentially correlated dimensions.

The first dimension of decision-making was the symptoms of serious emotional and behavioral disorders. Within this dimension, things related to the diagnoses of depression, anxiety, oppositional behavior, psychosis, and

<sup>1</sup> There was no youth representation in this project. A shortcoming that if I had a do-over I would have remedied.

conduct were identified. These categories were related to how people in the groups thought about the nature of interventions. Depression and anxiety were indicators of counseling or psychotherapy. Opposition and conduct were indicators of behavior management. Psychosis was related to involving a Board Certified Child and Adolescent Psychiatrist involved in the treatment. Although all of these categories had treatment indications, alone, they did not give much guidance in terms of the intensity of that treatment or the level of care at which that treatment should be provided.

In these focus groups, the consistent perception was level of care, particularly out-of-community placement, should be driven by concerns about risk. It is one thing to be depressed. It is something different to be depressed and suicidal. Therefore, the second dimension was identified as the risk behaviors of the youth. Such things as suicide, self-injury, dangerousness, runaway, delinquent behavior, and sexual aggression all were identified as key risk behaviors that should influence decision-making.

However, people participating in the groups expressed the perspective that it might still be possible to work with a depressed and suicidal youth in the community, if their community caregiver was able to provide the necessary supervision/supports and was knowledgeable about the youth needs. The characteristics of the caregiver became the third dimension identified as informed optimal decision-making for children and youth.

Based on this three-dimensional model of decision-making, a child and adolescent version of the SPI was constructed. Of course, it was entitled the Childhood Severity of Psychiatric Illness (CSPI; Lyons, 1998b; Lyons et al., 1998). The CSPI was designed to be an information integration tool because if the community re-investment strategy would have any hopes of success, it was important to know whether there were any youth CURRENTLY in residential treat that really did not need to be there. Only these dramatic 'over placements' could be moved into the community without existing intensive supports and interventions in place. As mentioned previously that 'step-down' process would take at least a year, so, given the short cycle of child welfare directors (average tenure around two years), it was necessary to quickly answer that question. To do so, we completed the CSPI on a stratified random sample of 333 youth *currently* in residential treatment across the state. Reviews completed the CSPI based on the youth admission presentation and their status in residence.

The results of this planning study were dramatic (Lyons et al., 1998). About 13% of all youth in residential treatment at the time of the review had NOT exhibited ANY key risk behaviors. An example of this type of youth was a sixteen-year-old girl. When this young lady was 14, she was removed her mother's care because of sexual abuse by a boyfriend of the mother. She was later re-united with mother after the boyfriend moved out. Two years later, another boyfriend abused this girl. She was placed in what was referred to as a diagnostic center that was a 90-day assessment placement. However, she was now 16 and 'hard to place' so since the diagnostic placement was housed in a

long-term residential care facility, the easy thing to do was just have her stay at that facility. This young person experienced triple victimization—twice in the community and once in the system. She did not need to be in a residential treatment setting. It was simply convenient for the system.

About 20% had historically engaged in risk behaviors but not in the period prior to the most recent admission. An example of this type of case was a 14-year-old boy who was recently transferred to a residential facility from another residential treatment center where he had originally been placed when he was seven due to an episode where he set a fire. He had done no other behaviors to suggest that fire setting was still a concern for him; however, his chart was stamped 'FIRE SETTER'.

Fully one-third of the youth currently in residential treatment in 1995 could be moved to community placements without intensive supports and interventions without fear of sentinel negative outcomes. Based on this project, we created a simple algorithm to identify youth who might benefit from residential treatment:

- Criterion 1: There must be something to treat (an actionable need on any of the Behavioral/emotional items on the CSPI).
- Criterion 2: At least one complicating risk behavior (an actionable need on any risk behavior item on the CSPI).

This decision model would now represent a ridiculously low threshold for residential treatment, but in 1995 in Illinois it was projected that one-third of youth currently in residential treatment would be identified as good 'step-down' candidates in support of the community re-investment strategy without concern of tragic outcomes while intensive community services were ramped up.

The next step of the project was to design a placement review and a step-down process to simultaneously manage both the 'front door' and the 'back door' of residential treatment placements. Leadership was acutely aware of the fundamental conflict of interest of residential treatment in a service industry—the business required filling empty beds and keeping them full. A successful residential program maintained 90% occupancy rate. If you started to go much below 80%, the programs would begin to bleed their endowments and be placed in financial jeopardy. Stated from a clinical decision-making perspective, if we only managed admissions, then the concern is that currently placed youth would be kept in placement longer to maintain occupancy. If we only managed currently placed youth, we were concerned that there would be new pressures to place more youth to keep beds filled.

Using this set of strategies and the simple decision model, within 18 months IDCFS was able to reduce the number of youth placed in residential treatment by about one-third, just as predicted by the planning study. They went from about 6000 placed youth to about 4000, saving about \$80 million per

year that could be used for the community re-investment strategy. While this project along with changes in policies around guardianship together resulted in what at the time was called ‘the Illinois miracle’, it was by no means without some controversy. Removing 730,000 bed-days (i.e., two thousand times 365) from a residential system resulted in multiple closures of residential treatment centers throughout the state. Some agencies were able to shift programming towards community-based care. However, agencies that were strictly residential and did not have the capacity to shift were at significant jeopardy of closing.

It is easy to derail any public sector system transformation process. All that would have had to happen would be for a few Executive Directors of a couple of residential programs to call their state legislators to complain about IDCFS closing down a business in that legislator’s district that brought in millions of dollars and employed a notable number of constituents. That did not happen. The process went forward without being derailed politically. I have always believed that the reason why no political sabotage was successful was that the entire process was guided by making decisions based on the needs of youth. Two specific experiences led me to that belief.

First, I met with Executive Directors of residential programs early in the system transformation effort and I made the statement that they should prepare for the reality that if we were successful their milieus would be harder to manage. Milieus that are combinations of easy and challenging youth are geometrically easier to manage than milieus entirely composed of more challenging youth. One of the Executive Directors spoke up to say that would be a problem for them ‘because we use the easy kids to subsidize care for the more challenging kids’. As soon as he stated this sentiment publically, it became clear to everyone in the room that such a business model was unethical. It is unethical (and likely immoral) to provide care to someone who does not need it in order to finance care for someone who does. Better to up the payment rates for those who need the care—which is exactly what was done in this project.

The second experience involved the Chicago Tribune. Before the initiative began, the Tribune had been running a series entitled ‘Death of our Children’ which was a litany of poor decision-making of children in the custody of the state that resulted in child death. When the tribune reporter called me midway through the project (about nine months into it), I told her the full story of the effort. The result was no story. The intended story was going to be something like ‘here goes IDCFS denying needed treatment to youth’. When the actual story was ‘here goes IDCFS effectively managing its system based on the needs of children’, it is no longer ‘newsworthy’.

Based on initial experience during this project, I drew the following tentative conclusions:

- Many people were not used to thinking about policy based on child-specific information.

- They thought about policy in terms of money and the activities of professionals.
- Everybody was interested in the best interests of children and families.
- If you made a reform initiative that was clearly focused on these best interests, the politics worked in favor of the reform rather than against it.

Following on the heels of this project was a bundled rate project in Florida. Florida had been requiring residential providers to document a large number of specific services provided within residential treatment setting in order to be paid. This strategy resulted in excessive documentation demands. For example, each time a staff member stood with a resident to help them brush their teeth that had to be documented as a separate rehabilitation service. The reimbursement model resulted in a variety of unintended and somewhat silly practices all intended to maximize billing under the existing rules. The question for the review would be whether it would be feasible to shift to a bundled rate model in which residential providers were given a per diem and expected to deliver a package of services based on the needs of the youth at their facility. The answer was of course ‘yes’ and a bundled rate methodology was developed. For me personally, however, that was not the important learning from this project.

The Illinois community re-investment project had generated a lot of interest in our approach and so I was invited to meetings with the Robert Wood Johnson Foundations, early system of care development grants. In these meetings, I was exposed to the emerging strengths movement. As noted above, strengths did not come up in the Illinois focus groups or we were insufficiently aware to notice them if they did. In the early days of the strengths movement, things were presented as a dichotomy—you were strength-based or you were deficit-based. In other words, the strengths movement leveraged themselves into the conversation by claiming that the strength-based folks were the ‘good guys’ they talked about positive and the deficit-based folks were the ‘bad guys’ because they only talked about negatives.

In order to be inclusive of a strengths perspective, I developed a strength assessment that we named the Child and Adolescent Strengths Assessment (CASA) and included in this Florida planning study. When we analyzed the data from the review, we found that strengths and behavioral/emotional needs each had significant *but independent* relationships to level of functioning and likelihood of engaging in high-risk behavior. From that point forward, we integrated both needs and strengths as separate, but equally important aspects, of telling people’s stories. As we will discuss later, the inclusion of strengths has provided information that may quietly revolutionize how we think about public mental health care.

## SUPPLY SIDE CONSIDERATIONS AND LOGISTICS

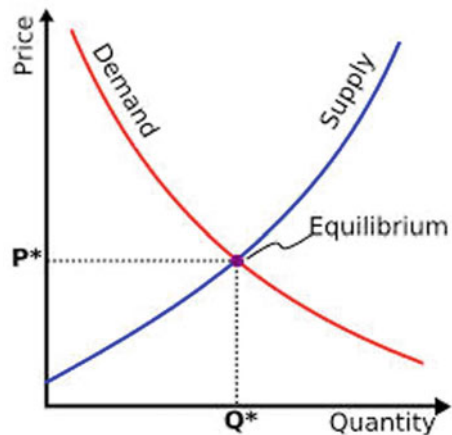
Any economist will tell you that supply and demand are equally important considerations in understanding the behavior of any marketplace. Although

sometimes neglected in outcomes management strategies, managing supply is also quite important in the helping sector. Public sector helping, in particular, can be a major rate-limiting step in efforts to achieve an effective system of care. For instance, the number of available ‘slots’ in an ACT program will influence whether and when some people with severe and persistent mental illness can step-down from the psychiatric hospital. Available beds influence decision-making on admissions to psychiatric hospitals (Mulder et al., 2005).

Any high school economics class will present basic supply-demand curves (e.g., Fig. 9.1). In the helping sector, demand at its simplest is described by number of people seeking a specific type of help. The number of people seeking shelter represents the demand for homelessness assistance. The number of people seeking mental health treatment represents the demand for mental health care. As we discuss elsewhere in this book, demand can be further defined using clinical, functional, or medical necessity criteria. Sometimes these more refined definitions are used to focus the helping efforts to those who optimally can be helped. Other times, these definitions exist primarily to reduce demand. Demand also can be influenced by factors such as stigma and awareness. Public awareness campaigns for specific medical conditions often raise the demand for specialized testing and treatment. For example, mass media campaigns for cancer screening demonstrate an uptick in demand for screening particularly in situations where there is sufficient supply (Black et al., 2002; Marcus & Crane, 1998).

Lack of sufficient supply can dramatically limit the impact of any quality improvement initiative including efforts to enhance overall system effectiveness. This challenge can be further exacerbated by the use of single providers within geographic boundaries (e.g., catchment areas) since these strategies can serve to eliminate competition and thereby reduce incentives for providers to achieve optimal productivity, let alone, effectiveness. In the absence of

**Fig. 9.1** Simply supply-demand curve  
(Source Praed Foundation, 2020)



strong system-level leadership, geographic provider monopolies sometimes must rely on the goodwill of regional providers to maintain productivity and effectiveness and implement innovations to enhance impact.

Later in this chapter, we will discuss how decision support criteria can be combined with information about available programs and resources to inform system management of supply. However, that work requires an effective strategy for measuring and managing supply. Unfortunately, in terms of logistics, grocery stores and other retail outlets are far more sophisticated about managing their inventory than most public helping systems.

Technology allows for helping systems to improve dramatically from the 'resource guides' that were usually old and outdated that were a staple of emergency room and crisis care last century. However, the existence of technology solutions does not guarantee that the information stays up-to-date or that direct care helpers actually utilize the information available in these applications. It has often been our observation in the TCOM group that helpers that are involved in referral or triage processes develop a set of personal relationships with different possible referrals and rely more on those relationships than on technology. Until quality indicators or other information that puts value on referral options, it is unlikely that automatic supply-side inventory management will become routine at the individual or program level. However, use of supply-side information can be quite helpful at the system level for 'right-sizing' a system.

The key for inventory management from a TCOM frame is to match the availability of different forms of help, in different locations with the actual identified needs of the people to be served. In other words, knowing the number of psychiatric hospital beds is only half of the equation. Using TCOM tools, it is possible to establish exactly how many people actually need hospital beds and where (geographically) those people live.

Management of inventory is further complicated by the idea that different people need access to help for different periods. As a simple example, there are two fundamental approaches to reduce the number of people in congregate care in a system by 50%. First would be to reduce the number of admissions by 50%. The second would be to reduce the length of stay in residential programs by 50%. Conceptually, either would have the same impact on reducing the number of people in congregate care. In reality, neither approach alone would likely work. As described in the original TCOM project, reducing admissions could easily lead to extended stays by those admitted. Speeding discharges could easily lead to more admissions. The only way to effectively manage inventory is to simultaneously manage access and egress (Lyons, 2004; Lyons et al., 1998).



## STRATEGIES OF SYSTEM-LEVEL TCOM

### *Reducing Redundancy—One Person Equals One Story*

If you talk to anyone who has lived experience in receiving help in the public sector or anyone who advocates for these individuals, you will hear that one of the single greatest and most common complaints is the reality that people seeking help have to tell their story over-and-over again. Some of this redundancy is in the natural of the process of finding help. The school first identifies a problem and the child and family have to meet with the school to discuss it. That problem is identified as a behavioral health challenge so the family is referred to the area clinic. The clinic uses a single intake process before referral to a therapist. In that very common example, the child and family have already had to talk to a minimum of three people before any real help is offered. And this is a simple example. If you add considerations of multiple helpers over time (i.e., the average tenure of a case is long than the average tenure of a therapist or case manager, Lyons, 2004), the number of times that child and family might be required to tell their story quickly leaps to double digits. When the system becomes more multifaceted through the use of an independent assessor or a managed care coordinator, the story must be told again. In most cases, the story is being told to a helper who is only a ‘weigh-station’ on the journey of getting help and is not the actual helper. This system-induced complexity must be managed if transformational offerings have any hope of creating powerful personal experiences. Without a reduction in the redundancy of required storytelling, the experience of getting help becomes at best annoying and at worst re-traumatizing.

### *Decision Support at the System Level*

Communimetric tools can be used in a variety of strategies to support decision-making at the system level within the TCOM framework. Primary among these decisions is the ‘right-sizing’ of the system—resource allocation decision-making. Between the action levels of the individual items and the decision support models<sup>2</sup> available at the program level, it is possible to support good planning at the system level.

A simple strategy for system-level decision-making is the use of individual items to describe the prevalence of intervention target needs. For example, if a system has a high percentage of children with a rating of ‘2’ or ‘3’ on Autism Spectrum, then ensuring that the system has the capacity to address these special needs is important to effective resource allocation. Communimetric item ratings can be mapped into physical space using geomapping technology to refine these applications to locate new programs or offices based on where people live who have these needs.

<sup>2</sup> I originally called them algorithms; however, the misuse of predictive analytics has led the TCOM group to shift who we describe these models.

A second level individual item system-level decision support can be accomplished by using individual items to predict other high-priority system-level outcomes. For example, several years ago, Illinois' Department of Children and Family Services (IDCFS) predicted placement stability with CANS items. One item, Adjustment to Trauma, was one of the best single predictors of unstable foster care. Since permanency is an important priority in child welfare, the administration used this finding to stimulate the creation of a trauma-informed child welfare system. Similarly, New Jersey discovered that youth with actionable Delinquent Behavior and Legal Functioning needs were the least likely to have good functional outcomes in their system of care initiative (Care Management Organizations). The state used this information to guide the funding of evidence-based practices consistent with these needs (i.e., Multisystemic Therapy and Functional Family Therapy).

A third approach to decision support at the system level is the application of decision models. By applying a decision model to all children and youth and mapping the recommended level of care/intensity of care/placement to the existing system, a gap analysis can be completed. Figure 9.2 demonstrates the utility of this approach. The following picture is a map the State of Illinois. On this map, the physical address of children and youth with any actionable behavioral/emotional needs is indicated. Those dots represent the possible need for specialty behavioral health treatment. Also on the map are the physical location of clinics that can provide Medicaid reimbursed specialty behavioral health treatment. Review of the map demonstrates that some areas have plenty of capacity to meet the behavioral health needs of children in custody of the State. Other locations have little if any capacity, despite foster homes in the area in which children and youth are living who might need specialty treatment. This map is a person-centered gap analysis.

Figure 9.3 presents a generic model for admission into two levels of care: Care Coordination and Residential Treatment Center (RTC)/Qualified Residential Treatment Program (QRTP). Models similar to this one are used in many states to support decision-making around these types of placements for youth.

### *Unmet Transportation Needs in Idaho*

There is a substantial body of research that has demonstrated that transportation access barriers impact utilization of check-ups and ongoing care for chronic conditions, particularly among patients with fewer socioeconomic resources (Arcury et al., 2005; Syed et al., 2013). Most of this research has focused on specific populations such as women, older adults, chronically ill patients, individuals belonging to racial or ethnic minority groups, and adults in rural areas and used access to health care as the key dependent variable. (e.g., Solomon et al., 2020; Wallace et al., 2005). Less attention has been paid to children and families and even less has attempted to understand the impact of unmet transportation needs on clinical and functional outcomes. Of

### Need for DCFS Contracted MH Programs April 2012

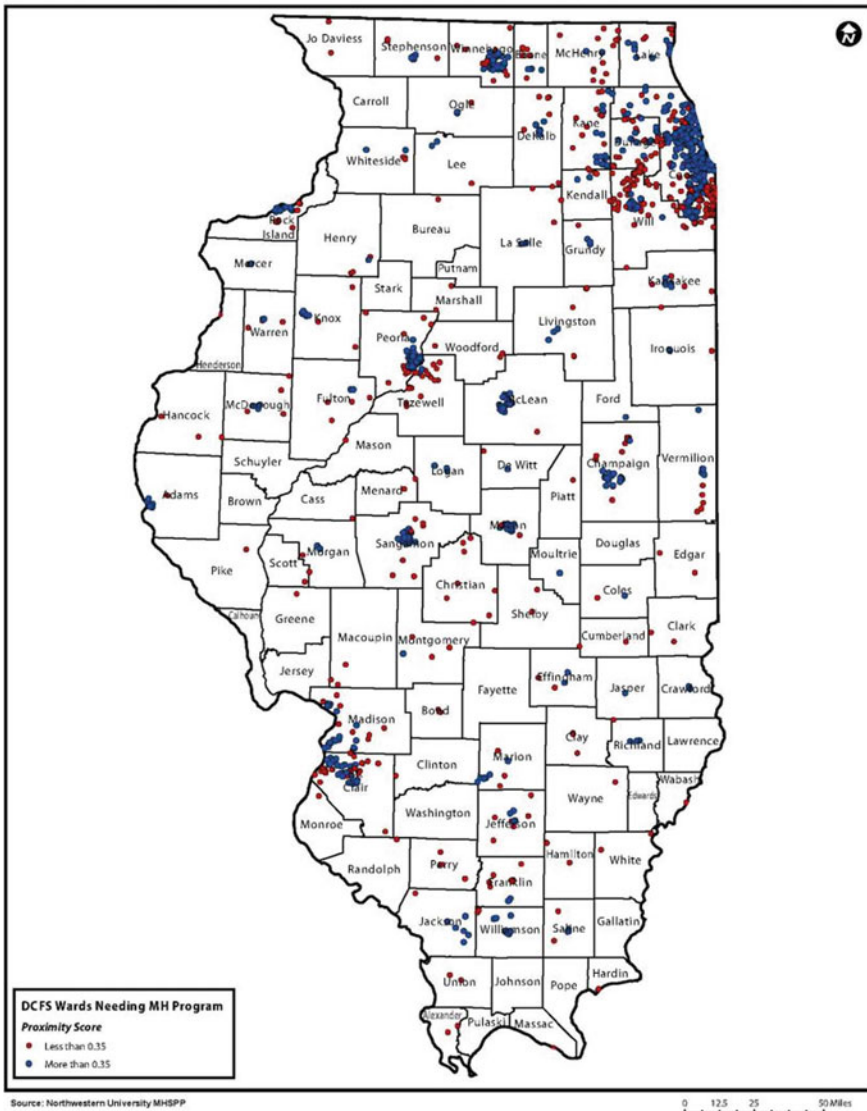
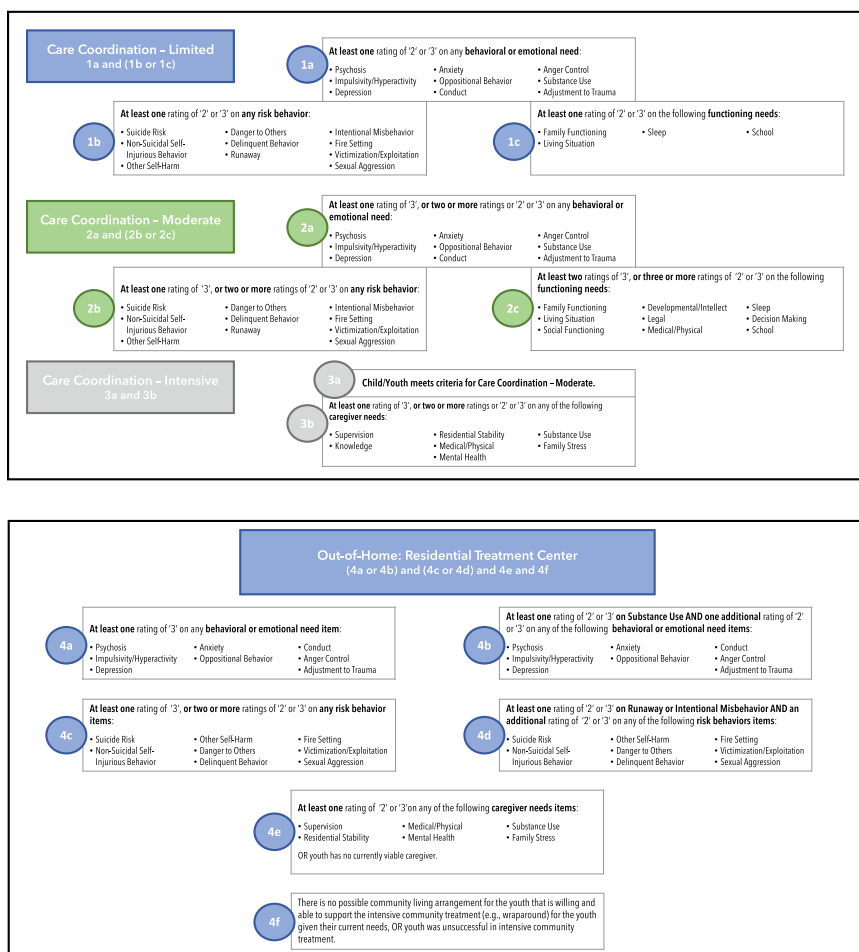


Fig. 9.2 Geomapping for child welfare in Chicago (*Source* Praed Foundation, 2014)

course, these outcomes are the focus of TCOM with access simply being a service system indicator of possible clinical and functional impact.

The State of Idaho Department of Health and Welfare (2017) implemented the CANS as a part of a comprehensive system transformation to improve intensive community service options for youth and families. Given the rural



**Fig. 9.3** Generic decision models for Care Coordination and Residential Treatment using the CANS

nature of much of the state, inclusion of an item assessing unmet transportation needs was a natural decision given the guiding of ‘what do you need to know to be effective’ in the mass customization of CANS versions.

