Supporting Youth and their Families in Crisis - Full Training Video 2020

KAPPY MADENWALD: All right, here we go. So let me start with just an acknowledgment of how far CBHI has come. When I developed this training, I think you'd pass the 10th year anniversary. But now I believe CBHI has actually passed its 11th year anniversary and has entered its 12th year of existence. And for those of you who have been involved from the very beginning of CBHI, you remember how complicated it was to stand up all of these different services statewide in about a six month period of time. It's difficult to do that work, to do that kind of implementation. It's even harder to keep these services up and running through a lot of staff changes and statewide changes and now COVID changes. And so I just really want to acknowledge the tremendous work that you're doing every day across Massachusetts. And to get a little bit more detail about who is on the call, we're going to start with a couple of polls. And the first poll is, how many years have you worked in any CBHI service combined?

So everyone should see the collective results now. And we can see we have a lot of experience in this room. Wow. OK, probably at least 70% of people have been with CBHI for at least three years, and 10 people on the call have been with CBHI since its launch in 2009. So those are the historians. So thank you for all of that, great variation.

And one more poll here. And that is, what best describes your position, your current position? OK, we have every single position represented on the call today, which is fabulous. We have six family partners, fabulous, and a senior family partner as well. So this is just great representation. Thanks, everybody, for that. I'm looking forward to a good diverse conversation today.

So this training was developed for IHT and ICC teams. But it does complement the crisis training that's been provided to MCI teams. Most recently, we had a booster training this past January. So it's been almost a year. We're going to be talking about a number of topics today. Some of them might feel basic, especially some of the competencies that we cover this afternoon. And on their face, they can sound basic because they're terms we use all the time. But they're not. They're complex and layered approaches and competencies that we use with kids and families.

And so even as we go through some of this content today, you actually might be surprised that some of it feels personal or some of it might feel provocative. And that happens any time we diversify our thinking and particularly when any new knowledge comes up against deeply held beliefs. Deeply held beliefs are those beliefs that are so deeply held that they feel quite factual to us. They are the way we see the world. And perhaps you'll hear information today that was sort of in a blind spot for you. It wasn't something you've thought about before. And when that happens, sometimes that can feel provocative. When you find new information coming up against deeply held beliefs, candor is important, particularly if the deeply held belief is something that is impacting your efficacy with kids and families. That can happen when we are holding any kind of a deficit view about children or families or even the systems in which we work because those deficit beliefs are really inherent negative biases or-- it's kind of those sorts of elements. When those belief sets come up, it's important to be able to say them out loud. You can say them out loud here. You can talk back at the office. You can talk about it with your supervisor. But it's very useful to air those elements. And this is how we in our work become more and more precise in doing good quality

care with kids and families. The more comfortable we are talking about any of those deeply held beliefs that have a deficit feel to them, the more we can clear those that out of our thinking, the better we're going to be with our work.

So what does it take to create a space for that kind of candor? If you've not heard this concept before, this is a really interesting one to pay attention to. And it's this concept of psychological safety, having psychological safety within work teams, having psychological safety within agencies, having psychological safety within training spaces or coaching sessions.

Psychological safety is creating an environment where people can be candid in an effort to improve care, in an effort to improve their own quality of work without fear of any kind of retribution or consequence or ridicule from peers or anything like that. So it makes it safe for me to say, I'm falling short here. I'm having difficulty figuring out how to work with this family. I'm struggling with this particular family of this particular culture or whatever that might be, that I can say those things out loud without there being any kind of retribution for doing so.

In psychologically unsafe work spaces, let's just say there's high competition or consequence around-- significant consequence around business objectives or things that just really create that kind of psychologically unsafe space. What can happen to a work team? What's the impact on a work team when you're working in a workplace or within a team that feels psychologically unsafe? What's the consequence of that? What is it that gets activated-- what is it that gets activated within the brain of team members that are in a psychologically unsafe workspace?

AUDIENCE: Trauma? No. I'm just guessing.

KAPPY MADENWALD: Yes. Yeah, you're right. it is a trauma reaction.

AUDIENCE: Yeah, a fear of being ashamed or blamed.

KAPPY MADENWALD: Yes, yes. Yes. I feel ashamed or blamed, and so it activates the limbic system of the brain, which is where trauma is stored and where all those kind of emotional reactions are processed. So Stephanie says fight or flight mechanism is activated. Ellen says inability to trust gets activated. What other kind of emotions and feelings and thoughts happen when you're working within a psychologically unsafe workspace?

AUDIENCE: Scared.

KAPPY MADENWALD: Anxiety, yes. Scared, anxiety, fear, resentment, decrease in morale and productivity. I'm reading all these things from the chat. Ah, you can shut down or want to quit. It leads to burnout, anger. And it prevents inability for growth. This is a really important one that Laura has just put in here. When our limbic system gets highly activated, it's the amygdala and it's really kind of the fear centers of our brain. That's really one of the most primitive parts of our brain.

But it's also the mechanism that keeps us safe. It recognizes danger and protects us by getting activated so that we're really paying attention. It gives us that burst of adrenaline to do that. And as Alexander says, we have that fight, flight, freeze response. When that's happening, it prevents our ability to grow because it diminishes our activity in what part of the brain? What activity-- what part of the brain gets diminished when our limbic system is lit up?

AUDIENCE: Your prefrontal cortex.

KAPPY MADENWALD: Yeah, yeah. So all of our good executive function, the creativity, all of our just smart thinking, our introspection, that gets inhibited because we are in that self-protective kind of mode.

So that happens to us in psychologically unsafe spaces. And it's a parallel process. The same thing happens to the kids and families that we work with.
When we can create psychologically safe treatment spaces for kids and families, then their creativity flourishes. Their frontal lobes get engaged. Their best executive function gets activated. Their introspection gets activated. Their internal curiosity gets activated. They're able to pay attention to their gut and what their gut's telling. They learn to trust their intuition a bit more.
And we want to create that kind of context in really every interaction that we have with kids and families. Wow. Beth is describing an example of, I'm assuming, Beth, a psychologically unsafe sort of workspace. Yes. You want to say more about that?
AUDIENCE: Oh, yeah. It was just my second year internship, and it was at a great-- what you saw as a great teaching hospital. And when the interns were in a seminar, when we made a comment, he put a stupidity scale on our comments, put it on a stupidity scale. It did not feel safe. And that was after having been at a small family service agency where the CEO did home visits the year before. Gosh, it's not surprising I went into home-based work in the community rather than working in a hospital.
KAPPY MADENWALD: Yeah, yeah, yeah. I mean, it's a great experience. So you were in a very kind of competitive, pressure-filled center. And if you got it wrong, you were ridiculed, which means don't take the chance, right? Keep my mouth shut. Don't participate. I get all anxious-- if I've got to perform in that kind of setting, I'm going to be anxious before it. The stakes feel very high.
And notice that none of that is really about the client. None of that's about the patient. It's this whole other dynamic that's going on that in addition to me trying to pay attention to delivering good, excellent patient care, I'm also really wondering how getting perceived by my colleagues. And I'm really wondering how getting perceived by the medical director. And that dual burden in a workplace is obviously quite dangerous.
I worked at that same place in a different state. Didn't do a stupidity scale, but it was close enough. And I note your earlier comment today in talking about experiences with crisis teams as well. And I do think that's-- and you said, is this a deeply held belief? It is interaction that's influenced how you're practicing. So there was an earlier comment about previous experiences with crisis teams. And so it does influence. As we interact with other systems and the systems are not performing the way we would like them to perform or somebody has a less than good-- less than good enough care experience, it does impact the way we function. And that's going to happen all across CBHI and all across the hospital systems in your areas. And what it ends up doing is diminishing relationships and all of those different paths.
So as we're chatting today, A, the experience was real and credible. It happened. It was a less than satisfying experience. What I'm really hoping in the second decade of CBHI is a different level of collaboration across teams that leads to joint exploration of those kinds of things. We want every service in Massachusetts to be delivering good care and to have it feel psychologically safe to discuss with each other when it's falling short and how to collectively change those care experiences.
So that's absolutely true. And left unsaid and left unaddressed, it can limit your willingness to contact them again or to make that recommendation to family or to view anything that team does as credible in the future. And so in that sense, it's something that is well worth paying attention to. And I'm really glad you brought that up.
OK. So in Massachusetts, over the past-- really as this whole MCI service was developed, the goal has been to deliver crisis responses that are early, meaning before things get super acute, to do them in-- to

deliver voluntary services, to deliver those services locally and in a community-based setting-- so home, school, something that's natural to the child-- and then to use intervention approaches that are resolution focused, not limited to assessment and referral, and by doing this combination of things, that that will lead to less use of law enforcement, less use of Section 12 initiation, or filing 51As for medical neglect reasons, and it'll decrease the use and need for inpatient hospitalization.

To achieve the results, the focus has really been on four core competencies that we're going to be covering today. The first is that crisis support and intervention is youth and family centered, second, that it's strength based, third, that it's resolution focused, and then the fourth is that the services are delivered within the context of a broader crisis system of care.

Now these first three here, I know these are familiar concepts to you. You've had all kinds of training in family centered care and strength-based interventions. And so that piece I know is not brand new. What might feel newer is using those same approaches within the context of an acute crisis. And the way I talk about it later today hopefully will just add more precision to the way you're already doing that work.

The one that we're going to start with today is the fourth one this morning. We're going to start with this crisis system of care framework. And then we're going to spend the rest of the morning just kind of laying some context around some habits and practices within the crisis system. And then this afternoon, we're going to go back to those first three core competencies-- family centered care instead of traditional medical model expert directed care, strength based rather than pathology focused interventions, and resolution focused instead of having interventions that are narrowly focused on assessment and level of care determination.

We'll have an immersive experience this afternoon. It's a large virtual role play. But it's a really easy one because all you have to do is move. And in that exercise, we're going to do an immersion into the shoes of parents whose kids are in crisis. And then we will end the day with some safety planning strategies. And that section will probably be very short because I have really one too many topics in the training day today. So I'll probably be just doing an overview of some of those remaining slides for you.

But we're going to start with this crisis system of care framework. So this framework is a way to think about the organized whole of a behavioral health crisis system. And until there is a broader organized crisis system, communities generally are reliant on default services, default safety net services like 911, police response, ambulance response, emergency departments.

And in a lot of the country, those are still-- those entities still do a lot of work related to individuals having behavioral health crises. And in Massachusetts, that still to some degree is the case. There's still a lot of care occurring in emergency departments. Law enforcement systems are still doing more transportation and interventions in the field than we'd like for them to have to do. And so the only way you decrease use of those default practices is to build something, because crisis systems of care are not naturally present.

This work is also systemic, meaning that a crisis system of care cannot be built simply on the backs of the mental health system or the substance use system. It actually requires multiple systems' participation to build a good robust crisis system of care. So in that sense, it's a little bit more like a public health model than a traditional mental health service that can really be a standalone service that does not have as much dependency on other systems.

So for example, if you look at something like an adult ACT team, Assertive Community Treatment team, those kind of services are internally reliant services. As long as all of the staff are well trained in ACT, then they can be expected to achieve some really good health care results.

But crisis teams are externally reliant. They're really reliant on the decisions and actions of a lot of different systems and a lot of different players. How they act, the decisions they make, the way they engage a child in crisis or the parent of a child in crisis will have a really significant impact on that child's care experience.

The other element as you're looking at this crisis system of care-- there's a lot of different ways to think about how you build out a crisis system of care. And five of those ways are looking at these phase opportunities, the ways that a community can think about investing in their crisis system of care. When a system is primarily doing default response, then the action is predominantly in this phase three response by law enforcement or somebody being taken to the ER in an emergency and then the phase four piece, which is hospital admission or CBAT admission or that kind of thing.

So you see all of this activity here. But you see very little activity in phase one and two, crisis prevention and crisis early intervention. And you see very little activity in five, which is post-crisis recovery and reintegration, because those aspects of the system have just not been built out adequately. And in Massachusetts, there's still a lot more opportunity around phase one, two, and five here, to really build out those pieces with particular attention to phase one and two, the prevention and early intervention.

And note that the default systems are not well leveraged to respond at phase one and phase two. And MCI teams, which have permission as that service is defined-- they have permission to not wait till things are super acute to get involved. They can get involved earlier in a crisis. But they're generally still leveraged in this phase two, phase three spot. They're not well positioned to do crisis prevention. So that means that really falls to other entities to do a lot of that work and do it well.

So why are those phases so important? I'll just show an easy analogy of why those are important, and we'll look at the fire services. So in fire services, acute intervention, the equivalent of acute intervention is that a structure is on fire, and the fire department comes out and puts it out. They wait till there's a big blaze. They come out. They respond. They put it out.

So that's the acute intervention phase, which means that post-fire, there's going to be investigations. There's going to be cleanup. There's going to be maybe tearing down buildings. There's a lot of work to do after a big structure fire. And there can be some significant recovery for any victims of that fire. A high cost, high harm sort of approach here if fire services didn't do anything until there were big house fires.

So as we know, fire services is more comprehensive than that, and it includes early intervention strategies including things like smoke alarms that we all have in our homes and reminders to change the batteries twice a year. And many of us also have fire extinguishers and learn how to use them so that we can put out fires while they are small. But it goes further upstream than that with prevention activities such as reminders to not leave lit flames in your home when you leave and building codes so that any new builds are required to do wiring, for example, in ways that decrease the likelihood of an electrical fire.

And this is obviously not a comprehensive list of all of the strategies. But we can see that we have a very comprehensive set of things. It crosses all of these five phases. And the goal is to really diminish the acute intervention need. Let's have as few structure fires as we can. And if we do fire prevention and early intervention well, then we'll have fewer circumstances where we ever reach this phase.

So that's what we're looking for here. How do we really build these things out? And from the IHT and ICC point of view, there's an opportunity to really look at this model and say, when IHT is at its best, what are the prevention strategies that work well for kids and families? And what early intervention opportunities do we have with kids and families before things get acute?

And if we call in maybe some other team, maybe MCI to join in an acute intervention, how are we coordinating and collaborating that with them in a way that delivers the best possible crisis service? How do we coordinate maybe with an inpatient treatment unit in phase four.

And then phase five, this really important thing, do we have a good plan in place? Do have a strategy for kids that have had a crisis episode or kids that have had a hospitalization or see bad admission? Do we have a strategy for this very critical phase five when kids are quite vulnerable to a new crisis? That's a really sort of risky phase as they're trying to get back into school and back into home and back into their communities after a really significant crisis event.

So this is the kind of set of phases that could come into a system of care type meeting, to really talk at a local or regional level to say, how are we doing here? And where are our opportunities collectively across all those systems that are present in a system of care meeting-- what are our opportunities to improve the care experience for kids in crisis and their families?

In addition to these five phase ways of thinking about this, there are these other key components of effective crisis systems. And the first of these is lived experience. And so that certainly includes things like having family partners. And having family partners as part of the mobile crisis response is excellent, and the family partners that are involved through the CSA is excellent. But we want to make sure that we're also incorporating that lived experience in program development and oversight and quality so that we really make sure that that is influencing the way that the professionals think in program development.

Another way to build out a good crisis system of care is by paying attention to the players. I said this was a necessarily systemic system, these crisis systems. And so who are the key players, whether they want to be or not, in a well functioning crisis system?

In a single episode, a child can touch multiple systems. For example, maybe the crisis starts at school. So that's system number one. And maybe the school calls the police, and that's system number two. And the police takes the child to the emergency department, and that's system number three. Emergency department calls MCI. That's system number four. And maybe the child gets admitted to a hospital. That's now system number five.

All of the people at all of those different systems can say things, do things that make it better or make it worse. They each have the opportunity to change the trajectory of the crisis care experience for the child. So it won't really matter how good your response is to that family or how good the MCI team response is to that family if the way the rest of those systems responded was problematic or made things worse. Because for the child, it's a single crisis. And they're not divvying it in that kind of a way.

So we want to make sure that we have a good strong set of cross-sector partners who are saying things and doing things and taking approaches that make things better for the child and family throughout that crisis episode. And I use that word players on purpose. I'm sure many of you have been to-- some of you probably facilitate systems of care meetings. And if you think about being in one of those system of-- in one of those system of care meeting rooms, and just scan around and think about who is in the room with you at the system of care meetings.

Do you know the difference between the people that are there as audience members and the people that are there as players? Some people are just there passively taking notes. I'm just here to get updates. And other people are in the arena with you actively saying, let's do something special. Let's create something new and different in our system. And that's what we're looking for. We need players, players who are coloring outside of the lines, because this cross-sector work requires a lot of coloring outside of the lines

to really co-create something exceptional that gets DCF and schools and mental health system saying, wait a minute, we can do something different here.

And so that's the opportunity. We really want players to make this stronger and to make sure that those initiatives also serve the other systems, because each of those systems have their own reasons for wanting good strong crisis response. It's disruptive to schools, and it creates emergencies for DCF. And for law enforcement, their officers spend a lot of time and hours responding to these kind of interventions. So there's a collective investment in having kids feeling healthier and safer in their communities. So once that's clear to everybody, it's easier to get on board and become a part of this crisis system of care work.

Logistics are really important to do this well, just like fire response. When there is a big structure fire, we need to have really good sound logistics, a good strong phone system, a dispatch system, the ability to get firefighters to the scene as soon as possible. And even though things like the MCI team, they're not responding at that same speed that fire services would, there's still a lot of complication in trying to make sure that teams can get out to respond to any crisis calls that happen. Can imagine how that works for the MCI team. Some of you might have had this experience. It's sort of-- you get these days that are either all or nothing. And some days, there's no calls, and the next day, 10 come in at once.

And so the logistics are complicated. It's complicated to track that availability and resource availability. It's complicated to try to move people and data across the state, even if some of that's virtual today. And so you need good strong logistical processes to make that work. And that's something Massachusetts is still really working on, how to let technology catch up with the vision for the crisis system in the state.

The fourth key element are competencies. That includes competencies that we're talking about today. But there are competencies that other sectors can invest in that can make things very useful for them as well. So, for example, mental health first aid training for schools or CIT, Crisis Intervention Team training for law enforcement agencies, which is an excellent 40-hour program with a lot of-- really, both mental health, first aid, and CIT have a lot of emphasis on destigmatization, knowledge for laypeople about mental health conditions, and then techniques for soothing and engaging people in crisis. So excellent skills that allow schools, for example, or law enforcement officers to use approaches that kids experience as safer and calming.

And so as each system develops some of these sets of competencies, it just improves the overall safety net in the community. And of course, there is the universal competency of trauma informed interventions. That makes a substantial difference in the work that we do when we recognize or just make the assumption that we're engaging somebody who has had trauma history or is currently traumatized in doing the work.

Then the last element here are the parts. Parts are nice. It's nice to have an MCI. It's nice to have a CBAT bed. It's nice to have an inpatient unit. Just because you have the part doesn't mean it is working as well as it should be. And so we don't just want the part. We want the part to be used as intended and producing good results.

Massachusetts is loaded with parts of all kinds. It doesn't mean that every part is delivering on its potential. And I don't even mean every part has to be superior. But we certainly want every part to be delivering consistently good results that people find satisfying. That's what's really going to-- that's kind of the glue that holds systems together.

When I go into communities-- I work all over the country. When I go into communities for the first time, what I'll generally see is narrow focus on these acute interventions and not as much development out

here, particularly where other sect systems and levels of care have to get involved. And I see narrow emphasis on parts and not enough attention to all of these elements that make parts good, that allow parts to deliver good, effective responses.

OK, so that's sort of an overview of that crisis system of care. That's a document that you can print, think about, bring it to a work team, and just really say, how do we beef this out? And for an IHT team, one of the ways I think about it for that type of team like IHT is, how do we take the crisis out of this for ourselves? How do we not have crises and families become crises for the teams by thinking in strategic ways about what the team process is at each phase and really kind of building in strategies for doing those things so it doesn't also become crisis for the agency ?

All right, next sort of topic here. Intervening in crises is complex. It's complex for each of us individually. It's complex for teams. And part of the complexity comes from the fact that crises can mean that it's a life-threatening situation, life threatening for the child, life threatening for somebody else. The risks are really high.

And so can be the sense of personal liability and corporate liability. And this is a topic that comes up in very many trainings that I do. And so I'm just bringing it up here first. It is a big deal. It's a big deal to intervene with kids who are feeling suicidal, for example. And we want to understand that these crises can put kids and families at risk. That's very true.

But we also have to understand the way a system responds to crises also puts families at risk. And we're going to pay quite a bit of attention today to this particular risk and to figure out ways to talk about ways that individually and as a system we can work to minimize iatrogenic harm, iatrogenic harm. You see it underlined down there at the bottom of the slide.

If this is not a word you're already using, I suggest that you learn how to spell it, learn how to say it, and bring it into your vocabulary within your teams, agencies, and at systems of care meetings. Iatrogenic harm. Of course, it's a medical word, so it can't a simple word. Iatrogenic harm. Iatrogenic harm is harm that's caused by treatment. It's generally unintended. But it's also often avoidable. Iatrogenesis means brought forth by the healer.

And I see people taking notes. I just want to double check. Did you all get the PowerPoint handout? OK. And if anyone has not gotten it, send a private note over to Ari, and he can put a link into chat in case anybody did not get it. You would get it on the email from which you registered for the training.

OK, so iatrogenic harm. In the medical field, physicians talk about this all the time. My stepdaughter's a doctor, and we were just talking about this last night. And she said, virtually every day at work, we're talking about iatrogenic harm. Physicians take the Hippocratic oath. First, do no harm. It's a key principle of medicine. First, do no harm.

And why is that? It's a recognition that any time we do any intervention with a child or family, we introduce the risk of harm that would not otherwise be there. There is no risk-free intervention. There's no risk-free conversation. With us in the health care role with families, nothing we do is risk free. We don't talk about this very much in our field. And so this might be provocative number one today, this idea that the work we do introduces risks to kids and families.

I'm a recovering expert. And you might hear me say that a few times today. Back when I was an expert, I thought that the effect of my intervention would be one of two things. Either it would be very, very helpful, and I figured that's what was happening most of the time. Or it would be neutral. But what did not cross my mind for probably the first 10 years of my career was that my interventions could be harmful.

It felt completely out of step with who I am. I'm a social worker. I'm one of the good guys. My intentions are very good. So how could a good guy social worker with good intentions do things that harmed? It was in a blind spot for me. And what that meant is because it was in a blind spot, I wasn't able to avoid it because I didn't see it when it was happening.

And there are a lot of factors in the mental health field that complicate our ability to see the harm when we're doing it. So we're going to be covering a lot of those elements today. So I'm going to give you some examples of iatrogenic harm in the general medical field. And while I'm doing that, go into group chat if you haven't already-- oh, already some good examples in here. If you haven't already, go into chat and just give some examples of iatrogenic harm in the behavioral health field.

But I'll give you some examples in the medical field. So number one is I go into the hospital to get my tonsils taken out, and while I'm there, I acquire MRSA. Or today, I might be concerned about acquiring COVID. It's a hospital-borne infection. And if I had not been admitted to the hospital to get the tonsils taken out, I never would have acquired the MRSA. That's what makes it iatrogenic. If the first thing hadn't happened, if the treatment hadn't occurred, that harmful result would not have occurred.

Or I go into surgery to have my right knee operated on, and, oops, they accidentally operate on my left knee. That's certainly iatrogenic. Or I am very ill and in a hospital bed, and there are staff in and out of the room all of the time. But none of them noticed that I have not moved in 24 hours, and I start to develop bed sores because I haven't been able to reposition myself. So my skin is starting to deteriorate from laying in the same space.

So those are three examples. And I see some great examples here. Oh, gosh, Colleen, this is a great one. Pathologizing without acknowledging the sociocultural context within which a person exists. Oh, goodness. Young clinician out of school, I used a diagnosis on a referral form with a mother on the first phone call. And it was a diagnosis she strongly disagreed with, causing anger and unintended harm to her and impeding services.

Wow, Michelle, my bet is that one really sticks with you. It is one of those humbling lessons that keeps us on track every day. Oh, goodness. A client who went inpatient and was sexually abused by a roommate. Absolutely iatrogenic. Giving somebody a diagnosis, oh, when something like ADHD is just a difference with just as much benefit as challenges. So just the idea of a label.

And if the label, particularly if it's experienced as wrong or shameful, if the child experiences it as shameful, if the label causes other things to change in the child's life, let's say how they're viewed by family, how they're viewed in school, if it causes people to have a limited sense of their potential, those are these kind of extra steps of iatrogenic harms that can come from this. Blaming the person for the disorder they're struggling with and, Stephanie says so importantly, blaming parents for causing their children's problems, like the refrigerator parent causing autism or the schizophrenogenic mom. Invalidating a client's emotions. Wow. And then decreasing their likelihood of emotional expression. Yeah. I love this. Some of these are so big and obvious, sexually abused in the hospital. Some of them are nuanced. And we particularly want to pay very close attention to some of these nuanced ones where we don't see-- if you accidentally operate on the wrong knee, that's like really apparent to everybody. But some of these things have this more nuanced kind of impact, like invalidating a client's emotions. Like, that's a more nuanced impact. It's harder to see that that harm has occurred.

Any time we're involving police, even when it's necessary, even if it's completely unavoidable, you can expect that it has an iatrogenic component to it. Oh, yeah, obviously Talie. With good intent, perhaps

police are called for help to help with the mental health crisis, and the person is killed as a result. And particularly, people of color are at high risk of this, and we understand this nationwide. Gaslighting, oh my goodness, yes. All our terms of 2020. Referring to parents that are strong advocates as resistant. Yeah. Not knowing the extent of trauma history and retraumatizing through an intervention. That's a really great example of certainly unintended but also avoidable. And just the broad training in trauma informed care makes us far more equipped and sensitive in doing this. But we have a lot of work and a daily responsibility to be diligent to that. Ah, distrust within a therapist relationship caused by dishonesty, a teen who feels she does not trust her outpatient therapist who's making promises she cannot keep. Really risky situation. Yeah, these are phenomenal examples.

So here's some other little points about iatrogenic harm. When there is iatrogenic harm, it implicates us. This is really important. It's hard to think about it. It can feel provocative. But it always implicates us as providers, and it implicates the systems in which we operate. In other words, this is never about the client. It's not the client's fault that they had the trauma history. It's not the client's fault that they have a particular sociocultural worldview. It's always on us. It's our job to be the ones to do the adjusting. It's our job to use approaches that are a good match to the person. So it's never about the client. It's never about the resistant parent. It's always about us and the approaches we use to engage.

So this is really important. And this is why I really recommend that you adopt this use-- if you're not already using iatrogenic harm, that concept, that you adopt the use of it because it very explicitly says in its definition that it's about-- that it's about us. And what that means is it gives us the power. Because it's about us, the power to do something different is always in our control. Even if some of the things are more complicated to fix than others, it's in our control.

If there is something to be done differently to reduce the number of times law enforcement has to go to a home and people end up shot, that's never going to be about the family that caused the officers to the home. That's complicated. But it's a systemic solution that's necessary, led by our field with the knowledge we have to inform how that goes. So that's complicated to do. But it's never about the family that called the officers to the home or anybody else who called them to the home.

So we're the ones in the driver's seat to find ways to reduce risk of harm. And it requires continuous improvement of craft and policies and habits of practice. We'll never get it done. But we should be in a continuous improvement process. Iatrogenic harm is easiest to recognize when we orient ourselves to the care experience of the youth and his or her family and when we view it from their shoes.

It's hard, particularly with the nuanced harms that happen in our field-- it's hard to see it sometimes from our treater point of view. It's easier to see when we immerse in the family's shoes or child's shoes and see it from their point of view. That's when it becomes evident. When we imagine that it is me getting that care, that's when it becomes evident.

Then we can really begin to put some three dimensional understanding of some of these iatrogenic risks into play and do something about it. And again, so much of the harms that we create are psychological harms or they have more kind of a family dynamic impact or a functioning at school impact or those kinds of things. They're just not as evident.

I gave you those three medical examples. And so I just want to acknowledge that some of these iatrogenic harms are easier than others to solve. Of the three I gave you, the easiest one to address is the surgical team that operated on the wrong knee. So let's just say the surgical team had all left knee

surgeries all day long and then, oops, suddenly, there's a right knee, but we were in the habit of the left knees. It's an acknowledgment that human beings make errors.
And so what do we do to decrease the likelihood of an error? So many of you are aware that surgical teams often use Sharpie markers. And before the person is put under sedation, the Sharpie marker is brought out, and we say, OK, do you and I both agree that we're operating on your left knee today? And then let's take the Sharpie marker and write this one, arrows pointing at it, and a big X on the other one. No, not here. Leave this knee alone. So that we reduce the likelihood that the surgeons operate on the wrong knee.
I had a friend who just posted on Facebook. She had had eye surgery, and she had a big circle above her eye. And she said that big circle above my eye is so the team knows what eye to operate on. So that's really controllable at the team level. What it mostly needs is a team that's humble enough to understand that mistakes happen. And so they're willing to use those approaches. Always choose the surgeons who use the Sharpie markers. That's my tip. So believe there's a potential for error and do something about it.
The second of those examples that I gave, the second easiest one to address are the bed sores. There are a lot of people in and out of patient rooms doing their two-minute task. But if they're not all collectively paying attention to this bigger picture issue that if people are not repositioned frequently, they can develop bed sores, then those bed sores will materialize over time.
And so that has to be a well assigned, well understood risk with multiple people having a role to play there to really make sure that somebody is paying attention to the big picture around repositioning and that multiple people have a role to play even if it's not their primary job. And there are hospitals that have virtually eradicated bed sores by taking those kind of broader teamed approaches to doing that work.
The most complicated of the three that I described are the hospital-borne infections because those things like MRSA can just lurk anywhere. It can be person-to-person contact. It can come into the room on a food tray. It can be unsanitized, not properly sanitized surgical equipment or a feeding tube or a doctor's glove that touched something. It can just sort of lurk anywhere.
And so every single department in the hospital has a role to play in infection control and making sure that what I'm doing in the cafeteria dishwashing area-- that I'm following all of the specifications there. And that if I'm the person coming in to clean the room, that I'm following all the specifications there. And then if I'm in charge of the durable medical equipment, I'm paying attention to all those rules there.
And then if we are all collectively doing those things, then we will diminish the prevalence of hospital-borne infections. Very, very complicated. It is an all hands on deck thing. But it's never about the patient who acquires that infection. It's always on us. It's always on the systems, even if it's complicated to do it. And there are hospitals that have brought down those numbers even with that complex work.
There are some things within the crisis system that are in your control, and there are some things that are bigger systemic elements that require, that necessitate that cross-sector partnering with ready players.
OK, so I'm seeing some good notes over here. Kelsey says, she intends to use this term. Yes, good. Yes, and Ellen says, so important. Walk a mile in somebody else's shoes, and you just get a whole new insight. Yes. Very, very good.
So another poll question for everybody. How familiar are you with this term and in considering the risk of iatrogenic harm in crisis response? So you have a few choices here. Ari's going to get the poll up for us. There we go. And it's possible you are familiar with the concept but didn't have this term for it. But as I said, I do think using this term specifically is quite useful.

I'm going to leave the poll up for about 10 more seconds. OK, so you can see the results here. So a lot of people are familiar with it. But we can see we have a lot of opportunity to really increase our attention to iatrogenic harm in supporting kids and their families in crisis.

And this is great. This is a chance-- when we see this, we can realize, aha, look, we've got some precision opportunities here. Just even being aware of the term already will make us more alert to it when we see it and try to do some things to prevent it. I love the idea of CE bingo. Yes. That's right. All right. Although there could be a guise of safety, coercive practices like calling 911 or using a Section 12 using a 51A to compel parents to consent to treatment-- coercive practices sometimes have less to do with imminent risk and more to do with habit or convenience or cost or transportation or concern about personal or corporate liability.

And I didn't mention this earlier when I was talking about when we do this work with individuals who are at risk. They're at risk perhaps of harming themselves or harming somebody else and how complicated this work is for teams to do these kind of responses. Of course it's natural to be concerned about personal or corporate liability.

What's really important is that we don't lead with that. We can't have the predominant worry be about us. We want the predominant worry to be about the child and the family. That's really where our emphasis is. And when we do that work well for child and family, it diminishes the risk for us as well. Unfortunately, in our field-- and this is across disciplines. So this can include emergency department physicians and psychiatrists and psychologists, social workers. All across the country, I see this.

There is a leading with my own liability kind of thinking going on. And how that looks, an example of that-- and some of you have probably seen this-- is one of the kids you're working with is in the emergency department. And so you go over, and you're talking to the child and the parent. And it's clear to you you've got a plan that would keep the child safe [INAUDIBLE] the community. And the child and family agree, and you've got a good plan in place.

And the emergency department physician says, nope, not going to happen. This child is going inpatient today. I'm not going to have that on my license. He came in saying he was suicidal. He's going in. So I see a couple of heads nodding. That's leading with your own liability. That's thinking first about your own license and not the scenario for the child.

I one time did a training, two-day training. And after two days, after everybody had left the room, the clinical director, nicest guy in the world, comes over to me and he says, Kappy, that was great. Thank you so much for those couple of days of training. And he said, I always say to families-- he says, at the end of the day, I always say to parents I will sleep better tonight if your child's in the hospital.

And I thought, oh, no, I know that content was not in my training at all. So if that's what you gleaned over the last two days, I need to revise my curriculum. I don't care if you sleep better tonight. I care if the child sleeps better tonight. This is about the child. Where will the child's sleep better tonight? What can we do that has the parents sleep better tonight?

Kids and parents sleep better tonight when harms are diminished, when plans are developed, when limbic systems, those amygdalas have calmed down. That's when kids and families sleep better tonight. And maybe they'll both sleep better if the child's in the hospital. Maybe they'll both sleep better if the child's in the home and aunts and uncles have come in to help make sure that somebody's awake all night long. Maybe they'll sleep better with some other combination of things.

But the goal is what makes this better for the child and family, not I will sleep better tonight if your child's in the hospital. So that is a very-- I'm going to say he's a very compassionate person who was leading with his own liability. His own frame of reference was his comfort with the plan as opposed to the child. Now I'm not saying you shouldn't trust your own gut on a plan. I'm just saying that cannot be our only consideration. We're really looking for a consensus plan that makes us all comfortable.

OK, so that's concern about corporate liability. What that means is-- if you look at these elements, have a convenience cost, that includes things like, well, we don't have another way to transport a child. So let's call the police in, who will put them in a cruiser and might have to transport in handcuffs, for example. That's not a reason-- the reason to use that isn't because of a public safety issue. It's because of an unaddressed transportation need. So those are the kinds of things that are controllable by a system if we can get our heads around some of this.

So we want to watch for the kind of patterns that suggest a likelihood that there's greater iatrogenic harm happening. And that could be when either the referral source or the admitting facility prefers that a child be on some sort of an involuntary status. The inpatient hospital might say, we just really prefer to admit everybody involuntarily because that way they can't change their mind once they get here. It's that kind of thinking.

Where there's routine use of security guards. Where there's a high volume usage of seclusion or restraints. Any time you see restrictions by rule rather than exception, like everybody must be in a gown in the emergency department, even if you just had a sexual assault last week. Got to change into a gown. One to one as an automatic thing. Anywhere you see carrot stick behavioral systems where the focus is so much about compliance, compliance with our rules as a unit, as opposed to what's the crisis that brought you here and how do we help you relief for that. When you see a high use of unscheduled or against medical advice discharges, probably an indicator that you have some relational issue between family and treating team or child and treating team.

And anywhere you see high volume referrals to DCF, be suspicious that there is perhaps some iatrogenic harm occurring there. And we'll get at that a little bit later. I'm not talking about the clear cut referrals to DCF like when somebody's clearly been physically abused. Talking about things like medical neglect allegations that have very much to do with our perception of circumstances. And those are ones that we really want to pay attention to.

OK. One of the easiest ways to begin to tackle iatrogenic harm is to pay attention to the stories that are being told in your workplace, in your own head, in team meetings, in systems of care meetings. Narrative is everything in our field. So much happens based on the narrative.

And let me start with a little story of my own. This happened way back when, probably 10 or so years ago. I was traveling to Massachusetts regularly, often getting there on Sunday nights. And this particular Sunday night, late Sunday, I flew into Logan, and I went to the rental car company. And instead of my usual Toyota Corolla, what was waiting for me was this big beautiful orange muscle car.

And I was shocked. I've never seen a car like that in the Hertz lot, and there it was assigned to me. And the first thing that went through my mind was, I can't possibly rent this car. What will the MCI agencies think when I come rolling up in this big muscle car? But I also thought I have to drive all across the state today-- or this week. I have to go out to Pittsfield, and I'm going to be putting a lot of miles on the car. So this would be kind of fun.

So I decided to go for it. So I got in my beautiful orange muscle car and drove to downtown Boston. I only had about four or five miles to go to my downtown hotel. And this is a hotel I had stayed at quite a bit and had come in on a lot of Sunday nights, and so I knew the valet. Like, the valet and I were buddies.
So this dark and empty street, I did a U-turn in front of the hotel. The valet comes over and opens the door, and he just cracks up laughing. And I said, what is so funny? And he said-- and I just can't tell the story without trying to recreate his accent badly. He said to me, I saw the car coming around the corner, and I said to myself, who does that guy think he is, having a midlife crisis and thinking he looks so cool in his muscle car? And I open the door, and it's you.
So we had a big laugh that I was the last person he expected to see when he opened up the door of the muscle car. And I went to bed. And then the next morning, I got up ready to go. And I called down to the valet and said, I'm ready for my car. And they said, Kappy, I've got some bad news. Your car has a flat tire. There's a piece of construction metal stuck in the tire, so we can't patch it. And your fancy muscle car has one of those little doughnut replacement tires instead of a full tire.
You can't drive this all week long all across Massachusetts. You're going to have to take it back to Hertz and get a new car. And I kid you not, Hertz gave me that. And that one tells a story, too. That's the soccer mom van. And there's not a valet anywhere in Massachusetts that would find it the least bit funny to open up the door and find me driving a white minivan, even though I have never been a soccer mom.
So what's the point of this? The point of this is we are storytellers as human beings. It is in our DNA. Narrative is how we work through the world. And we are in the business of narratives all day long every day. Sometimes people will say to me, Kappy, when I go in to see a family, I'm a blank slate. And I say it's impossible. Because even if you think you're a blank slate consciously, we all have these subconscious narratives at play, implicit biases at play, deeply held beliefs at play, things in our blind spot that we have no idea are at play. And so narratives are always driving what we do.
In our field, we are disadvantaged that we have so many historic deficit narratives at play in our field. And somebody was already referencing them, talking about the refrigerator mom causing the child's autism, for example. How quick we are to blame a parent for their child's behavior. And many of us learned these stories when we came on to the job-- the resistant parent, the attention seeker, the malingerer, the manipulator.
We just heard these stories from the very beginning, some of which come with a diagnosis, the borderline, and all of the connotation that comes after that. Have you ever stopped to think about the fact that we tell very few hero stories in our field? We tell very few stories of bravery. And compare that to other fields.
Think about pediatric oncology. We tell stories of heroic brave kids battling those illnesses and their heroic brave parents. And we just don't do the same in our field. And it has such a consequential impact on the work that we do. So as we're talking today, we're going to pay quite a bit of attention to narrative and how we can control the narrative and that as we control the narrative, it will change the way we do our work.
So think about the stories of individuals with behavioral health conditions, the stories that we tell about how families use our services, even stories about our own role in the work. For example, I've been working in another state that has very heavy use of involuntary treatment. And it's really-- at the moment, it's their only mobile crisis response to go do an involuntary evaluation. They don't have like a treatment oriented crisis intervention response.