Recently, the Center for Innovation in Population Health at the University of Kentucky performed an analysis of the relationship of unmet transportation on clinical and functional outcomes in the Idaho system of care of youth and families (Riley et al., 2021). Caregivers were classified as either ‘Never Having’ unmet transportation needs (always ‘0’ or ‘1’ through follow-along period), ‘Resolved’ transportation needs (initially having a ‘2’ or ‘3’ on transportation but later having a ‘0’ or ‘1’), or ‘Unresolved’ transportation needs

(always having a ‘2’ or ‘3’ on transportation across the follow-along period). Youth outcomes were defined by CANS domain—Behavioral/Emotional, Functioning, Risk Behaviors, and Strengths—as the proportion of resolved needs or built strengths relative to the number ever actionable. A cohort of 4,341 youth and families with at least two assessments (schedule for every 90 days) were followed over the course of care over the one-year period from March 2019 to March 2020. We specifically excluded following along during the pandemic given the dramatic shift to telehealth during this period.

Analysis demonstrated a clear and consistent relationship between met transportation needs and clinical and functional improvement including more strengths built. Only youth for whom the caregiver was never able to resolve their unmet transportation needs across the course of the follow-along period showed no improvement. While youth whose caregivers initiated care with unmet transportation needs started with more needs and few strength than youth without transportation needs, by the end of the follow-along period their clinical and functional improvements were equivalent to those who never had transportation needs. These results have notable policy implications. Ensuring that once identified, transportation needs can be met, and it is an important responsibility for effective community-based care.

### *Maintaining Integrity of Decision Support*

Although we discussed decision support models for program entry management in the previous chapter, the most common application of these models is at the system level. As described above, the original aspiration of TCOM was to assist in supporting reliable decision-making (Lyons, 2004). To this day, the most common reasons, jurisdictions choose to implement TCOM, are for decision support. Although the TCOM tools can support the full range of decisions from individual plans of care to placements, intensity of case management and level of care, for clear economic and restrictiveness of care concerns, often the focus of new implementations is on the most expensive and intensive levels of care. Typically, implementations expand over time to include other applications including supporting decisions to a wider array of choices in the system.

***Strategies to Increase the Accuracy of Decision Support Strategies.*** A good implementation of any decision support model must understand the historical challenges presented by these approaches. For many of the reasons discussed in Chapter 1, the system has created inherent conflict of interests regarding clinical assessments. For example, in health and behavioral health, providers are incentivized to see problems while third-party payers are incentivized to ignore problems. This service system reality bleeds into system partners perceptions of decision support. Over the last two decades of implementing these approaches, we have learned things that help.

*Not an expert system.* Decision support does not ‘make’ decisions. In TCOM, we emphasize that the goal is to *support* more reliable decision-making. Originally in our work, dating back to the mid-1990s, we used the word ‘algorithms’ to describe our decision models. This was before Google, Facebook, and other companies that use algorithms to make decisions. So recently, we have shifted away from the use of this term because it is important not to associate the approach with these newly controversial strategies.

*Aspirational.* I think it is impossible to underestimate the commitment of the majority of the people who work in the helping sectors. They are clearly not doing it for the money. The vast majority of people, regardless of their position in the system, care deeply about the well-being of those the system is intended to help. Keeping the focus on this single common aspiration in all actions and communications can be very important to ensuring effective use of TCOM tools and decision support processes. The TCOM tools are designed specifically to allow the focus to stay on the best interests of the people to be helped. Consistently, reminding everyone involved of this common purpose is one of the most powerful strategies in initiating and maintaining and implementation.

*Consensus.* Sometime inaccurate assessments become from inherent bias in trained professionals who have a specific focus to their work. When more than one person is involved in a decision, usually that decision is more balanced. Consensus in the assessment process tends to balance out these biases by ensuring that second, third and potentially more opinions inform the assessment. Other times, inaccurate assessment or flawed applications of decision support can be understood from the perspective of competing agenda, exacerbated by an absence of trust. A clinician may be more likely to feel it is ‘right’ to provide an inaccurate diagnosis to secure treatment if they believe that the funder is unfairly restricting what conditions are given access to funded care. Separate from this issue, intentionally inaccurate clinical assessments are a form of fraud. Multiple people who work together to create inaccurate clinical assessments are a conspiracy to commit fraud. Consensus works to keep processes honest. Fraud is usually committed in the dark; consensus brings light to the process.

*Transparency.* Use of transparency has a potentially more subtle impact on the implementation of decision support models and can work in multiple ways. Communication of the results of assessment results broadly so that they inform care planning, supervision, referral, etc., is very helpful in rebuilding trust. When assessment results are used exclusively to inform a decision that has financial implications, problems or the perception of problems are more likely to arise.

Transparency in publicly sharing the decision model to all partners can be valuable to rebuild trust. We people think something is ‘secret’ they are prone to invent theories that are generally wrong and ultimately destructive. Transparency reduces rumormongering.

*Reliability Audit.* Financial audits have been used extensively to ensure the accuracy, legitimacy, and integrity of financial transactions and the record keeping. If we accept the basic premise of TCOM that the helping sector should be about the people we help, then the accuracy, legitimacy, and integrity of information about people should be valued with the same level of scrutiny and accountability as financial information. With this concept in mind, we have often used clinical audits to monitor the field reliability of TCOM tools (e.g., Anderson et al., 2003; Lyons et al., 2002).

Clinical audit of TCOM tools simply requires obtaining clinical notes and other assessment information from the time corresponding to the completion of the tool. The auditor reviews those notes and completes the tool based on the written assessment information. This audited version of the tool is then compared to the officially submitted version using an intraclass correlation coefficient exactly as is done with certification reliability. Above, a 0.70 is considered sufficient audit reliability. Perfect audit reliability is neither feasible nor desirable given the consensus nature of the communimetric assessment process. However, other documentation and consensus assessments should be consistent with each other.

Selection of files to audit can either be random as is often done with financial records and quality assurance reviews. However, it also can be targeted. We recently have reported on a machine-learning (neural network) approach for identifying potentially anomalous applications of the CANS (Cordell et al., 2021). Select of audit cases could be targeted to look at those cases with the greatest potential to be problematic. Alternatively, cases that do not follow the recommendations of decision support models also could be selected. It is important to note that any targeted approaches might reveal problems with the completion of the tool OR they might reveal different challenges that require expansion of interventions or activities or adjustment of decision support models. A diversion from the recommended decision may be due to clinical brilliance, unreliability, or suboptimal performance. An effective targeted audit should be able to identify each of these three circumstances.

### *Why TCOM Seeks to Avoid Risk Prediction Decision Models*

Given the pressure some helping sectors feel to identify people at particular risk of future bad outcomes, there is always interest in using TCOM tools in a precision medicine or predictive analytic way to predict future risk. With some exceptions, generally to meet systems where they are, we try to avoid pursuing decision support in this particular way.

The problem with risk prediction models lies in their logic. If you have a valid risk assessment, or in other words if at Time 1 you can validly predict a bad outcome at Time 2, then you have a failed system. If you know someone at Time 1 is in danger of having a bad outcome and then in fact, that bad outcome occurs, the system has clearly failed that person. Therefore, only an unsuccessful risk management system would have a valid risk assessment.

Rigorous research on risk assessment in a successful system would logically find that the risk assessment is invalid—it does not accurately predict bad outcomes. Of course, we could do research where we only assess risk and then do nothing. However, the ethics of this line of inquiry would be questionable at best and only justifiable in a minimal or no resource environment. Therefore, the very concept of ‘risk assessment’, although appealing at a superficial level, quickly defeats itself upon careful consideration.

For the reason described above, the field of TCOM is more interested in identifying the reasons why someone would chose not to re-offend (i.e., citizenogenic factors) rather than the factors that predict their re-offending (i.e., criminogenic factors). Similarly, the field is more interested in factors related to people decide not to use drugs or alcohol rather than those associated with relapse.

While aspects of this argument are purely semantic (focusing on the other end of a success-failure continuum), the subtle distinction between these two foci is not entirely simply about the use of words. For example, often the best predictors of bad outcomes are static indicators (which cannot be transformed) or trigger events that must be avoided (e.g., peer influences, trauma reminders). The factors related to recovery (regardless of the specific form) involve finding meaning and reasons not to place oneself in triggering positions. These factors have more to do with strengths and resilience than they do with understanding needs and pathology. In this way, a focus on positive outcomes rather than negative ones can result in a substantively different research and policy agenda.

### *Options for Defining Outcomes*

System-level outcomes management is the primary goal of all outcomes management initiatives. The types of strategies used here include provider profiling and performance/value-based contracting. Unfortunately, performance or value-based contracting in many jurisdictions is devolved into a utilization management intervention rather than actual outcomes management. This is because more likely than not the ‘outcome’ has been defined from a service system perspective and involves the use of services. This devolution occurs when systems manage service data (e.g., length of stay, number of sessions) rather than transformations (e.g., changes experienced by the people served). However, some jurisdictions are beginning the process of learning how to understand clinical and functional outcomes, and some are even beginning to incentivize effective care from a transformational perspective (e.g., Indiana’s public mental health system). The five most common outcome indicators for systems include:

- a. Percentage of people with actionable needs/useful strengths at Time 1 versus Time 2.



- b. Percentage of ever actionable needs as a baseline versus percentage actionable at Time 2.
- c. Domain scores.
- d. Reliable change index (using domain scores).
- e. Trajectories of recovery (typically using domain scores).

These five approaches provide different information but both can be quite useful to understanding system-level performance.

*Change in the percentage of actionable needs.* This first approach is the simplest to understand and easiest to calculate. All that is required is a frequency of people served with a '2' or '3' on a need (i.e., actionable need) or a '0' or '1' on a strength (i.e., useful strength). A simple comparison of what percentage of people come in with a need that is then resolved or the absence of a strength that is then built can be a simple but compelling piece of information about system performance by specific needs/strengths.

The advantages of this outcome metric lie in its simplicity. If necessary, it can be calculated by hand. Everyone understands what it means to have an actionable need that becomes resolved during the course of care. It is not hard to convince even skeptics that resolving needs or building strengths is a meaningful outcome. The disadvantages also arise for its simplicity. First, it presumes perfect knowledge of the person's story at the initiation of care. That standard is unrealistic over the group of people. Invariably, trust and attention issues limit a full understanding of all needs and strengths across a population of people helped. Second, no credit is given for stabilization. Moving from a '3' to a '2' on any item is a notable improvement. The uses of actionable needs sacrifices this information and is less sensitive to outcomes of intensive and crisis interventions.

*Percentage of ever actionable needs as the baseline.* The second approach is a modification of the first that recognizes that helpers do not always have the full story of a person's needs and strengths at the initiation of care. There are hosts of reasons why individuals and families might not be forthcoming with their full stories early in an episode of care and including that reality in the outcome-monitoring strategy can be a useful strategy to reassure the perception of fairness in outcome-monitoring initiatives. This approach is calculated by counting the number of needs and strengths that were rated '2' or '3' at any time during the course of care and comparing those counts to the number of '2' or '3' ratings at the last assessment. Of course, to capture the full promise of this approach, people must be followed for at least three assessments. Only two assessments either miss the identified needs in the interim period or do not provide sufficient time to resolve those needs that identified later in the course of care.

The primary advantage of this approach is that it is better able to give 'full credit' for resolved needs and built strength. This metric directly addresses the limitations forced by using initial assessments as a baseline when often those assessments are underestimates of actual need. Although more sophisticated

than the first metric, this metric still will underestimate outcomes that involve a person or family moving from a rating of '3' to '2'. If a program is intended to serve primarily as a stabilizing intervention or if the program enrolls a high percentage of very high need individuals or family, then the numerator of this metric can be shifted from 'resolved' to 'improved' by counting an movement from a '3' to a '2' as a successful outcome.

*Domain Scores* are commonly used outcome metric to date. These metrics are calculated by average items in a domain (e.g., Mental Health, Functioning, Strengths) and multiplying by ten. Since there are typically a different number of items in each domain, this algebra services to create uniform domain scores ranging from 0 (i.e., all ratings of '0') to 30 (i.e., all ratings of '3'). It should be understood that if a decision is made to use domain scores these metrics are psychometric in design and, therefore, subject to the requirement of either classical test theory or item response theory (Lyons, 2009). Prior research has indicated that needs can be combined together in meaningful ways, as can be strengths. However, combining needs and strengths into a single metric violates the scaling requirements of a psychometric tool. For this reason, there is no total score of measures like the CANS, ANSA, and FAST, but there is a total score for the RISE as this tool uses a strengths action level approach throughout.

When calculating a domain score for purposes of studying outcome trajectories, it is useful to include only items that are likely to change over time as the result of an intervention. For example, Trauma Experiences are lifetime events and thus do not make useful change metrics. Items like Intellection or Developmental Functioning are also unlikely to change and should not be added to metrics to study change.

If domain scores are desired a quick and easy way to determine whether the selected items scale in the required manner of a psychometric measure is to calculate a Cronbach's Alpha on the items to be added. If the alpha for that set of items is at or above a 0.70, it is defensible to add the items to create a scale. Alpha was proposed as a measure of internal consistency reliability; however, in communimetrics, there is no such form of reliability—only inter-rater reliability matters (Lyons, 2009). However, alpha is calculated by essentially taking all possible split half reliabilities so it is essentially similar in form to a factor analysis—above a 0.70 would be consistent with a single factor solution. If you select a group of items that underperform relative to that standard, simply include the calculation of the 'alpha to remove' for each item which will give you the alpha calculation in each item were excluded. The non-fit items can be quickly identified and removed from the domain score until the alpha reaches a minimum 0.70.

The primary advantages of domain scores are that they are familiar concepts for evaluator and researchers, and they are likely more sensitive to change since the reliability is enhanced (i.e., linear combinations of items are always more reliable than a single item) and there is a wider range of scores.

The disadvantages of domain scores are two-fold. First, they create arbitrary metrics so they can be very difficult to interpret. Second, adding up items results in a substantial loss of information. For example, in a domain score involving nine items, a person could receive a score of ‘6’ by being rated with six ratings of ‘1’ or they could score ‘6’ by having two items rated ‘3’. A person with two Dangerous/Disabling needs is likely quite different clinically from a person with six things to key an eye on. Given these challenges, the clinical interpretation of the domain scores of communimetric measures can be challenging as any psychometric measure.

*The Reliable Change Index (RCI)* can be a useful strategy if you wish to use domain scores and return to the person as unit of analysis (Lyons, 2009). Many program evaluations look at mean changes on functional assessments to estimate outcomes. These analyses are problematic because no one is the mean. Further, mean changes mask the reality that some people get better while others get worse. Averages simply do not tell the story. There are many possible equations for an RCI. Here is a common one:

$$RCI = 1.28 * (\text{standard deviation}) \times \text{SQRT}(1 - \text{reliability})$$

We generally calculate RCIs for each dimension score of the CANS or ANSA (e.g., Functioning, Risk Behavior, etc.). This analysis is accomplished by scoring the dimension (item average multiplied by 10). The standard deviation of the baseline dimension score and the reliability at training are then plugged into the equation to calculate the RCI. Change scores from Time 1 to Time 2 are then compared to see whether the size of the observe change is higher than the RCI indicating a positive outcome. Of course, case worsening can be estimated in the same way—if the person has a change for the worse that is larger than the RCI, which would be a reliable worsening situation.

*Outcome trajectories* represent an interesting strategy to understand the rate of recovery within and across programs in a system. Figure 9.5 demonstrates a simple hierarchical linear model analysis by program type for the system of care in New Jersey. CMO is the Care Management Organization that used care coordinators in a wraparound model to manage care. YCM is Youth Case Management that was supportive. TRH is a Treatment Home that was designed to be a residential program of one model in a foster home. GRH is Group Home. PCR is Psychiatric Community Residence and RES is Residential Treatment. As you can see from Fig. 9.4, Treatment Home (TRH) outcome was not particularly effective at the time of this analysis.

Figures 9.5 and 9.6 take this trajectory analysis a set further. This figure represents the results of a growth curve analysis of CANS data for all children in New Jersey’s children’s system of care (Lyons et al., 2009). A hinged analysis method for hierarchical linear models was developed by Zoran Martynovich, Ph.D., to allow growth curves to be calculated independently both before and after a child’s referral to different types of placements. Since growth curve analysis was used, these lines represent a theoretical best fitting line

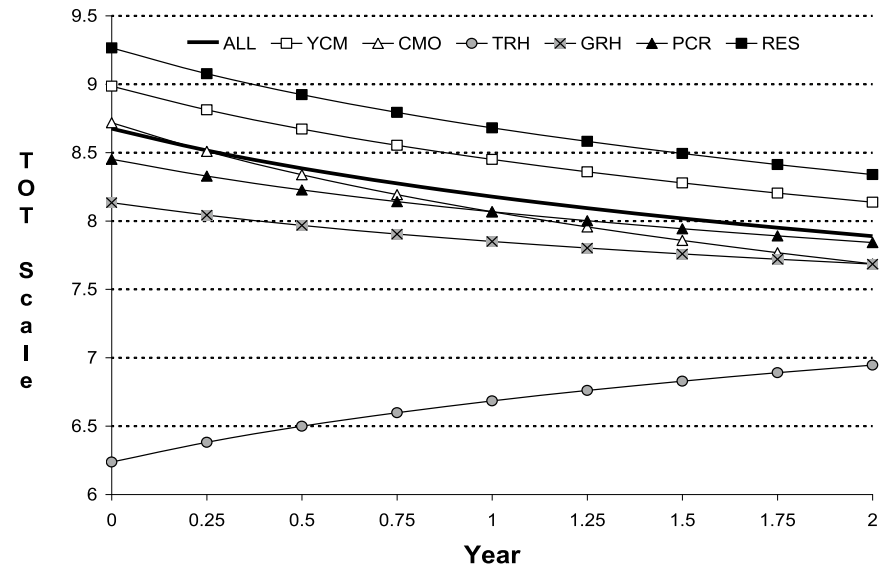


Fig. 9.4 Trajectories of change over time in the CANS (*Source* Praed Foundation, 2008)

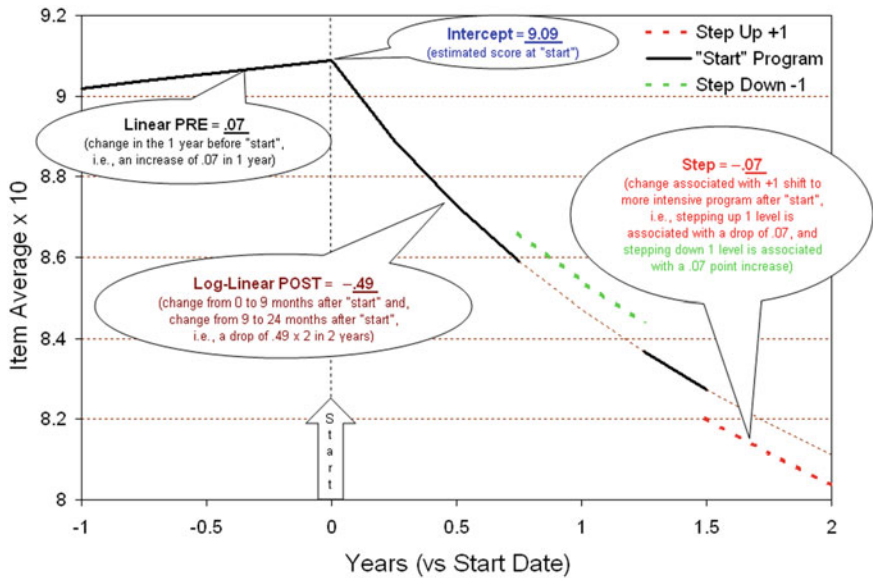
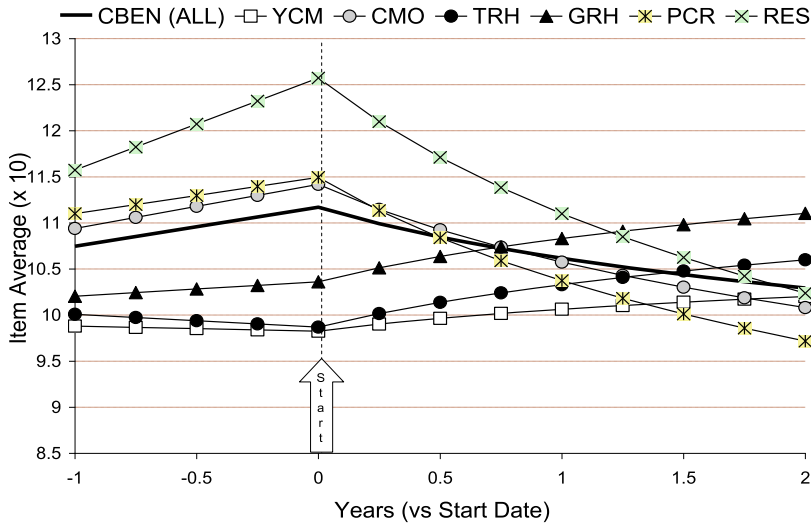


Fig. 9.5 Details for performed a hinged outcomes trajectory analysis (*Source* Praed Foundation, 2008)



**Fig. 9.6** Trajectories of recovery before and after entering different program types (Source: Praed Foundation, 2008)

combining data from more than 10,000 children and youth and more than 150,000 completed CANS. Figure 9.6 demonstrates how to interpret this type of hinged analysis. The CANS overall score (CEBN) was calculated as a linear combination of scores on the Behavioral/Emotional Needs, Risk Behaviors, and Functioning domains of the CANS used in New Jersey during this period. This overall score functions like a traditional psychometric measure of functional status (Lyons, 2009).

Review of Fig. 9.6 demonstrates that Residential Treatment (RFC) is a step-up placement. In other words, youth are ‘escalating in their needs’ (i.e., their average trajectory has a positive slope indicating that these youth are ‘getting worse’). After placement, they begin to have diminished needs and the most efficient period of residential treatment is in the first six months. If one conceptualizes the duration of treatment until a youth looks more like a youth at a lower level of care, scrutiny of this figure reveals that the recommended length of stay for residential would be seven months before youth in residential would look like youth starting wraparound (CMO) involvement. However, if wraparound was unavailable, it takes more than one year before youth in residential treatment, on average, improve the admission level of youth in Group Homes. Neither supportive case management (YCM) nor Treatment Homes were observed to be transformational.

In part because of these analysis and others, the State of New Jersey learned that their system design was not sufficiently effective. While the COMs had good outcomes, because wraparound is a philosophy, not a program, they learned that once all their CMO ‘slots’ were filled, these programs struggled

to step youth down to less intensive care. If all a youth needed was respite but the only place to get respite was in the CMO, they would stay in the CMO. Therefore, youth languished in Youth Case Management when they really needed wraparound. The state then implemented unified case management so that youth got what they needed once they were in the system of care. This innovation resulted in tripling the number of youth in care while cutting the number of youth sent to residential treatment by one-third. In addition, the state was able to close one-third of their detention centers and their children's psychiatric hospital (Manley, 2016).

**Creating comparisons.** Anytime data is presented on anything relevant to performance people seek a comparison. We often call these comparison data 'benchmarks'. Merriam Webster's online dictionary first definition of benchmark is as follows:

- 1a: Something that serves as a standard by which others may be measured or judged
- b: A point of reference from which measurements may be made.
- c: A standardized problem or test that serves as a basis for evaluation or comparison.

What this data is fit into the breakthrough work by Tversky and Kahneman (1974) discussed elsewhere in this book on anchoring heuristics. We are not providing the comparison (anchor) so people can understand their data per se; we are providing the anchor in order to produce the anchoring effect. 'It occurs when people consider a particular value of an unknown quantity before estimating that quantity' (Kahneman, 2011).

In the case of measuring helping skills at a system level, we are priming the system by providing a comparison anchor. The system does not have a sense what percentage of their population should have these skills. The anchor serves a primer to help them decide on when to provide technical assistance/supports in an attempt to improve their actual results on the Collaborative Helping Quality Inquiry (CHQIn), a tool that we developed for this purpose which is further described below. Their results (A) in relation to what they estimate the number should be (B), which they derived based upon the anchor (C) we provided. The number (B) will most likely be greater than (C), but not that much greater.