And as you can imagine, not all patients-- not all adults took very kindly to teams coming out to do that evaluation. But the narrative that this particular evaluator-- she talked about it in training. She said, I've just always told-- the story of my job has been that I'm in the job of saving lives. And I've so deeply believed that we are doing life saving work that I just never really stopped to see the harms when they were happening.

Because if somebody was quite resistant, I just continued the narrative that I was doing life saving work. And because of that, was really blind to the other and the idea that they could shift their approach in ways that decrease the iatrogenic harm. And then of course, going out and offering interventions instead of going out to offer an involuntary evaluation is one way of changing that experience right away. Also stories about the parents and the kids. We've already kind of touched on this one a little bit.

Wow. Michelle's talking about situations of kids having to wait a terribly long period of time in the emergency department for boarding. It's such a good point, Michelle. And across the country, this is a factor. And all of the narratives at play in that situation, think of the narrative of this whole idea of we have a child boarding, meaning what? Waiting. Meaning what? What's the role? What's the role of everybody else in that emergency department when a child is boarding or a child is waiting?

Is it active treatment? Is it continued effort to calm and relieve the crisis state? No, it's boarding. It's like an absence. It's like a vacuousness of services. There's like a complete void. Of course, if your team's there, you're supporting it. Oh, nice, Beth, a shift in language from parental guidance to parental coaching. A switch in the conversation. Yes, switch in the language and all that it implies. Yeah.

So stories that we tell predispose the actions that we take. The stories that we tell predispose the actions that we take. And this is why we want to pay so much attention to the stories that we're telling because-- may not even be consciously-- it influences the actions that we take.

That a parent is never a barrier. A parent is never a barrier. We could also train it to read a child is never a barrier. But let's just go with this one for the moment. A parent is never a barrier. Have any of you ever met a parent who appeared to be a barrier to their child's recovery? Anyone? Ever meet a parent that appeared to be getting in the way of their child getting good treatment?

So assuming that most of us have met a parent or two that hadn't fell into that category, or some of you might find, yes, that makes up most of the families that I work with, assuming that we've all kind of had this experience before, why would it make sense for a treatment team to adopt the mental belief that a parent is never a barrier, never? A parent is never a barrier. Why would it make sense for a team to adopt that belief?

AUDIENCE: [INAUDIBLE] is more solution-focused.

KAPPY MADENWALD: Absolutely, Cody. Yeah, it keeps us solution focused. What else? And people, feel free to unmute or to put in chat. It empowers the parent to see things differently. Yes. Because the parent is an expert on the child, yes. Why else would it make sense?

AUDIENCE: I think when you--

KAPPY MADENWALD: Go ahead, Rebecca.

AUDIENCE: I think when you view the parent as a barrier, it causes that friction, and the parent doesn't want to work as a team member.

KAPPY MADENWALD: Perfectly said. Perfectly said. Go ahead, Viv.

AUDIENCE: I think I was also thinking about like creating space to understand what the barrier is for the parent versus the parent being the barrier, so really thinking about what's getting in the way of viewing it

about like what it potentially could provide or not provide. I think being a parent, I often think about how challenging it would be to make a decision when both options aren't what you would want.
KAPPY MADENWALD: Yeah, we don't have a whole lot of perfect choices in this field, do we? So right along Viv's line. It can be the resistant parent, or the parent is resisting the recommendation, which is a very different way of thinking about it. Because then, as Viv is suggesting, we can try to understand more. Why resisting? What's the resisting about? As opposed to saying, I have a resistant parent. It's a little bit more person first thinking. I have a parent who's resisting this recommendation. Does that change how you think about it? I have parent who's resisting the recommendation.
AUDIENCE: The parent who's resisting could also be burnt out.
KAPPY MADENWALD: Yes. It could be-- it could be that I'm using the word resisting because that's the narrative I'm telling in my own mind. But if I stood in family shoes, as Helena suggests, it might be I'm exhausted or I'm burned out. Or were you talking about the treater, Helena, when you said that or the parent?
AUDIENCE: No, the parent. I actually have a parent right now that she just constantly is like I'm burnt out. I'm burnt out. I'm done. Nothing's changed.
KAPPY MADENWALD: Yeah. Yeah, so they're just saying, I'm exhausted. I'm spent. I don't even have the energy to resist maybe.
AUDIENCE: Or there's more cons than pros to this intervention in my mind.
KAPPY MADENWALD: Yes. There you go. There you go. So I say I've got a resistant parent in Beth as opposed to Beth's resisting this. I wonder why. And Beth says, because as I think about it, there's more cons to this than pros as I imagine it for my family. And already in that shift narrative, look what opens up just by changing around the language.
We've got some really great elements here in the chat. Jussara says the parent is part of the team that's working with the client. So we can't view them as a barrier. It keeps us focusing on strengths. Like in a CSA, the parent and child should be leading. And less resistance happens when the parent is making informed decisions.
And it's really difficult for us as a team to really install the parent in that lead seat if we view them as a barrier. Those two things are hard to have happen at the same time. It puts providers and families on the same team when we don't involve-- when we don't inform-- excuse me. It puts providers and families on the same team when we're not identifying somebody as the problem.
And Viv says, gosh, what a big change. What a big change if we use the word reluctant instead of resistance. Already that shift. Can you feel how it changes the energy in your body if we shift from saying the parent is resistant and instead say the parent is reluctant? Already things shift. This narrative stuff is everything. And again, notice what it does to your body when you change the word. That changes us, and it's going to predispose how we act. And this is incredibly useful for us to do this.
OK, but let's start with a little bit of background. We've already covered a little bit of this today, all you very smart people on the phone. Not many hero stories in our field. Not many hero stories about parents for sure. And in fact, we have some very long standing deficit perceptions of parents in the field, held still by many of us in the field, or they may just sort of rise up in certain tough circumstances for us, but also held by a lot of those other entities, those other systems that play a big role in the crisis system of care-- hospital teams and DCF teams and school administrations who may hold similar views here.

The number one perception of parents of kids with mental health conditions is that the parents are the cause of their child's condition. And because of that, they become a primary target for us in our work. You need to change the way you are parenting, and that's the cause of your child's condition. This is still the number one easy story to tell. This is the Monday morning quarterback, backseat driver approach. It's just the easy, easy answer. Child's misbehaving, look to the parent to see if you can figure out why.

The second perception is that the parents are lacking in education. And because of that, they're viewed as incompetent to appropriately parent and meet the emotional needs of their kids. And because of those deficits, we need to teach them how to be emotionally responsive to their kids and to parent correctly. And so we get ourselves into this teaching mode that parents can experience as quite condescending.

The third story is that parents are in need of support services themselves. And again, these are underlying perceptual beliefs. These are not necessarily even consciously in our mind. But they're driving the work that we do. So in the third category, it might be a belief that the parent has their own mental health or substance use condition or perhaps a developmental disability that is somehow inhibiting their skills as a parent.

We might even believe they've got some fragility to them. So we need to be careful to not burden the parent with too much, for example. So we may do some deciding for or speaking out on behalf of a parent who hasn't asked us to do so. That one is not quite as blaming, but it is still quite dismissive of their abilities. And it assumes a limitation that may not be there.

The fourth one and the one that we're going for is the perception of parent as collaborator. That's obviously consistent with the wraparound principles of care. And it's an underlying team perception about parents, that we view parents as collaborators in the education and treatment of the child. It's a teamed approach. We view parents as capable partners in that work.

However, this is really not well taught in academia for many of us. We were never taught how to use those kind of models. And a lot of parents have never had that experience. So it's quite new to them, this idea of partnering with the physician or partnering with the team. And in fact, some parents may have experienced consequences when they tried to partner or collaborate with their child's treaters in the past. So it's not always gone rewarded. So that's still really an underdeveloped component here.

So perceptions, how can you know you have them? This is tricky because this can really be in the blind spot sometimes, that we don't even-- we're not even consciously aware that we're holding the belief. But I can remember back when I was an expert. I was working on one of those competitive inpatient hospital units at a competitive teaching hospital.

And as social worker, I did family sessions and did a psychosocial evaluation. And I just-- thinking back, I can remember that I had underlying goals and conversations with families to find the weaknesses, to identify the gaps, to identify the problems. And so I was looking for it. I was looking for those explanations when they came in.

I was pleasant. I was engaging. I generally liked the families that I was working with. But I had this underlying agenda to find out what was wrong. I was looking for pathology as an explanation. So it's that sort of a piece. I was really honed in in general on deficit. I liked the abnormal psychology classes in graduate school much more than the normal development courses. I was there to learn how to diagnose the bad stuff, not to work with kids that were well.

So what is that that happens with this storytelling? I love this brain diagram. It's quite simple, really focuses on these three key functions related to narrative. And the first is the spinal cord. This is where

information enters our brain. So what we smell, see, taste, the story, that enters the brain through our spinal cord.
And our limbic system receives that information first. This is the amygdala and other parts of the limbic system. This is the flight, fight, freeze sort of piece. This is our body's harm risk detecting kind of component. Whatever information that comes in, it gets distilled through this limbic system. So you get a first emotional sense of how you should respond to the story.
And after that, then it goes up here to the higher executive function parts of our brain where we then think, act, and engage in a much more conscious kind of way. So how's this work with the narrative? If you remember the valet saw the car coming around the corner, and he says to himself, who's that middle age guy thinking he's so cool, having a midlife crisis?
So he sees that. That story pops into his mind in a couple of seconds, enters his brain. And he has a limbic system feeling about it-- dislike, derision, judgment kind of stuff. He's all prepared to act accordingly until he opens the door, and he sees me instead. And so that sort of pops that whole emotional thing that he has built up.
So what happens if the story that enters the brain is that the parent is a barrier? Let's just say you're about to go out to meet a parent who is a barrier to their child's recovery. If you know you're about to go see a parent that is a barrier to their child's recovery, what kind of thoughts and feelings do you have on your way out to the home? What kind of thoughts and feelings does that bring up for you?
AUDIENCE: I think, ugh. That's what I think.
KAPPY MADENWALD: Ugh, yes. Ugh. Ah, and Stephanie says, I need to get that child away from the parent. What else? What emotions do you have when you're on your way out to go see the parent who's a barrier to their child's recovery? Amara says, there's nothing I can do that will help as long as the child's in these homes. I have lack of hope. I'm anxious. What else are you feeling going out?
AUDIENCE: Defensive.
KAPPY MADENWALD: Defensive. So I got I'm feeling defensive, anxious, frustrated, lacking hope, feeling nothing I do will help, feeling defeated, feeling I need to get this child away from the parent, frustrated with the parent. Yes, everyone saying, I already feel frustrated. I feel protective of the child. And if I'm feeling those things, if I get to the home feeling frustrated, defensive, this is hopeless, defeated, anxious, nothing can change here, then how would I be predisposed to act when I get there?
AUDIENCE: Reactive.
KAPPY MADENWALD: Say it again. Reactive. What else? Whoops. I am reactive. I am closed minded. I am shut down. How else am I predisposed to act when I get out there? How am I predisposed to engage the parent when I get out there?
AUDIENCE: Accusatory.
KAPPY MADENWALD: Accusatory towards the parent. Reactive, accusatory. What else am I predisposed to do?
AUDIENCE: Try to teach them, get them on board.
KAPPY MADENWALD: Yes. Reactive, accusatory, teach them, get them on board. Annoyed. Attitude that you know more than them, avoidant of the parent, condescending of the parent, aggressive, close minded. Ah, and Kelsey says, when this kind of stuff happens, then I find myself super anxious seeing them again. And so it even gets bigger. I come out blaming the parent.

And now we're going to do our first little immersive thing here. If you take off your professional hat and set it aside for a minute, stand in the shoes of the parent. How do you experience it when the team comes in teaching you, trying to get you on board, accusatory towards you, reactive towards you, blaming you, anxious? How do you experience when the team comes in frustrated and annoyed with an attitude that they know more than you do, when they come in avoidant of you, or they come in with a condescending approach, or they're aggressive or close minded? As parent, how do you experience it?
Ah, Helen says, walls up. Jussara says, I feel insecure. Defensive. Parent, defensive. As parent, not wanting to try new things. I'm not wanting to try things that take energy or work. I have a lack of trust with the team that's in my home. I'm anxious to have them in my home. Or I feel incompetent as a parent, Melissa says. I'm frustrated, annoyed, shut down, overwhelmed.
They do not understand me or know me. They cannot help me. I'm worthless. I cannot do this. Frustrated they don't know who they are dealing with. I'm guarded. I feel unsupported, not understood. I feel like a failure. I don't want you in my house, Shavonne says.
At which point we, who didn't want to be there in the first place, say, oh, do you want to not do these services? Sign right here. Sign right here. We'll close this down. Feel incompetent as a parent. I feel not a part of the team but the problem. Helena says, I want them to understand what I go through every day so they see how tough this is.
As parent standing in those shoes, has the crisis gotten better or worse for you? It's worse. It's worse. And standing in those shoes, what is that experience that you're having there? Those things that you're describing-- it feels worse for you, you feel more incompetent, you feel like a failure, you feel unsupported-- those are examples of what? Those are examples of what?
Oh, and Kelsey says I've had parents tell me you don't have kids, so you have no place trying to help me. Yes, yes, because they felt you wouldn't understand. And Stephanie nailed it. Those are examples of iatrogenic harm. When you're standing in parent shoes and the experience of care makes you feel unsupported, makes you feel on guard, causes your walls to go up, makes you feel like a bad parent, makes you feel condescended to, those are all examples of iatrogenic harm.
Yeah, felt like a horrible parent. I feel judged. So we immerse ourselves there, and we're like, oh my gosh, here's how that is experienced when I go in those shoes. If I'm not in those shoes, I can easily misunderstand the parent reaction when the parent walls go up, when they kick us out of the house, when they're avoidant.
If I'm not standing in their shoes understanding that's iatrogenic harm, it's easy for me to see those parent reactions and think, yep, the reports were right. I've got a barrier parent here. Look how uncooperative she is. She's just as rude as everybody said she was going to be. She's just as noncreative and low energy and non-trusting as everyone said. Yep, I'm so tired of getting sent out to these people that are barriers to their kid's recovery. Ah, and Rosie says, I feel like they don't understand my culture. Is it Rosie or Roseni? The names are together.
AUDIENCE: Rosalie.
KAPPY MADENWALD: Oh, Rosalie.
AUDIENCE: Yes.
KAPPY MADENWALD: OK. What happens instead if I tell not a parent as cause story or parent barrier story? But I actually remind myself, of course, the parent can't be a barrier because a parent is never a

barrier. And then I take that even further, and I manually feed a new story into my spinal cord that will change the way I think about it and change the way I act.
And so I go even more forcefully not just that a parent is never a barrier, but that I'm about to engage a parent that is credible, capable, intuitive, and able to collaborate. And I manually feed that into my brain to change my perception and then see what happens next. So if you were about to go out to see a parent who you deeply believe is credible, capable, intuitive, and able to collaborate, what kind of thoughts and feelings are you having on your way out to that home?
I'm thinking the parent's a superhero for the child, and I'm looking forward to working with them. I am hopeful. I'm excited. I'm eager to work with them. I'm optimistic that progress will be made. I'm curious. What else? This is going to be a great visit. I'm open minded. I'm hopeful to better understand the parent's experience. I'm ready.
And when I get to the home, what approaches am I predisposed to take? When I get to the home, what approaches am I predisposed to take? I'm predisposed to be collaborative. I'm predisposed to be strength based, understanding, curious. I'm predisposed to meet the family where they're at. I'm predisposed to be collaborative and client centered. I'm predisposed to be solution focused. I'm predisposed to be open, actively listening, and working together.
And take off your treater hat for just a minute and go back in the shoes of the parent. How do you experience it as a parent when the team comes in open, actively listening, working together, solution focused, collaborative, client centered, meeting you where you are at, curious, understanding, strength based, ready, hopeful to better understand your experience, open minded, excited, eager to work with you, hopeful, viewing you as a superhero for your child?
And look at what that experience is like. As parent, I feel relieved, supported. As parent, I'm hopeful. I'm engaged. As parent, I feel understood and as an ally. I feel thankful. I'm welcoming. I'm hopeful. I feel open minded. I feel caring, sympathetic, and hopeful.
And as Stephanie says, I imagine this would shorten recovery time. You're absolutely right. How is the crisis date for you as parent? Better or worse? Already in those shoes as you experience the team that way, it's already better. I already feel relief. How long did it take you to feel that way? When the team comes in with this kind of an approach, how long does it take you to start feeling relief?
It's immediate. It's immediate. And as Michelle says, it certainly can be influenced by past experience with other providers. I might be feeling good, not quite trusting it. So I might be hesitant to fully trust this. But it can happen immediately. And the other Michelle-- or Monica said that, and Michelle said, almost instantly it happens.
This is the power of narrative. This is the power of narrative. Now I don't have to wait for a parent to demonstrate that they're credible, capable, intuitive, and able to collaborate. I go in with the deep belief that they're credible, capable, intuitive, and able to collaborate. And that's a trick that I'm doing in my own brain to counteract that historic deficit narrative. Because I know that historic deficit narrative will lead to me choosing approaches that will not be effective.
But that if I manually feed my mind a better strength-based story, it will predispose me to use different approaches. And as a result, I will get a different reaction from the parents. They will feel relief. I will choose approaches that are change promoting and that are relieving and resolving. And that's the magic of the narrative.

You may have different mantra you already use. I consider this mantra here my short math. I did long math for a long time, of really sitting down and thinking, why do I like this parent? And what's a strength-based story I can tell about them? And how do I rid myself of my deeply held deficit view of this particular parent? That's how it started.

And over time, you just began to see when you do that long math often enough, you're like, wow, this just consistently works. This actually works in all of these different circumstances. I don't have to do the long math every time once it's clear to me that it works. And thus, the mantra is born. And so I use this to guide my interventions. This is my 15 seconds before going in to meet with a parent. I'm about to, I'm about to, I'm about to.

It's universally useful. Same approach with a colleague. Same approach with a school administrator. Same approach with a DCF worker. Same approach with the child. It's a change promoting way to think about doing interventions with individuals. And it lets us bypass, override those historic deficit narratives. Imagine the valet could have done this, too. I'm about to open the door to find a credible, capable, intuitive, person, and automatically opens the door with a grin and a smile and a welcome, overriding that narrative.

Stephanie says, how is it different from the honeymoon period? It's an interesting question. And we'll talk about this in a little bit more detail this afternoon. In our work and especially when you're doing long tough work like IHT-- it's complicated work. It goes for a long period of time, and you have a lot of different phases of work.

And so sometimes it can be easier to take this credible, capable, intuitive story. It feels more believable at the beginning. And it maybe tougher in the middle of your work with them. And so you have to just keep figuring out how to apply it as you go during the different phases and let it be a reminder at any point.

So for example, Viv and I were chatting a little bit earlier about resistance. And she suggested we could talk about a parent is reluctant or instead of saying the resistant parent, let's say a parent who is resistant or a parent who is reluctant. And so what I end up doing is saying-- in one of these tough times when the honeymoon is over and suddenly my mind is saying, oh, she's suddenly a resistant parent.

But I slow myself back and say, that's a deficit story. I'm engaging a credible, capable, intuitive parent who is reluctant. And when I say it that way, how am I predisposed to pursue that? This group already said it a few times. When I believe I'm engaging a credible, capable, intuitive parent that's reluctant, I'm likely to be curious. I'm likely to be open minded.

I'm likely to ask. I'm likely to partner with. Yeah. And Shelia said, I'm getting curious. And in that instance-- and Beth mentioned this earlier. Beth would say, because as I see it, the cons outweigh the pros. And so now we are continuing to collaborate in that way. Yeah, I come in ready to listen.

So whenever I find myself in that tough spot with the family that feels like the honeymoon is over, it's possible that part of that honeymoon has to do with me and my approach. And if the honeymoon is over is kind of evidence of some iatrogenic stuff is beginning to happen, then it's my job to get more precise in this new phase of work with the client.

Yes, helpful to attend to the parallel process, Helen says, of how the provider is feeling about themselves, yes, as capable, intuitive, collaborative. Yes. And I'm glad you're bringing up the parallel process element of this. The more the same approach is used within the team, the more it's used in supervision, the more it's used in peer to peer consultation, the more likely it is for the team to go do that in practice.

If instead-- if supervision is very direct and you need to go out and do this with the family, then the team's likely to go out and do this with the family. But if the supervision is really modeling that kind of credible, capable, intuitive approach, the use of Socratic questions, the use of curiosity, then the team is more likely to go out and do the same with families.

Provider engagement and activation of parents as informed drivers of their children's health care is underdeveloped. Many of us, especially in the child field, we go to classes about how to work with kids and build our skills there. But far fewer of us have gone to good classes about how to engage parents effectively as collaborators in treatment.

And so it's underdeveloped. And again, this is particularly true in the mental health field. Because in the mental health field, we have particular concerns about the judgment of parents. It's one of those deficit narratives. So it's really an underdeveloped field. And to the degree that you're not fully taking advantage of this as you do so, you will find yourself getting more efficacy in your work with kids and families.

Yeah, Viv, great. Every time we want everything to be aligned with the perception and perspective of child and family and for them to tell their stories from their own points of view as it makes sense for them to tell it.

This is a 100% of the time approach. This isn't waiting for a parent who's worthy of telling the credible, capable, intuitive story because, again, remember this is about me priming my brain to use productive approaches. It's about me changing this underlying story. It's my perception that I'm shifting when I use this credible, capable, intuitive mindset.

And so I'm applying it 100% of the time, even in tough circumstances like when parents are opposed to our treatment recommendations or when we are turned off by how a parent's treating a child, even when we think a parent's own trauma history is creating issues and how they're parenting today, even when a parent appears to be impaired by a mental health condition or an intellectual disability. Even then, we want to use this approach, even when we need to file a 51A because there's a clear instance of child abuse.

So why do that? Why would we do this credible, capable, intuitive frame even in these tough circumstances? How is that even smart and ethical? Why would we do that even in these tough circumstances?

AUDIENCE: Parents are doing the best they can.

KAPPY MADENWALD: Excellent. And?

AUDIENCE: Just understand.

KAPPY MADENWALD: Say it again.

AUDIENCE: To just understand their perspective and experience again.

KAPPY MADENWALD: Yes, to understand. To be understanding. Why else would we do it even in these tough circumstances? Oh my gosh, Michelle says, because if we don't, the hope for change is ultimately diminished. Wow. That's powerful. That is powerful. If we don't do it, we have just decreased the chances of this going well or getting better. That's really significant

And why else? It shows there's no judgment. And it shows we're a team. And it shows that we're with them. Yeah. That I can be reporting child abuse and choose to hold no judgment at the same time.

AUDIENCE: I think it could also provide context like why a parent is opposing treatment or even context like if you need to file that-- you have to file, but there is context to like why they did what they did.

KAPPY MADENWALD: Yeah.

AUDIENCE: It sometimes is out of their control and can be like systemic barriers.
KAPPY MADENWALD: And these are really vulnerable points for parents, right? The vulnerability of a point-- of a filing of a 51A has to be one of the more devastating periods for a lot of families.
AUDIENCE: It could be what they're doing in their culture and in their country of origin is what's acceptable and what they believe is what's most going to be helpful.
KAPPY MADENWALD: Yeah. Yep. Yeah. And so for all of those reasons, we're not wanting to pile on. We're actually wanting to relieve. Let's imagine that situation where we're about to file a 51A and there's been this abuse that has occurred. We can imagine that the parent's limbic system at that time is on hyperdrive, that their amygdala is swamped and swarmed with any number of emotions-- anger, regret, shame, fear. Who knows?
But we can imagine it is swamped and swarmed. I want to take approaches that calm that limbic system and allow the parent to resume more executive function. Why? Why does that help the child? Even in a situation where foster care might be clearly going to happen, why even then what I want to take the time to do this?
Ah, Stephanie nails it. Because they will make better choices for their family and better choices for themselves. Because if I can help the parent shift out of that swamp, swarmed amygdala to higher executive function, they can participate in the referral to DCF or be in the room when we do it. They can prepare their kids for what's going to happen. They might be able to identify some kinship options where the kids will be more comfortable. They'll be able to give some thought to the kinds of things they can pack for their kids to give them things that they'll experience as soothing.
They'll be able to communicate their children's care needs effectively to DCF even in that circumstance where a child might get removed from the home. And imagine the difference if kids receive that kind of action from their parent perhaps before they're placed in foster care compared to a parent who's limbic systems are on overdrive with all of those emotions. And that's the point at which they're removed from the house.
Yeah, and, Rebecca, great point. This approach continues to show transparency from us and that we're trustworthy, that this therapeutic relationship is something that's trustworthy even in these tough circumstances. Is there iatrogenic harm any time we file? There is. It does have an impact.
But we can do a lot to diminish the impact by these kinds of approaches. And it's useful for the child, and it's useful for the family when we do that. So there's really no exceptions to this credible, capable, intuitive collaborator kind of mindset because, again, this is just about us controlling our own narrative so that it allows us to choose approaches that are common and relieving. It predisposes us to do that.
And I cannot hold strong judgment towards the parent's action and be calming and relieving at the same time. Of course I can cognitively understand that this was a bad parenting choice. It's reasonable that I might do that. But I don't want to let that control my emotion and change the way I act. So nothing about this is about taking a Pollyanna view of parents. Parents are stressed that we work with. Of course they could use different approaches as parents.
There's no profession in the art and science of parenting. There's no perfection there. But it also doesn't help for me to point out all these things I think they should do differently. I'll never get it right for another parent anyway. So you have to-- the ups and downs of parentings, hold that aside and different from this believe in credible, capable, intuitive parents who are able to collaborate. Those two things can exist at the same time.

AUDIENCE: Kappy, I was also thinking like by having opportunity be moving into the work this way gives reason to what informs their decisions versus excuses. Like, I've been part of meetings where it's like providers might try to give excuses to why a parent is responding in the ways, which I don't find to be helpful. But more if you're thinking about the context in which like what informs the reasoning behind it is different.

KAPPY MADENWALD: Yeah, yeah. Yeah. Absolutely. Yeah, and there could be some narratives there as well that are at play. But we want to create-- I mean, can you imagine this kind of scenario that we're talking about? The amount of psychological safety that's essential for a parent to have the kind of conversation that Viv is talking about, where we make a psychologically safe enough space that a parent can say, here is why I think I'm doing this. Here is why I'm using corporal punishment.

I'm starting to sort out what I think might be behind this. And what an incredibly vulnerable topic that is for a parent to talk about, and the need to create real safe space for which that occurs. And recognize what a significant role the limbic system plays in that as well, particularly if the abuse comes out of some sort of crisis state that the parent is in when their limbic system is on overdrive, meaning that they're acting in more impulsive, reactive, emotional way. We really want to help them restore that higher executive function. That's the place where they're going to have some insight into what it is that was happening. OK.

AUDIENCE: Just briefly, I'm sitting here and I'm thinking about the role of supervision and the role of collaboration across systems. Just I'm sitting here thinking about how you started, Kappy, with talking about like our own biases. And so even a consult that I was in fairly recently where any one of us, myself included when I was doing the work, can actually be in a place of sitting with that judgment. What about our own life experience? And just the space to be able to like talk that through. I love all of this. And even knowing kind of these phrases doesn't magically do away with what is coming up.

So I don't know. Just again kind of that piece about being aware of our own biases, being able to bring that in, being able to not worry about shame in a supervisory space around like, OK, what is this about. But I'm also thinking about so many systems and especially DCF, and not to throw DCF under the bus, but just the times where it feels like we may hold a different position. Like, our team may hold a different position with a parent. Where is the department sitting?

And just the importance of having meetings where we're just trying to kind of get at those pieces and name them, and what are they about, and what is the impact on a parent. Anyway, just those-- I'm constantly going back to what our own biases are and the importance of being able to be aware and bring those forward and talk those through so that they don't get activated in the work.

KAPPY MADENWALD: Beautiful. Everything you said is just beautiful. And I'm so glad that that's the kind of cascading of thoughts that you're having, Helen. I just think-- this is peeling back the layers over the rest of our career. That's how I think about this work. You just never get it done. We are such complex beings made up of these life experiences.

The riskiest situation is the bias-free worker. Anyone who says they're bias free, that's the harm because that's all blindspot stuff. That means I'm not even aware. That's a really tricky place to be. It's difficult because we live in a world where there's also like a political correctness. And we understand the importance of that.

But political correctness can't be the same as me not being able to talk these things through in a constructive way in a psychologically safe space so that we can talk about big differences in culture and race and power and really begin to understand them and how those intersections of things work uniquely

for each of us and influence the way we practice. And I can never be a bias-free person. But I certainly can manually feed my brain in ways that help to control and contain some of those biases. They give me some-- they overdrive some of those things when I manually feed in that way.

And when I hear something that feels so opposing to what I believe, when I've done that manual feed, it just lets me go towards curiosity instead of judgment. And I am able to do that in an empathic way. And that's one of the things that's so remarkable about doing this. Instead of judgment, I can go to a, say more. Say more. I'm curious. Say more. Say more, credible, capable person that you are. Say more about that.

And I can do that with the DCF worker. And I can do that with the school administrator. And I can do it with the parent of the child, and I can do it with the child. And I can do it with my supervisee. And I can do it with the parent partner that's on my team that seems to be viewing the parent in such a different way than I am, and I'm not getting it. And I can say, say more. Say more about what I'm not understanding about that lived experience, and create a safe space for that to happen. And it's really remarkable.

So I described myself as a recovering expert. I say recovering, meaning I can still bounce back to that occasionally, into that expert role. Even the harder battle-- and they were a little bit tied together-- is that I'm also a recovering perfectionist. And that kind of gets to part of what Helen is talking about.

When you are really working hard to defend yourself and your reputation and your correctness and always getting it right and don't let them see me sweat, it's really difficult to have those candid conversations that Helen was describing. Perfectionism doesn't lend itself to candor about my vulnerabilities. Those things just aren't safe.

So we really want to create a soft landing for the team doing this really complicated work with families that have led extraordinary lives. We really do want to create soft spaces, not because we're particularly vulnerable people, but because these are particularly vulnerable topics. And we are in our field so exquisitely aware of the importance of voicing these things so we can get out of our own way.

It's our version of precision. If I'm a surgeon, precision is about moving my scalpel in ways that I'm not making zigzaggy lines or having to cut multiple times. Our precision is so much about our mind and our narratives. And I get more precise by talking it through. I can do some of that in my own head. But it's so much richer when I hear the perspectives of another hundred people because I'm limited to the ways I can see the world. But when I can see the other 99 ways, that really broadens my point of view.

Wow, Kelsey, great professor tip. Be aware of your own values and expectations, but push those aside to become mindful of others' values and expectations when I'm with them. And if I do that every day, I can let the client lead the way and then show my interest when they speak.

And Lori says, I always say, judgment is a part of us as human beings. It is going to happen. Yes. It's what we do with that judgment that makes the difference. Yes. Phenomenal. Really phenomenal. Great, great chat. This is the beauty of these Zoom trainings, because we would never get this side bar rich chat if we were in a room together. This is really wonderful.

OK, I'm going to switch tacks to talk about rethinking hospitalization. Whether or not the child needs psychiatric hospitalization is often part of the conversation in crisis situations. And there's a lot of narrative around hospitals as well. And for some reason, they have retained an allure. In crisis situations, there is often pressure to use hospital. The school might be pressuring that. Maybe DCF is pressuring it. Maybe a parent deeply believes their child should be in the hospital. Maybe the outpatient therapist or psychiatrist deeply believes that, or the emergency department physician.

There's just a lot of push and energy around this, a lot of deeply held beliefs, deeply held beliefs like the hospital is the best and highest quality service. So if a child doesn't end up hospitalized, the belief can be that they got something lesser or even that nothing was done. We called in the MCI team, and nothing was done. The child wasn't even hospitalized. There can be that sort of sense.

There can be a belief that the hospital is a safer place or a safe place, a believe that inpatient treatment is something you do to a person when really that's just a bed on a locked unit. That doesn't speak to the actual course of care at all. That's specific to the hospital and the team and their skills and abilities and the tools that they use. So we need a lot more detail when we say somebody needs inpatient treatment.

There could be a belief that a fabulous test will uncover the answer, and excellent medications will treat the problem. There can be a belief that when there's a significant crisis, sending the child to the ED and them getting inpatient treatment is always the best, safest course of care, and that following hospitalization, kids are now stable. They wouldn't have been discharged if they weren't stable and able to get back to business as usual. And that kids who are discharged are always linked to good, proper treatment services in the community.

So you can hear some of the fantasy talking here. And we just want to get more real about hospitalization. In our field, we are at risk of selling hospitalization as 100% good and effective. And collectively, there's this deep enough belief about inpatient hospitalization that every state in the country has a law that we can admit you there involuntarily to this 100% good and an effective hospital. This is one course of care that you can be mandated to do, court ordered to do. It might surprise you, maybe not, that there's very little research about the efficacy of inpatient hospitalization.

AUDIENCE: I have a question slash I guess more of a comment.

KAPPY MADENWALD: Yeah.

AUDIENCE: I'm also the intake coordinator for our program. So I get referrals from inpatient and CBATs and things like that. And from my understanding, usually once you get in, it's talking about discharge. It's talking about aftercare. But so often, going back to your first chart of everybody working together to benefit the family, very often, I'm getting a referral the day that they discharge or the two days before that they discharge.

And most of us-- I mean, right now, sadly, most of us probably have a lot of openings. But usually, we're working with a wait list, and we need to prioritize families coming out of the hospital. But there could be three other families coming out of the hospital. So it's just to come way back from the beginning of, how do we get the CBATs to the inpatient on the same page of how to do aftercare? Calling the day before and just sending a referral through fax is not the way to do it. But yeah, that was my comment slash--

KAPPY MADENWALD: And I'm curious, Lori-Ann. As you see that happen, just kind of play that out a little bit further. Of all of those calls that come in that way, via fax and whatever else, how many of them actually turn into well-established treatment within your agency? What percent would you say?

AUDIENCE: I would say probably a good 90%.

KAPPY MADENWALD: Well, that's pretty darn good.

AUDIENCE: Or 80%. I think most of the time, families do call back and they do respond, and we do get things started. There are some of those families that don't call back, and there's not much you can do there. But part of it feels like passing the baton over. Like, I did my part. That's my liability. This is what I was supposed to do. So I did it. That's what it usually always feels like when it comes to the referrals.

KAPPY MADENWALD: Yeah, I'm glad you're bringing that up.

AUDIENCE: [INAUDIBLE] hear from them after discharge. It's like, oh, well, they just discharged already. I can't help you there.
KAPPY MADENWALD: Wow.
AUDIENCE: You made the referral.
KAPPY MADENWALD: Yeah, yeah, you're bringing up just a key point of discontinuity. I'm working in a state right now where something like 22% of people make their first appointment after discharge. So if you're at 80% or 90%, something's going well. And that might be about how you're engaging families when they call. It might be the way the hospitals accurately enough describe what it is that you're doing so that when families call, they say, yes, this is the service that we thought we were getting.
So there is some good there. But absolutely, as you said, this could be much better. We could be doing it sooner, giving families more choice and opportunity to ask questions, and get far better continuity in this care. You're absolutely right. It's a really significant piece of this and quite a high risk period, that point right after hospitalization.
So in the absence of good scientific information about hospitalization, we're going to do some practice-based evidence here, a little bit of our own research. Kate, the CEs, you're going to get six this morning and six this afternoon. You're just going to-- when you put it in the system at the end, it's going to be just 12 digits in a row. So it's not particular sets. But you should have-- by the end of this morning, you will have six. You'll get your sixth one right before lunch.
OK, so some practice-based evidence. So I have two poll questions for you. And here's the first one. Based on your experience and in talking to the families that you work with, roughly what percent of time would you say families say that the kids experience a good health benefit from psychiatric hospitalization? Based on your conversations with families that you work with, roughly what percent of time do kids experience a good health benefit? Meaning the parents would say, that was worth our time and money. That many, many thousand hospital stay, that was worth the time and money spent. Things are better for the child and family because of this hospitalization.
AUDIENCE: Are you considering CBAT level care or just hospital?
KAPPY MADENWALD: Just inpatient hospital for this. We could do the same for CBAT. But for this one, we're going to do traditional inpatient psychiatric treatment. We're going to just go about five more seconds here. OK. And the most common answer is 20% of the time. But I'm looking at the whole list here.
If I'm averaging out everything-- this is going to be rough. I think we're closer to about 30% of the time at least. So I'm going to use 30%. It doesn't have to be exact. When I do this exercise, sometimes it's as low as 15% average. Sometimes it's as high as 60% average. Notice it's well below 100% of the time. This is not a service that produces excellent health care results 100% of the time.
And I don't intend any of this to be hospital bashing. It's a really important level of care. It doesn't mean we get good health results every time, however. So we want to be honest about that. We don't want to talk about a good and effective hospital service 100% of the time when this group says we're getting good health results about 30% of the time is the average of this group.
So this is a quadrant model. It's a way to think about the intersection of two points. And we're going to be talking about the two kind of elements here. And the first one that we just did a poll on is the expected health benefit of hospitalization. And what this group said is about 30% of the time, kids experience a good health benefit from hospitalization, which means that 70% of the time they don't.

But now let's look at this horizontal arrow. This is iatrogenic risk. So consider in your conversations with those same families, roughly what percent of the time would you say kids experience iatrogenic harm from hospitalization? Are you there, Ari? OK, so roughly what percent of time do youth experience iatrogenic harm from hospitalization?

We're going to go about five more seconds here. Get your votes in. OK, so let's see. I think we are at about 75%, my rough averaging of the numbers here. This group thinks that about 75% of the time, kids experience some iatrogenic harm. So that's over here, which means that about 25% of the time, that's not something that we're particularly concerned with.

And so you can see here with this quadrant model, we end up with four buckets of kids here. We have this group, best case scenario where kids are getting a good health benefit with minimal iatrogenic harm. And the worst case scenario, we have kids that are not getting a good health benefit and they're getting high harm. So that's sort of the worst case scenario. And you can see these other two are a bit more of a mixed bag.

Now I'm curious. When hospitalization is on the table, when it's getting considered for a particular child, are there factors that have you more or less optimistic about the health benefit, the potential of a good health benefit? And are there factors that have you more or less concerned about the iatrogenic risk of hospitalization? What are those factors that would be clues to you ahead of time around the potential for health benefit and the potential for iatrogenic harm?

Maria says the hospital, the hospital the child's going to, the reputation of the hospital. So absolutely, we need a quality health care provider in the mix. Mm, Rebecca says, well, it depends on maybe if they're using the hospital just to prevent somebody running away or to run away from the issue, like I want to go to the hospital so I can avoid talking about it in the community, or if there's a clear need to be stabilized. Patty brings up a really interesting point-- previous experience with the hospital. How important is that? How did it go last time? If the child was admitted before, did it produce good health benefit the last time? A really important consideration. How long they boarded before they got there. Wow. That could be sufficient-- significant. Hospitalization can absolutely be traumatic. And if we have reason to think the child will experience it in a traumatic way, then that has us more concerned about iatrogenic risk.

And so there are categories of diagnoses that we are going to be concerned with for that-- a child with PTSD, a child with reactive attachment disorder, a child with autism spectrum disorder. We may be particularly concerned about iatrogenic harms in those kind of categories. Wow, whether parents are allowed to visit and for how long. That could impact both of those things, both health benefit and iatrogenic risk.

The impact of that hospitalization on relationship and attachment. Yes. Oh, gosh. Helen, this is so important-- when everybody is in agreement with the decision to hospitalize, child, parent, team. We all agree in hospitalization-- with the hospitalization. Involuntary hospitalization decreases the likelihood of a good health benefit, increases the iatrogenic risk. Does that make sense? When I'm being forced to do it. Yes, can be very traumatizing if the child already has separation difficulties. How much communication there is between the hospital and the parents and the quality of that communication, the way the parent experiences that communication. Hospital's willingness and availability to coordinate with outside providers. Not surprised that Lori-Ann brought that one up because she's living that life, and she sees how essential that coordination is.