Maryland's child welfare system used a similar idea when they set an anchor for the percentage of CANS completed quarterly. On the comparison, line initially was drawn at 70% but then moved to 80% after a year. When set at 70%, the conversation about what counties need technical assistance revolved around that number (what counties were not close, what counties were close, what counties exceeded it). When we moved the line, the conversations revolved around the new anchor. Interestingly, one person who argued with us 'who gave you permission to move the line!!?'. Of course, you do

not need anyone's permission to use or shift any comparison anchor. You can use shifting anchors to facilitate system change by changing the standard and thereby shifting the conversation and resultant expectations. Most companies create their performance expectations based on performance the prior quarter or year, not based on some static standard. Developing consensus on outcomes standards is an important collaborative goal in TCOM.

## RE-VISIONING COMPLIANCE MONITORING AND UTILIZATION MANAGEMENT

### *Audit from a TCOM Framework*

When a system establishes policies, they must devise strategies to ensure that policies are followed. Without some strategy for monitoring the implementation of policies, systems have little manner in which to ensure that the system functions in the manner in which it is designed. One common strategy systems use to ensure that policies are followed is the use of audit. I described the use of audit to check the reliability of clinical assessments earlier. However, evolved audit methods can be used to monitor a variety of system priorities. In fact, shifting what is audited can have a dramatic impact on the performance of a system.

Because of their role as a strategy of policing policy, often providers see audit methodologies as a form of 'gotcha'. Therefore, provider organizations develop internal procedures to ensure that direct care staff document in a fashion that reduces audit findings. Consistent with the zero-sum game of service system design, the audit methodology is devolved into an adversarial relation between system administrators and provider agencies and sometimes even individual providers.

TCOM revisions the audit process. Clearly, systems have a responsibility to ensure that system policies are followed. That is a non-negotiable reality. However, that does not mean that it has to be experienced as an adversarial process between system administrators and providers. Audit methodologies can be pursued from a quality and effectiveness improvement perspective.

As with all communications, a story might help clarify the TCOM shift. New York State's Office of Child and Family Services (OCFS) ran a program called Bridges to Health (B2H). B2H was an intensive community program modeled consistent with wraparound philosophy that was designed for children with additional complexities—medical, developmental, or behavioral health. B2H used a version of the CANS. Originally, the OCFS state administrators audit whether or not B2H staff completed the CANS within the required time frame. This is a classic traditional audit focus. Of course, that lead to the CANS form being completed but it also led to considerable complaining about the CANS—it is too long, takes too much time, difficult to get done in the required time frame, certification is challenging for staff with zero training, and so forth. After several years, state administrators shifted the

audit to whether or not the needs and strengths identified in a specific child's CANS were fully integrated into that child's Individual Health Plan (IHP), the name of the required treatment planning document for B2H. Intriguingly that shift fundamentally changed B2H staff and supervisor's view and use of the CANS. The complaining slowed way down (it never goes away, of course), but the new audit requirement forced programs to do the little bit of extra thinking to understand the logical relationship between the CANS and the IHP. They could have done that work before, but they did not as there was no requirement for them to do so. Once required, they became inspired and suddenly the value of a careful, timely, and comprehensive person-centered assessment document was recognized.

**Collaborative Helping Quality Inquiry (CHQIn).** Another TCOM approach to monitoring and managing the quality of an implementation is with a structured survey approach that we call the Collaborative Helping Quality Inquiry (CHQIn). The CHQIn is designed to use web-enabled survey methods to obtain information from direct, helpers, supervisors, administrators, and people to be helped along with their families. The CHQIn assesses TCOM-related skills for direct helpers and their supervisors. As such, it utilizes a different action level rating as compared to the TCOM assessment approaches. For skills, the action levels are:

- 0 Have never done
- 1 Tried, not yet comfortable
- 2 Comfortable but not routine
- 3 Routine
- 4 Mastery, could teach others

The items of the CHQIn go through the key skills necessary to implement a person-centered assessment approach including the following domains: Assessment and Planning, Collaboration and Teaming, Consensus Building, Re-Assessment/Outcome, Mindful Organizing, and Psychological Safety. As you can see, the CHQIn provides actionable information for both improving care and organizational climate.

### *A TCOM Approach to Site Visits*

TCOM strategies can be embedded into our approach for monitoring residential and treatment facilities. The first full application of this approach was done as a collaboration with New Jersey's Department of Human Services. With Seth Bassion and his Field Safety and Services Unit (FSSU) of the Office of Program Integrity and Accountability, we developed the Safety Assessment and Field Evaluation Tool (SAFE-T).



The SAFE-T was designed based on a specific legislative mandate. Thousands of adults with developmental challenges live in state-supported community residences. Over the past few years, there had been a number of high-profile death of residents of these facilities. A group of parents became active in an effort to seek improvements to avoid future deaths. As a solution, on May 1, 2018, the NJ legislature passed Public Law 2017, Chapter 238, which among other things formed the FSSU and stipulated that this program of NJ DHS be required to do two unannounced visits each year for each resident living in a state-funded community residence. Given the state's positive experience with the use of the CANS, they requested our assistance in designing the assessment process to be used in the FSSU.

What is novel about the SAFE-T approach to site visit review is that it capitalizes on the mass customization perspective of TCOM. Most site visitors have a set of things that they need to review—fire exits, staff monitoring, lines of site, etc. Every site is subjected to the same review. With the SAFE-T, the FSSU staff first reviews the resident's current plan to identify their specific needs on a limited set of dimensions that cover the majority of all possible needs. For instance, on the Sensory needs item they might identify a need based on the person requires glasses. Alternatively, on the Mobility needs item, they might require some type of assistance or perhaps are wheelchair bound. On Nutrition, do they need chopped food to avoid choking or do they require a special diet due to diabetes or another medical condition. Now armed with an understanding of *each individual's* pattern of needs, FSSU drops in unannounced to look to see whether the community residence is effectively addressing each individual's needs. For instance, if they need glasses on their plan, then does the person have an operable pair of glasses on site? Alternatively, is their food chopped if that is specified on their plan? The communimetric action levels for the SAFE-T are designed to be simple and efficient to follow the decisions that FSSU staff must make at each visit.

- Green:* no need or the identified need was met
- Yellow:* the identified need was not met but this circumstance was not placing the individual at imminent risk of harm
- Red:* the program is not meeting the individual's needs and this failure is putting the person at notable imminent risk of harm

Of course, the colors can be given numerical values for analytic purposes; however, that is unnecessary for program purposes. The FSSU visit ends with all greens then that is positive feedback to the agency. A yellow is communicated to the agency and a corrective plan is required. With a red rating, the FSSU worker will stay on site until the situation is remedied.

This method has now been used for about four years with appreciable results on the system. After the first 20,000 assessments, common themes

of unmet needs tend to center on equipment and devices, dietary and physical environment. All of these issues can be corrected leading to a community residence system that more consistently meets the needs of its residents.

### *Sending Utilization Management to the Dustbin of History*

Currently, there are a large number of people involved in a job called ‘utilization management’. Most systems and even some large agencies have employees who describe themselves as ‘utilization managers’. Sometimes they are hybrid ‘quality and utilization managers’. Even a cursory review of the existing literature on this topic reveals that different people use this term to mean different things. The existence of different meanings for the same word makes the use of that term more difficult. In effort to address this challenge, the Institute of Medicine (IOM) Committee on Utilization Management by Third Parties (Field & Gray, 1989) defined utilization management as

a set of techniques used by or on behalf of purchasers of health care benefits to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision. (Field & Gray, 1989, p. 1)

With this definition, most forms, managed care, or prior authorization processes are covered by this definition. However, so are strategies where service receipt is reviewed a posteriori such as billing audits and similar strategies. An entire cohort of consultants travels the country teaching providers how to document service provision to ensure that utilization managers will not deny payment for services already provided. These consultants advertise themselves as being able to maximize (e.g., Medicaid, Medicare, etc.) billing.

While there are increasing efforts to include some clinical logic or medical necessity criteria into utilization management, review of the IOM (now called the National Academy of Medicine beginning in 2015) demonstrates that no requirement exists in this definition for the use of any clinical criterion whatsoever. In other words, it is legitimate ‘utilization management’ to only manage service receipt. This logical gap sometimes lead to utilization management focusing on billable hours and staff productivity independent of the best interests of the people to be helped.

This type of thinking was the original logic for the ‘just say no’ model of managed care that was popular beginning in the 1980s (Freidlin, 2002). The logic for this approach was a classic combination of traditional economic theory and service system logic. Economists at the time noted that some health care was ‘elastic’ in its utilization—that is price sensitive which remains true today (Ellis et al., 2017). In this way of thinking, if people really need something they will be willing to pay no matter the cost. If something is viewed more as ‘luxury’, then consumers will purchase it only if it is affordable but would be less willing as the price goes higher. In the theory at the time, you

can manage things whose utilization is sensitive to price by either manipulating the price or reducing access. Access barriers became a reasonable utilization management strategy in this way of thinking. Not coincidentally, this economic thinking is congruent with service system thinking as described in Chapter 1 which focuses on access to care and the most important aspect of the service system.

Although some versions of utilization management have begun to approach strategies congruent with TCOM, the ideal of managing utilization is an ongoing, slow-moving disaster from a TCOM perspective. Even the language is problematic since utilization is the focus and that predominantly is used to manage or contain costs. Service use is an easy indicator for cost of care. The focus on systems should not be to contain costs but rather to provide effective help. Efforts to contain costs are as much of a waste of money as the supposed over expenditures they are designed to prevent. From a TCOM perspective, investments should be made in system management efforts that monitor the impact of care, not access to care. Of course, investments in effective help must be made with consideration of the cost and the limitations of budgets; however, at least in our current environment, in my experience effective care is often less expensive than ineffective care.

The simplest monitoring strategy for impact is to monitor outcomes by provider grouping. This approach would be congruent with the audit methods and utilization managers have used to date. As with nearly everything else, in our experiences most providers have outcomes that cluster at an average. Sometimes one or two stand out as particularly effective and almost invariably, one or more stand out as very ineffective.

One of my first experiences with this type of audit was a review of residential treatment programs that I consulted to in the State of Oregon (Lyons et al., 2001). At the time, Oregon had nine residential treatment programs that served youth in child welfare. They had a third-party oversight group and used the Childhood Acuity of Psychiatric Illness (CAPI; Lyons, 1998a) as an outcome-monitoring tool. The staff of the review organization completed the CAPI after training and certification. We used hierarchical linear models to calculate trajectories of care. While eight of the programs had evidence of improvement over time, one program had reliable worsening. In other words, over time, on average, youth in this program can reliably symptomatic. Since the state already has limited options for placing youth in these facilities, it was not in a position to close this failing facility. Instead, they sent in a consultation team that reviewed the program and made suggestions for improvement. What they discovered ‘on the ground’ is that there had been very unstable leadership at the organization with massive turnover at the supervisor level and above. The result was that direct care staff received almost no guidance. So essentially, it had become a Lord of the Flies (Golding, 1954) situation with young adults staff with unresolved adolescent issues trying to provide ‘treatment’ to youth with many of the same issues. Once leadership was stabilized

and proper supervision provided outcome trajectories returned to expected positive improvements as observed in the other programs.

Multiple aspects of this project illustrate key aspect of the TCOM perspective. First, the status of youth in the program over time drove the quality improvement initiative—not some status at time of discharge (e.g., return to community). Second, audit methods were used to determine the clinical status of youth beyond the report of direct care staff—placing clinical information on par with financial. Third, the response was not punitive but rather constructive and educational—creating an aspirational learning rather than compliance culture. In the subsequent year when the same analysis was applied to the CAPI outcome data after the quality improvement intervention was completed with this struggling facility, their outcome trajectories improved to being consistent with the average performance of all sites.

In summary, system-level applications of TCOM offer systems notable opportunities for system transformation. System change guided by knowledge of what is the best interests and most helpful to the people who the system should represent a sensible strategy. The fact that it can be very successful in generating improved system effectiveness should come as no surprise. As stated in Chapter 1, the key to any successful business is to manage the intended business. Our business is transformational—helping people towards their best lives.

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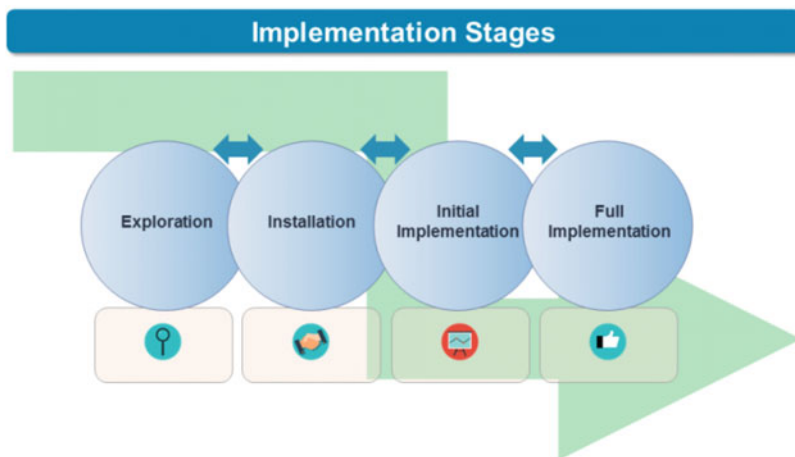


## ‘Doing’ TCOM—Strategies, Barriers, and Opportunities for Implementing and Sustaining

Anything can fail but not everything can succeed

There is a saying that if you have seen one implementation, you have seen one implementation. In addition, while it is true that each implementation of TCOM is unique, there are important learnings from science and practice about common strategies that are useful for any TCOM implementation. There are strategies that are useful for initiating and sustaining components of the TCOM approach, per se. To inform this work there is a burgeoning science of implementation. Although the term ‘implementation science’ was in some ways co-opted early by one particular approach (Fixsen et al., 2015), there is growing body of work on different approaches to the science of implementation (e.g., Bauer et al., 2015). Most approaches propose some version of a phased model of initiating an innovation that follows either program evaluation methods from the 1970s or Plan-Do-Study-Act evolutions from the original Schwert Cycle from the field of Continual Quality Improvement (CQI).

Simple phase models go from planning to full implementation such as the following from the National Implementation Research Network as shown in Fig. 10.1. The first phase is ‘Exploration’ where the need for the implementation is studied and opportunities and potential barriers are identified. The second phase is called ‘Installation’ and involves putting things in place in preparation for the third phase, which is called ‘Initial Implementation’. The implementation is rolled out in this third state. The final stage is called ‘Full Implementation’. That is when everything is operational and the issues tend to revolve around sustainability.



**Fig. 10.1** A simple model of the phases of implementation (National Implementation Research Network, 2022)

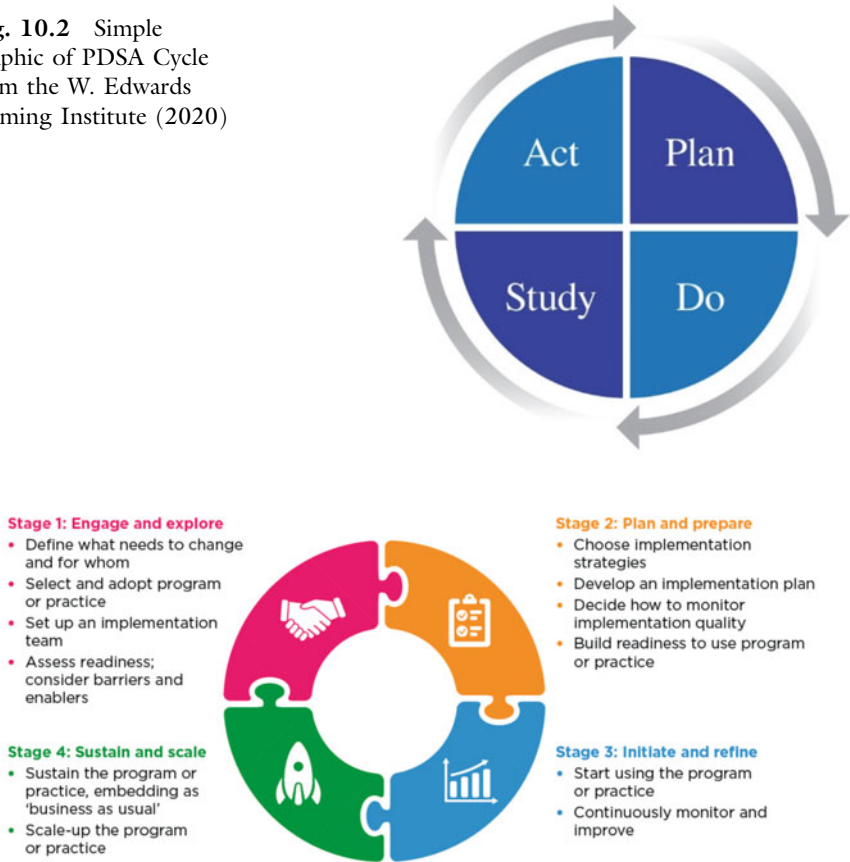
This simple model takes a linear approach to planning and implementation that focuses on the importance of design on the success of an implementation. It represents the ‘measure twice, cut once’ philosophy that leads to successful product launches. Careful planning clearly results in implementations that are more successful; however, the challenge of this approach is that the design process must be both fully understood and completely anticipate the application. Testing prototype designs generally occurs prior to implementation in the exploration or installation phases. Sometimes,

in what would be considered a worst-case scenario, designs are tested and adjusted during early implementation. In these types of models, careful pre-planning should mitigate against having to adjust the model during early experience of applying the innovation. A simple phase model might fight the implementation of a TCOM tools (e.g., implementing the CANS or ANSA in a particular jurisdiction) but does not fit a full TCOM implementation.

Approaches that evolve from CQI more explicitly focus on the importance of feedback in the implementation phase so that the implementation adjusts as it rolls out based on the experiences in the field. Although design considerations are important in this approach, they are balanced with experiences in the anticipation that all designs will be flawed in practice. This conceptualization of implementation is a bit more akin to building an airplane while you fly it. Not always desirable but often necessary if we do not have an a priori clear concept of the optimal design of the airplane. In most helping sectors, there is little knowledge regarding the optimal system or program. What knowledge that does exist is insufficient to entirely complete a guaranteed effective design concept for any innovation. Thus, this implementation



**Fig. 10.2** Simple graphic of PDSA Cycle from the W. Edwards Deming Institute (2020)



**Fig. 10.3** Implementation cycle from the Australian Institute of Family Studies

approach is quite common. The process of this type of implementation is captured with the commonly used Plan-Do-Study-Act cycle (Fig. 10.2).

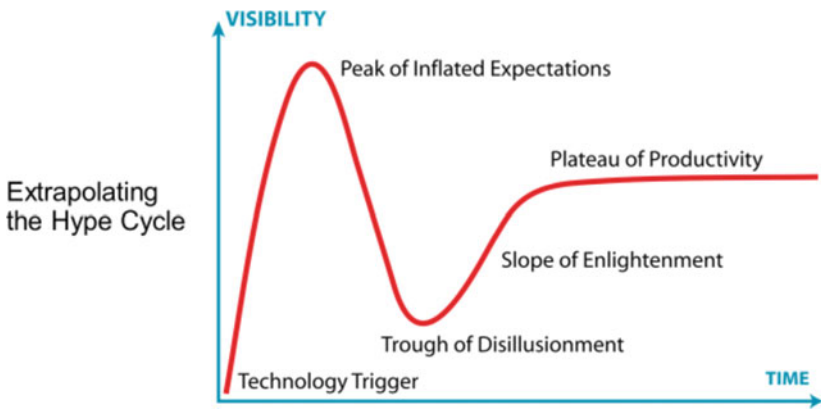
The following is an evolution of the classic PDSA cycle developed by the Australian Institute of Family studies. This model is designed specifically for the implementation of innovations in helping systems. Note the explicit value placed on preparing the organization through efforts to engage onboarding for a change process (Fig. 10.3).

One of the challenges of the CQI cycle is that it is considered a 'cycle'. In other words, in graphic representations, it often is depicted as a circular process that repeats itself. Sadly, this design creates a metaphor that is a bit like a dog chasing its tail. What you want instead is a pathway towards improved effectiveness. The process of implementation should not be a 'rinse-and-repeat' cycle, it should be a spiraling process that moves, albeit unevenly, towards increased effectiveness. We should expect a feedback process to create the

opportunity for nonlinear progress on one or more dimensions of impact. However, without a clear vision of how to define long-term program, agency, or system aspirations and benchmark progress towards these goals, the CQI cycle becomes a repeating process with no means of understanding what if any progress has occurred.

### AN ALTERNATIVE WAY OF THINKING ABOUT IMPLEMENTATION

The field of technology innovation has led to a large number of experiences with the introduction of new ways of doing things. These experiences led the technology firm Gartner to propose the ‘Hype Cycle’ (Flew, 2008). Although criticized for the lack of data providing empirical support, there are aspects of this way of thinking about the implementation of innovation that is useful for our purposes (Henton & Held, 2013). Figure 10.4 provides a basic outline of this descriptive analysis of implementation. At some point, an identified need triggers the development of a new technology. In our example, a jurisdiction has defined the need for an evidence-based assessment approach and the CANS is selected for this purpose. The hype begins. In other words, in order to get initial buy-in, it is seen as useful for the jurisdiction to create excitement and enthusiasm for the innovation, for the use of the CANS. Hype at the introduction of a new technology leads to a rapid escalation of expectations that often peak well above the ability of any new technology to full deliver on its promise. That peak invariably results in experiences short of expectations. As a result, a dramatic decline in enthusiasm ensues which bottoms out in the Trough of Disillusionment. If the implementation provides sufficient support and the technology delivers on its original intent, this depression of enthusiasm can be followed by what he called the Slope of Enlightenment leading to



**Fig. 10.4** Gartner’s Hype Cycle for the introduction of new technology

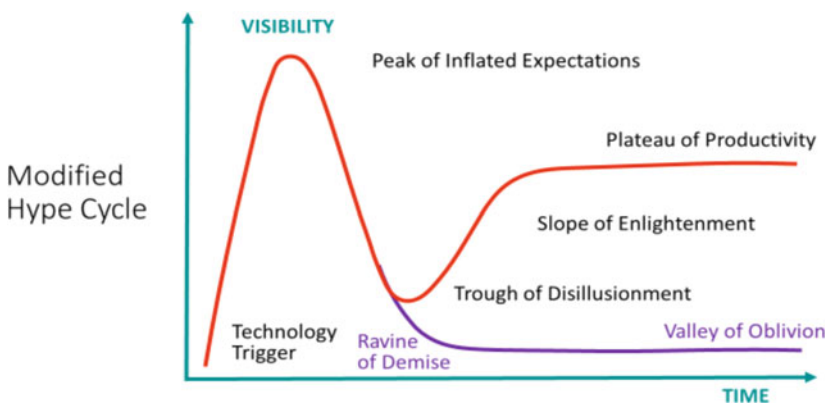
ongoing success on the Plateau of Productivity. In our example, the CANS becomes realistically understood and used in a fashion that fits its purposes.

People in the field see that it is not going away (i.e., 'the flavor of the month') and invest in learning how to do it well.

However, if the technology is ineffective or the implementation support is insufficient to help people in the use of the technology, the approach will never ascend from the Trough of Disillusionment (Fig. 10.5). This results in the innovation continuing loss of support in the Ravine of Demise ending its journey in the Valley of Oblivion. Either the CANS is simply used as a form and no one invest much in learning how to use it or it is abandon and the cycle begins again.

While amusing, the Hype Cycle offers an important insight into the role of managing expectations in the initiation of any innovation. It is likely a necessary condition of the launch of any innovation that some excitement must be generated. However, it also is likely and perhaps inevitable that this initial excitement will lead to an experience of over-promising. New implementations struggle when they fail to meet expectations. While you need initial enthusiasm to fuel the start, that same enthusiasm if not met with early success can challenge the implementation process down the road.

Since most innovations require a learning curve before they become fully integrated into a workflow, it is often impossible to achieve the promise immediately upon first use. In this understanding of implementation are necessary—first, the innovation has to actually work (i.e., to be helpful) and second, care should be taken to soften initial disappointments and frustrations and maintain sufficient focus to work through until the 'Plateau of Productivity' is achieved. Investing in second level training in TCOM tools at this stage of an implementation to help people move from 'do' the tool to 'using' the tool is key in the success of any implementation.