So we have some factors that let us consider these things. And we can have good broad conversations with kids and families about this as well. We just want to make sure we've got the language to really broaden the conversation.

In crisis work, here is the classic crisis question. Does the individual meet the criteria for hospitalization? That's what the inpatient hospital wants to know. That's what the insurance company wants to know. And so often this becomes the primary task for a crisis team to sort out. Do they meet the criteria for hospitalization?

But here are the questions that are not getting asked often enough. What's the expected health benefit? Separate from whether they meet the criteria, what's the expected health benefit for this individual? And what are the risks of iatrogenic harm specifically for this individual? And then given the answers to those questions, are there alternatives that could offer this individual equal or better potential health benefit while decreasing the risk?

Those are the conversations we're not having enough of. And boy, this is really consequential. Let me make this a little bit personal for you. Imagine that you have a bum knee, and you have been waiting and waiting for your insurance company to approve knee replacement surgery.

What changes as you get more information? First, your doctor calls to say, good news, your insurance company has approved the knee replacement surgery. Yippee, great. And then your doctor says, the surgery is effective 30% of the time. And it causes iatrogenic harm 75% of the time. And here are some alternative considerations.

Does your personal health care decisions shift as you get more information? That's informed. That's broadening this informed consent conversation. And the answers-- there are more than 50 of us on this call today, 58 people on the call. We have 58 different sets of considerations here, as Beth says, 50 considerations of weighing the cons and the pros. And for some of us, the cons may outweigh the pros. And for some of us, the chance of the pros may outweigh the cons.

And so this is shared decision making, no perfect decision here. But each of us weighing, given these odds, do I feel like I can live with it the way it is? Or do I feel like it's worth it even if it's only a 30% chance of being better? Or do I say, I'm just going to try these alternatives and see if it gives me a good enough result that I can live with it? 58 different answers, and they're all acceptable. They're all really coming from your particular point of view, what makes sense to you, what you value more.

We are collaborating with families that have led extraordinary lives. For treatment providers, it can be difficult to try to sort it all out, to feel like we understand the timelines of their lives and all the significant events that have happened. The good news is we don't have to understand all of somebody's history in order to be of service to them.

What we do want to understand is the essence of the crisis not just for the child but also for the parent And sometimes for other entities like school administrators, or sometimes it's the physician in the emergency department or the DCF worker, anybody who is, for whatever reason, stuck, stressed, impacted by the child's crisis experience.

We want to understand their distress, the nature of that distress, because that's really where the opportunity for resolution lies. It's that stuff that is kind of swamping and swarming the amygdala of all of those individuals that are making it difficult for them to do some of the creative problem solving that can happen when we get to that higher executive function place.

Essence of the crisis is not fundamentally about the diagnosis. And it's also not fundamentally about the problem, like the problem that a child is suicidal or the problem that they just threw a chair through the window or something like that. Essence, when it comes right down to it, are these kind of human experiences-- feeling fear, feeling grief, feeling lack, powerlessness, shame.

This is not a complete list, but it's a decent start of a list of the kind of human experiences we all have that can swamp and swarm our amygdala and render us temporarily less able to cope and to access coping mechanisms and to feel hopeful that we can get out of situations or any of those kinds of things.

In a crisis situation, it can be really easy for a service provider to focus on things like level of care assessment and disposition and just say, and where do I send them? Where can I send them to get this solved, for example. Or to focus in on things like diagnosis, as if all crises stem from some kind of diagnosable condition, or for a person who already has a diagnosis condition, that that diagnosis explains any crises that they might experience.

Or we're trying to focus on the unwanted behavior by managing, containing, controlling what it is they're trying to do, restricting as a strategy. And then our own priorities can certainly come into play here as well when I'm maybe behind in the day and trying to manage it and get onto the next family. Or I'm leading with my concerns about my own liability. I can have all of these things happen and miss getting to the essence of the crisis.

This is where a person first and whole health thinking is so important. And we started some of this conversation this morning. It's really essential that we don't assume that the diagnosis explains everything that we're seeing. I can have schizophrenia and also be experiencing a crisis that has nothing at all to do with the schizophrenia. Or maybe it's indirectly related to the schizophrenia, like isolation that comes from having a difficulty keeping up personal relationships or something or poverty because I found it difficult to get and keep a job.

Or maybe it's not even that indirect. Maybe it is grief because my best friend died or fear because I'm getting victimized in my housing. If I take a diagnostic focus, a diagnostic first approach, if I say the schizophrenic is in crisis, if I think that in any way in my mind, it has [AUDIO OUT] and explain away everything I'm seeing. Are you all hearing me? OK.

AUDIENCE: You muted for a quick second, and then you came right back.

KAPPY MADENWALD: That was odd. I don't know why that happened. OK. I explain away everything I'm seeing by this diagnosis. Oh, that's explained by the ADHD. That's ADHD acting out by the child, instead of thinking, gee, could there be any other explanation for the restlessness in class? Could there be any other explanation for the inattention?

Maybe they have ADHD, and they're quite bored. Maybe they have ADHD, and their jeans are uncomfortable. Maybe they have ADHD, and they're tired, but they're also just tired of sitting next to Johnny in the training or in the classroom. So we want to make sure we're not trying to explain everything away.

When I'm in a room with somebody and they're getting agitated and I'm thinking, well, that's just their diagnosis, I might not be thinking maybe they're having a normal human being in response to the approach I'm taking. Maybe what I'm seeing is not a symptom of their illness but a system of the iatrogenic harm that's coming from my approach. So when I brought in my lens and think in a whole health way, it's easier to have that happen.

So essence is talking very much about, what's the crisis state? What is really swamping, swarming the amygdala? And I don't have to know a whole lot of detail in order to be of use there. Evidence-based practices, like solution focused therapy, actually have that as sort of a [INAUDIBLE] of that work, that really you don't need to know much about a person in order to be of service. It's just the way you engage and create circumstances for the person to come up with the insights and figure out a path forward.
AUDIENCE: Kappy, may I share something?
KAPPY MADENWALD: Yes, please.
AUDIENCE: I had a family, and the little guy's on the spectrum. And he went into school and started doing a lot of self-harming. And right away, it's due to his diagnosis. But what it was truly dealing with was it was the year anniversary of his grandmother passing away. You know what I mean? It was like-- that brought him up. So you don't know. It's what you were just saying.
KAPPY MADENWALD: That's such a great example. Yeah, I can be a little guy that has autism. But I also can be just a little guy that's grieving and has a grandma that I missed. and I still have some of my normal brain functions that are reminded me of the anniversary. And it was this time last year. And maybe that's the conversation at home.
And it's astounding how those kind of narratives-- like, oh, there's nothing we can do about this because that's the autism, and this, that, no, we have a little boy who's fundamentally normal who is grieving and that that piece of him is doing exactly what we would expect it to do on a significant anniversary. It's a great example.
So we're going to do a little bit of an experiential exercise here to just really get a feel for essence of the crisis and also to understand how it is quite individual. It's quite a subjective experience. So get a little scrap of paper and just jot a couple of notes here just to my questions.
So imagine if you found yourself to be suddenly, completely, and totally homeless with no opportunity for immediate housing. You can't sleep on anybody's couch. You can't move in with anybody. You find yourself completely and totally homeless with no opportunity for immediate housing. What would the essence of the crisis be for you if you found yourself in that situation?
What would the essence of the crisis be for you if you found yourself suddenly, immediately, and totally homeless? And after you've had a chance to write it down, put some of those thoughts into chat. What would you be feeling? What would you be thinking?
The need for heat as winter descends. And let's look at the variety coming in. Hopeless, panic, unsafe, like I failed, terrified. Where will I sleep tonight? Abandoned, alone, embarrassed, grief. How did I get here? Crying, overwhelmed, regret. What did I do to get myself here? Despair, fear, hopeless, terrified. Who can I call?
Nervous, unsafe, panic. No sense of security. Fatigue, scared I might get hurt. I don't have supports in my life. Where will I sleep? It's over. Uncertainty, shame, worthlessness. Are they going to take my child away from me? What will happen? How do I get clean? Where will I shower?
I don't know how to navigate this system. I need to find a semi-safe place to sleep. What choices did I make that landed me in this lonely spot? Where is my next hot meal? What will happen to me on the streets? It's over. No one cares. How do I keep my son safe? Will they tow my car from here? I never thought I would be in this position. How did I let this happen?
So we have more than 50 people on the training here today, 60 people on the training here now. And this experience, even though the problem is the same for everybody, [INAUDIBLE], the essence of the crisis

is different. And that's subjective, and it's based on so many things, so many different factors that may be unique to you.
And so if I'm going to be of support to somebody in crisis-- powerlessness just came up as an option as well. If I'm going to be of help to somebody in crisis, then I really want to try to understand what is hierarchically most important to them? And if it's a hot shower, that's different than a hot meal. And that's different than how do I keep my kids safe. And that's different from overwhelming shame that's swamping and swarming my mind. And that's different from anxiety. And that's different from fearing being very cold. All of those things are different. But if we understand what is it that swamping and swarming the amygdala of that person, if we create a safe space so they can articulate that that has them most concerned, then we might be able to help them as they think through solutions for those things that concern them most-- my children, my car, my health care needs, my physical safety, any of those kind of elements.
Is it possible that even if the circumstances don't change, even if you are still homeless at this moment, is it possible that the crisis state can get some relief? And if so, how? How is it that the crisis state could get some relief even if you're still homeless? What can change that can impact the crisis state?
Finding some resources, resources. Getting a sense of hope. Identifying things that can be fixed so I get some amount of control. Understanding options. Trying to resume a feeling of optimism and determination. Having supports and having goals. What else can change that makes a difference? Reaching out to others who have gone through the same thing. Natural support. Short and long term goals. Yes. What else? What things in my head can change? What other things can I do that make a difference? Any other thoughts here?
Enduring the night day to day. I make it through one night, and then I feel more confident about the next night, yes. Feeling like you're gaining some power and control. Ah, understanding. Yes, for us, understanding what the crisis situation is for that person.
Kelsey, using some deep breaths. Positive self-talk. Building confidence that I can get through this. Validation of people's experience. Kirsten says, reframing my mind, purposefully moving into survival mode. Yeah. So certainly there are some crises that kids and families are in the circumstances are not going to change. They're permanent things that have occurred.
But sometimes we can get so overwhelmed with the bigness of the circumstances that we feel like we can't be helpful. Like, I can't find them a house. So I'm of no help. Instead of understanding that if we really can connect with the essence of the crisis and give them space to talk that out, that they really may be able to identify some next steps that make sense for them to take. Making short term goals, Robin says, yes.
OK, so let's do just a quick little scenario here to think about essence. We're going to talk briefly about the essence of the crisis for Louie and the essence of the crisis for Louie's parents. But here's the scenario. Eight-year-old Louie was transported by police officers from his school to the emergency department, and you're the one that's going to be doing this intervention.
So you call the school to get more information. And here's what the school says to you. Louie has been continuously disruptive. He's restless in his chair. He interrupts other children who are trying to focus on their work. And he has repeatedly left the room without permission. Today, he threatened another child with a ruler, holding it like a rifle and threatening to kill him.

Louie's mother, the school says, has been very difficult and defiant. She won't answer the phone when the school calls. She's missed several meetings. She's gotten verbally abusive with school staff at previous meetings. And the adjustment counselor thinks that Louie is subjected to similar verbal abuse at home and suspects that's why he acts out so much in school.
Louie's dad left when he was three years old. And the school thinks that also probably contributes to trouble at home. The school has asked repeatedly that Louie's mom take him for an evaluation for medication. They've warned her that he's at risk of suspension. And they believe that Louie needs a different school or therapeutic residential treatment and medication.
The school lets you know they filed neglect charges on Louie's mom for her failure to act in her son's best interest. And finally, the school says they've left a message for Louie's mom on her cell phone informing her that the police have taken Louie to the emergency department.
So question number one, do any of you know Louie? Are you familiar with this little guy? It's not an unfamiliar scenario, these sort of complex relationships between kids and schools and parents and these kind of preemptive actions in crisis situations. So this is not an unusual scenario certainly for kids that are linked to IHT an ICC type teams.
But let's focus in on the essence of the crisis and, to start with, trying to understand this from Louie's shoes. Eight years old, you're in the emergency department. A lot has happened over the last hour or two as you were removed from your classroom and the school principal sent you by police in a police car to the hospital. Maybe you were handcuffed. And now you're in the emergency department.
Using first person language-- this is just very useful. Any time you do an immersive exercise, think in first person. Talk in first person. I, I feel. Describe your feelings. What are you feeling? What are you thinking? How are you acting, eight-year-old Louie?
I feel scared and alone, abandoned. I'm a bad kid. I feel afraid. I am in trouble. Am I going to see my mom again? I am scared and mad. It's hard for me to trust others. Anybody's going to leave me. No one cares about me. I'm alone. I'm overwhelmed. I must be a very bad boy.
Where is my mom? I'm angry. I feel anxious and scared. I don't know anybody here. I want my mom. I don't understand. Am I being taken away for my mom? I don't have anyone to turn to that is safe. Hmm, Michelle says, I feel paid attention to and powerful. It's certainly possible that that could be what's happening to Louie.
I hate you. Get away from me. Maybe if I act out more, they'll take me home. Who cares? No one here cares. I need to act out. No one knows why I did those things. I'm terrified. I'm angry. No one understands or listens to me.
As you're standing in Louie's shoes, having been sent by the school via police to the emergency department, and there you are, how much is your limbic system reacting to what happened back in the classroom with the ruler rifle? And how much is your limbic system reacting to what's happened since then? In other words, how much are you thinking about what happened in the classroom right now? And you're not thinking it right now because of why? Because why? Especially for an eight-year-old.
This is a new situation now, as Rebecca says. A lot has happened since. On top of this initial event at the school, we've had these other big things happen to me-- what the school did, what the law enforcement officers did, how I'm experienced in this emergency department. And each of these things are kind of stacking up and supplanting that initial situation that happened at the school.

So if I go in to do my treatment with Louie and I start off by saying, tell me what happened when you pointed the ruler at the other child and you threatened to kill him, how well will that question register for you if you're Louie? And how safe will you feel telling me if you do remember it? Not too much, because the amygdala is swamped and swarmed with so much else since then.
And as Jenny says, I'm focused on what's happening and worried about what's going to happen next. That is what's first and foremost in my mind. And not every child is going to be overwhelmed and scared by these circumstances. But a lot of kids will be. And it'll be very difficult to think back to that other-- what was happening back then.
Josephine says, I hate hospitals. Why did they bring me here? These are scary places. I might even have a scary context, maybe a relative that went there, and it didn't go well. Or maybe because there are doctors there and doctors have shots, and I don't like shots. Or maybe it's all these other scary people that I'm seeing wheel by me, and I don't know who these staff are that keep popping into my room or why I have that security guard here or why I'm locked in.
There's just a whole lot that can be swamping and swarming that little amygdala for this child who is also a storyteller. And stories, his interpretation, that's entering his spinal cord, and his limbic system's reacting, and he's acting accordingly. Yeah, am I in a safe place?
So we want to understand a little bit of how Louie got here and try to imagine before we go in to meet with him the range of emotions and reactions he might be having so that we're really aware of and paying attention to those. So when I go in to meet with Louie, I can try to understand what is hierarchically most important to him. If it is am I under arrest, that's different from where's my mom. And that's different from what are these people going to do to me here.
And whatever it is that's happening for him, I want to get relief for that. I want to be able to de-escalate those fears, calm down his limbic system so that then we're able to kind of move up to more executive function sort of place. And I'm not going to get good information about what happened back at school until I've done something to calm down that limbic system overactivity that's going on right now.
Let's shift our attention to Louie's parent. And now imagine standing in the shoes of Louie's parent when you listen to the voicemail and learn that the school has sent your child to the hospital via police officers because he was homicidal. How are you thinking? What are you feeling as you enter the emergency department? What kind of thoughts, feelings? How do you look to others when you come into the emergency department?
Is my child safe? I am scared. Is my child OK? What else? Stand in parent shoes. Think about you're at work. This call comes in. I need to see my child. What can I do? I feel anxiety. I feel scared, ashamed, embarrassed, worried. I'm shaking and screaming, where is my child? I want to see my son. Is he safe? What is going on, and what happens next? I feel judged. They think I'm a bad mother. What was this like for you to leave work? I feel guilty, stressed, anxious. Yes, scared, angry, fearful. Angry about what? Angry about what? I did not authorize this. What have they done to my child? Why did they call the police?
I feel hurt, ashamed. I'm angry that I was not involved with this decision. I feel powerless. Get more specific about the anger. Angry what? Angry that my son might think he's in there because of me, ooh. Hoping I don't lose my job because I keep getting these calls from the school.
Angry at the school. Angry the school couldn't handle it. Angry that my child is in this position. Feeling I should be the first person to know anything and make decisions. I know my child the best. The school did

not have to call the police. Why didn't they call me so I could be there for him and go with him so that he's not alone?
Angry that my child had to go through this. Anyone a little angry with Louie? Anger that my child that did this. Jussara says, I'm angry at everybody involved. Angry and ashamed of myself. I didn't do my job as a mother. Angry with my child for not behaving in school. So let me ask you this. Of all this list of things I just read and you all put in chat, which of these reactions are appropriate?
Got a unanimous opinion here-- every single one of them. Every single one of these reactions are among the range of normal reactions in normal parents to their children's crisis, and we think about this kind of crisis. Every one of those reactions is normal, every single one of them. Kirsten says, no one can tell a parent how to react when their child's in crisis. And Kelsey adds, we are all validated to any feelings. That's the credible part. What you are feeling is real. Credible, capable, intuitive parent. This doesn't mean 100% forthcoming when I say credible. It means this place you are, these thoughts you are having, these feelings you are having, they are real. I'm not going to try to talk you out of them. I'm not going to try to shame you for having them. They're real. I'm just going to join you there. I'm going to join and get curious. So every one of these are normal.
If the emergency department staff, particularly if it's an emergency department staff that doesn't have some specialized staffing, if they see you coming in raging and screaming, how might they interpret it when they understand that you are Louie's mom coming into the emergency department? What are the narratives that can play themselves out?
Ah, here comes the unreasonable, unreasonable number-- or mother. Like mother, like child. That's where he gets it from. The hostile parent has arrived. No wonder Louie's unstable. Look at his mom. Look at her absence of emotional control. The apple doesn't fall far from the tree.
That's why the child behaves this way. She's a bad parent. Maybe we should just file. Can you feel how easy it is for that narrative to grow? And yet all of these reactions, we can anticipate them. We can anticipate them. We can even do some prep, go out to the triage desk, say to the security guards up at the front that are may be doing wanding as people come into the ED or whatever it might be, whoever's going to first greet the parent that comes in, be prepared.
Because we have a mom on our way here, and she is going to be really angry at some decisions her son's school's made. Or there's a chance she's going to be really angry, really scared, really concerned. And so when you see her, please let her know that we're waiting for her, and we will see her as soon as she gets here, so that the first contact the parent gets is somebody who is saying, yes, we've been expecting you. Yes, come on in. Yes, we're waiting.
Yes, what's most important to you right now? And maybe it's I need to get to Louie's side right away. And maybe it is I am so angry at the school, I just need to calm myself down before I even go into the room with him. And whatever place that is the parent's in, we want to be prepared to offer that, what's hierarchically most important to the parent right now that can calm the crisis state for the parent.
Periods of experiencing crisis state are normal. It's a normal component of the parenting experience and particularly when kids are in significant crises. Now is it possible that your crisis state-- you as Louie's mom, is it possible that your crisis state can get relief and resolution even if that doesn't happen to Louie, even if maybe there is something more serious going on with Louie? Is it possible that the team can work with you and relieve the crisis state for you?

I see Monica nodding. Yeah, absolutely. These are separate elements. You're in crisis state. Louie's in crisis state. But we can actively work to relieve the crisis state in Louie's parent even if Louie's crisis does not immediately resolve. And why is this so important? Because as Monica's crisis state relieves, since I saw you nodding, Monica, she's then now able to partner with me in what happens with Louie and becomes a really important asset to this team.

Yeah, and Michelle says it perfectly, which in turn may calm Louie. All of this co-regulation-- excellent, Monica-- this co-regulation, calming, calming, calming. We want to get as much of that as we possibly can. But we really want to start with a belief that this is, A, normal, that it's among these normal human stress response kind of reactions. We want to get to the essence of the crisis. We want to see it as they see it. I don't have to agree. I don't have to agree that your anger at the school is justified. I just have to see it and then try to understand some of the antidotes.

And some of the antidotes are really the basics. For Louie, think a drink of water. Think a snack. Think a stuffed animal. Think a warm blanket. Think some things to color with. Calming, soothing conversation. A cell phone call to his mom so that he can hear her voice. A reminder that she's coming soon.

A telephone for the parent to call back to work and give an update. Time for a parent to make arrangements for another child to get picked up from school or off the bus. Information. Anything that helps to calm and relieve. And we want to make sure, of course, that we're not compounding the crisis. If we did that, that would be iatrogenic. And so we deliberately engage the person, the credible, capable, intuitive person, child or parent. Get very curious about what matters.

When you were standing in parent shoes having that experience as you walked in, was that best described as crisis state that you were experiencing or character trait? Was that one of your parenting traits? Or was that crisis state that you're experiencing?

Yes, it's frantic crisis state. It's crisis state. And general rule of thumb, when you're seeing escalated behavior from somebody or resistant behavior from somebody or numb behavior from anybody or burned out behavior from anybody, make the assumption, tell the story that it is crisis state, not character trait. Because as soon as I tell a trait story, that is equivalent to a barrier story. And the barrier story is going to predispose us to take approaches that aren't going to be as effective. When I say crisis state, that brings up a dynamic feeling in my mind. That's a changeable, fixable thing. And so I'm more optimistic and will use approaches that are more likely to be relieving.

Many years ago, I was working in at a Children's Hospital that was-- as a consultant that was adding family partners to their clinical team. And even six months in, the family partners were having a very difficult time making any headway. The culture on this inpatient psychiatric program was absolutely toxic. It was just as negative as it could be-- pathologizing kids and terrible stories about parents and led by a child psychiatrist who was just quite vicious and cruel in her approach and led in this kind of dynamic of parent and child bashing in rounds, which I had the displeasure of sitting in a number of times.

No surprise, family partners not getting anywhere there. And when they talked in strength-based ways about families, they were just really ignored, sort of kumbaya ignored by the rest of the team. And so many months in, not much progress. I had a chance to sit with the charge nurse from that unit one day. And she happened to tell me that she had been a floating nurse at this particular renowned Children's Hospital. And as a floating nurse, she had actually worked on every one of the medical units in that hospital. And I said, oh, really? I'm curious. Did any of them do a particularly good job with parents?

And she said, oh, hands down, it's our oncology program. And I said, really? Tell me more. And she said, well, the oncology team knows that when parents bring their kids to the unit, they are terrified. And they are angry. And they are grieving. And they're wondering if they could have done anything to prevent it. And they are just incredibly self-absorbed by their own crisis state.

And she said the oncology team knows that as long as parents are in that self-absorbed crisis state, they're not going to be able to meet with the treatment team and make the kind of tough medical decisions they're going to have to make for their child, because it's very difficult to listen to all of those options when your brain is swamped and swarmed.

And she said the oncology team also knows that as long as parents are involved in that crisis state, they are not going to be able to learn the procedures for caring for their child at home, learning about the medications, learning about the medical equipment, learning what signs and symptoms to watch for, because it's really difficult to learn when you are self-absorbed by that crisis state.

But she said, first and foremost, what the oncology team knows is that while parents are self-absorbed in that crisis, they cannot be there for their child the way they want to be there for their child because it doesn't work to be sitting next to your child's bedside sobbing on the oncology unit. So from the minute the team meets the family, the team is actively working to support parent through that crisis state so that they can get up to a higher level of function, and they can be there for their child the way they want to be there for their child. It's an active purposeful role that they play.

And I was just amazed hearing it all. First, how similar the parent journey is, that it's a different condition, but the journey was remarkably similar. Of course, there are differences in how the community gathers around families when the crisis is cancer and their bake sales and lemonade stands and casserole deliveries and piles of cards from school, that some of that happens. And we know for our kids and families, there is often a kind of sucking sound as support systems pull away from families rather than gather around. So that can be different.

But a really significant difference is that the oncology team just works from the belief that they have capable parents who are experiencing crisis state. They tell a story of crisis state. They act accordingly. In our field, our risk is that we tell a story of character trait, and we act accordingly. Really, when it comes down to it, it's the same parents. It's just the belief set of the system that's different.

So I loved just the analogy of that. Kids with cancer come from a whole range of families as well. Some are parents that-- some are kids that are in single parent homes. Some are in homes where there's chaos in the home. And some are consistent parents, and some aren't consistent parents. Some kids have been abused that are on oncology units, and 51As have been filed.

They're all varying levels of economic status. All cultures are represented. So it's not like we get a particularly different set of parents. And the oncology team isn't saying, some of these parents we're going to do this for and work on this crisis state, and some we won't. So it's really the same group of parents.

It's so easy for us to say, ooh, the parent's the cause of this. It's hard to say that on an oncology unit. We're not quick to turn to the parent and say, ah, you're the reason your child had this. So it's a little tricky for us to get around that. But a really nice analogy because all these things are true for us, too.

Parents have big decisions to make for their kids. Parents have a lot to learn around medication and the illness and what it means and the things to look out for and the risks to pay attention to. There's a lot to learn as you're learning about this whole new illness. And of course, parents want to be there for their

kids. And so for all of those same reasons, when we pay attention to parent crisis state, obviously it benefits the parent. But it also has tremendous benefit for the child.

OK. We're onto the afternoon session. And we are back to these three core competencies, these initial three. And this part of the training is really about us, like individually the approaches that we can take to support kids and families in crisis.

So I mentioned earlier today when we started that these are not new concepts for you, many of you have been to these kind of trainings. And I also forewarned that I'd bring the game of golf into this somehow, because that's kind of how I think about these three competencies. I think of them a bit like the game of golf.

When it comes right down to it, golf is a pretty easy sport. There's a stick, and there's a ball, and there's a hole. And you use the stick to hit the ball, and you try to get it in the hole. It's pretty simple. But an incredibly difficult game to get really good at and an impossible game to perfect. No one has ever played a perfect game of golf.

The very best golfer in the world, I'll say Tiger Woods. You might care to differ. Has won some 80 tournaments, 80 or 85 tournaments. He's played thousands of them. So even the best golfer has only won 80 or so times.

Think of what you have to do to win a golf tournament. In a single hole, there are multiple components of the game. You have your shot from the tee. You have your fairway play. You have the short game. Maybe you have to pitch. You have to-- or chip in. You have to have a good putting game. You have to be good out of sand traps.

Every hole looks different, the way the grounds ungulate. Maybe you're playing on the short grass. Maybe you're in the rough. There's just so many parts of the game. And that's one hole. But you have to do that 18 times in a round. And if you're in a tournament, you have to do that four days in a row. That kind of sounds like IHT, don't you think? It's complicated. There are so many variables.

And you have so many phases of your work. We have that initial engagement. We have treatment planning. We have that course of care, safety planning, acute crisis response, how we work with families at the end during that point of Transition and how do I look at these three competencies and figure out how to apply them in all of the phases of the work?

And how do I figure out how to use these approaches not just with the child but also with the parent and maybe with the second parent and maybe with the grandma who's somehow involved? And how do I do them with all these other systems that happen to be involved in this child's life? So that's the complexity of the work.

On the surface these things can seem simple. In play, they are complex and never fully mastered. So as I talk about this today, I know you're not hearing it for the first time. I'm hoping to just offer you new ways of thinking about it that add more precision to your game, the same way Tiger Woods, even when he wins, looks at the video to see how he could have improved each of his shots along the way. So this is it. It's really about just adding more detail for you to bring more precision to the work.

And we're going to start with youth and family centered. And I'm going to talk about this two different ways. And the first is looking at this arrow. I told you that I work all across the country. I've worked with hundreds and hundreds of teams. And really, everywhere I go in the country when I work with kids' teams, they will often describe themselves as family centered programs. If you look at websites, agencies will describe themselves as family centered. It's really the-- or they might say family driven.

It's really the lexicon of the day. No one would say, we absolutely do not practice family centered work. It'd be like saying, nor are we culturally competent. I mean, it's just not language that agencies would use. But as I meet with teams and they talk about their work with kids and families, many times what they're describing is not really family centered care. I think of it as more like family nice care.

And by family nice care, I mean a kind of an approach of accommodation. We accommodate families. Maybe that's with evening appointments. Maybe that's by free parking or coffee in the lobby or letting you ask questions. It's an accommodation. But that's not the same as a family centered care orientation. Family nice care maintains the old traditional power structure where the treatment provider is hierarchically in power in the relationship. I know somebody talked about power earlier in the comment. In that traditional medical model structure, the expert is in charge, and they hierarchically hold the power. And the child family has diminished power in the relationship. And care is directed from the point of view of the treatment team.

And of course, the team can use expertise in doing that. But it's really coming solely from the point of view of that expert team. And the information that the child or parent brings to it is sort of diminished in importance. I care much more about what I, Kappy, think in my own mind than I care about, Viv, what you think as the parent, for example. And that can have varying degrees of do not interrupt me at all, or I'm listening but not because I think what you're saying has a whole lot of merit.

This is still how most care is delivered in the country, not just in the mental health field but also in health care in general. And some of us are quite culturally not just familiar with that approach but find comfort in that approach of just trusting a doctor implicitly, for example, or handing my child over to the team to do the work and that it's my job to step aside and let the treaters do the work.

And so some of us, speaking of narratives, really grew up with this kind of narrative about trusting a treatment provider, for example, or trusting a doctor. Others might have grown up with a very different narrative. A colleague that I work with says, my mother always said to me doctors practice medicine, and that means they are practicing on you. And don't you let your guard down for a minute, and always speak up for yourself.

Whereas my mom taught me not to talk back to authority, and authority included doctors. And I carried that narrative with me well into adulthood where I did not feel comfortable speaking up on my own behalf in a health care relationship. So that can either happen in a broader cultural kind of sense or family specific cultural beliefs that can be at play there.

So anyway, we've got this power differential in that traditional expert model, child and family in a diminished role. When we do family centered care, we have an equalization of power in the relationship. It is collaborative, and the treatment provider understands that they bring expertise to this but that the families bring essential expertise as well, that their knowledge of what's happening to themselves, to their child, the specific role of culture, the essence of the crisis for them, their own interpretation of the pros and cons, that all of that is essential and valuable, and that this collaboration gives the best chance of getting a good health care result.

As we said earlier today and a couple of times today, a lot of families have never truly had this experience. And so it's not always familiar. Some families will come in, and they will put themselves in this position because it's a comfortable place to be. Or because when they tried to collaborate before, they got their hand smacked by the doctor, and they were told to get in their place. So it will not be comfortable for everybody.

Sometimes when it's not comfortable and the family says, just show me, just tell me, just teach me, we say, gladly, and we assume this place instead. And that's going to cause trouble for us. This place, when we achieve this kind of collaborative equal power relationship with kids and with parents, this is a fabulous opportunity for both kids and parents to find their voice, find and learn to exercise their voice. This is a place where empowerment grows, where hope grows, where sense of agency grows. And kids really began-- and parents began to figure out how to really drive care on their own behalf.

And as they get better and better at doing that, clearer on what works and what doesn't work, then they're really positioned to move to this third sort of element, and that is family driven care. And now the family, child and/or parent, is really in this hierarchically higher seat. And they're far more able to be specific and explicit about what works and what doesn't and to build sort of the right family specific set of services and supports that are best useful to them.

There are a few families that come to this naturally. They are like my colleague, are kind of born to be drivers of their own health care. They have a lot of confidence in their ability to smell out the good stuff and leave the not good care behind. But the majority of families will not come to us in this place. And so family driven care is a skill that develops over time as they become more familiar and practiced in finding their voice and using it in health care.

So that's one way to think about this is just sort of these dynamics of hierarchical shift as we evolve to family centered orientation and then to family driven care orientation. But I'm going to show you another kind of analogy here as well.

OK. So this next analogy way of thinking about family centeredness builds off of some of the work of Don Berwick, who's a Massachusetts trained, Harvard trained physician who is one of the architects behind the Affordable Care Act. And we've heard a lot about the Affordable Care Act, Obamacare. The parts we tend to hear about are Medicaid expansion and the insurance marketplaces, and those are really important parts of the Affordable Care Act.

But there were a ton of elements in that act that had to do with physicians becoming more patient centered in their work and reducing iatrogenic harms and reducing service duplication and improving the care experience of patients and their families. There's just a tremendous amount of information there. And Don Berwick is really one of the brilliant minds behind much of that.

And what Don Berwick said is, if we're going to achieve the promise of health care transformation in the United States, then the experience of consumers and families and communities must serve as true north. You can't just take a group of experts and put them in the corner and have them design your crisis system and think it's going to work out well. You have to invite to the table and actively learn from and listen to people who have lived that experience who can describe what works and what doesn't work. That's what gives us a chance of getting the service right.

And Joyce Burland of NAMI, national NAMI fame says, "This means that the ordinal point for system quality is derived from the recipient's reality. This is our lived experience, our needs, our beliefs, our strengths, as well as our reactions to services extended on our behalf." My subjective view of my care experience matters.

This morning when you were contemplating getting a knee replacement surgery, imagine you actually followed through on that, and you got the knee replacement surgery. What matters most to you, the physician that says, I did that perfectly, that was a textbook knee replacement surgery, or you saying, I still have limited mobility, and I'm in pain? Whose opinion matters most?

The first is a measure of objective care. Objectively how did this procedure go? The second is a measure of care experience. And which one matters most if it's you, your opinion or the doctor's opinion? Rebecca says, my opinion matters most. My opinion matters most. Yes, how I feel about the service that was delivered on my behalf, that matters most.

Maybe you did a great knee replacement surgery. Maybe that wasn't the problem with my knee in the first place. Maybe you used the wrong procedure. I don't know. I'm not experiencing the kind of relief I should be getting from this. So that's care experience, and it matters a lot. And the more we build systems and align them with care experiences that people have, the less likely we're going to do approaches that harm, the more likely we're going to offer approaches that help.

This quote, to me, is the best description of what it feels like to receive person centered interventions. So I'm going to read this to you, and then I've got a question for you about it. This is a description of a care experience by somebody who's involved in a treatment program in Georgia. And he says about the treaters, "I wish everyone else could see me in the way that you see me. I don't even know how you see me, but whatever it is, I want to feel this way forever. I feel like how normal people must feel. But if it doesn't last forever, I'll remember this period in time that I was respected and heard and appreciated for the rest of my life."

Imagine being the parent. And imagine that I'm the treater. And imagine this is the way-- this quote is the way you see me seeing you. What becomes possible because this is the way you see me seeing you? Because you think, "I wish everyone else could see me in the way you see me. I don't even know how you see me, but whatever it is, I want to feel this way forever. I feel like how normal people must feel. But if it doesn't last forever, I'll remember this period in time that I was respected and heard and appreciated for the rest of my life."

What becomes possible because that's how you see me seeing you. And Kirsten says, anything. Anything becomes possible if this is the climate in the room. Alexander says, alliance becomes possible. Validation becomes possible. I feel empowered. Trust is being built. I feel like more than a number.

And what becomes possible because of that? What becomes possible because I feel empowered? I can achieve my goals. Why does it feel that way? Why does it feel like I can achieve my goals? I feel heard, confident. And I can succeed in anything. I know I'm not the condition. I know I am a person.

If you feel this way with me, what becomes possible? What will you do? I feel respected. I heal. I can bring more of what I brought to you to other people, too. I feel like I can make changes because I feel this way. I feel like I can make changes.

What else? What becomes possible because of this? Healing is possible. And why? What will I do here? What will I do in these interactions because I feel this way? Michelle says, I feel like I'm a whole, not just a sum of my parts. Self-belief, feeling motivated, feeling I have purpose. I see the best of me because of this.

Agency, I feel agency. It's such a good word. I feel agency. I've grabbed ahold. I have dug in. I've got this. I have agency. I can create change in my life. I'm motivated. I'm excited. I feel empowered. And what am I willing to do in sessions that I might not have otherwise? I can be honest. Become more attuned to myself and others. I trust. I can open up.

And let me ask you this question a different way. Because this is how you see me seeing you, what do you not have to waste time doing? Hiding, impressing. What else? Pretending, lying, self-doubt. I don't have to waste time wondering what you think of me. I do not have to convince you that I am worthy.