**Fig. 10.5** If you cannot get out of the Trough of Disillusionment it leads to failed implementations in the Valley of Oblivion

## IMPLEMENTATION OF COMPONENTS OF THE TCOM APPROACH

There is substantial experience now in implementing various aspects of a TCOM approach. There are recent experiences fully implementing TCOM and it is reasonable to say that implementation is a process that does not end. Nor should it ever end. Every implementation is different and every system, agency, or program starts at a different place in its own story. It is important to recognize then that no ‘formula’ exists to ‘do TCOM’. Rather, a conceptual framework comes with an identifiable set of strategies and processes that can be used in any number of sequences over a time. In all systems, but particularly in publically funded helping systems, people and circumstances are always changing.

Leadership changes with changes in elected governments. Direct helpers generally do not stay in the jobs more than a few years. Given the context of the publicly funded helping sector, it is wise to consider the fact that the process of implementing the TCOM approach is perpetual. In fact, in our experience, implementations have a natural ebb and flow across different leadership and time. Once we embrace this natural progression, then the inevitable challenges of sustaining and re-engaging ongoing applications become less daunting and are just a part of doing business.

The reason to begin to adopt TCOM also varies. Sometimes a few agencies in a state adopt TCOM or TCOM tools first. When they share their positive experiences with others in the system, this builds interest and reassures state level administrators that they might not receive enormous pushback should they choose to implement. Alternative, a lawsuit brought against a state can provide the impetus for an implementation of the approach. In reaching a settlement, it is often a point of negotiation and easy agreement to include one of the TCOM tools or even the approach. A court settlement provides a different type of motivation to secure a good implementation—often to resolve the lawsuit. We have worked with a number of jurisdictions to resolve lawsuits using the TCOM approach. The pathways to implementation are many but implementation science is clear with regard to the types of things that facilitate good fidelity to an approach (Fixsen et al., 2015).

## GETTING STARTED

*Creating an Implementation Team and Starting a Plan.* Successful implementation of TCOM begins with educating leadership and key system partners on the TCOM framework. Ideally, an implementation has a small leadership group for decision-making and a larger partner group for input into those decisions. Active representation should include key system functions (e.g., direct care, supervisors, leadership, quality and compliance staff, clients, fiscal staff). Inclusion of people with lived experiences relative to the implementation should be included in at least the larger system partner committee.

The implementation team must be empowered by leadership to make decisions or have direct access to system/organization leadership when decisions are 'above the pay grade' of the committee members. Ideally, the implementation team will be co-construct both the tools and the implementation plan using co-production approaches. Generally, teams start with a version of a tool from the TCOM suite (e.g., CANS, ANSA, FAST, and CAT), identify the decision-making points (e.g., assessment, service plan review, step down, outcome/impact) to support, and customize the tool to fit those applications in their local jurisdiction. The implementation team should be a communication 'hub' that organizes information and input from all partners. A communication strategy should be part of the implementation plan.

*Managing Expectations.* One of the most challenging tasks of the implementation team and system leadership is managing expectations. Given that implementations take time to get started and never really end, it is important for everyone to have realistic expectations about the process and impact. Unanimity of expectations is of course aspirational. Reality suggests that a large enough segment of the system buy into the process for the long term to deal with the inevitable rumors, misinformation, and pockets of willful ignorance expressed by people resisting the change process.

When a new innovation is introduced and adopted, people fall along a continuum of adoption (Fig. 10.6). The same person can be on different places on the continuum, depending on the innovation. Identifying the 'early adopter' group is key to the successful diffusion of innovation (Implementation of something new). That's the group that drives the early majority, which drives the overall adoption of an innovation. Spending time trying to persuade your *entire* audience can be ineffective and a poor use of resources. Addressing the late majority is best done six months to one year into the implementation. Addressing the laggards requires job sanctions that generally cannot be accomplished until the standard assessment process is fully operational. With most

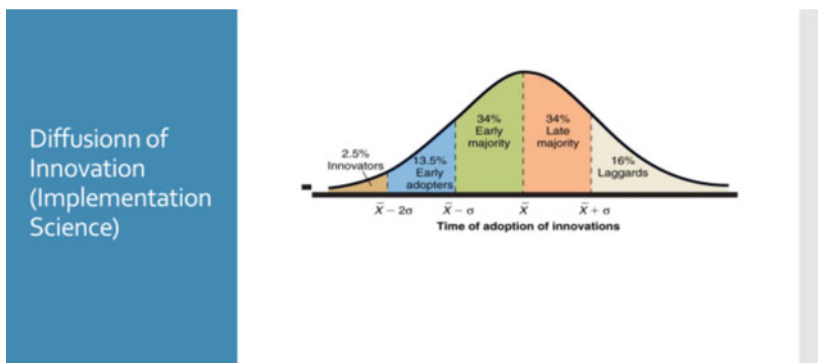


Fig. 10.6 Continuum of adoption of innovations

people completing the measures, the opportunity is created to hold the latest adopters accountability for their failures to comply.

It has been my repeated experience that the best way to manage expectations is to return repeatedly to the shared vision of TCOM—the best interests of the people served by the system. Nearly everyone shares that aspiration. Even if they do not, few people will openly state that they care more about something other than the best interests of the people to be helped, not even lobbyists. It is a very powerful moral argument. However, if you say it you need to back up that vision and your words with action—actions taken must clearly be in the best interests of the people to be helped. Otherwise, the implementation leadership can end up looking like a classic authoritarian misinformation campaign where leadership says the opposite of what it means and accuses others of the things for which they are guilty. The reality of needing to ‘walk-the-walk’ with TCOM’s shared vision is a primary reason we give nearly everything away free. If we can a wealthy patron(s) to cover costs, absolutely everything would be free.

### DESIGNING AN INFORMATION STRATEGY/BUILDING A MEASURE

Generally, once an organization or system decides to implement, the next step is to select a version of the communimetric tool that will underlie this person-centered application. While standard versions exist and are sometimes selected to speed this phase of the implementation, that approach, while efficient, is not the recommended strategy. As discussed in Chapter 3, effectively managing complex system requires collaboration. In our experience, collaboration should occur with as many activities as possible beginning as early in the implementation as possible. Establishing a collaborative process of selecting/designing the communimetric measure is an opportunity to begin to either establish or grow a collaborative culture within the system.

The nature of a collaborative design phase can take many forms. A completely open process is difficult and time consuming. One of the reason pure democracy seldom exists is the challenging of getting everyone’s active and informed ‘vote’ on everything. Thus representative democratic processes were created to ensure different perspectives were included in the decision-making process without overly burdening the decision-making process. Some version of a representative democratic process is recommended at this stage. Generally, a small group of decision-makers is identified with a clear lead—usually the implementation team. That group reviews options and makes an initial decision regarding the inclusion of items or the selection of a specific existing version.

Once a draft version is identified then a larger system partner process is initiated to get input and assent from any and all relevant perspectives. Webinars or conference calls can be used or in larger jurisdictions, regional stakeholder meeting can be convened. Another option is to widely distribute or post on an

open website, the draft version to get people's comments. The disadvantage of this approach is that sometimes it is more valuable to explain the approach before seeking input.

Uninformed input is generally not particularly helpful and actually might make collaborative (consensus) solutions more challenging. The design team and lead, of course, should remember that there is nothing that everyone will like. The key is to receive and document actionable input that potentially can inform the design. Documenting the consensus design process can be very useful in later stages of implementation when questions arise after changes in leadership, etc.

One hard lesson we have learned for this stage of implementation is that it is very useful to train and certify the version design team in a similar version PRIOR to initiating the design process. It saves an enormous amount of time wasted on pointless discussions and the team going down the rabbit holes of bad ideas that we know will not work. If everyone understands the structure of the tool, the six key principles of a communimetric measure, and its uses, then discussions are far more focused and efficient. Requiring certification just confirms that team members all did their homework. In addition, it gives them a clear sense of what the training component of the implementation plan might look like.

## BUILDING AN IMPLEMENTATION PLAN

Of course, any good implementation requires good planning and then sticking to that plan unless and until event(s) require a modification of the plan. TCOM implementations are no different. What is sometimes different is that the initial plan is not a plan to implement all aspects of a TCOM system. In fact, the implementation of TCOM is aspirational, therefore, never is implemented fully. Instead, plans involve key components of the TCOM conceptual framework. The most common starting component, of course, is the implementation of one of the TCOM person-centered assessment strategies. With that caveat in mind, we will discuss the structure of implementation plans generally. The specific challenges always lie in the details of the initial and long-term aspirations of the implementation.

The components of an implementation plan are similar to any other plan—a set of defined tasks, ordered by start date and completion date, with an identified point person or person responsible and a listing of persons involved. In addition, benchmarks for the success of the plan should be identified along with aspirational dates of when these benchmarks can be achieved (e.g., by the end of the first year, 70% of the time a CANS will be completed and submitted on time). Generally, the more granular the plan the better. In addition, someone must be on-point for monitoring progress on the plan. In addition, the implementation team should provide ongoing monitoring and oversight to ensure that the plan is followed and key benchmarks are reached.

## DESIGNING A REPORTING STRUCTURE

Although this implementation challenge has shrunk over the past few years, it is still important for the implementation team to think about what information (e.g., reports, data) is desired once the TCOM tool(s) is implemented. Data architecture matters for future use, so considering that use early; before decisions are made about, the information management approach is important. Simple challenges like linking assessment information to administrative and claims information should be considered. More recent, flexible programming platforms make it a bit easier than before to resolve data extraction, synthesis, and matching needs but no software platform can solve a situation where a matching identifier is available in different databases.

For about five years, the TCOM team required all software systems to follow specific guidelines and offer a minimum set of standard reports. We initiated that process in 2012 because so many Electronic Health Records were designed exclusively for data capture and had no reporting functionality. Since we give away our tools for free, we used that as leverage with software companies essentially saying if you are going to use Praed Foundation intellectual property for free to sell your systems, then you have to follow basic ethical guidelines. There were three basic ethical standards. The software vendor could not sell the use of the tools. They had to ensure users were certified in the tools that they were putting into their systems. In addition, they had to generate standard reports. Those standards worked quite well to force software vendors to not make reporting part of their ‘hook and bleed’ business strategy (i.e., sell their system and then nickel and dime their customers to death with anything they did not think to include in the original purchase).

In fact, the strategy has worked so well in terms of reporting vendor cannot compete without reports. Given this, we do not want the standard reports to stifle innovation in reporting, so we have dropped that as a requirement for use of the TCOM tools. The marketplace now incentivizes vendors to provide many reports and the creativity and utility of those reports are expanding rapidly.

## SUPPORTING AN INFORMATION MANAGEMENT APPROACH

Early in the development of the TCOM framework, we had to make a mission critical decision of whether or not to create a stand-alone information system to support the TCOM tools. At the time, many outcome measures were requiring use of their own information systems as a part of their business models and as a means for making implementations easier (e.g., plug and play). I remember trying to convince a major assessment developer at the time to allow us to put her measure in an online outcomes system we were developing for residential treatment in Illinois. She refused primarily because she did not trust us to report the use number or separate uses of her tool accurately. She thought that we would cheat her of income. So many of these measures used a pay per use business model so having their own software helped them



ensure that people paid for each use. We decided against that strategy for several reasons. First, it takes capital investment to build an electronic system. The initial implementations of CANS and ANSA were accomplished on a 'shoe-string' budget.

The effort was never intended to be a 'business' in any traditional sense. Second, during the past thirty years, technology has been developing very fast. Systems that are state of the art today are out of date within five years and require major evolution to stay current, which is more capital investment. Third, many implementation have been in systems that have existing information systems. Taking an assessment approach that is designed to be central to the work itself and then forcing it to be completed in an entirely different information system than the rest of the work is at cross-purposes with the TCOM approach.

For all these reasons most implementations evolve their existing information systems to incorporate TCOM tools or a large number of vendors have sprung up whose business is to provide information management platforms for these tools. Like everything else in life, some of these are quite good and some are not. Due diligence is important before selecting a software vendor as it is very much a buyer beware marketplace. Sadly, once you commit to a system and spend the initial investment, the vendor can keep charging things that are 'out of the original scope' or use other strategies to keep payments coming. In this model, a suboptimal performance of the information system is necessary to keep new payments coming (i.e., if everything was operating well, who needs to change) so it can become extremely frustrating for customers of these companies. We have not figured out how to solve this problem but it strikes us as similar to the fundamental problem in the business of helping—the reimbursement model is at cross-purposes to the goals of the business.

## TRAINING AND THE INITIATION OF TCOM

The logical next step in most implementation is teaching people how to use the TCOM tools. Embedded in that training should be exposure to the TCOM framework as the 'why' for the training on the 'what' (i.e., the person-centered assessment tool). In order to start training supervisors and direct care staff in the consensus-based common assessment cycle, it is necessary to generate some excitement—to sell the approach. This is a necessary part of any launch of any innovation. However, the process of getting people excited and onboard with anything new comes with an inevitable costs. That cost is the experience of 'over-promising'. All implementations of anything are rocky and are experienced as never fulfilling the original promises during the first phase of an implementation. This results in inevitable disappointment that we discussed in the 'hype cycle' as discussed previously.

*Training and certification.* Because TCOM tools such as the CANS, ANSA, and FAST are different from traditional measures, we have found that training is necessary to ensure that people completed these tools know how to use

them appropriately. I am fond of describing the two essential types of training approaches as either ‘prison’ training or ‘school’ trainings. Prison training, the trainee just has to put in the time and they are released from the training based on good behavior. In a prison-training model, no documentation beyond a certificate of attendance is required. Therefore, there is no way to understand whether any transfer of knowledge from the trainer to the trainee occurred. In the school training model, the trainee has to pass a test. We have found that the school training approach is required to ensure the necessary transfer of knowledge to support the effective implementation of TCOM tools. From a communication perspective, certification is a vocabulary test. Fluency in the tools requires use with feedback.

In the more than two decades using these approaches in a variety of clinical settings, we have found that training and certification on the common assessment strategy is essential. There are several key goals of this training

- Helping people understand how this approach is different than a traditional measure.
- Helping people re-moralize people about the importance and value of documentation activities.
- Ensure a basic level of comprehension of the common language framework.
- Documenting to system skeptics that the information is reliable and therefore can be trusted.

*Understanding the difference.* The CANS, ANSA, and FAST, the most commonly used assessment strategies in TCOM implementations to date on the surface look similar to other measures. People often comment that the content of each of these tools is similar to other measures that they have used. This should be more reassuring than surprising because the goal of these approaches is to define a ‘minimum standard of understanding’ of the person(s) served. Thus content overlap should be high if the version is relevant. This ‘just another measure’ perspective can lead people into believing that you use these tools exactly like the previous measures were used. Such a belief tends to foster, the CANS, ANSA, or FAST becoming just another form that has to be filled out with no real relationship to the work. To counter this dangerous inertia, a primary goal of training is to help explain to prospective users how this approach is different:

- It is not the assessment process (how you get the story); it is the outcome of the assessment process (how you measure the story once you understand it).
- It is intended to be collaborative (post-triangulation measurement).
- It is highly contextualized (by culture, development, interventions in place, and time). Rather than a fixed procedure, like a traditional

measure, TCOM assessment tools are more like the output of a conversation(s) (i.e., mass customization of the discovery process). Understanding these three distinctions between a communimetric measure in a TCOM context and traditional measures is an important goal of training.

*The importance of documentation.* Anyone who has reviewed any substantial amount of documentation is aware that the quality of documentation in the helping professions is quite variable and often quite problematic. Some people use 'cut-and-paste' strategies whereby boilerplate treatment plans are inserted. The same two- or three-sentence description of an individual is sometimes placed in multiple parts of the file including admission information cut-and-pasted to document continuing reviews. New information systems sometimes allow text descriptions to pre-populate leading to the same sentences repeating through a person's chart. Descriptions are brief and commonplace phrases are repeated often (e.g., out of control behavior). Having read more than 20,000 files across North America in the past few decades, my experience has been that while some are quite good, major deficits in clarity and individualization exist.

As we shift faster and further into the Information Age, this deficit in documentation becomes increasingly problematic. Information is that which is documented. Good information supports good decision-making. Poor information results in bad, sometimes even tragic, decision-making. We must help professionals understand to respect documentation of a person with the same level of respect that they give that person is an important goal of a training experience. After all documentation represents that person. TCOM tools communicate the person's story. It does not exist solely for some legal or reimbursement compliance reason. Documentation is a fundamental part of the helping enterprise.

The optimal way to clarify the importance of documentation and to help people value it appropriately is to make *the work and the documentation of the work* become the same thing. This goal is achievable in all helping systems. It just takes work and attention to detail. It also requires a good redundancy assessment and the leadership to work through all the small p politics of documentation. Anyone who has served on the onerous 'forms committee' of an organization has learned that nearly every piece of information collected as a constituency that will lobby for keeping it the way it is. A good communimetric measure can replace a substantial amount of less efficient documentation processes. However, this solution is discussed not a training issue. It is an implementation issue. To optimize the impact of training it is necessary to remind trainees about the importance of effective communication through documentation and to discuss how this information is used fully in a TCOM implementation. Reduction or elimination of redundant documentation requirements is an important aspect of the implementation plan. Put simply—do not give people new documentation requirements without taking something away.

*Basic comprehension of the common language.* As previously discussed, communimetric measures are a common language. As such, it is important to train new partners in the vocabulary and grammar of that language. We must make sure everyone understands the terms (i.e., item names) so that when they use the metrics everyone is using the terms in the same way.

Interestingly in the original design of the first truly communimetric measure—the CANS—there was substantial early controversy about the use of language. The original design team of the CANS was a group of parents and professionals in Allegheny County, Pennsylvania at one of the first SAMHSA System of Care sites. We had a two-day meeting in which the action levels were institutionalized because parents reported being very frustrated that they did not understand what the results of assessment processes meant in terms of what they needed to do next. There was also an interesting debate about the use of language. The professional were pushing that the CANS be converted into ‘accessible language for everyone to understand’. The parents pushed back aggressively stating that professionals should stop ‘dumbing down’ things as if parents and youth were ‘too stupid to understand’ how professionals talked about them when they were not in the room. They stated clearly that their preference was that if professionals were going to talk about their families they should teach families about how they (the professionals) talk so that families could be full and equal partners in the conversation. The use of clinical jargon in tools can then be seen as an advocacy strategy whereby through the consensus-based, person-centered assessment process professionals are teaching the people they help a common language so that they can advocate for themselves in the future.

*Documenting reliability to system skeptics and other outside partners.* Related to the conflict of interest inherent in service system management and the subsequent demoralization about documentation (i.e., the perception of meaningless paperwork), there is widespread skepticism among researchers and analysts regarding the reliability and validity of anything other than what they consider ‘objective’ measures. This skepticism is a *folie deux* with service system thinking. The bigger issues in this regard are discussed elsewhere. For present purposes, it might suffice to say that it is important to repeatedly document to skeptics that person-centered information is reliable and valid. Thus certification at training (and with audit) is necessary to communicate this rigor to that audience.

Ironically they do not request that type of documentation for measures that they a priori define as objective despite the fact that there is evidence that such measures are also subject to reliability and validity risks in the field. In all TCOM implementations, we recommend certification of reliability at training (initiation of use) and then at regular intervals over time (e.g., typically annually). Table 10.1 presents reliability results over time from several large jurisdictions.

Although we have shifted to offering full training on a distance-learning platform, our experiences to date are that live training events are more effective

**Table 10.1** Annual average reliability using an intra-class correlation coefficient on a randomly selected test vignette on the CANS over the past four years for five jurisdictions in the United States

<i>INDIANA</i>	<i>2013</i>	<i>2014</i>	<i>2015</i>	<i>2016</i>	<i>2017</i>	<i>2018</i>	<i>2019</i>	<i>2020</i>
Number of unique users certified	5816	6984	7218	8639	8655	6326	9196	13,359
Average passing score	0.78	0.79	0.79	0.79	0.8	0.79	0.79	0.79
<i>NEW YORK</i>	<i>2013</i>	<i>2014</i>	<i>2015</i>	<i>2016</i>	<i>2017</i>	<i>2018</i>	<i>2019</i>	<i>2020</i>
Number of unique users certified	1978	3264	3530	4067	3991	2944	3680	3620
Average passing score	0.77	0.77	0.77	0.77	0.77	0.77	0.77	0.77
<i>VIRGINIA</i>	<i>2013</i>	<i>2014</i>	<i>2015</i>	<i>2016</i>	<i>2017</i>	<i>2018</i>	<i>2019</i>	<i>2020</i>
Number of unique users certified	3079	3167	3372	3268	3462	2476	3133	3216
Average passing score	0.79	0.78	0.78	0.79	0.79	0.79	0.79	0.79
<i>TEXAS</i>	<i>2013</i>	<i>2014</i>	<i>2015</i>	<i>2016</i>	<i>2017</i>	<i>2018</i>	<i>2019</i>	<i>2020</i>
Number of unique users certified	4439	5826	7139	8199	7890	7006	9198	9309
Average passing score	0.78	0.79	0.79	0.79	0.79	0.78	0.78	0.78
<i>CALIFORNIA</i>	<i>2013</i>	<i>2014</i>	<i>2015</i>	<i>2016</i>	<i>2017</i>	<i>2018</i>	<i>2019</i>	<i>2020</i>
Number of unique users certified	2252	3418	5436	6134	6844	9540	21,981	20,078
Average passing score	0.78	0.79	0.79	0.79	0.78	0.77	0.78	0.77

at least in terms of getting trainees quickly to certification status. By ‘live’, I am including face-to-face webinar training models. On the distance-learning platform, we have learned that forced progression—requiring training to go through the entire course—leads to better certification results than allowing trainees to pick and choose what aspects of the training that they wish to take.

*Certification.* The majority of currently active TCOM implementation sites uses a certification standard of a reliability of 0.70 or higher on a test case vignette. In other words, trainees are requested to complete the tool using a case vignette. The trainee’s ratings are then compared to suggested standard ratings using an intra-class correlation coefficient. As long as this reliability is at or above 0.70, the trainee is considered ‘certified’ in the approach for a designated period (e.g., typically one year).

Recertification is generally recommended annually, although some jurisdictions allow a two-year certification for trainees who achieve a reliability of 0.80 or higher on the test case vignette.

We are beginning to explore other mechanisms for certification. Although we have used the current certification model for TCOM tools for nearly 25 years, we have identified some challenges to this approach. First, test vignettes do not represent real-world practice. The vignettes are essentially assessments of a trainee’s ability to apply the rating logic of the action framework to a brief story about a person. There is no aspect of consensus building or creating the types of conversations that allow sensitive topics to be discussed openly. We have frequently observed that very experienced practitioners struggle to pass the vignette tests while newly minted, inexperienced

practitioners breeze through the test with very high scores. The problem is that with experience comes a tendency to read into the brief stories aspects of the tool that are not explicitly mentioned. We can only expect people to rate based on what is written so no accommodation in the recommended scores based on reading into a story is allowable.

A second challenge involves the limitations of an intraclass correlation coefficient. While this form of reliability has the advantage of giving credit for being close (e.g., rating a '2' when the suggested score is a '3' is valued above rating a '1' which is valued above rating a '0'), it is less influenced by specific issues of sensitivity and specificity which can be important concepts in understanding decision-making. The sensitivity of a measure is its ability to detect something that is 'there'. The specificity of a measure is its ability to know when something is 'not there'. The challenge arises from the reality that different common themes (i.e., items) on the TCOM tools have different expected rates in different populations. For example, needs surrounding Family Functioning are quite common in behavioral health systems.

These needs are practically universal in child welfare systems. Fire setting, on the other hand, is extremely rare in behavioral health systems and although more common, generally less than 2% of child welfare populations (Lyons & McClelland, 2010). Both sensitivity and specificity are impacted by base rates of a characteristic in the population (Meehl, 1973). Accurately transferring those base rates into training vignettes is nearly impossible; however, vignettes do vary on the frequency by which they include various needs and strengths. These complexities leave us relying on intraclass correlation coefficients as the best estimate of reliability despite knowing that it may not translate into desired levels of sensitivity or specificity for any specific need or strength.

*Translating Learning into Practice: The Use of Heuristics.* It has become quite clear over our two decades experience of implementing TCOM-related tools that a single training and certification process—while critical to launching an implementation is insufficient for sustaining system change. It is very hard for helpers to make the transition from 'doing' a measure to 'using' that measure. However, this transition is critical to the long-term success of any TCOM implementation. Ongoing coaching and supervision is an important strategy for supporting helpers learning how to use TCOM tools in their work. We have also found guidance from the science of decision-making (Tversky & Kahneman, 1973).

Research on decision-making has identified that people often use heuristics to guide day-to-day decision-making (Tversky & Kahneman, 1973, 1974). In their 1974 article, these authors defined a heuristic as:

"a mental shortcut for making frequency or probability judgments based on the ease with which instances or occurrences can be brought to mind" (p. 1127).

Nobel laureate Herbert Simon (1955) was the first to identify the idea of a heuristic with the concept of 'Satisficing'. In Simon's view, the rational boundaries of decision-making were limited by the difficulty of the problem,

the cognitive limits of the mind, and the time allowed making a decision. In this model, people seek satisfying decisions rather than optimal ones. Building on Simon's concept that satisficing was the driving guide to decision-making, Tversky and Kahneman (1973) identified three heuristics that guided decision-making—availability, representativeness, and anchoring. Availability is the degree to which an experience is readily available for someone to draw from. This is the heuristic that explains why rare but vivid experiences—which are generally more available for people to remember—tend to become more important in decision-making, than more common experiences that should likely guide routine practice (Sutherland, 2007). Representativeness heuristics are those guides that people use to place others into categories (Tversky & Kahneman, 1974). Helpers use this heuristic frequently to put similar people into common groups to guide practice. Diagnoses would be a formal heuristic procedure in this regard. The items of a TCOM tool are representative heuristics. Finally, 'anchoring' refers to heuristics people use when estimating numbers—they generally start with an anchor in their heads and then adjust from that which can introduce bias depending on the accuracy of the anchor (Baron, 2000).

Since this original work, additional types of heuristics have been proposed, one of which is particularly useful for our purposes—'judgement heuristics' (Hastie and Dawes, 2009). These heuristic are those that guide the judgments at the heart of what TCOM tries to shift. To apply these ideas to TCOM implementations we have created simple to remember concepts that can be taught for everyday use. While the somewhat 'automatic' processes by which we all make decision is important. What is more important is to provide individual decision-makers with simple rules to help them overcome their natural and expected biases driven by heuristics. We call these TCOM heuristics. Simple reminders of the bedrock concepts that should guide our decisions in our daily work. We place them in short entertaining videos on the TCOM YouTube channel as an accessible reminder.

*Overarching TCOM Heuristics.* These simple thoughts are universally applicable to everyone in the helping system that is working to achieve the aspirations of the TCOM model. The following are some examples:

- Our common goal is the best interests of the people we work to help.
- All relationships are 'therapeutic'.
- The quality of our work is defined by the reliability and effectiveness of our decisions.

The first thought is to remind us of our common vision. A simpler (but perhaps less timeless) way of saying the same thing 'it is about the people we serve'. The second of these thoughts represents and acknowledgment that it is *everyone's* responsibility to help all with whom they interact to become better versions of themselves. In this sense, we are all agents of positive personal

change. The third of these three thoughts is to remind us that these personal transformations invariably come from improved decision-making.

*Supervisor and Direct Helper Heuristics.* These are thoughts to guide how helpers and those that supervisor helpers think about implementing the aspirations of TCOM:

- Sometimes you have to slow down to speed up.
- Collaboration resolves complexity.

The first of these thoughts is to help helpers remember that just because they are busy does not mean that they should rush. Slowing down and making better decisions results in working smarter rather than harder and over time is less work than rushing through things and failing to be effective. The second thought is actually overlapping with the first in that often collaboration takes more time, however, beyond that collaboration allows for the resolution of conflicts that often result in competing decisions that work at cross-purposes.

*Administrator Heuristics.* These heuristics are simple thoughts for program, agency, and system administrators working to achieve the goals of TCOM. Here are some examples:

- You can't manage what you can't measure and you can't measure what you can't define.
- Access to care is not an outcome.

The goal of the heuristics described above is that they provide highly communicable, easy to remember talking points about how to think about decision made from a TCOM frame. One way to think about these concepts is that they are the things that people in the system need to repeat—not once or twice but again and again (and again again) in order to help people shift from their established or traditional ways of thinking into a person-centered, action-oriented framework as a means of guiding their day-to-day efforts.

## LEARNING TO USE INFORMATION

One of our greatest challenges in the helping professions is the assist helpers in learning to use data to understand and improve their work. There are a variety of possible reasons for this challenge. First, people attracted to the helping professions may be less inclined to be sophisticated with numbers. I have had more than one person tell me that they were attracted to a profession based on personal relationships in part because they really did not like math classes. Therefore, it is possible that the normative level of understanding of the symbolic logic of numbers will be lower among people attracted to helping as a career. It is also possible that helpers find numbers too reductionist and impersonal. I am sure all of us have heard the criticism of the



experience of 'being reduced to a number'. However, you cannot manage what you do not measure. You cannot easily combine stories without the use of a number framework. Therefore, a primary principle of any outcomes management approach requires that data on outcomes are analyzed and presented to develop into information about treatment effective and the development of program and practice policy. Despite the challenges of providing data to an audience that may be intimidated, uninterested, or even hostile, it is crucial to develop strategies to overcome these challenges.

When I managed crisis support services in Illinois (SASS), we used to provide feedback on all children and youth regarding decisions about admission to psychiatric hospitalization (Lyons et al. 1997a; He et al., 2004). We found that about 75% of all decisions to admit or not could be predicted by seven items on the CSPI. From a CQI perspective, we were not interested in those routine, predictable decisions.

They were sort of the 'no-brainer' decisions. Everyone was in agreement on those cases of whether or hospitalize or not. Instead, we focused on the approximate 25% of decisions that were not predicted by the model. We distributed monthly reports to participating agencies asking them to explain these exceptions. Essentially, we asked the programs to respond to the following questions. 'You hospitalized Johnny when most people would not have, what was special or unique about Johnny's situation?' Alternatively 'You did not hospitalize Mary when most people would have, what was special or unique about Mary's situation?' Just requesting this feedback each month from the workers, resulted in more consistent decision making and nearly eliminated racial disparities in those decisions (Rawal et al., 2008). If people are encouraged to understand data, they will learn to use that data. Sometimes you have to take the horse to water, and make it drink.

It is worth noting that after a few years of this *posteriori* decision support's impact on psychiatric hospital admissions for children and youth in child welfare, the contract that funded this project was terminated (yes, I was fired). What I heard and have no way to substantiate was that hospitals and attending psychiatrists teamed up to lobby for an end to the project after we reported on the large number of children continued to be admitted to psychiatric hospitals despite their absence of notable risk. I always suspected (but had no way of proving) that the aspiration of filling hospital beds was more powerful than the aspiration of reducing unnecessary psychiatric hospitalizations. As many systems administrators will tell you, you have to maintain your provider network. Sometimes I guess that might mean using children and youth for the benefit of the system. This experience was a powerful source for my conversion to TCOM as a way of thinking about system management.

*Evaluator Dilemma and TCOM.* Anyone who has done much evaluation work has experienced a potential conflict of interests with evaluation findings. This evaluation dilemma can be described as follows. Anyone who successfully puts a program together must 'sell' key partners, and particularly funders, on the desirability of the program. The program developer has to present a case

of how this program will have value. As soon as the evaluator has achieved funding for the program, a problem for any evaluation presents itself. If an evaluation demonstrates that the program is good, who really cares, because partners and funders were convinced it was good or they would not have supported it in the first place. The evaluation is simply telling people what is already known. However, if the evaluation demonstrates the program does not work, then the program developer is in the horrible position for being shown to be a fool or a liar or both. Thus developers may have very little interest in actually doing an evaluation because it is might be a 'lose only' proposition.

This same dilemma applies to all outcome feedback systems. Providers sell their interventions to funders and the people they purport to help. Getting feedback that it is not working can be perceived as a risk to the business enterprise. This challenge, along with the fact that current business models incentivize billable hours over effective help, are among the reasons why executive directors of community agencies are often the most resistant to a shift to TCOM. In my experience, the most effective strategy for working through this challenge is a twofold approach of requiring the outcome feedback by a state agency or funding entity combined with a safe systems type approach of avoiding shame and blame to focus on learning from experience.

### CHANGING PRACTICE AND POLICY

We define 'practice' as the ways things are done, while 'policy' is the written declaration of how things ideally should be done. While some policymakers prefer to believe that good policy always drives good practice, the reality is often somewhat more complex. The influences between practice and policy are both bi-directional and fluid.

Although Otto Bismarck the first Chancellor of Germany is often credited with this quote, it appears that it was actually lawyer and poet John Godfrey Saxe who said 'Laws, like sausages, cease to inspire respect in proportion as we know how they are made' (Daily Cleveland Herald, 1869). The same observation has been applied to policy creation more generally. Currently, the process of developing policies is often neither systematic nor science-based but rather some combination of a number of competing processes. However, informing the policy process with data and finding is a realistic aspiration. The key to this process is getting policymakers and the staff and consultants who write policies for them to be aware of specific findings that have policy implications. This type of access is a small 'p' political process in most cases but legislatures can include a large 'P' politics. Laws create a structure for policies and policies represent written efforts to turn laws into practice. We recently used CANS data in one state to demonstrate the utility of maintaining telehealth options post-pandemic.

## SUSTAINING THE APPROACH

A good way to create a sustainable implementation is to create one or more champions to the process. The larger the implementation, the more champions are required for sustained success. A good TCOM Champion would have at least the following characteristics:

- Ability to translate key concepts of TCOM and Communimetrics into the language of an agency and staff.
- Ability to persuade others to follow their lead.
- Positive, resilient, and problem-solving approach to the work. Complainers make lousy champions for anything.
- Have the ability to inspire and find the common aspirations. Find champions that embrace the aspirations of TCOM as their own.
- Ability to think both strategically and tactically. Innovation is a hallmark of sustainability of the TCOM approach in an always changing work environment.
- Effective at communication.

While finding the right people to Champion TCOM in any workplace is important, it is equally important to establish clear roles and responsibilities so that champions can understand what they should do. The following are recommended roles and responsibilities:

1. Communication and linkage within the organization and with system partners.
2. Understanding TCOM and translating it into the organization's business drivers.
3. Active and enthusiastic support of new learning by organizational employees at all levels, including the use of person-centered data to guide practice and policy evolution.
4. Serve as translators between leadership and direct care helpers to ensure that the interests of each are accurately and fairly represented to the others.
5. Know the technical aspects of TCOM and its measurement approach.
6. Identify and eliminate barriers and obstacles to the sustained implementation.
7. Advocate for investment in the approach in terms of both time and resources at all levels of the organization.

## THE MOST COMMON COMPLAINT IN EARLY IMPLEMENTATION

We have done hundreds of implementations of different TCOM tools in a large variety of settings. Of course, we have heard complaints—many complaints. We call the most common of these the Frequently Expressed

Complaints (FECs). In implementation, knowledge and acceptance of the FECs are as or perhaps more important than FAQs. One complaint is universal.

*It takes too much time.* This is a universal complaint that always arises in every single implementation. And of course, since we always implement in systems that consider themselves services, time is money, which results in a corollary complaint, of ‘we don’t get paid for this time’. If they are paid, that creates a different problem as I discuss elsewhere in this book.

We should consider three components of time when understanding this complaint. The first component is the time it takes to learn the TCOM tool. This is real and unrecoverable time. Since a communimetric tool is different than a traditional measure that one simply hands out to complete, it does take some time to learn. It is more of a common language approach and it will take time to be able to speak fluently in this new language. Although this is real time, it doesn’t amount to that much time. Typical TCOM tools take about four hours of training to obtain certification as discussed above. It also takes a few actual applications of the approach before it becomes easy. Most people report that after about five experiences completing the tool it becomes easy. In addition, people who have used it for a longer period report that it becomes easier *to do it than not to do* once they become fluent. TCOM tools are like closet organizers, once you get organized, your work is easier and more efficient.

The second component of time is the time it takes to actually fill out the document—do the paperwork. This is also real and unrecoverable time. However, once you know the person(s) to be helped and the tool, typically it takes between 5 and 20 min to complete most form versions depending on technology and personal style. That is not very much time, particularly if it is understood that the tool is the primary way of documenting the story of the person seeking help.

The real time is the time it takes to understand someone well enough to complete the TCOM tool in a consensus-based fashion. This is also real time, but this time has nothing to do with the TCOM tool, if that tool is properly designed. A good TCOM tool simply captures the information that any helper needs to know if they are going to be effective. If one does not have enough time to do that, then they simply do not have enough time to do their job. That is certainly possible given the artificial periods we assign to people to complete certain tasks in some service systems. However, having enough time to do your job is a problem of properly engineering the process of care to ensure that everyone has enough time to be effective.

I recently was on a call with a large state where someone was complaining about how much time it was taking to complete the CANS in a referral of a youth to residential treatment. I stopped the complaining by reminding the person that sending a youth away from a home setting into a residential treatment facility for three to six month of their life (maybe longer) was a big decision. It is particularly big for that youth who has to endure what the

system is deciding is in their best interests. It seems only fair to everyone to take our time to make sure we understand the youth's story fully and make the decision most likely to be in their best long-term interests.

### MAINTAINING INTEGRITY THROUGH RELIABILITY, CONSENSUS, AND TRANSPARENCY

The central feature of any TCOM implementation is the strategy to represent the person-centered assessment. Beyond applications at the individual level, these clinical assessments must overcome additional barriers that have been created by a variety of historical factors. The first barrier is the one of perceived expertise. If professional helpers seem themselves as an expert and if that view of expertise requires their assessment to be exclusively based on their expertise, they might find the concept of person-centered difficult. Nevertheless, even the greatest expert cannot change another person's life. Only the person themselves can do that. Reaching a consensus between the professional and the person is blending the broad expertise of professionals with the deep expertise of people. Once experts understand that basic truth, they can usually get their professional ego out of the way of doing person-centered care.

A second historical barrier is the flawed understanding of measurement of person characteristics.

It is likely fair to say that there is substantial distrust of person-centered information among some system-level partners. This distrust comes from two related but somewhat different perspectives.

1. As discussed earlier, the essential conflict of interest inherent in a service system has led to a belief by some system partners that clinical information is simply generated to ensure that clinicians get paid.
2. Research and evaluation experts working in the system are well aware of the substantial body of research documenting the unreliability of clinical information. This has led many analysts to emphasize a focus on what they consider 'objective' measures that are perhaps less subject to challenges with reliability. Unreliability of clinical assessment does not arise strictly from the conflict of interest problem identified above, it also comes from the use of measures that are disconnected from the clinical process and therefore viewed as an irrelevant nuisance by the very people tasked with completing them.

Any sustainable implementation has to take the issue of ongoing reliability of the common language assessment seriously. In the TCOM collaborative, we have developed a number of strategies to help build, maintain, and grow the reliability of the tools. As Table 10.1 demonstrates, people are able to achieve and sustain reliability on the tools. This stable reliability builds the confidence of system partners in the accuracy and utility of this information

thus beginning the process of overcoming the strong historical bias against person-centered information in the helping field.

As discussed throughout this book, person-centered care requires an equal partnership between the person receiving care and those providing it. Use of a consensus-based assessment process thus is a fundamental aspect of this partnership. Person-centered care begins with everyone on the same page regarding what is target for any care (help) provided. But consensus-based assessment has another advantage. By getting everyone in agreement regarding the needs and strengths of people served, the consensus building process helps keep everyone 'honest' in the documentation of these needs and strengths. In this model, any potential bias can be identified and addressed early in the process. Thus the use of a communimetric tool in the manner in which it is designed to be used is an important strategy for ensuring the accuracy and subsequent utility of the tool.

One major impact of our evolution into the Information Age is that information has become increasingly transparent. This is both an opportunity and a risk, of course. The opportunity lies in the reality that people generally work harder to be accurate in their documentation if they believe others are likely to see that documentation. When a communimetric measure is used to communicate, that process of communication creates a transparency that can facilitate accuracy. When information is aggregated and reviewed at the program and system level, those processes also create transparency.

*Embedding in Planning Processes.* In the chapter on individual level applications, a detailed approach to embedding the person-centered assessment into the plan is presented. Using some version of this integration is an effective strategy to facilitating accurate completion of the core assessment tool.

*Supervision.* Ensuring that the person-centered assessment is a core component to all supervisory processes is equally critical to supporting and maintaining an effective implementation of TCOM. While Supervision is discussed in detail in the Chapter on Program level TCOM, it is important to note that embedding the person-centered assessment process into the supervisory process is a key ingredient for a successful implementation. Counterpoint, failure to train and certify supervisors on the approach is a sure recipe for a limited or even failed implementation. If supervisors cannot help their supervisees on learning and using person-centered information, then they will either implicitly or explicitly undercut or even sabotage the implementation.

The best implementations train supervisors to be trainers so that they can train and support their staff fully. As discussed previously a clear distinction between a service system and a transformational system is a shift in the work focus of supervisors away from an emphasis on compliance (service system) to teaching (transformational system). If the entire system is focused on being as effective as possible then supervisors are ideally in a position to do the needed teaching to help staff develop their personal skills and expertise. In TCOM, those skills begin with person-centered assessment and outcome monitoring.

*Audit.* Since communimetric measures are not intended to reflect the process of discover, only the results of a discovery process, it becomes possible to audit field reliability by comparing a completed assessment form to one generated by reviewing concurrent records. Another audit strategy that has demonstrated significant value for enhancing effective use is to audit the relationship between the assessment document and the plan.

In sum, when implementing any aspects of TCOM or the entire approach it is good to have a plan. That plan should be sequential and collaborative. Someone with some decision-making authority should be on-point and supported by leadership. However, regardless of the plan, adaptability and flexibility should be built into the plan (Fixsen et al., 2015). Using data on early successes and challenges should be used to adjust and continue moving forward.

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## Social and Political Considerations in Evolving Effective Helping Systems

In the original book introducing the concept of TCOM (Lyons, 2004), I described a series of observations from the first two decades of my career in working with systems. I organized these observations into categories I referred to as Tensions and Syndromes. Tensions are competing pressures that can never be resolved. Instead, people involved must decide where on the continuum between these competing valences they would like to function. These are perpetually competing pressures that leaders in the helping sectors will always experience and must decide how to balance. Syndromes, on the other hand, are bad habits that result from fallible human beings making complex decisions within the vortex of multiple competing agendas. Unlike tensions, we can limit, prevent, or eliminate syndromes. In this chapter, I will revisit and update this work based on nearly two additional decades of attempting to implement TCOM around the world.

Given the TCOM focus on making people full partners in their care, the most obvious sociopolitical challenge is the sad reality that there will be people in the system who do not want decisions guided primarily by the best interests of the people served within the helping system. Money and power invariably have potential to be corrupting influences on some people. It is only human; therefore, that greed and ego can compete with the guiding principles of TCOM. There is really no avoiding this uncomfortable reality of human nature. However, people are much more likely to be able to stay focused on the common good if there are many people with different stakes involved in decisions and if the decision and the decision-making process is transparent. Paraphrasing the phenomenal therapist Irvin Yalom in his discussion of his approach to group therapy—we have to learn to trust the group (Yalom & Leszcz, 2005).

Collaboration, consensus, and transparency reduce the opportunities for the corruption of greed and ego. The first strategy to deal with these challenges is the full use of consensus and transparency in all processes. The second strategy is to make sure business models are in alignment with the values and principles of the system. In other words, the money follows good work. This design consideration follows standard economic thinking that people will do what they are paid to do.

Beyond these challenges, there are structural barriers at each level that have the potential to profoundly or subtly detract from our ability to implement TCOM. Parallel to the organization of the original TCOM book, I will update these by level—individual, program, and system.

## TENSIONS

### *Person Level Tensions*

**Unequal Information.** George A. Akerlof won the Nobel Prize in Economics in 2001 for his work that demonstrated that free market controls did not operate effectively for transactions in marketplaces where the buyer and the seller had dramatically different level levels of information about the product. This research resides at the tension between the two old saws ‘Don’t let the cat out of the bag’ and ‘Don’t buy a pig in a poke’. Both of these sayings refer to opposite sides of the same transaction. At fairs and markets in the Middle Ages, thieves used pretend to be selling people piglets, carry the piglet in a sack (the Old English word was ‘poke’). Instead of having a pig, they would put in a cat in their bag. So if you ‘let the cat out of the bag’, you would not be successful in defrauding your potential customer.

The smart customer would not buy a piglet that they have not laid eyes upon directly—they would not buy a pig in a poke. A clear information disequilibrium between a seller and a buyer leads to all sorts of possibilities of corruption large and small.

TCOM’s focus on person-centered care is a key strategy to address this notable tension.

Collaborative assessment allows a learning-teaching process that equates information for all parties. A person-centered assessment represents a teaching opportunity to help ensure that those provided help are equally informed about the process as the helpers themselves. Taking advantage of the learning-teaching moment of collaborative assessment process is a key to engagement and simultaneously ensure more informed and balanced decision-making within helping sectors. This approach also reduces fraud. One person engages in fraud. Two or more people are engaged in a conspiracy to commit fraud.

**Personal Preference/Choice vs evidence-based practice.** It has become clear that using evidence-based practices results in better outcomes than not

using approaches backed by research (e.g., Cook et al., 2017; Melnyk, 2022). A helper educated in evidence-based approaches will have a good deal of knowledge about how interventions that are most likely to be helpful to many person seeking assistance. On the other hand, people deserve choice. They should be informed of their choices so that they can make good choices but it is their life and, therefore, they should ultimately be in control of what happens with their body, mind, and lifestyle. This tension between what professionals know works and what people want can create challenges for individuals seeking personal change.

This tension is addressed in TCOM with collaboration in all steps of the process. Collaborating starting at the assessment/discovery process generates the possibility of learning/teaching moments to help people understand the relative value of their choices.

Embedding the idea of choice into a consensus process provides a window for professionals to help people understand the advantages to their well-being that might arise from accepting an expert opinion about the most effective treatment approach. The importance of taking a learning-teaching approach to helping cannot be over-emphasized.

**Person vs Family Focus.** Many helping systems use insurance models as their primary funding mechanism. These models are individually based—whereby each individual is treated separately. When dealing with children and youth (and sometimes with elderly), the help is actually focused on a family—a group of people rather than an individual. This creates an obvious tension. For example, if an outpatient therapist is working with a 16-year old who is struggling with their behavior. That youth would be the client. If they had a younger sibling who will likely endure the same struggles but is currently OK, that helper might not be reimbursed for trying to help the younger sibling avoid the same problems. The younger sibling will need to fail into eligibility. In other words, helpers are sometimes forced to wait for failure rather than to prevent it by intervening early.

At the same time, it is rather difficult to recreate complex funding and financing models that are based on units with varying numbers of people. Some families have only two members. Some have more than twenty. Many helping approaches have historically had an individual focus creating a scientific knowledge-based support that approaches rather than a family-based approach.

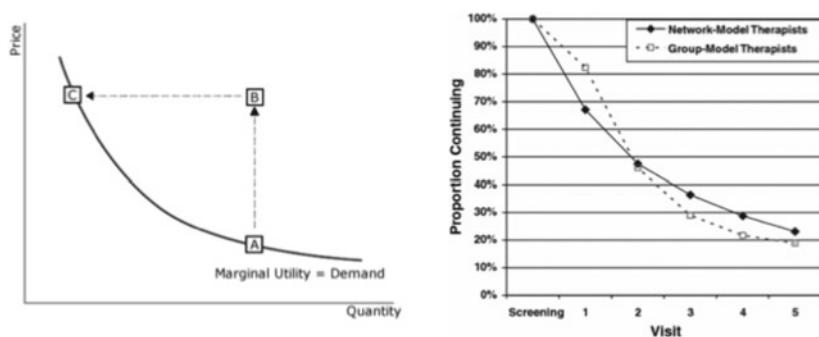
TCOM generally comes down in the middle—trying to understand the individual within the context of their family. This provides some opportunities to do family work as part of the individual plan of care. The FAST is a family-based TCOM tool. It is expanding in use for programs that are specifically family based. In the FAST, a good outcome is both improving the family system functioning AND raising the level of all boats—improving the well-being of each family member.