I do not have to waste time having a wall up. I don't have to waste time wondering if you are judging me. I don't have to waste time and self-sabotage. I don't have to waste time justifying. What else do you not have to waste time doing? Figuring out what you want to hear.
What else? Being somebody I'm not. I don't have to waste time hiding my inner feelings. I don't have to waste time figuring out how to get out of this service. I don't have to waste time being defensive. I don't have to waste time wondering what your motives are. Wow. That is a good one.
Because that gets right to trust, doesn't it, Josephine? I don't have to waste time wondering whether I can trust you or trust this. And I'm curious. You work-- oh, more time can be spent addressing what my needs are. Yes. You work with some families who have gotten treatment services for a long time. They've been involved with-- often, many of them have been involved with a lot of different systems. They've had a lot of previous care experiences.
And I'm curious. As you think about some of the conversations you've had with families, what percent of time have they had to waste in the past wondering about what the agency's motives are, being defensive, trying to figure out how to get out of services, hiding their inner feelings, being somebody that they aren't, figuring out what the treater wanted to hear, justifying, self-sabotaging, feeling judged, putting walls up, convincing you of their worth, wondering about what you think of them, self-doubt, lying, pretending, impressing, hiding? What percent of time have families had to spend doing those things?
And if you can express that in a percentage-- I know it's a little tricky-- what percent of time would you say? Most of it, too much. 75% of the time. What would other people say if we talk to families and said, what percent of time are you spending in those kind of tasks? 905? 75% to 80%?
Yeah, don't have to waste time pleasing you. Yes, 80% of the time. Wow. So we've get some consensus building here that families are wasting 75% to 90% of their time historically in these kind of activities. And it's not quite a waste of time because, of course, all of these things that you describe are self-protective. And in that sense, they're necessary because what's entering the brain stem for the family is, this isn't safe. I've got to protect against this. This isn't comfortable. My amygdala is sort of swamped with that. This makes me feel like a shitty parent. My amygdala's swamped with that. So it's not necessarily-- it's time that has to be spent. It's just not time that's spent making things better.
It's just families spending time trying to hold the ground, trying to not get worse, trying to protect against harm. But wow is it inefficient. This is asking families to get better by paddling upstream in the river that has rapids. And yes, they might-- yes, they might make progress. But it is exhausting. And for all the effort you're putting in, you're just not making much ground.
When we can accomplish this quote here, when you felt that way, how quickly-- how quickly did you feel seen? How quickly did you feel heard? How quickly did you feel safe when you felt this way about how you thought I saw you? And how quickly did you feel that way?
I felt validated. I felt heard, seen, listened to. That feeling happens right away when we create this kind of psychologically safe treatment space, which means healing can begin right away. Trusting can begin right away. Opening up can begin right away. Feeling motivated, feeling capable, all those things can happen right away. And now we're going with the current rather than trying to paddle upstream in the current.
Using this true north analogy, the parent or the youth, whoever it is that's the focus of your attention, they're in the true north spot. It's easier when I'm standing in front of you. I have my arm all the way up in the air, true north. That's where they are. But I, Kappy, don't see the world the same way they see it. I see it from my Kappy view. My Kappy view, comfortably my arms at my side, it's about as opposite from the

family as it can be, just to illustrate how different my Kappy worldview is from anybody that I'm working with.
But boy is it comfortable to have my arm at my side, talking about it from my point of view. It's less comfortable to put my point of view aside and come up here, reorient my work up here so I'm joining the family where they are, joining the parent where they are, joining the child where they are.
So on our little screen here, I'll do it this way instead. Here's true north. Family's in the true north spot. But I naturally come at it from my point of view down here. That's the traditional medical model kind of approach. So I have to step out of that point of view, come up here and see it the way you see it instead. And we start here. I don't have to agree with your point of view, but I see it. This is the epitome of join them where they're at.
Join them where they're at. It was never a great grammatical sentence. But it's the one we've all heard, right? Join them where they're at. So I come up here, and we move from there. Essence of the crisis for me if I find myself homeless, what to do about my kids, join them up here. I feel shame about this. Join them up here. Whatever it is that's fundamentally most important, I go here. We start here.
Why? Because people change from where they are. You are where you are, and you move and evolve from where you are. So I can't say to Helen, Helen, meet me halfway. No, Helen is exactly where she is. So for me to do precise work, I go there. I go there. This is my surgeon's scalpel. I go right here precisely and join in. Credible, capable, intuitive Helen who's able to collaborate feels this way. I go there.
And it does take my ability to do some of this kind of manual feeding, if I've got any kind of deficit story at play, so that I'm really willing to view any concern that the person raises as credible and to see them as fundamentally capable of sorting some of this out and having the intuition and trusting their gut and letting that be a guide for us, a barometer of how this is going. And it takes into consideration beliefs and culture and preferences, interpretation of experience.
But it's easier said than done if you haven't been in the habit of doing it because it's such a shift in perspective. Because I'm not coming at it from my provider point of view and particularly within the context of crisis, when I think this is a significant crisis situation, but the family thinks, no, it's not. It feels really complicated or strange or uncomfortable to begin with the parent point of view instead, and yet that's exactly what I want to do here if I'm doing person centered care.
So here's the family in the true north position. I'm not naturally there is the treater. So I have to stand out-- step out of my own point of view, come up here, and see it the way they see it. You should see the analogy, of course, with wraparound principles of care here. It's more complicated than this with kids and families because families don't fit into one little happy true north bubble.
So of course, we really have child in their true north. I join there. Parent and their true north, I joined there. Maybe there's a second parent and their true north, and I join there. So there may be multiple perspectives. And my goal is to see each of the sides without taking any of the sides. There's no sides taken here.
I'm not sitting back and judging who's most credible in the group, whose perspective is the valid one, who's right and who's wrong in the situation. There's no wrong. It's all credible. It's all where they actually are. And so I'm joining there. I'm seeing the sides but not taking the sides.
In kid's world, it gets more complicated because some of these other system players that are involved. So in this case, we have a school administrator, like in the situation with Louie. So maybe things have

stabilized with Louie and Louie's parents at the hospital. But we still have a school administration that thinks it would be dangerous for Louie to be back in school.
So my first step is to engage credible, capable, intuitive school administrators, listen deeply to what they have to say, get curious with them until that way they think and talk about Louie and Louie's parent begins to shift. And now we can collaboratively come up here and join with the family.
And you know how this looks in care planning meetings when you have multiple systems represented. You know the difference when you're in a room and you have all these different players, and they're holding their own ground, holding tightly to their stance. Well, I believe this is the problem. No, I believe that is the problem. That's the example of a lot of people stuck down in that expert way of thinking.
And you know what happens when you get all of the group seeing it the way the family's seeing it, understanding it from their perspective, and how this just creates a really dynamic useful change process when we all orient ourselves to parent point of view, child point of view and guide the process from there.
OK. So we are going to do a little bit of a role play on this just to demonstrate. I want to show the difference between care when it's delivered from down here and care when it is delivered from up here. And to do this exercise, I'm looking for a volunteer who's willing to do some back and forth with me. It's a pretty easy role play.
I'll ask you to play the role of the parent whose child is in crisis. But I'll have really specific questions to guide it. And then we'll ask everybody else in the group to participate as well. So is there anyone willing to volunteer to do a little back and forth with me for this exercise?
AUDIENCE: I will.
KAPPY MADENWALD: Thank you, Stephanie.
AUDIENCE: No problem.
KAPPY MADENWALD: We are going to make sure everyone can see your video, and this will probably be recorded. So we can see you. Just kind of warning so that everyone can see you since we're videoing it. But thank you very much, Stephanie. So in this scenario, Stephanie's the parent, and I'm evaluating her son or daughter. Do you have a preference?
AUDIENCE: Daughter.
KAPPY MADENWALD: Daughter. So I'm evaluating her daughter. And I have finished my crisis evaluation. And what's clear to me is that the only thing that can happen today is that Stephanie's daughter must be admitted to a psychiatric hospital immediately. It is crystal clear to me that is the only choice. So I go back in the room with Stephanie to tell her the results. And I say, Stephanie, I finished evaluating your daughter. It is essential your daughter get admitted to a psychiatric hospital immediately.
And here's a question for the big group. If Stephanie's response is absolutely not, no way, over my dead body are you putting my daughter in the hospital, and-- and please play along with this-- I am coming at it from way down here from this expert point of view, then what will I necessarily think of Stephanie when she says, absolutely not, no way? If I deeply believe hospitalization is essential and Stephanie says, absolutely not, and I'm coming at it from this pure medical model point of view, then what will I necessarily think about Stephanie?
I will think she is difficult, doesn't care about her child, does not understand what is needed. She doesn't care about the safety of her daughter. She does not want the best treatment for her daughter, that she is medically neglectful, unreasonable, incapable, doesn't know how to take care of her daughter properly.

And does it make sense, if I'm coming at it from this point of view, that that's the instant narrative that would form for me? Can we all see how quickly and instantly that narrative forms when I'm coming at it from down here? Because even if this is not the narrative that you would tell, that you wouldn't get yourself stuck in this situation, we watch this happen all around us to others around the family's sphere of influence that find themselves quickly telling that sort of story.
She's a parent who is unable to reason, doesn't understand the safety concerns, is not following through with recommendations. She's clearly a neglectful mom. And when that's the story that quickly forms in my brain, what am I predisposed to do next? Still from this pure medical model, what am I likely to do when that story forms in my mind about Stephanie? What's my next move as the treater?
AUDIENCE: Jessica suggested a 51A.
KAPPY MADENWALD: Ah. So I'm going to start upping the ante a little bit, right? You don't understand, Stephanie. Your daughter is getting admitted today.
AUDIENCE: No, she's not.
KAPPY MADENWALD: You can do that voluntarily, or I'll file a 51A, or I'll move forward with the Section 12. The choice is yours.
AUDIENCE: No, that's not really a choice.
KAPPY MADENWALD: It's the non-choice choice. The first time I said it to you nicely, this time not so nice. And, Stephanie, I'm curious. If you deeply believe your daughter should not be hospitalized-- and now I've come in even more threateningly, you need to do it or else, what kind of thoughts and feelings-- what's your initial body reaction to that if you deeply believe your daughter should not be hospitalized?
AUDIENCE: Initially, I--
KAPPY MADENWALD: And talk first person. I am. First person, real time. I am.
AUDIENCE: I would say, OK, well, then you're going to have to contact my lawyer or come back to my house with a warrant and the cops.
KAPPY MADENWALD: And talk about your emotions.
AUDIENCE: Anger.
KAPPY MADENWALD: What else? I am angry. I what?
AUDIENCE: Scared. Frustrated. Disrespected.
KAPPY MADENWALD: Would I know you were feeling angry and disrespected?
AUDIENCE: More likely than not, because mama bear going to get angry and she going to get verbal.
KAPPY MADENWALD: Ah, ah, mama bear is coming out. And that's going to look like what? Like you're in your greatest mama bear moment. What's that going to look like?
AUDIENCE: Yelling, profanity, probably a few threats coming back at you.
KAPPY MADENWALD: And would you be sitting, standing, moving about?
AUDIENCE: It depends. If we were on Zoom, I probably would have closed the computer.
KAPPY MADENWALD: Oh, no, let's pretend we're in person.
AUDIENCE: In person, standing, arms crossed across my chest.
KAPPY MADENWALD: And so, group, here I am down here. I told her once nicely that her daughter would be hospitalized. I let her know that it was going to happen. And Stephanie is now yelling. She's using profane language. She's threatening to me. She's out of her chair. Her arms are crossed. How am I experiencing this now, me as treater? How am I interpreting what's happening now? Same thing, I'm coming at it from purely down here.

AUDIENCE: Aggressive and assaultive.
KAPPY MADENWALD: Yes, oh, I've got an aggressive, assaultive parent.
AUDIENCE: Who's uncooperative.
KAPPY MADENWALD: Who is uncooperative, and I need security. She is now a personal threat to me. I have a parent decompensating before my very eyes. And I'm starting the rest of my narrative. No wonder. No wonder her daughter is in crisis. I would be in crisis, too, if I were living with this mom, who has no insight and no awareness of her daughter's needs. Even if her daughter is stabilizing now in the next room now that I've got them a part, I'm not sure I'd be comfortable sending the daughter homeless Stephanie today, not with this kind of instability.
Now I understand I'm exaggerating this a little bit, but not that much. Imagination runs wild. Because when I'm operating from down here, I am deeply believing all of these interpretations. The story that I'm developing about Stephanie feels very factual to me. If I call in a 51A day for medical neglect, these are the facts I'm going to be using-- a parent who is clearly unaware and unable to protect a child who's at very high risk. And so I'm going to act accordingly.
If, on the other hand, when Stephanie first gets angry, stands up, crosses her arms, and starts swearing at me, if, on the other hand, I let that be the cue to me, uh-oh, I got myself out of alignment, I'm clearly coming at this from an expert point of view, I need to get myself up here in a true north orientation, I'll probably start with an apology.
Stephanie, I am terribly sorry. I got ahead of myself. Obviously, you've heard my recommendation that your daughter be hospitalized today. And it's clear to me that you feel very differently. And I'd like to hear your point of view. And then you might find yourself wanting to be very explicit about this so it's clear that I'm setting aside my opinion so that I can hear your opinion.
I come up here and I say, say more, Stephanie. What are the good reasons to not hospitalize your daughter? What are your good-- you got some good valuable information here. So say more about that. Why is it a good idea to not hospitalize your daughter? And you might say what, Stephanie?
AUDIENCE: Things like I've got really strong community and family support. I've got support from my church. But if she's hospitalized, all that support disappears. I can't afford it if she goes into the hospital. So maybe in-home therapy would be a better option.
KAPPY MADENWALD: And why else? What are the other good reasons to not hospitalize your daughter, Stephanie?
AUDIENCE: Because I can't be part of the treatment team.
KAPPY MADENWALD: And everyone playing at home, stand in Stephanie's shoes for a minute. Imagine being in her mom's shoes. What are the good reasons to not hospitalize your daughter? Put some notes into chat. And any other thoughts you're having, Stephanie. What are the good reasons to not hospitalize your daughter today?
AUDIENCE: It would be really hard for a child, even if it's a devastating environment, to be separated from their parents.
KAPPY MADENWALD: So hard for my child to be separate from me.
AUDIENCE: Yeah. Oh, yeah. That's a good point. Kate points out that she might not be discharged by the holidays.
KAPPY MADENWALD: Oh, yes. Holidays coming. She will learn new behaviors from other kids. The last time she was hospitalized, she came back with more problems. She's never been away from home

before. I don't think that-- view of what's happening is different from your view. There must be other options to try first.
I want to know my other options first because I can't guarantee her safety when she's in the hospital. She's just doing this for attention. It's not a big concern. She's not in any danger at home. I don't want my daughter to be out of my home and alone. It's not helpful to have her in the hospital. I fear of the unknown of her being in the hospital.
So these reasons-- we have strong community, family, and church supports if she's home. She can't get those same supports if she's in the community. I can't afford having her there. I can't be a part of the treatment team if she's there. It's hard for her to be separated from me.
Are those examples of a neglectful mom? Are those examples of a parent with poor judgment? Are those examples of a parent who is unconcerned with her child's safety or unaware of safety concerns? Of course not. Those are examples of? Those are examples of Stephanie as what?
AUDIENCE: Concerned mom.
KAPPY MADENWALD: Yeah, concerned, rational, caring, confident. She's all of those things. And I'm not thinking of filing a 51A anymore at all because I've got a caring, concerned, confident, thoughtful parent who did identify some things that I did not. And what is it that she identified? What is that pile of things that she and all of you in the chat-- what are the things that she identified that I did not?
Yes, absolutely some protective factors. And what else? I thought of all of the good reasons for her to be hospitalized, and she identified-- I think it was Monica that noted it earlier. Yes, the good reasons to be home. Yes, yes, yes, yes. She identified-- where's Monica's text up here? She identified the iatrogenic risks specific to her daughter. She identified the iatrogenic harm that could occur should her daughter get hospitalized.
And do you notice I did not? In my rush to get her there-- it's essential that she gets hospitalized today. She meets all of the criteria. The risk factors are there. I didn't stop to think, will she actually get a good care experience? And will she experience any iatrogenic harms? But Stephanie, who knows her daughter, was able to bring those in. It is hard to spell, Michelle, but you're getting there. You're getting there.
Now this is not the end of the process. And sometimes I think where teams can get it wrong on family centered care is we can confuse it with order fulfillment like we went to McDonald's. Stephanie ordered a burger. So she gets the burger. Stephanie says no to hospital. And so that's it. It's done. Child's going home with Stephanie.
But this is not the end. This is the start of a shared decision-making conversation. So I've come up here. I've joined with Stephanie where she is. And where Stephanie is is this stance of absolutely not. So I step out of my point of view. I come up here. I say, say more. Say more. What are your thoughts on this? What are the good reasons to not hospitalize her?
And Stephanie shares all of that. And I give her a chance to do that until she's had a chance to really kind of catch her breath. And I can tell she's been able to articulate this set of emotions perhaps that has just sort of swamped and swarmed her amygdala when I said she's getting hospitalized. She's got this set of emotions. She can talk it out. Some of these things she may be saying out loud for the first time. Maybe they've had enough hospital experience that it's easy for her to say it. But maybe she's thinking about it for the first time.

And after she's had a chance to do that, then I can come in with the next question. Stephanie, all of those reasons that you just identified are really important. And I had not thought of any of those. I'm very glad that you brought all of them up. You clearly know your daughter well and have a good set of resources. I'm curious. Even given all of those good reasons and all of the resources that you have at home, are there any circumstances in which you yourself would agree to hospitalize your daughter? And you might say what, Stephanie?
AUDIENCE: I don't know.
KAPPY MADENWALD: Are there any circumstances in which you would consider hospitalizing her?
AUDIENCE: If she was suicidal or homicidal.
KAPPY MADENWALD: Mm-hmm. So if you had-- any other thoughts on that?
AUDIENCE: Not really. Sorry.
KAPPY MADENWALD: No, that's OK. I understand i it's a complicated role play. But already you've given-- you've given some exceptions. Yes, I would consider doing that if she were suicidal or homicidal. And I didn't give you very much detail about the scenario for the role play, so just play along here with this.
I'm curious, Stephanie. When you think about what's been happening in the last couple of days, on a scale of 1, meaning no concerns at all, to 10, it's really reached the point where you think she is enough of a risk of harm to herself that you would consider hospitalization, where would you say she is today?
AUDIENCE: A seven.
KAPPY MADENWALD: A seven. And I'm curious, what's the highest she's ever been on that scale?
AUDIENCE: Nine.
KAPPY MADENWALD: So this doesn't seem as bad to you as it's been before. Now if you can, Stephanie, separate from the role play, can you-- can you describe what the experience was like in your brain to be asked that exception question? Even given all your good reasons, are there circumstances in which you would? What did that kind of force your mind to do when I asked that question?
AUDIENCE: Look at the extremes and then consider the option of hospitalization as a reality instead of just saying absolutely not, this can't happen.
KAPPY MADENWALD: And what was it like to get the scaling question? On a scale of 1 to 10, what was the task in your brain for that?
AUDIENCE: That was a little bit harder just because you're always asked those scale questions. And if it's a pain threshold, if you're above a six, they give you pain meds. So if that's what you're looking for, then that's what you're going to go with. And so it's always tough to gauge those.
KAPPY MADENWALD: It felt a little loaded.
AUDIENCE: Yeah.
KAPPY MADENWALD: And how about when I said, what's the highest it's ever been? So now you're comparing worse and current. What was the task for you and your brain?
AUDIENCE: That kind of made it seem like the current experience is not as bad as it has been. And so maybe this is manageable.
KAPPY MADENWALD: OK. Now where is the hard work happening with these questions, my brain or Stephanie's brain? Yeah, Stephanie's brain. Is that clear to everybody? The thinking, the introspection, the sorting it out. And even in this kind of artificial example here, this role play here, Stephanie's saying, it had me put hospital out on the table in a different kind of way. It had me compare current and worst. It

had me kind consider all of these elements. And that's all happening in her brain. It's beginning to sort itself out. How is it feeling-- as I've changed and come up here, Stephanie, what's the relationship feeling like with me from up here?
AUDIENCE: There is a lot more trust. I feel a little bit of control, as opposed to I'm taking your daughter away from you and putting her in the hospital. It's like there's no control there at all.
KAPPY MADENWALD: Yes, yes. And so now-- and especially now that I've asked you a couple of questions, really heard your point of view, now I may be able to bring in some of my expertise and what I've gleaned in the interview as well.
Stephanie, when I met with your daughter, here were the things that had me most concerned with a recommendation for hospitalization-- the amount of time she's spending thinking about ways to kill herself, for example. Or I was concerned about the way she answered the scaling question because her answer was 9.5, which seemed-- and she said that for her that was the highest or whatever. So I just bring in a little bit more information. And how does it feel to get some of that info? I'm asking you that outside of the world play just for you, Stephanie. What's it like to bring in that kind of new info?
AUDIENCE: It'd be a little eye opening. Because if the parent thinks that the situation is like a seven or an eight, and the child is thinking it's almost a 10, then there's some discussion that needs to happen there because it's really the child's perception of the events that are completely uncontrollable, not Mom's perception of, well, we can get through this.
KAPPY MADENWALD: And so I'm kind of going back into the role play. Collectively, we can see that there are some real concerns today that you've identified, that she's identified. You've also identified some resources in the community. I'm curious. Are there alternatives to hospitalization, given these circumstances, that feel like they would be sufficiently safe to you and acceptable to me and to your daughter as you actually think of pulling something together in lieu of hospitalization? Do you feel like there's an alternative that's worth considering instead of hospitalization?
AUDIENCE: PHPI OK?
KAPPY MADENWALD: So the idea of partial instead of inpatient treatment as an option today. And again, what's that task like in your own mind as you imagine that service versus inpatient? Like, what's the task for you? As parent, what are you weighing?
AUDIENCE: Like, how often I would be able to see her versus how much actual care she'd be given and then like the level of the care that she's given, whether it's psychiatric or therapist.
KAPPY MADENWALD: So it can feel like there's all this activity that's happening in the parent mind. Whether or not it gets spoken, there's a lot that's occurring in there of sorting it out. And, Stephanie, over the course of this whole conversation, have you felt yourself shifting at all in your thinking about psychiatric hospitalization for your daughter?
AUDIENCE: Mm-hmm.
KAPPY MADENWALD: What's shifting?
AUDIENCE: It's kind of stepping up to maybe this is something that she needs as opposed to me thinking that it's the absolute worst thing that could possibly happen.
KAPPY MADENWALD: And so kind of along that point, Stephanie, I'm curious. If you were to decide to admit your daughter into psychiatric hospital, can you think-- is there anything that could be useful to you in making that consideration? Or are there any thoughts you have about how you could get the best

benefit-- how your daughter could get the best benefit from it and minimize the kind of concerns that you've raised?
AUDIENCE: If the church could be part of her treatment and if the family could go in, too, and be part of the treatment.
KAPPY MADENWALD: So your active participation and the church's participation is really an essential part of this for you and for her.
AUDIENCE: Absolutely.
KAPPY MADENWALD: Yeah. Now let's just say we got to this point. And maybe Stephanie really doesn't want to pursue it. But I, as treater, I do still at the end of the day have the right to move forward because the law permits that in Massachusetts to recommend moving forward anyway. And let's just-- and hopefully we have a consensus decision at this point.
But just in case we don't. And that's really our goal. We're looking for consensus, Stephanie, Stephanie's daughter, and me. So we're talking this out with Stephanie. Of course, at some point, we're going to bring Stephanie's daughter into the mix. All of us get on the same page, a consensus plan. But let's say we don't really get there. And I just can feel clinically, as much as I understand that Stephanie is opposed, that there just is not a safe enough alternative to that.
And I say that to Stephanie. I'm listening to everything you have to say, Stephanie, and it's just my sense based on my professional experience that there isn't a safe enough alternative to hospitalization, including partial hospitalization. I really do think you need to hospitalize your daughter today. I really think that's essential that that happens today. What's that experience feel like at this point compared to me pursuing hospitalization for her from down there? Is there a difference? Is it worth all of this discussion if the end is still hospitalization?
AUDIENCE: I think so because you allowed me to have a say. And then we talked about it. You brought in the child's perspective as well. And then yeah, so now I'm thinking, well, what clothes should I pack for her to take?
KAPPY MADENWALD: Isn't this fascinating? Here that. That is absolutely fascinating. Keep going. Is there anything else happening in your brain?
AUDIENCE: Like, who do I need to contact at the church that could be in contact with her at the hospital, how far the hospital is away. How we can get there and still get to work.
KAPPY MADENWALD: Here we are doing a role play. That is activation. That's parental activation. Do you all know what I'm talking about? I'm using an approach that has assisted in activating the parent. And look at all this change process that's happening. She still doesn't love the idea that her daughter is getting hospitalized. But look at this. Planning is in place.
Now what's the experience like-- where are we going to get the better health outcome, if she was hospitalized from down here or if she's hospitalized from up here? There's no contest, right? This gives us the best chance. Imagine the hospital team greeting Stephanie when I hospitalized the daughter and Stephanie's kicking and screaming and opposed to it. And that's how the hospital team see Stephanie for the first time.
And how different it is when we've done this up here and Stephanie is actively thinking about how to make this most comfortable, how to get the team around her daughter that's going to be most essential. And how is that hospital going to view Stephanie for the first time when they meet her? Because what's happened to your crisis state throughout all this, Stephanie?