**Responsibility vs Blame.** Personal responsibility is an important aspect of health.

Blame is often an unhelpful result of stigma. They have very similar origins—both are identifying either a locus of a cause of some challenge or a locus of the solution of some challenge. The difference can be subtle but profound. Blame implies some type of moral shortcoming. Personal responsibility does not. This tension can be very challenging to manage. Different people have different thresholds for experiencing blame when being held to standards of personal responsibility. Encouraging people to take responsibility for their behaviors and their health without it being experienced as a blaming process requires a mass customization of an approach that recognizes these individual differences in thresholds of feeling blame.

In TCOM, the focus on forward thinking and action is helpful to address a tension in which we strongly emphasize the personal responsibility end of the continuum. Less time is spent trying to figure out why current circumstances exist. The focus is on how we will potentiate personal change moving forward. Backward thinking, while sometimes necessary to focus the intervention, often leads to people feeling blamed.

**Help as a process vs help as a product.** All evidence-based interventions designed to help involve a process of care. Nearly all programs are similarly designed—they have an intentional beginning, middle, and end. Evidence from research in outpatient mental health suggests that people are not actually purchasing that process (e.g., Howard et al., 1986). Dropout curves look like marginal utility curves where people might be purchases sessions but not a process of therapy. The idea of marginal utility is that each additional unit of purchase has a decreasing value to the consumer. The first piece of pie is delicious. The second pie good. By the fifth piece, perhaps you have had enough pie. Figure 11.1 compares a standard marginal utility curve with a standard dropout from psychotherapy curve. As can be seen, dropout curves are similar in structure as are dose-response curves (e.g., Olfson et al., 2009). Perhaps people dropout of therapy when they receive ‘enough’ benefit.



**Fig. 11.1** Standard marginal utility curve demonstrating reduced utility with increasing units (left) compared to a psychotherapy dropout curve (right)

Although helping programs are, attempting to sell an entire process, people seeking help often are investing in a number of days, weeks, sessions, etc. We believe people want enough help to feel better. When they feel better, they stop. If they do not start to feel better at some point, they stop. Only a small percentage appear to be buying a long-term therapeutic intervention.

In my experience, this tension creates disappointment from helpers—particularly in the behavioral health sector. The proportion of clients who drop out of outpatient behavioral health care against the recommendations of their therapist is typically between 70% and 90% (Lyons, 2004). Only a small percentage of clients complete the full course of a treatment at least from the therapist's perspective. Outcomes research with psychotherapy indicates that people still benefit from smaller doses of treatment (e.g., Howard et al., 1986 among many others). Interesting in the early days of managed care, a study by the Rand Corporation demonstrated that people stayed in outpatient behavioral health treatment longer if they had a restricted benefit (i.e., a 20-session limit) than if they had an unlimited benefit (as described in Lyons, 2004). Perhaps knowing that the end was in sight increases clients' motivation to continue farther along the therapeutic path.

## PROGRAM LEVEL TENSIONS

**Business Model vs Clinical Model.** In the shift in TCOM over the past decade from Total Clinical Outcomes Management to Transformational Collaborative Outcomes Management, this tension has become the focus of the approach. As such, we will not revisit it in detail here.

Creating business models that are supportive of the transformational goals of the work of helping systems is a primary aspiration of TCOM. We propose that we must reconsider completely our outdated business models and develop ones that actually support and incentivize effective help. Of course, the success of this paradigm shift first requires good evidence of what is effective help for each of the helping systems. In addition, we must build an infrastructure that allows for the management of effective clinical models.

There has been a notable movement over the past decade toward performance-based and value-based contracting, although much of this work has not demonstrated large or consistent impact on helping systems (e.g., Burwell, 2015; Porter, 2009). We would argue that this relative inertness of these approaches results from current applications not including person-centered assessment information as at least a part of the definition of performance or value.

**Accountability vs Quality Improvement.** Accountability requires that a program or agency 'looks good' while quality improvement requires that a program or agency identifies something they are not doing well and fix it. These two priorities can result in constantly competing pressures. Oftentimes from program leadership perspective looking good overrides any interest in

discovering flaws. This tension is not unlike the evaluator's dilemma discussed elsewhere.

Some accrediting agencies such as National Council on Quality Assurance (NCQA) and the Commission on Accreditation of Rehabilitation Facilities (CARF) have attempted to implement accountability standards that require continual quality improvement processes. This concept of an integrated and balanced approach between the two poles of this tension is the preferred approach within the TCOM framework. Shifting away from process and status indicator to personal change indicators then evolves this testing and evolving approach to a TCOM framework.

In addition to encouraging Continual Quality Improvement (CQI) as a component of accountability, it is also possible to create accountability metrics that reflect effectiveness rather than compliance. In this book, we have discussed a number of these metrics. For example, holding providers accountable for integrating identified needs into the plan of care is a simple accountability metric that functions must differently than a metric assessing whether the provider identified needs.

**Training versus turnover.** One of the most challenging aspects of managing any community-based helping enterprise is staff retention. The problem is most acute in publicly funded programs because the pay is generally the lowest. In circumstances where the average duration of a case is longer than the average duration of the employment of a case manager or therapist, it is no longer cost effective to training the workforce in evidence-based approaches. Therefore, only agencies that emphasize proficiency in their workforce would see the value in implementing EBPs. One could argue that agencies have a disincentive to train workers, and it might make them more employable elsewhere.

TCOM does not profess the problem of underfunded public helping systems. However, the TCOM strategy of engineering effective practice into the operations of the program allows for more rapid development of effective direct helpers. With TCOM tools and processes, the onboarding process becomes training in effective work in that program. Supervision is designed to continue the workers evolution in effective practice.

**Leadership Salaries vs Line Staff Salaries.** In many places, there are growing disparities in compensation between leadership and staff. In general, the closer a worker is the people helped the lower their compensation. The differences can be dramatic. Anyone who has visited residential treatment centers for children knows that you do not need to find the executive parking spot to pick out the car of the executive directors. It is often obvious simply by picking the only expensive car in the lot. We need to reconsider a more equitable distribution of salary. People in positions at the highest levels are compensated at rates that are geometrically higher than those even one of two levels below in the organizational chart. People will argue that you cannot attract top quality leadership without paying them. OK. Nevertheless, you also cannot attract top quality clinicians without paying them. You cannot attract

top quality supervisors without paying them. Boards must consider the mission of the agency in thinking through this challenge.

From a TCOM perspective, this salary disparity is another unanticipated consequence of service system management, which considers the work as spending time with people. Creating a business model that values effectiveness inherently builds incentives to ensure that agencies employ staff who can be effective. Agencies that develop effective intervention strategies will not be able to maintain that effectiveness if they fail to retain their workforce. Of course, talent does not matter if the business is spending time with people. A babysitter brings in the same revenue as a talented clinician. It is quite likely; however, feedback mechanisms offered in real time will generate true expertise. A new 'effectiveness' reality might encourage agencies to invest in their staff using a different model than the current 'churn and burn' workforce management approach.

**Liability vs Learning Culture.** This is a uniquely American tension. In the United States, suing people might be a national sport. If you do not like someone or something, take them to court. Advertising from lawyers who want to help the aggrieved populate our highways and television commercial breaks. In a civil society, the rights of citizens to seek justice in court is a fundamental right. However, a constant threat (or fear) of litigation is chilling on efforts to create transparent work cultures and learn from mistakes. Since mistakes represent one of the most powerful sources of learning, such fear can prevent organizations from effectively learning (Cull et al., 2013).

From a TCOM perspective, we think litigation is often a good thing. It should represent individual level accountability. The key to ensuring that the threat of litigation is helpful is to maintain the focus on due diligence rather than effectiveness per se. No program is one hundred percent effective. However, if a program puts together a transparent, person-centered program that consistently attempts to understand individuals circumstances and bring to bear effective strategies given that individual's needs and strengths that is the standard of due diligence. TCOM provides a framework for documenting due diligence and following the TCOM approach is protective. Failure to follow the TCOM protocol might, in fact, be legitimate grounds for legal action unless some other process is used to document due diligence.

**Clinician vs Administrator.** Much of the executive leadership of helping agencies start as direct care workers and work themselves up the organizational chart. Sometimes in these circumstances a new administrator has never had to do a budget until they are promoted into a position where this is job responsibility. Thus learning business administration in many helping systems is a lived experience rather than a product of an intentional educational plan. That has advantages and disadvantages, of course.

From a TCOM perspective, the goal is to engineer all positions so that on the job training is simply a part of learning how to do the job effectively. That philosophy is just as true for administrators as it is for clinicians. Agencies and systems must create supports in the process and requirements of the each

position thereby using documentation to support effective practice. It is likely that some of these skills are universal across a system(s). The collaborative creation of sharable supports would be a TCOM aspiration.

### SYSTEM-LEVEL TENSIONS

**Cottage Industry versus System of Care.** Many, if not most, helping programs started out as small programs responding to a specific need within a target population. Some were literally ‘mom and pop’ businesses. Over time, those with charismatic leadership often expanded as new opportunities presented themselves based on relationships built in the original work. Over the past several decades, for a variety of intersecting reasons, these agencies have amalgamated to increasing form larger agency that provide a range of programs to serve a variety of overlapping populations. Large agencies vary on how integrated they are across programs within the agency.

Of course, having many small businesses can be a positive. Local businesses can be responsive to local cultural considerations and create competition in the provider marketplace. Competition is the seen as the heart of a capitalist economy—it incentivizes innovation and impact. Those that cannot compete do not stay in business. However, the more units in system, the more complicated it is to establish and maintain collaborations. We see this challenge in the relationship between school districts and community mental health centers. A large agency might serve 20 or more different school districts requiring an equal number of distinct collaborative relationships for the behavioral health agency to work effectively with ‘the school’.

The TCOM perspectives on this tension are to emphasize collaborative processes to ensure that different agencies work together towards the common purpose. Creating community cultures that expect professionals representing different agencies to work together seamless can be a thought of as system-level organizational climate and culture. Leadership is always the key for establishing both culture and climate. Efforts at this form of collaboration is one of the greatest contributions of SAMHSA’s long funding of System of Care Grants.

Through a singular focus on the best interests of the people served, complex systems can learn to work together. TCOM tools, designed for cross systems applications, provide the strategy to communicate this shared vision and ensure that it can be present in all decision-making.

**Multiple (theoretical) Models.** Historically, there have been many theories of human behavior. More recently, a plethora of evidence-based and effective practices have been identified. While a good theory is invaluable in guiding decision-making and having evidence about what treatments and strategies are more effective is valuable information, the presence of these multiple models creates notable tension in the management of systems. Sometimes professionals are followers of one particular theory expect others to ‘pick sides’ in disputes between competing theories. In many ways, the original concept of



evidence-based practices was an effort to get past a theory-pure approach to mental health treatment. With EBPs, the theory of change does not matter. All that matters is that the science demonstrates reliable improvement among those served.

The TCOM perspective on this tension is to remain agnostic as to theory or model. In fact, TCOM proposes the development of collaborative theories of change that fit the specific individual/family and circumstance. This process might involve adopting an existing theory or it might require the development of a unique theory of change that fits an existing system's culture and perspectives. Aggregating these customized theories of change to inform a broader theory of change represents a novel research direction in the TCOM collaborative.

**Central vs Local Control.** In politics, there is a long-standing argument between who should make system-level decisions. At one pole of this debate are those that feel all decisions should be local. At the other end of this continuum are those who feel that central authority is the more effective, efficient, and equitable strategy. Oftentimes, proponents of local control do not trust central authorities to 'do the right thing'. At the same time, proponents of central control do not trust local authorities to 'do the right thing'. This has become an ongoing and perhaps fruitless debate in political circles.

From a TCOM perspective, local control is recommended to increase as the decisions near the people to be helped. Individual level decision on such things as treatment planning, placement, and intensity of care should be made 'on the ground' with the directly involved parties. As the decision, making moves away from direct helping then a greater level of central control can be executed. These higher-level decisions impact more people and the only way to represent all those affected would be with data from the stories of all people involved. Central authorities are best prepared to make difficult decisions regarding allocated limited resources across disparate interests. Central authorities are also best situation to manage accountability and quality assurance processes and monitor for inappropriate or fraudulent activities. Nevertheless, the best interests of the people to be helped must still inform those centralized decisions.

**Budget Silos vs Blended or Braided Funding.** Everyone knows that work follows the money. Logically, then, if a system wanted to encourage integration, it should integrate the funding streams. While there is an appealing sensibility to this thinking, experience does not suggest that it actually works all that well. What appears to happen is that the locus of decision-making just moves upstream when you blend funding and actually, less people might participate in the decision-making regarding the use of resources. Braided funding offers a partial solution to this problem in that generally braiding is accomplished at the local level (e.g., community agency). However, it is seldom accomplished at the person level, so there remain some challenges for it to be person-centered.

The TCOM perspective is completely agnostic as to whether funding is blended, braided, or in a specific program silo. The more important consideration is how the incentives are structured to ensure collaborative processes among the parties in a system, regardless of how they are paid. Collaboration at the direct care level offers person-centered ‘braiding’ of funding streams to occur.

**Multiple, Overlapping Service Delivery Areas.** This tension comes from the fact that each funding authority divides out its territorial responsibilities differently. All these differences represent different manifestations of ‘gerrymandering’ that occurs with the creation of congressional districts after each census. Challenges with deciding how to divide territory among interested parties with power have been around through the history of civilization.

In TCOM, we do think collaborative processes could help but given the inherently non-collaborative nature of politics and power sharing, we suspect that aspiration is naïve. Rather, we propose that once the people in power have worked out their power sharing arrangements, then those various regions should determine how best to work together towards the common purpose of helping others. We do think that to degree that citizens can become informed about the EFFECTIVENESS of helping system, and then politicians and political appointees can be held to that standard rather than the standard of helping friends and allies to ensure re-election. We also recommend taking advantage of technology to increase options for people living in ‘helping deserts’. With advances in videoconferencing, a shared physical location is not always required for all forms of help. This new reality gives people living in rural settings greater choice, if jurisdictions can get past the restrictions that arise from the business of licensing, registering, and otherwise controlling the behavior of some professional guilds by geography.

**Insurance models vs Biopsychosocial models.** As our understanding of the human condition has expanding, traditional views of health care have evolved. However, oftentimes eligibility models have not kept up with these broader conceptualizations. Therefore, a tension exists between medical necessity criteria and more holistic approaches that recognize social and psychological determinants of health.

The TCOM perspective suggests multiple strategies to address this complex issue. First, we to propose an evidence-based approach to the evolution of our eligibility models. We believe that over time, the evidence will be clear that a more comprehensive understanding of people, paired with an equity-based model of the allocation of helping resources will prove to be the most effective strategy. Of course, only time and data will address this issue. Second, we suspect that the answer too many health challenges, including mental health and substance use, lie outside of the traditional concept of health services. Helping people find meaning in their lives, creating collaborative communities that respect and include all are the types of things that might move the dial on population health in way far greater than access to health care (e.g., Hayes, 2020).

**Eligibility vs Prevention.** In order to get help a person has to have a problem. That is how eligibility models work. Without the problem, help is not indicated and will not be provided. In order to prevent the development of a problem, however, one must intervene BEFORE the problem is manifest. This is an impossible tension to resolve. This tension has been a contributing factor for the observation that people have to ‘fail up’ in order to get help in the system (Lyons, 2004). It also contributes to the conflict of interest in a service system for providers needing to ensure that people fit eligibility standards in order to receive reimbursement.

The TCOM perspective is to abandon the concept of prevention services. The emerging evidence from our group at the University of Kentucky is that what we currently called prevention is actually strength building. When people have internal and environmental assets, they can mitigate and moderate the impact of problems resulting in less functional impact (Griffin et al., 2009). Prevention success in this regard is better considered a strength-building enterprise rather than trying to stop something from happening. This shift is far more consistent with transformational thinking. Prevention interventions always run into an essential outcome dilemma. To prevent something, the program/evaluator has to demonstrate that nothing happened. Nothing happening is successfully prevention. However, how does one ever know whether the bad outcome would have ever happened without the prevention intervention? This dilemma has resulted a historically cyclical approach to funding prevention activities. We solve the dilemma as soon as the intervention is understood as a strength-building activity.

## SYNDROMES

### *Person Level Syndromes*

**The Expert.** The notion of expertise and its impact on practice is an interesting and complex consideration. Professionals develop broad expertise. They learn a lot about how to understand the needs of people served, what strategies might be effective, and how the system works. However, despite this broad expertise, no professional knows someone better than that person knows themselves. People have deep expertise. This conflict between broad and deep expertise is a fundamental challenge. Professionals look at the people they serve and know they are not doing what they should—they are non-compliant. People are looking at providers saying ‘you do not walk in my shoes. You do not know what it is like to be me and you are arrogant if you think you do’.

This dynamic creates what we call the Expert syndrome. In that model provider come to believe that they are *changing the lives of people, they serve*. However, that is simply not true. What helpers are actually doing is *helping people change their lives*. It is necessary to translate broad professional expertise to broaden the deep expertise of people seeking help.

As we discussed before, true expertise requires a combination of both experience and feedback.

The lack of consistent feedback might be the reason that experience has seldom predicted clinical or functional outcomes in many helping settings. Further, as discussed previously in complex systems expertise involves helping achieve a consensus, not knowing more about something than anyone else.

Consensus-based assessment processes commonly surface the 'expert' syndrome. Sometimes professionals whose professional identity is formed around being an 'expert' are uncomfortable sharing expertise with others, even the people they purport to help. A psychiatrist once lectured me about how forming a consensus with his patients would dilute his clinical expertise. Of course, I asked him whether his believing something to be true could help his patients if those patients did not agree with his opinion. He then called me dangerous. I suppose I was, but only to his self-esteem, I think.

The expert syndrome is related to culture. Most helping systems in North America have evolved from a European worldview that sees expertise from a hierarchical perspective—we seek truth or the answer from the king, the priest, and now experts. Consensus-based assessments have their cultural origins in Inuit culture (and are congruent with many traditional cultures) in that expertise is considered something that everyone brings to the conversation in different ways. In Inuit culture if a problem is to be resolved, a circle is formed and everyone in the circle is given the opportunity to speak. Sometimes circles use a whalebone or feather to be held by the speaker to remind others in the circle to listen to the speaker and not interrupt. That culture difference can be jarring for some professionals; however, once they learn the power of the approach, most are able to adjust their understanding of this alternative model of expertise.

**The Hammer-Nail.** The old saw is 'if you only have a hammer, then everything looks like a nail'.

That is the essence of this syndrome. If a program does one thing, then everyone who is referred to that program can be reframed as needing that one thing. Helping professionals sometimes struggle with saying no or sending people away who they should not try to help because of non-fit. In a service system design, there is no financial incentive for not engaging in treatment even if there is no reason to believe that treatment might be of no value (or even harmful).

This problem is often exacerbated by program policies that are based on an equality doctrine of fairness. In other words, many program policies treat all people served as equal. Each new person seeking help is served in the same way. Anyone who has working in the field has heard some administrator saying 'We cannot set a precedent'. That language is invoking the equality definition of fairness. However treating everyone, the same does not work when there is a good deal of diversity or heterogeneity among those served. Instead, what is needed in most helping setting is the application of the Equity definition

of fairness Equity and mass customization go hand-in-hand in the design of helping systems.

**The Happy Face (Be Positive).** Since the advent of 24 h news and the professional ‘spin doctors’ that politicians employ, there was been a growing belief that if you just keep saying positive things then no one will be held accountable for any negative things. Nearly everyone is familiar with the three monkeys—hear no evil, speak no evil, and see no evil. These caricatures were created to describe three ways people learn to avoid doing anything about something that is wrong—pretend you never heard about it, pretend you never saw it or simply do not say anything about it. In our current culture, we really need to add a fourth monkey—reframe evil (Fig. 11.2)—spin it into something positive sounding.

Leaders sometimes surround themselves with an inner circle of advisors who just always say ‘yes’ and reflect the glory of the leader and the agency he/she is leading. This syndrome can actually work in the short term. However, it is a long-term disaster for the organization and often leads to leaders leaving the agency disgraced. While being positive and celebrating the success of others are important organizational culture strategies that does not mean that refusing to acknowledge any problems or misleading others about those problems is a good idea. Speaking truth to power is not just a social justice slogan. It is the best way to run an organization.

**The Ostrich.** A large number of professionals have come to believe that if they simply do not document a person’s need, then they will not be held accountable if they are unable to meet that need. They worry that documenting a need puts them at risk for a lawsuit. This is the ostrich syndrome and it is false. In truth, most lawsuits are generated when there is evidence that professionals are purposely avoiding recognizing a need so that they do not have to attempt to address it. Documenting a need that circumstances prevent a professional from addressing actually is a buffer against a lawsuit not a magnet for one. Engaging in the ostrich syndrome places the professional at great risk of lawsuits that just doing their job.

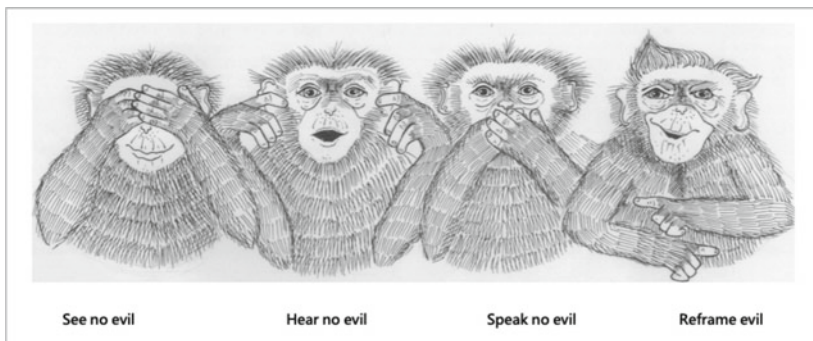


Fig. 11.2 The Four Monkeys

**The Fuzzy Pathogen.** In most helping professions, we do not understand the cause of most any of the challenges with seek to help address. However, successful interventions often require an understanding of a cause-effect relationship. However, causal relationships are often complex and multi-faceted. The proximal cause of homelessness may be a lack of housing options, but available housing alone does not general resolve homelessness. In fact, recent data suggests that traumatic stress may play an important role (Pope et al., 2020).

Mental health offers a fascinating example of this problem. Not a single diagnosis in the DSM-V has a known cause. Not even one. Yet every EBP was generated with a specific theory of cause-effect. None of these theories has ever been fully confirmed as the cause of the psychopathology the EBP is targeted to address. Cognitive Behavioral Therapy (CBT) has a clear causal model proposing that how we think influences how we feel and what we do. Changing how we think then has downstream impact on feelings and behaviors. The causes of emotions and, therefore, emotional disorders are likely more complicated than a simple linear relationship with how we think (e.g., Fox, 2018).

In the TCOM framework, we believe that helping can be thought of as a hypothesis testing intervention. Once a person's story has been told and multiple storytellers integrated into a single story, the next step of our model is to generate a theory of change. This theory requires the identification of putative cause-effect relationships that then can be tested by applying interventions to what is believed to be the cause. If the intervention is adequately applied but ineffective, then it is often reason to propose that the operating theory of change is not correct. The helper or helping team, in collaboration with the individual or family, should create an alternative theory of change that will allow testing a new hypothesis. This iterative process can be repeated until the circumstances that led to the person or family seeking help have been resolved. The evidence for a cause-effect relationship will arise from the success of an intervention. As with research, good hypothesis building narrows the number of 'trials' to success.

**The Imagined Cure.** Most helping interventions do not result in the resolution of all the problems. While there can be relative success, there is often no 'cure'. In a recent TCOM podcast, a survivor of Traumatic Brain Injury said, 'there is no recovery'. For example, for people with depression you can learn how to manage yourself when you start feeling low so that you do not become suicide or withdraw from social connections. Instead of returning to some baseline, you learn to move forward as a new version of yourself. One that understands your limitations and opportunities in a new way.

Further, even an effective program is not being to be effective for everyone. Often effective helping is not to eliminate the specific need or needs for which the person originally sought help. Rather the transformation involves helping the individual minimize the risks and functional limitations that have resulted from the needs. They learn to adapt and move forward to health.

**The Endless Treatment.** This syndrome is common in behavioral health sectors and arises, in part, from the service system structure described in Chapter 1. However, it arises from the earnest belief of many helpers that everyone could benefit from their help and there is no end to people need for this help. The more intensive and personal the intervention, the more helpers are subject to the draw of this syndrome. Psychotherapists are famous for their belief that therapy has no end, but the same phenomenon happens in Wraparound programs and Assertive Community Treatment (ACT) teams. When you are engaged as a professional in an intensely personal helping endeavor, it is only normal to become emotionally attached to the people you help. This attachment can be accompanied by a false belief that the person always will benefit from the helper's involvement in their life.

Sometimes the belief becomes shared between the helper and the helped, resulting in dependency. People receiving help who may come to believe that the helper has become a natural support rather than a paid helper.

### PROGRAM LEVEL SYNDROMES

**The Colonel Sander's Syndrome.** This syndrome might require renaming because the ad campaign on which it is based is now somewhat outdated. In its original advertising, Kentucky Fried Chicken (KFC) boasted 'We do chicken right'. Of course, if you go to KFC you are getting chicken, right. This syndrome often results in the hammer-nail syndrome described below but the nature of it is that once a program is set up to do something specific, then that is what the program does, regardless of the specific needs of people referred to that program. Unless the triage mechanisms for referral are very precise it becomes quite likely that some people are referred will not necessarily benefit from the program as it is designed. Since service, systems emphasize 'access' and 'filling case loads' as priorities necessary to effectively managing the business, there is sometime no effort to refer out inappropriate referrals. This impact of this syndrome is most common and acute regarding people who really do not need help but are worried that they do. These 'worried well' become easy cases to manage within a service system. Generally speaking, service providers do not have much difficulty saying no, because a cases is too challenging, complex, or high risk.

**The Therapist Illusion.** John Vessey and colleagues published an analysis that explains an interesting paradox. If you look at data on psychotherapy utilization it is clear that the vast majority of people who seek therapy stay in treatment a short period of time (Vessey et al., 19,940). Only 15% to 20% of people stay in treatment long term. However, if you ask therapists about what they do, the majority will say that they predominantly do long-term therapy. What Vessey and his colleagues demonstrated that with an evolving caseload it takes the average therapist a relatively short time until the majority of their time is spent with this small subset of long-term treatment episodes.

**The Rose Reversal.** As William Shakespeare famously stated in *Romeo and Juliet*, ‘a rose by any other name smells as sweet’. So true. However, calling a dandelion a rose does not make it so. This syndrome has been evolved into somewhat of a challenge with political ‘spinning’ and politically correct language so that sometimes people simply say what they think others want to hear rather than the reality of the situation.

This syndrome can be a major barrier to a successful implementation of evidence-based practices (EBPs). For example, if a funder creates a policy that they will only reimburse evidence-based practices, a provider might say, ‘I use evidence-based practices’ regardless of the fidelity applied to that practice. Such claiming of an EBP without proper training and adherence to the fidelity of the EBP defeats the purpose of the policy. In the end, such behavior destroys the reputation of the EBP. For this reason, some EBP developers become rather draconian in their requirements for fidelity and sometimes even litigious about unjustified claims of use. These challenges raise the cost of implementing EBPs, driving some jurisdiction into creating ‘as-if’ or ‘light’ versions of the original EBP.

**Public Funding as an Entitlement.** Given the large P political nature of many public helping systems—leadership appointed by elected officials and the small p political nature of human relationships, sometimes provider organizations are able to secure funding primarily based on these relationships. In these circumstances, these organizations can view their accountability only to their ‘friends’ or ‘benefactor’ in the bureaucracy rather than to the work of helping. While this is not necessarily a common syndrome, it does happen. When other organizations become aware of these relationships, it can be demoralizing and give a clear message that leadership in the jurisdiction care less about helping people and more about taking care of friends. Again, the best cure of this type of patronage approach to public service is transparency in terms of contracting and relationships.

Regulations limiting potential conflicts of interest likely would be helpful as well.

## SYSTEM-LEVEL SYNDROME

**The Political Dog Walk.** If you have ever had a dog, you know that when you take your dog for a walk, dogs do not just go with you on a walk and immediately take care of their business. Instead, they try to give a little bit here, a little bit there and so forth over the duration of the walk. There are two basic reasons for this dog logic. First, it extends the walk. Second, it marks the dog’s territory.

Politicians are precisely the same as your dog. There is very little political value in giving a large contract to one agency when it is possible to give multiple smaller contracts to a larger number of agencies. That is just simple political calculus. There is far more political and relational value in spreading the wealth when possible. Potential recipients play into this dynamic



when a large contract is award to only one agency as protests commonly are immediate, robust, and sometimes accompanied by accusations of cronyism or insider dealing.

While the political dog walk actually offers some protections against favoritism, it can also work against collaboration and system integration. If the funded agencies see themselves as competitors for a limited pool of resources, they are sometimes less likely to work well together. Incentives for collaboration and integration built into funding mechanisms are one way to offset the potentially damaging impact of the dog walk. Executive Directors of potentially competing agencies understanding and embracing the value of collaboration across program sites is a second route to address this syndrome.

**Field of Dreams.** The famous ghost line from this classic movie was ‘If you build it they will come’. If you are a system leader and you built something, they had sure as heck better come.

Nothing is worse than creating the infrastructure for a new program and not having it filled. I once was on a call with a group of system leaders of one state about a project to reduce detentions. Included on the call was the Director of a newly opened multi-million dollar detention center. At one point, he exclaimed something to the effect of ‘I will be damned if I am going to support anything that leads people not to use our brand new facility’.

The renowned program evaluator Joseph S Wholey (1983) argued that once created programs are essentially impossible to disband. Although exceptions exist, it is uncommon. Ronald Reagan ran on a platform that, in part, called for the dissolution of the federal Department of Education, thereby leaving education to the states. He never succeed despite repeated attempts. The downside of this reality is that over time it may not matter whether or not a program serves any useful purpose. For example, my son when pursuing his doctorate in political science got a top-up on his fellowship to learn the Mayan language (which is a dying language). The program that funded him was a cold war relic of efforts to win the hearts and minds of people in Central America. Sadly, although he can now speak Mayan, that skill has limited or no value despite his living and working in South America.

Once established, programs develop their own constituency that will always seek to maintain the status of that program. Concerted, collaborative efforts are required to end programs that have limited or lost value so that limited resources can be optimally targeted to real needs.

**The Perfect as the Enemy of the Possible** (you cannot fix anything unless you fix everything).

This syndrome is the classic excuse for people who do not really want to engage in a change process. It is the helping sector’s equivalent of the political strategy of ‘whataboutism’. It is invariably true that any useful idea to fix something that is wrong with a system or program will never fix everything that is wrong with the system. The art of this syndrome is to point this problem out and say that we simply cannot move forward on a partial fix and that would not be equitable, efficient, or a similar rationale.

This syndrome is deadly powerful and is practiced often with great success. Any good solution-based conversation can be easily derailed by shifting the discussion to things that the initiative does not address. It does not even matter when the initiative is not even intended to address the problem; the shift in focus is compelling and can successfully work to stop any initiative in its tracks.

Addressing this syndrome takes good leadership with a strong sense of commitment to the common aspirations. Sometimes trying to untangle the personal aspirations of the individual or individuals raising this objection is helpful to the process. Once personal aspirations have been identified, they can be aligned with the common aspiration. Alternatively, if these skilled saboteurs do not wish to reveal their personal aspirations, then it creates the opportunity for a gentle ‘put up or shut up’ situation which can send a distraction to the ‘parking lot’ for later discussion.

**What is mine is mine and what is yours... well that is negotiable.** Consensus-based work is always a negotiation. Negotiations almost invariably involve compromise. Some people are quite competitive and do not necessarily do well in collaborative relationships. Narcissism among leaders or partners can torpedo collaborative relationships. Empathy begins to develop around age five. By age five, most children learn to lose gracefully. That is the age at which emotional meltdowns that result from ANY losing cease and the child develops the sense of sport and competition—that is ‘you can’t win them all’. Some children struggle with this developmental stage more than others do. Some adults have not really developed on this empathic journey. Of course what happens with these individuals is after a while nobody wants to play with them anymore, although if they have power, money, or charisma, that may take some time.

It would be nice to believe that taking a collaborative stance would work for everyone. That belief is likely naïve. Some people will likely never be able to be collaborative. Systems, agencies, and programs simply must try to avoid hiring these people into helping sectors. If they are hired, efforts should be made to place them in positions that require minimal expectations for fostering and supporting collaborative relationships.

**Imperialism/Privilege.** It can be a great feeling to be important. It has said that power is one of the most powerful drugs. Alan Kelly (2016) an Irish politician was once quoted as saying ‘Power is a drug...it suits me’. John Dalburg-Acton (1887) in a letter to the Archbishop famously said, ‘Power tends to corrupt and absolute power corrupts absolutely’. The addiction to power and the privilege associated with it can create imperial leadership—insular and out of touch with those that they profess to lead. At times imperialism sounds quite compassionate (e.g., parental) when it is patronizing. There are many popular phrases in our culture to capture this phenomenon: country club liberals, bend over backwards racism, and so forth. More recently, this concept has been described ‘privilege’. Oftentimes people with privilege do not even recognize the implications of the advantages that come with differential power.

Currently, it can be popular for some helping agencies to advertise that they serve ‘the most vulnerable’. Having talked to many people in the circumstances for which this term used, I can guarantee that ‘vulnerable’ is not part of their vocabulary of self-description. Advertising to privileged groups that you are serving ‘vulnerable’ people could trigger the generation of ‘guilt capital’ as a fund-raising strategy. While perhaps the end justifies the means in this way, it is important to note that this type of language only furthers stigma and the perceptual divide between the ‘haves’ and the ‘have-nots’—the ‘us’ and the ‘other’.

## SUMMARY

It has been our experience that, at least for the most part, a focus on implementing and maintaining person-centered care at all levels of a helping system can go a long way to eliminating the syndromes described above. System partners themselves must decide how to manage the tensions by deciding where on the continuum for each, policy should be focused. This is best done as a collaborative process and in our work, we find spending time deciding collectively how to balance tensions a more fruitful approach than traditional strategic planning. However, that is a policy decision that will be decided separately for any helping system based on their structure and the relationships among partners.

Awareness of the tensions and syndrome can be helpful in both starting and sustaining TCOM implementations. They represent the likely areas where barriers might be experienced and unexpected challenges might arise. As they say, forewarned is forearmed. The journey towards a fully person-centered approach is fraught primarily because people other than those to be helped wish to be at the center. Learning to play well with others is easy to say and hard for many of us. A focus on teaching and learning effective collaboration is as important as finding effective helping strategies and interventions.

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## Developing and Managing the Field

If TCOM exists as a strategy used and supported by only one group, the likelihood of its ongoing success in creating change in the helping sector is extremely limited and, in all likelihood doomed over long term. Any approach that requires the involvement of a group of experts, a central authority of some type, will suffer insurmountable barriers to widespread use. First, the ability to support new implementations is limited by the capacity of the central authority. In order to fund the central authority, charges to implementations must be established. To expand the central authority, increased revenues are required. As the central authority builds its capacity, it creates a bureaucracy of its own that invariably raises the cost to implement the approach. Second, innovation is likely discouraged unless it comes from the central authority. Centralized control of any innovation generally limits further innovation to the central authority, as outside parties are seen as ‘threats to the integrity’ of the approach or even as completion. Third, the central authority place themselves in immediate competition with all other experts who seek to make their careers in the same space and must, therefore, discourage the implementation of one approach so that they can encourage the implementation of their approach. Anyone who has ever consulted to public agencies knows that consultants often create a zero-sum game with other consultant resulting in ‘winners’ and ‘losers’ and frequently changing frameworks depending on today’s winner. In our approach to support and use of TCOM, we understand and embrace these barriers and seek a different path to support widespread use.

The central concept of TCOM is that the same types of processes repeat themselves at all levels of the system simultaneously. A focus on personal change and working together towards a common purpose should be a part of everyone’s experience in both receipt of care and all the different roles of

providing help to others. The work of direct care is akin to the work of supervision, and even to the work of program, agency and system management. It is also similar to the work of quality improvement or even research. All of these processes share the need to encourage other people to learn from their experiences and change their behavior to become more effective in whatever it is they do.

Of course, the concepts of aspirational management apply as much to the development of the field of TCOM as they do to the application of TCOM in practice. In order to begin to think about how to create a field is first important to think about what would be the advantage for people to decide to participate in such a development. Fundamentally, everyone asks ‘what’s in it for me’ before deciding what to do in most circumstances. It is therefore critical to determine what the benefit would be of joining an emerging field and then to try to optimize access to these potential benefits for anyone who chooses to join.

As discussed throughout this book, a key concept of behavioral change is to create experiences for people that allow them to experiment with change and receive feedback on the results. This is the ‘transformational’ aspects of TCOM. Moreover, in all cases these complex change processes might be most effective if approached in a collaborative fashion. It has also been discussed throughout the book that the nature of complexity in helping systems benefits from collaborative solutions in order to facilitate the desired behavioral change. The need for collaboration is equal at all levels of the system. Direct care should be collaborative. Helpers engaged people to be helped through establishing a collaborative relationship. Supervision engaged direct care staff by establishing a collaborative relationship. Management should engage all staff by establishing a collaborative approach to the evolution of the work. Given this dual reality across the system—a focus on personal change and collaboration—it would seem only logical that the process of supporting TCOM implementations as a field should also involve a collaborative approach to personal change that focuses on building experiences of all participating parties.

Given this framing of the work, the people who support the implementation of TCOM around the world, approach their own work in the same philosophy as the team recommends to others. In others, we practice TCOM as a management approach to supporting the implementation of TCOM. The foundation of this approach is an international TCOM collaborative. The international collaborative that meets annually and provides an active blog to facilitate communication and sharing among all of the individuals who are working to gain experience in working within the TCOM framework. National and regional meetings are also a part of engaging participants in the development of the field.

In 1999, I decided to place the intellectual property rights for the CANS into the Praed Foundation. This decision was informed by a bad experience in the proprietary test/measurement business that soured me to an approach

whereby customers purchase copies of measures to use. So instead, we formed a US Charitable Organization (501.c.3) to hold the intellectual properties so ensure that the measures would be forever free. The regulations around these types of organization forbids that any intellectual property is ever sold. While I did not fully realize it at the time, this decision was an important part of setting the stage for the collaborative approach for people using the tools. The various TCOM measures are forever free to use.

At the time, I had been collaborating with Ken Howard, Ph.D., the founding president of the Society for Psychotherapy Research and arguably one of the founders of outcomes management as an approach. In his seminal work to implement an outcomes management approach, it became clear that the psychometric measurement theory created challenges.

Specifically, the requirement of making a measure out of a defined set of items that must always be presented in the same order was a significant obstacle to getting organizations to buy-in to outcomes management as an approach to their work (see the previous chapter on Communimetrics). Around the same time, Ogles, Lambert, and Master (1996) published a review of outcome measures in which they identified around 1400 different published measures—truly a Tower of Babel in terms of the language of outcomes. Just after their review was published, Mike Lambert published the Outcome Questionnaire (OQ-45), and Ben Ogles published the Ohio Scales. A core premise of successful outcomes management is that everyone uses the same definition of outcomes so that it becomes comparable. Unless one were to compare programs and interventions using only meta-analytic approaches, this heterogeneity of measurement options works at cross purposes with an outcomes approach. In my mind, it had become clear that such sensible common measure approach was at complete and unresolvable odds with our current proprietary measurement marketplace. It was a zero-sum game. If one test was purchased for use by a jurisdiction all other tests ‘lost’ that business and then would be working to undercut the success of the ‘winner’ for future business opportunities. While competitive marketplaces are a great stimulus for market innovation, they represent a poor stimulus for universality.

Beginning in 2002, a formal process of supporting an international collaboration began with the first annual CANS Conference which was hosted at Northwestern University in Chicago. The original thinking behind the conference was that I wanted to accomplish three basic goals:

1. give people who were working hard to attempt to implement the CANS and chance for personal recognition,
2. start conversations across implementations, and
3. Pitch the approach to places that were considering implementations.

The first conference had 125 attendees for one day of keynotes and a half-day of breakout sessions. I think that the first two goals were met and

the third was an utter failure. People involved in the initial implementations did get a chance to shine and good conversations were started among early participants. Some of these conversations are still ongoing sixteen years later. However, none of the jurisdictions considering using the CANS decided to move forward after attending the conference. In considering why this happened, I concluded that the first conference felt very ‘cult-like’. Everyone who spoke was always referencing me in their presentations. My deep involvement in every one of the initial implementations was recognized as a barrier by anyone not involved in those implementations. So beginning with the second conference (also in Chicago), I work hard to increasingly remove myself from the presentations and discussions so that it new participants would not be dissuaded in joining by feeling as if the group was a cult of personality. Consistent with Derek Siver’s work on how to start a movement—people do not following the leader—they follow the first followers (Sivers, 2010). By the second conference, we were getting nearly a 100% uptake by new jurisdictions considering the approach when attending the conference. That experience was one of my first true realizations of the power of collaboration.

## TCOM CONFERENCE

Chicago was home for the 14th annual TCOM Conference in 2018. The first conference, called the CANS Conference, was in 2002 and held nearly every year (with two 18 month conference separations) from then on. In 2012 and 2013, the conference was called the CANS/TCOM Conference and by 2014, the rebranding of the conference was complete, and it has been called the TCOM Conference for the past five years.

The original concept of the conference was to bring together all the people using the CANS to share their experiences. By 2002, there was a critical mass of people in Illinois, New York, Florida, and New Jersey to have a 1.5-day conference. The first conference was all keynotes. For the first conference, 125 people attended and it was a mix of system administrators, agency leadership and direct care staff. By year two, we have enough presenters to establishing a combination of keynotes and breakout sessions. The first five conferences were focused on training and implementation. Since 2007, the focus of the conference has shifted each year to a greater focus on data-driven presentations. Interestingly, as the shift has occurred to increasingly data sophisticated presentation, the percentage of direct care staff representation at the conference has consistently shrunk. By 2018, the majority of the conference attendees were system and agency administrators and evaluators.

The primary purpose of the conference, however, has stayed true to its original intent—to create an opportunity for sharing experiences—good, bad and ugly—to help build a field of interested partners pursuing system improvements using collaborative assessment strategies. As importantly, the conference also provides an outlet to celebrate the contributions of members of the



emerging field. All collaborations need to recognize and celebrate accomplishments by individual members. The common aspiration is to build a field but this aspiration must remain aligned with individual aspirations of the people that comprise it. We see the conference as the meeting of the international collaborative. We see the conference as a fundamental approach to building a field of people who pursue outcome management within the TCOM framework.

Over the first fourteen conferences, the focus has gently shifted. Initial conferences were primarily about training and implementation with the balance shifting from training to implementation. Starting around the 10th conference the focus began to shift towards more data based presentation. The 2018 conference in Chicago was predominantly data based—most of the presentations included data from existing implementation and thinking about the practice and policy implications of the findings.

### COLLABORATIVE TRAINING WEBSITE

For the first use of the SPI and the CSPI, we trained and certified users. Since the tools were designed to be what we called ‘information integration’ strategies from the start, we felt that demonstration of reliability was important. In addition, during the 1980s and 1990s, there was significant distrust of the reliability of all available clinical information capture in practice.

Researchers at the time felt that only a robust implementation of a research measure into clinical practice on a small sample of people was a reliable and valid approach to the measurement of clinical and functional characteristics. A large body of research had developed by then documenting the unreliability of clinical diagnoses and other clinical and functional information collected in standard documentation procedures (Lyons et al., 1997). In this zeitgeist, we felt it was critical to document the reliability of these tools so that they could ‘pass muster’ as legitimate sources of information about people receiving care.

The methodology for assessing reliability after training was using case vignettes. This method had been established with measurement approaches that were already in use as we began the use of communimetric measures. Clinical and functional measurement strategies such as the Child and Adolescent Functional Assessment Scale (CAFAS, Hodges, 1999) and Severity of Illness (Horn, Horn & Sharkey, 1984) used case vignette methodologies to establish reliability. We selected a minimum reliability of 0.70 on an intraclass correlation coefficient as this represented the lower bounds of acceptable reliability and the intraclass correlation took into consideration the structure of a communimetric tool where adjacent ratings have more in common than non-adjacent (a ‘3’ is more like a ‘2’ than it is like a ‘1’).

In one of the very first large scale, trainings of the CANS in Florida, I reached the end and announced that ‘Now we are going to do a reliability assessment’. Two thirds of the nearly 50 people at the training just stood up

and walked out. I immediately realized that I would have to present the certification process differently if I were going to get professionals to be willing to be tested—something very few people actually enjoy. Thirty years later, reliability certification is a widely accepted standard. People realize that if you want to use information to guide decision-making you need to ensure that the information is good. If you want people to learn and use a common language, it is necessary to develop some form of fluency test. The method or certification and the application of reliability statistics remains an ongoing discussion in the TCOM group. There is some thought of moving towards a sensitivity/specificity approach to reliability in future.

In 2012, we initiated a distance-learning platform to support efficient training and certification. Initially developed for the province of Ontario this platform is now home for training and certification on most of the suite of TCOM tools that are used around the world. The original design of the website was to essentially a replication of the in-person training model on a distance-learning platform. Because long videos took some time to load which slowed the experience for trainers we selected to make short videos of 2 to 5 min in duration and string them together to capture the content of the live training in the distance-learning platform. We were also able to add to the practice and test vignette training model by including quizzes that were one or two sentence examples for each of the items to allow trainees to test their understanding of the meaning of each item.

In 2014, we required all people using the CANS, ANSA, or FAST to become certified on this site as a form of quality control. A few jurisdictions—New Jersey, Massachusetts, and Wisconsin—who had their own robust certification site were ‘grandparented’ in and allowed to continue providing certifications within their states. However, with time the expectation is for all to migrate to our platform at TCOMtraining.com. New Jersey moved in 2021. All new implementations would certify on the collaborative site hosted by the Praed Foundation. The primary reason behind this shift in policy is that ‘rogue’ implementation of the approach were starting and failing because people did not really understand the approach and were not implementing the tools with any fidelity. When the implementation failed, the tools were blamed as ‘not working’. The rumor mill around this small number of failed implementations damaged the credibility of those jurisdictions that were attempting to implement the approaches with fidelity (and success) and so therefore, the TCOM team determined that it was necessary to take more central control over this process to ensure its validity. In other words, when direct care staff were not properly trained and certified in the approach, it was implemented in ways that were not helpful and, therefore, it was not helpful. This would create people saying at meeting things like ‘We tried the CANS and it didn’t work’. Which of course, while true, is a false simplification of the challenge of their implementation. Without having people knowing how to use the approach effectively, it is difficult for people to use the approach effectively. Unlike standard psychometric measures which one only has to hand out and collect the

data, assuming that it is accurate and relevant, a communimetric measurement approach requires both knowledge and skill on the part of the helper in order to obtain accurate and useful information.

## TCOM TEAM MANAGEMENT

In 2014, we began the formation of a group at Chapin Hall at the University of Chicago and the Praed Foundation to support the implementation of TCOM around the world. In 2019 and early 2020, we moved the team to the Center for Innovation in Population Health (IPH Center) at the University of Kentucky. The concept of this group was that it would serve as a central hub for the development of the field of TCOM. Metaphorically, the IPH Center functions as TCOM sun around which planets orbit, each independent but coordinated with the sun and its solar system. Since its formation, the team has grown rapidly from the initial three members to a 22 within the first five years of operation. Of course, with growth, it becomes increasingly necessary to create management structures. Otherwise, work efforts are duplicated, priorities are inconsistent, and inefficiencies interfere with the productivity of everyone.

During this growth, it became clear that the challenges of collaboration that confront direct care, supervisory, and management staff in the work of helping, also challenge those of us committed to supporting this approach to person-centered care. We aspired to establish a collaborative work group that effectively supports the evolution of an international collaboration all committed to effectively implementing the TCOM approach. Initially, we attempted a fully flat organization with no hierarchy, each person doing their role as projects came up in a collaboration with the others on the team. As the TCOM group numbers grew, it became necessary simply for purposes of efficiency to create a management team for our group. One of the first activities this team undertook was a strategic planning process that included a modified Delphi process to establish parameters to guide our decision-making. In the process, we initially identified key tensions in our responsibilities. These tensions were designed as polar concepts that create ongoing competing pressures that while unresolvable in the sense the tension will always exist are management if the team can develop a position on the continuum to guide decision-making. Figure 12.1 presents the key tensions along with our initial average rating on each of the identified tensions.

The tensions in (Fig. 12.1) flow from those initially inventoried in the original TCOM text (Lyons, 2004) but are limited to those tensions related to management of the TCOM leadership group. The first tension is the pressure between incubating the success of others (i.e., Building a Field) and ensuring that the central team itself was sufficiently funded (i.e., Building a Business). A significant challenge of all collaborative enterprises to create a method of funding the hub of collaborative activities. Our early experience of having absolutely no funding for any central authority proved to be limiting

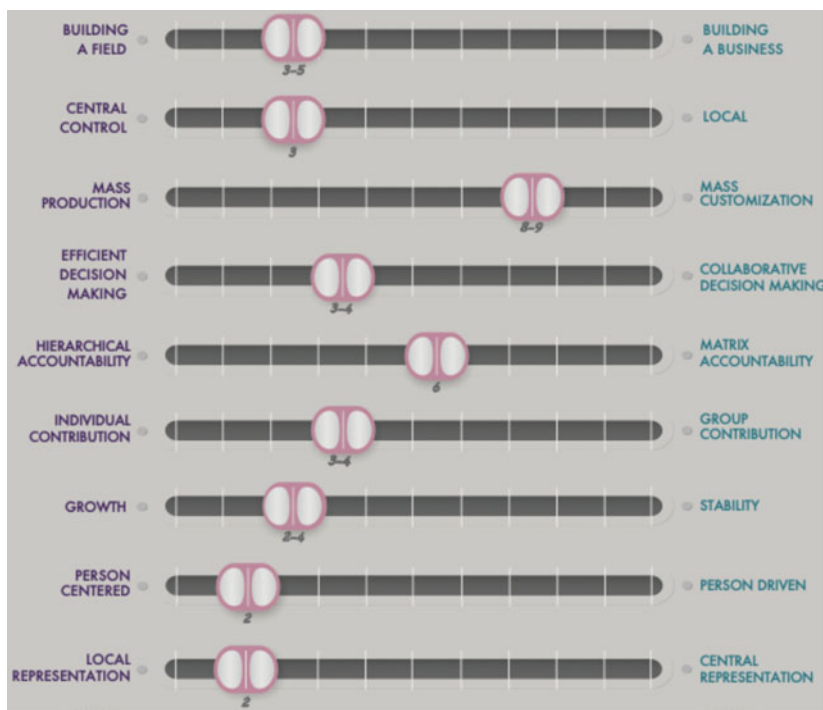


Fig. 12.1 Key tensions of a growing collaboration

to managing the development of the field effectively. As you can see by the balance structure by the leadership team, the strategy was on successfully building a team; it had to be accomplished in the context of ensuring sufficient resources to fund a central entity to support this field development. As the field develops, it may be that this valence could shift further to the left. A policy decision arising from the team's decision was that we would distribute without charge any products or materials that were developed but we would monetize the distance-learning platform to cover its costs. Since the standardized certification process was found critical to maintaining the integrity of the approach, this financing strategy remained congruent with our organizational philosophy as long as we keep the costs of the distance-learning site low. The costs of learning the approach should not be prohibitive to people wanting to join the collaborative.

Related to the first tension but covering a different set of decisions the second tension is the pressure between having central control over decisions as opposed to allowing decisions to occur predominantly or even exclusively at the local level. Here, the team moved more to the center to find the balance between the two poles of this tension. One of the frustrations, across the various implementations was the lack of consistency in the definitions of

items even with similar versions. For this reason, we moved to standardize all item definitions and resource guides to create consistency across implementations while respecting those different implementations would require different subsets of items.

We have already discussed the Mass Production versus Individualization in this discussion we choose just half of this continuum—the tension between Mass Production and Mass Customization. Of course, Mass customization resides at the balance of the continuum of Mass Production versus Individualization. However, given the need to standardized measurement to allow for any combination of stories in order to apply TCOM principles at the program and system levels, individualization is simply not possible. The pressure in the field of outcomes management and program evaluations is standardization that flows from a Mass Production view of the work.

The fourth tension is an interesting one. This is then tension between make quick and efficient decisions versus engaging in the always slower process of collaborative decision-making. This tension resulted in a rating that favored one side of the tension more than the other at least compared to most of the other ratings. The leadership group came out strongly in favor of slowing down decision-making in an effort to ensure that key decisions were done collaboratively. The team realized that some decision did not require collaborative processes but that in general caution should err on the side of collaborative decision-making.

Matrix accountability is a concept first advanced in the original TCOM text (Lyons, 2004) whereby everyone is accountable to everyone else in some fashion. Matrix accountability exists in counterpoint to more hierarchical models of accountability than are generally built as top-down management structures. The teams placed our perspective somewhat on the side of Matrix Accountability—seeking mechanisms of shared and mutual accountability. The rating was closer to the midpoint of this tension in recognition that we must exist within historically hierarchical power structures.

Individual contribution versus group contribution represents one of the challenges of collaboration in traditional academic and business settings. The question is fundamentally how credit is distributed in a group. Many large collaborative research endeavors (e.g., Diabetes Complications and Control Trial) establish a list of member and publish with attribution to the list. While that is equitable, it does less to allow individual members of the group the opportunity to advance their careers. It is noteworthy, however, that the team balanced this tension on the side of individual contributions. For this reason, the collaborative seeks to support, promote, and celebrate individual accomplishments within the collaborative.

The next tension might have been the most delicate. TCOM tools now represent by far the most commonly used approaches to outcomes measurement and management in behavioral health and child welfare in the world. In the late 1990s, only one state (Illinois) used any of these tools. The growth of the use of the tools in 25 years to a worldwide approach was, at times, quite

daunting. Naturally, there were members of the TCOM leadership team that felt it was in the best interests of the work to slow thing down in order to ‘get things right’ before continuing to expand. On the other hand, anyone who has worked in this type of space quickly learns that if you start saying ‘no’ to people, then people stop asking. We settled on a position favoring growth while recognizing that in this model, we could not accomplish everything we wanted to do as a central authority. Building support through University Partners and local expertise was identified as a strategy to support growth while maintaining stability.

The question embedded in the next tension requires a clarification of the role of lived experience in this TCOM leadership team. Looking at the valences of this tension should be clear that only a portion of the entire continuum is included—just the distinction between person-centered and person-driven. On the one hand, ensuring the people are full partners in the system is the fundamental of person-centered care. However, it is possible to go farther than that to a system that is controlled by people seeking help. Although there was a plurality that felt that person-driven care is an important aspiration, the consensus was that aspiration is not currently within the reach of the existing system. A number of notable infrastructure improvements to the systems would have to be designed, implemented and sustain before it would really be possible to achieve a helping system driven by people seeking help. For that reason, we placed the TCOM work on the side favoring adherence to person-centered care.

The final tension that the TCOM leadership group discussed was now to represent people with lived experiences in the work effectively. At one end would be a centralized approach in which the TCOM leadership group would hire people with lived experiences to work as a part of the core team. At the other end of tension would be supporting local representation at implementation sites. Note that we only included a portion of this continuum, as none of us would consider no representation of people with lived experience as a reasonable approach to the work. We settle on a position of favoring local representation.

A number of factors influenced this outcome including the reality that if we hired one person—they would be one person—and this approach might not give all that much voice to people seeking help. In addition, although none of us identify ourselves as people with lived experiences, in fact, a number of members of the leadership team (included some of the present authors) have lived experiences. The feeling was that we should make it a standard expectation of TCOM implementation to encourage representation at the local level in decision-making bodies. We have had some notable successes with this process, for example, in Idaho children’s behavioral health, and have struggled with helping local sites understand the value of this type of representation.

## SURVIVING 'REGIME' CHANGE

One of the most daunting challenges in the public helping sector is that leadership of code agencies responsible for both funding and managing helping sectors are appointed by politicians. Such a model is good for democracy in that it promotes responsivity to citizen voters. If political leaders become out of touch with the aspirations of the majority of citizen voters then they can be voted out of office. Politicians who express willingness to further the aspirations of the voting citizenry likely will replace them. Of course, when political leadership changes so do appointed members of their administration. Elections often lead to changes in the appointed political leadership of all code agencies responsible for the funding and management of public helping sectors.

While good for democracy, this process offers enormous challenges to the ongoing success of any initiative. First, political appointments are not necessarily well-versed in the actual work of the agencies for which they become responsible. Some appointees are well versed; some are not. There is no requirement that political appointees have any experience whatsoever in the work for which they become responsible. I do not know of any research on this topic but it is my observation of the course of my career that the worse the reputation of the code agency, the more likely someone talented from another field will be appointed to clean things up. It is also my observation, that politicians who are more to the right on the political spectrum tend to approach public helping systems with some skepticism unless they have had some personal experience in that area, while politicians more to the left of the political spectrum prefer career bureaucrats. Both approaches have advantages and disadvantages. All of these considerations are neither here-nor-there because the system simply must adapt to whomever is appointed and confirmed. The point is, regardless of who is appointed; the turnover in leadership is always disruptive particularly in the top half of the state or county or municipal agency.

The biggest challenge of this system design is that whomever is appointed to lead will come with their own aspirations. Very few of these appointments are long-term jobs—four years if you are lucky—more likely two or less. Therefore, professionals take these positions for reasons other than this where they plan to end their career. The individual aspirations can be as varied as the number of appointees. Some will see the appointment as an important line on their resume—credentialing them for a career in consulting. Others will see the appointment as an opportunity to pursue an agenda for which they have become passionate. Still others will experience it as a duty. In addition, sadly, a few may see it as an opportunity to exercise power and influence others. Many, if not most, political appointees to lead public helping sector agencies agree to a cut in pay to accept the position. At least in the short term, we can safely say that it is 'not about the money'. All political appointees are first-and-foremost human. They are people with strengths and dreams and fears and foibles.

Given the circumstances described above, invariably the individual aspiration of nearly all political appointees is to establish a legacy. Typically, the effort to build this legacy is through a signature program or initiatives or to focus the agency on a specific objective. For example, some child welfare directors focus on safety, others on return to permanency, and others on well-being or identifying and treating trauma. It is infrequent that a new political appointee assumes the leadership of a code agency with the aspiration of continuing the good work of the last director. That would be seen as building the legacy of the last director, not your own. More likely, the new director might attempt to dismantle the work of the previous administration either because of a political shift or because resources are needed to pursue the new director's aspirations. Some may view this analysis as cynical and a destructive structure component of the public helping system. I believe it is actually a good thing. We want leadership invested in the work of the public agencies that they lead. In my view, the key is in aspirational management, what is necessary is to ensure that the aspirations of new political leadership can be aligned with the boarder and more permanent aspirations of the work of the agency. TCOM creates that opportunity by always focusing on the well-being of the people helped rather than on how they are helped. The approach is fundamentally apolitical (both small p and large P).

## PRODUCTS, PLATFORMS, AND PROCESS TO SUPPORT THE FIELD

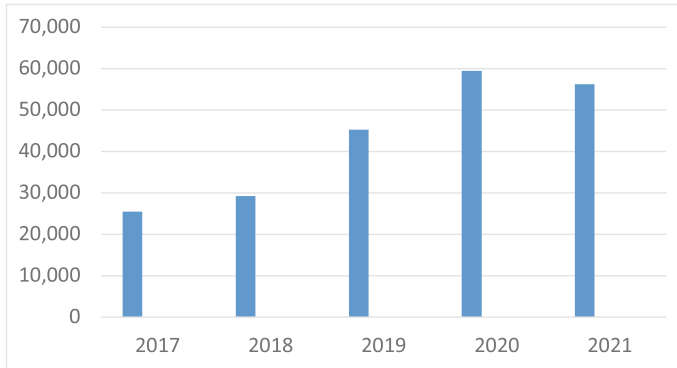
### *TCOM Blog*

Beginning in 2016, we established a blog as the virtual location of the international collaborative at [TCOMconversations.org](https://TCOMconversations.org). The TCOM team generates about half of the weekly blog posts and the remaining half come from member of the collaborative. In addition, we post materials for sharing so that jurisdictions that do not use the collaborative training website have easy access to materials and information about processes developed across the collaborative. Figure 12.2 provides statistics on the total number of views by year. We suspect the stabilization and slight decline in views in 2021 corresponds to our launch of The TCOM Channel on YouTube.

## UNIVERSITY PARTNER COLLABORATIVE

As mentioned previously, an intentional decision early in the development of the field of TCOM was to create local capacity to support the work within the target jurisdiction. Originally, this was a decision of necessity since the implementation support team was an army of one. However, as discussed elsewhere, we worked to build a central support group. However, a fully centralized support model reduces the advantages of long-term success within any given jurisdiction.





**Fig. 12.2** Blog views by year for the start-up of TCOM Conversations.org

A more effective strategy is to identify a local partner who will develop a stake in the success of the implementation. In my experience, finding a University partner is ideal whenever possible. The advantages include creating a local partner, external to the code agency that has a stake in the success of the implementation. In many cases, a local university has a strong presence in a state and considerable intellectual cache if not gravitas within that state. Often these universities train a substantial portion of the workforce in the state. Contracts between states and local universities are often easy to execute and practically ‘ever-green’. As Bryan Samuel’s the Executive Director of Chapin Hall once noted—‘it is easier to move a person than a contract’.

As of this writing, there are now 15 different university that have a funded entity that supports some aspect of TCOM in their respective states, including in this list are

- Case Western Reserve University
- Indiana University
- Loyola University at
- Chicago Marshall University
- Northwestern University
- Oklahoma University
- Rutgers University
- University of Illinois,
- Urbana/Champaign University of Kentucky
- University of Massachusetts
- University of South Florida
- University of Texas at
- Austin University of
- Vermont University of
- Wisconsin Vanderbilt University

Each of these university settings have general training components and most also provide coaching and consultation supports. A growing number have or are working to develop analytic supports and research components to their academic center. This evolution follows that natural course of implementations of course. It is hard to use person-centered information until that information is collected. It is hard to trust the use of person-centered information until there is a developed confidence within the system that the tools are completed reliability and completely as indicated by system policy. Both of these stages simply take time and attention.

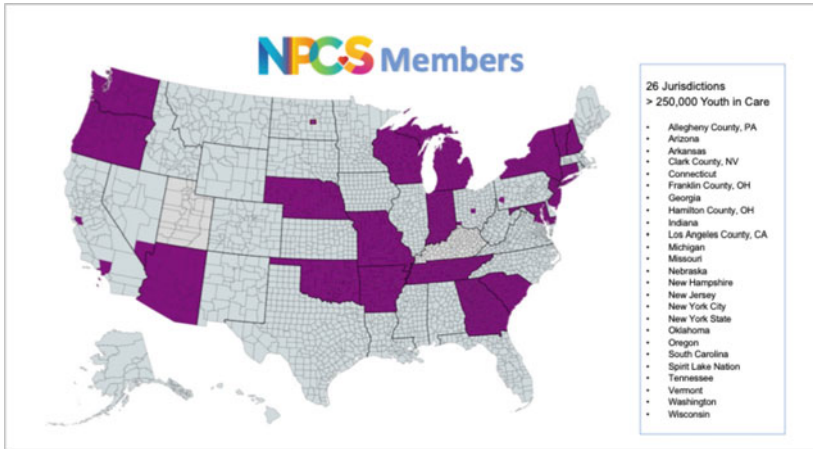
## INTERNATIONAL COLLABORATIONS

There are now TCOM implementations in a number of countries. While TCOM tools are used on every continent except Antarctica, the intentional implementation of TCOM is somewhat less prevalent. The first national implementation was in Singapore, led by Karen Sik and others. Singapore uses most of the TCOM tools in a variety of applications. Italy, led by Antonella Costantino, MD and Stefano Benzoni, M.D., implemented TCOM around 2015 and has now had five annual TCOM Italia conferences in Milano. England, led by Mark Kerr has launched a TCOM England implementation process focusing on child welfare. Colombia, led by Juan Barco, has initiated a TCOM implementation in the child protection sector.

## NATIONAL PARTNERSHIP FOR CHILD SAFETY

Organized in 2018 by Michael Cull, Ph.D. and Tiffany Lindsay, ED and funded by Casey Family Programs, the National Partnership for Child Safety (NPCS) was established using a similar design concept to the TCOM international collaborative but with lessons learned incorporated into the role out. As of this writing, the NPCS has 21 participating jurisdictions after an initial membership of nine. Plans are to continue to add cohorts each year (Fig. 12.3).

The purpose of this member led partnership is to support the use of safety culture concepts developed originally by Cull et al. (2013) in Tennessee's child welfare system to support the process of understanding child deaths. While thankfully a rare event, child deaths have an outsized impact on child welfare systems in the United States and around the world. In the US, the average tenure of a state child welfare director is about 18 months. This duration is too short for any director to accomplish much of anything. Typically, child welfare directors are fired at a rate much higher than other leadership of code agencies across states and counties. Typically, the scenario is that something bad happens (e.g., often a child death), it is reported in the newspaper. If it is bad, political leadership feels compelled to take dramatic action. That often involves sacrificing the leaders along with the caseworkers and supervisors involved in the incident. If leadership survives the first such incident, they



**Fig. 12.3** National Partnership for Child Safety

are less likely to survive a second. Since child welfare system serve those of our children at the greatest possible risk of bad outcomes, so child deaths, while thankfully infrequent, are to be expected.

Since the use of sanctions (i.e., punishment) does not further learning, child welfare organizations can easily become fraught with the types of workplace dysfunction described in Chapter 5. When bad things happen every one scatters and little or no learning occurs. This challenge has been identified as one of the greatest challenges to improving child welfare outcomes, which have sadly been stagnant for decades (Cull, 2020; Cull et al., 2013, 2022). By starting with death reviews, the NPCS is working to develop a safe systems culture within child welfare that is similar to approaches used successfully in aviation and hospitals and other high-risk industries (Cull et al., 2022). By creating a successful learning process at this most difficult and challenge aspect of child welfare work, the death of a child in care, the plan is to move this work ‘upstream’ to sentinel events less horrific but important to the overall improvement of child welfare. Eventually, the goal is prevention of the circumstances that lead to child death and other bad outcomes in the system.

### SHARING STRATEGIES ACROSS THE COLLABORATIVE

In 2018, the TCOM team decided to shift away from academic and industrial terms for describing itself into the use of organic terms. The idea is that TCOM tools and methods are always growing—they are never static. Organic terms communicate this concept of perpetual growth and change in a manner that academic and industrial terms never can.

## THE DATA RESERVOIR

As discussed elsewhere in this book, most large-scale policy and services research in the United States and the world has relied on existing data sources. Economists and other researchers have used this information to guide and evaluate policy. Historically, most of these datasets have severely limited information about the actual clinical and functional status of the people served in the helping sector beyond simple demographic and diagnostic details. This lacuna leaves us with administrative datasets that rely on information about what professionals do. We know a lot about what we do with people who need help. We know far less about the stories of people seeking help. In this context, policy decisions are often informed by the activities and costs of professional. The Center for Innovation in Population Health (IPH Center) actively building a partnership of the willing to address this circumstance using a theory guided approach to system change.

Given its widespread use in the United States and around the world, the CANS is the natural initial focus of building the capacity for person-centered policy research. The CANS tracks the change in the child and family's circumstances over time throughout the treatment and intervention process. Given its proven reliability, validity, and widespread use, for the first time in the social services field, we have the ability to build substantial body of evidence across very diverse setting to help us identify what works for whom and under what circumstances.

The TCOM Data Reservoir provides a unique opportunity to discover the key drivers of success in person-centered care. We actively recruiting states, counties, and large agencies participation in building a solid and rigorous foundation of research with this information. The TCOM Data Reservoir allows participating jurisdictions to share their information in a fashion that allows us to apply advances in precision analytics and machine learning. These precision analytic approaches can address important issues of treatment outcomes, benchmarking, and the development of decision support model. We believe findings will prove to be applicable and relevant across many jurisdictions.

The TCOM Data Reservoir has been built to comply with a wide variety of security requirements (including HIPPA) and is maintained by the sophisticated technical staff at the University of Kentucky's Center for Clinical & Translational Science (CCTS). The IPH Center is collaborating with CCTS on the reservoir project since the CTSS technical team are skilled in building and supporting enterprise-level technical infrastructure to carry out large-scale research projects. They offer a variety of methods for data transfer and can accept a wide array of data files to allow flexibility for collaborating jurisdictions and agencies.

## DOCUMENT CONSERVATORY

One of the ongoing challenges of the mass customization approach to TCOM is the creation of standards. The very idea of standards imply a ‘right’ way for things to be or a ‘correct’ way of doing things. Our efforts of applying standards to TCOM implementation is that each individual item has a defined, standard structure. To apply the language metaphor of communimetrics, each word (item) has a standard definition. Just like with language the individual can combine words in any manner, they choose and they try to communicate meaning, versions of TCOM tools can combine items to create meaning. However, the individual words always mean the same thing regardless of where the approach is being implemented. To facilitate the ‘mass’ aspect of our mass customization approach we have built a conservatory to maintain all the products, reports, and documents to support the work around the collaborative.

## VISUALIZATION GARDEN

One of the most compelling innovations of the Information Age has been the rapid expansion and evolution about how information can be shared in tables, graphs, and other forms of visualizations. In addition, the types of measures used with communimetric measures and the way data can be considered through the lens of TCOM can be different from more traditional approaches to program and system evaluation. Moreover, a large number of software vendors have selected to install various TCOM tools into their platforms. There is also a tension between foster innovation and re-inventing the wheel, so in order to minimize the later while encouraging the former; we have developed a visualization garden. To take advantage of the explosion in visualization options, we hope to use this garden to seed innovation through the TCOM field.

## METHODS GARDEN

Similar to the challenge of visualizations, methodological and statistical variations offer the possibility for innovations within the field. At the same time, we should be able to share approaches that have been found helpful by members of the collaborative. For this reason, we have also established a methods garden.

In order to maximize sharing, we have intentionally chosen to program predominantly in the statistical package ‘R’. This is an open source statistical package allowing up to post data analytic code for others to utilize if they wish to replicate a particular analysis. ‘R’ has create a collaborative approach to analytics that is quite simpatico with the TCOM conceptual framework.

## SUMMARY

Although this book represents the culmination of the work of tens of thousands of people from all over the world over the past two decades, in many ways, the work of TCOM is just beginning. The proof of concept has been established. Using person-centered assessments, where people are full partners in their helping experience works. It can facilitate and improve the helping transaction. It can better inform program management to improve effectiveness. It can lead to system improvements that have broad and lasting clinical, functional, and financial implications. The hope of TCOM is that in time the specifics and even the name of the approach become irrelevant. Our hope is that person-centered care, through collaborative assessment process become the accepted norm in all helping sectors. Our hope is that data collected from these assessments can inform policy research and transform the field of 'health services' into a field that understands and includes the transformational goals of helping enterprises. There is much work to be done. Old habits and ways of thinking about service systems must be replaced with new ways of thinking about optimizing the business of personal change. Our hope is that we can all learn to work together on this vision. Let's get to it.

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