AUDIENCE: Initially, I probably would have had to been hospitalized as well. But now it's more of let's take care of the daughter focus as opposed to you're going to have to call the cops.
KAPPY MADENWALD: And what part of your brain is most active now?
AUDIENCE: Prefrontal cortex.
KAPPY MADENWALD: So can everyone feel that? And notice the only thing that's changed is my orientation to care. From down here, I activated the limbic system, created iatrogenic harm. Up here, this was parental activation. This is resolution focused parental activation. And we can just feel the shift in Stephanie as we've done that. Yeah, Viv, you have a question?
AUDIENCE: Yeah. I think-- I don't know what other people's experiences are. I often find myself in the reverse experience of like a kid is meeting higher level of care and can't access it because not enough beds, not-- the issue's not big enough. And I think that often is like the frustration we're sitting in is like the family is feeling like the kid needs to.
But then what's happening from top down is like, what else could the parent be doing to keep the kid safe at home? And we're like, this is not a situation about how much more a parent or parents or caregiver can do it. It's more the question of this kid needs higher level of care, and that's a conversation we're willing to have. But the idea that we maintain a kid who's presenting in this way creates a lot of concerns for us. So it's similar to what you are experiencing. But it's like you flip it.
KAPPY MADENWALD: It is a flip. And so the approach is kind of the same. It's a little-- it's a little bit tricky when you have like maybe an insurance company. You've got all these sort of players. But I'm really wanted to take kind of the same approach, which is to join whoever that person is that's got the stance where they are.
So let's say, for example, Stephanie was saying, my kid needs to be hospitalized today. And I'm saying, yeah, she just doesn't meet the criteria, Stephanie. I'm sorry. You're going to have to take her home. And then Stephanie might be yelling and angry and refusing to take her child home.
So same scenario. It still can feel counterintuitive just to put my belief aside and to come up and say to Stephanie, say more. What is it-- what's your thinking? Why is it essential to hospitalize your child? What are the reasons for doing that? What do you think I'm missing? What part of this do you think I don't understand?
And notice how important it is that I have loaded my brain with the belief that Stephanie is credible, capable, intuitive. And I'm asking the questions with that kind of perception of her. Because if I already think she's a bad mom, then that comes across like, well, what do you think I don't understand? Or what are the good reasons? And that's not going to work.
But if I'm saying credible, capable, intuitive, that's my mindset. To me, it doesn't look like he meets the criteria, Stephanie. What is it you think I'm-- what do you think I'm missing? Is there something here I'm not understanding? Now I'm inviting the parent into that conversation.
And notice that if at first I say absolutely not, doesn't meet the criteria, that will create in Stephanie a limbic system reaction. And it'll be very difficult for her to articulate the reasons why. So I'm going to say, no, she's just trying to dump her kid. Hospital's not for respite, that kind of thing.
Maybe she'll say, I can't take it anymore. Well, it's not my job. It's not our job to parent your kid, all those stereotypic kind of reactions. But if instead I listen to her deeply, and I say, as I evaluated him, it doesn't appear he meets the criteria. It's clear you have a different view on this, Stephanie. What is it that I'm not understanding? Say more about that.

Now, same thing. She has the chance to feel seen and heard and articulate that from this higher executive function place. And maybe she says five or six different things. And say more, say more, tell me more. And I can still come in with an exception question. I'm curious. Even given all those good reasons to hospitalize, is there anything about it that gives you pause?
Or I'm curious. How do you think she'll experience it? So maybe the parent's bringing up the good reasons and not seeing the iatrogenic risks, for example. So when I ask those questions, is there anything about it that gives you pause or how do you think your daughter would experience it, that helps to open up and broaden the conversation as well.
So in any of those situations, I'm trying to kind of accomplish those piece of it-- those pieces of it. And it gets a little bit trickier. So maybe I'm having this conversation with the MCI team that saying, no, doesn't meet criteria. Say more. Say more, MCI team. what part of this feels hardest to defend or hardest to justify? What part of that, capable, credible MCI team? So that we are creating not a power struggle between us and them, but a collective shared understanding to see if we can move this through further. Does that makes sense?
AUDIENCE: Mm-hmm.
KAPPY MADENWALD: So what I'm doing in those situations, Viv, is I'm really-- when I hear an opposing point of view, step one is to try to control my limbic system reaction to that. Because as soon as my amygdala gets activated, then I am not going to come across the way I want to come across to whoever it is that's standing in the way of this. And one of the ways I do that is to, again, remind myself a credible, capable, intuitive person has a different opinion on this. Get curious. And it keeps me out of the power struggle.
AUDIENCE: Yeah, and I find that to be the harder of the conversations. I feel like when a parent's reluctant, it's like you know that there's underlying care and intention behind it. And I think when you're dealing with systems you're just like, I mean, what else would you need to see for this kid for you to see that this youth needs more services than this parent or caregiver can provide?
KAPPY MADENWALD: Yeah.
AUDIENCE: And sometimes it's hard to like-- after like a six hour day of crises, then managing, getting them to a place where they finally are willing to be evaluated and they're like, she might've cut her arm to her bone, but she can go home today. And you're like, oh.
KAPPY MADENWALD: Yeah.
AUDIENCE: And then it's the professional experts leading us to a parent who was already reluctant to be like I don't want my kid to go.
KAPPY MADENWALD: And this is where some of the outside system of care work becomes so important as well, that we get habits and patterns that form, let's say, between IHT teams and MCI teams and have to have some mechanisms to go up the channel, to have offline conversations, to talk about the trends and patterns, to improve the way that we're collaborating together.
And sometimes that won't work well in the event of a specific crisis. But that if we have some of those offline kind of relationships, we've got just mechanisms and loops to go back and say, hey, you know what? This one didn't go as well as, and how can we improve the way we collaborate in these kind of crisis events? I really appreciate you asking that question.
OK, so these next couple of slides are just really descriptors of that exercise. Stephanie, that was phenomenal. Thank you very much. Very well done. During that exercise, I can understand and

appreciate a parent guardian feeling all those emotions. But to play devil's advocate, if the child is at imminent risk, then inpatient care might be needed to keep the child safe.
And you're absolutely right. And it may be, as I continued on, I kind of played that out a little bit more with Stephanie. You can see how I can continue to proceed, if I need to, with inpatient hospitalization. And it may be that I deeply believe I don't have much choice.
That doesn't mean I can't suspend that stance and really listen and hear and engage. And it is very possible that I will hear something from the parent that helps me to agree, that, given the whole situation, that some alternative is going to have to be considered. Maybe, for example, this is a child with reactive attachment disorder or PTSD or who has deteriorated during previous inpatient stays or something like that.
And as we collaborate, we're really able to put something together that feels like it'll have the necessary safety and security. And it's one of the reasons that we spent time earlier today talking about the efficacy of inpatient hospitalization to make sure that we are countering weighing things differently. We're not talking about 100% good and effective hospitalization. In fact, this group said 30% of the time that kids are getting health benefit from hospitalization, which means there could really be some alternatives that we can consider on a child specific basis.
We have an opportunity in crisis situations to go far further being person centered, giving parents a chance and kids a chance to think it through and sort it out and ask those exception questions and ask some scaling questions and look at-- consider alternatives, that it's worth the time to do all of that with the hopes that we arrive at a consensus that makes sense to all of us.
So even if I deeply believe that's the only option, it's really important that I set it aside and deeply listen and give a parent a chance to sort it out. And you could see that as I did that, Stephanie's brain was working two tasks. I don't want it, but it might be essential. Things started to shift away from that first stance to becoming more and more open to the possibility.
And so that's just an essential change process. And we want to create for that-- create space for that change process to occur. But certainly, at the end of the day, I can play that final card if I need to. The more I practice this approach, the less likely I'll have to need to ever play that card. So I think of this as trying to reach a consensus 99% of the time.
And some of what you might be doing is buying a little bit of time for watchful waiting, to think it through more, to explore some options. Maybe a family can figure out how to put a good plan in place, bringing natural supports for 24 hours, even if they can't do it for an extended period of time. And maybe that 24 hours is a period of time to really have a more extended version of this conversation that I have with Stephanie.
And meanwhile, we can watch and wait and see. Is the crisis abating? Is it getting worse? Are people getting clearer on their decision? Have they had a chance to look at a few hospitals and see what the options are? Have they had a chance to consult with other people who they trust in making the decision? I really want both child and parent to reach a point where even if they don't love the idea, they think it's the approach to take for now, because that's when we're most likely going to get a health benefit. So I just want to not rush that. Because if I rush it, all those feelings that Stephanie didn't get a chance to say out loud will continue to impact how that care gets experienced if I do force her daughter into the hospital.
OK, our next session here is quick. This is on strengths. And mostly, what I really want to talk about here is that it's easy to take a narrow view about what strengths are when we're doing strength based care.

And when we take that narrow view, it's hard to figure out how to do strength-based intervention consistently with every intervention.

So for example, I used to really take the view that strengths were mostly talking about talents, gifts, assets, those sorts of things. And so I'd be identifying things like Billy's good at basketball, and he's got a lot of friends. Well, those are lovely strengths, but it's hard to incorporate them into treatment all the time. I can only incorporate the game of basketball so many ways.

And so I think it's really useful to look more broadly at strengths. And the word strength actually has a number of different definitions. Asset is just one of the ways, one of the definitions for strengths. So let me share with you some of the others. The capacity for exertion or endurance. The power to resist force. Impregnability. The fourth bullet, we see asset or attribute. But that's just one of a number of ways the word is defined.

Force is measured in numbers. A person or a thing regarded as embodying or affording strength, like the faith of-- the strength of faith, for example. Concentration, intensity, potency. Moral force, intellectual force. Strength of mind, strength of judgment. Strong place, stronghold. Strength of argument, strength of evidence. There's a whole array of ways of thinking about that.

Now think back to my scenario with Stephanie and particularly when I was coming at it from down here. What are some examples of strength that I can see down here that I could have been paying attention to? What are some examples of what was strong when I was doing my intervention from down here, even if it wasn't pretty looking? What was strong when I was working with Stephanie from down here? What was strong even if it scared me?

She did care for her daughter. I didn't recognize that from down here. What could I actually see from down here? What was my narrative down here that was strong? Yeah, she had a strong opinion. She had a strong opinion. In fact, she had a strong stance. Now it was the complete opposite of my belief. But it was strong stance, strong willed.

What else was strong? What was the energy in the room when I said, your daughter's going to the hospital? Yeah, strong feelings. And not this warm and fuzzy feelings, right, Viv? It was anger. It was fear. It was mama bear fierce stuff. As treater, it scared me. But it was nonetheless strong. Strengths are not always pretty. But they give you a very good indicator about where a person is on something.

And so I want to join with the strength. When Stephanie is extremely angry, I recognize, wow, something here is very important to her. I need to get curious. I need to go there. Because I ignore that anger at my own peril. It's not going to go well for me to ignore it. So I've got to go there. It's of dominant importance to her. Her stance to not hospitalize is of dominant importance to her.

And so I can't just power struggle my way out of it. No, you don't understand. She is being hospitalized. I don't care what you think. I have to actually go there. Say more. Say more, the thing that's very important to you as indicated by your anger. So we want to watch for anywhere that there is intensity and go there and not try to ignore it or work around it, where there's resistance. Go there.

We started our day with this. A credible, capable, intuitive parent is reluctant, right, Viv? Not resistant, reluctant. They're reluctant. Ask more. I can see your reluctance. I can see you're reluctant. Say more. What's your gut telling you about this? Can you say more about the reluctance? I trust your thoughts here. What are your thoughts on this?

Of course, when I moved up here, it was a lot easier for me to recognize Stephanie's strengths. But even from down here, the strong stuff was apparent, the stuff that I needed to pay attention to was apparent.

And then I can move there. I think it'd be helpful if we call them strong-based interventions. What is strong now? What is strong now gives a really good sense of where is a person, this credible place where they are. What is strong now? Because then I just get to go there.
When Leo's mom come to the emergency department, what is strong? Her anger at the school, her fear for her child, her upset that she'll lose her job, her shame that she's coming into the emergency department this way. Whatever's strong, I want to go there because it's what is swamping and swarming the amygdala. That's the essence of the crisis. So I want to go there.
So I think if-- for me, if I think of it as strong-based interventions, I have a wider menu of ways to think about it. If it's just the pretty stuff, it's just the assets, it's just the talents, that's really narrow. And it's hard for me to incorporate that in all of the work that I do. So you may just find that piece of this useful to think about strong in a broader way.
Some more definitions here. So we want to see it. Get curious about perspective, beliefs, and cultures, the strength that comes from lived experience, where they are on their individual journeys, strength of their priorities, and any time somebody's drawn a line in the sand. No medications. Say more. Say more. That sounds very important. Say more. No new services on top of the ones we have. Say more about that. We want to join right there and assume there's something important.
OK, our third competency is resolution focused care. So family centeredness is this strength-based alignment-- credible, capable, intuitive parent, joining where they are, figuring out what's strong, and going there. Resolution focused that means using approaches that are resolving and relieving.
And I should see evidence of it-- symptom reduction, health activation, clarity, diminished risk, diminished iatrogenic harm, diminished angst, increased hope, return to higher level function. As you think about the conversation that I had with Stephanie, could you see evidence of relieving, resolving interventions? What was the evidence in my interaction with Stephanie that I was using approaches that are relieving and resolving?
We [INAUDIBLE] about the parental activation. She began to consider the options. Yes. What else happened? She got calmer. And she actually said, I'm feeling calmer. She was feeling heard. We [INAUDIBLE] about the parental activation. She began to consider the options. Yes. What else happened? She got calmer. And she actually said, I'm feeling calmer. She was feeling heard.
Other examples of relieving and resolving? She's no longer yelling. She's moved up to higher executive function. Her autonomy. What did she say about that? She said, I feel like I have control. Stephanie, I think that was one of the things she said. I feel like I have control now. I feel like I'm a part of this. She feels valued. Ah, more evidence. Robin says, she was more open to what I was saying, and she felt heard and validated.
All examples that I'm using approaches that are having the intended impact. I'm not waiting for two months later for her to say, oh, that thing Kappy said to me two months ago is so helpful. I'm looking for evidence now, evidence now. I don't have to send them to a hospital for them to get relieving, resolving stuff. I can deliver relieving, resolving stuff now. And even if Stephanie's daughter goes to the hospital, there still will have been benefit in both Stephanie and her daughter getting relieving, resolving stuff now. We can provide incremental relief at every point of the crisis process. Nothing has to wait till the next place. And this relieving and resolving work that I've done with Stephanie and her daughter here around any ambivalent thoughts they have about hospitalization, we resolve that. And that's going to make that

next care experience that much more effective, that much more likely to be effective. So every point of contact is a chance to be relieving and resolving.
But we have to intend to do it. And this is another narrative. This is another narrative. What am I in the business of doing? Am I here to assess? Or am I here to relieve? Am I here to relieve? And in the crisis, when it's crisis situations, we often find ourselves trapped in assessment think, level of care determination kind of thing, instead of focusing on relief. And relief is what we're really wanting to get to here.
And because we talk, because we've got this-- talk is our tool, because we're talking when we're assessing and we're talking when we're treating, we have to be really clear in our own minds. What am I in the business of doing right now? If we're doing physical health care, it's clearer, like, for example, if you found yourself in the hospital with a badly mangled foot because you fell off a ladder. And here you are in the emergency department bed.
The doctor comes in and starts to poke and prod and twist, maybe gets you sent for a CT scan. Both the doctor and I understand that that is part of the assessment. None of us-- neither of us think that that's part of the treatment. And nor would we be happy if we just got sent away and all we got was the assessment. And even if we've mangled our foot badly enough that it's going to need future surgery and future physical therapy, there's an opportunity for me to get some relief right now.
And maybe that comes in the form of an ice pack and pain medications and a splint for my foot. And when that happens, when I get the ice pack and the meds and the splint, the doctor and I both recognize that now we've done some treatment, even if it's incremental, even if more will come later. So we want to make sure we are doing our version of this brief incremental care. But I have to be purposeful about that.
Likewise, I'm going to differentiate between crisis disposition and crisis resolution. If it's your mangled foot, what's resolution for your mangled foot? Disposition is when you're sent over for surgery. What's resolution for your mangled foot?
AUDIENCE: Cast.
KAPPY MADENWALD: Healed foot, walking, pain free, mobility. That's resolution. And maybe that's incremental. Maybe we're going to do that in stages and steps. But that's resolution. Disposition is when you're sent over to the surgery, the surgery that may or may not be the thing that's relieving. So we're looking for a crisis resolution, not just crisis disposition. Crisis disposition is when I send them off to somewhere else in the hopes that's where some resolving stuff will happen.
Let's just test this out a little bit with one last poll question. Is admission to a psychiatric hospital an example of crisis resolution? We're going to go just 10 more seconds. Get your votes in. OK, 84% of the people got it right. No, it's not an example of crisis resolution. It's an example of crisis disposition. We're sending them somewhere else with the hopes that resolution will happen.
And this group that happens-- says that happens about 30% of the time. So it's a disposition in the hopes of resolution. Resolution is when the child and parent say, better, resolved, back to normal function. So we want to not be confused. It can feel like resolution to us because I'm able to move on and do other things in the job.
But resolution for a child is I'm back to functioning better, feeling better and for their parent as well. Yeah, so Stephanie said it perfectly. It's disposition. So we want to be really clear on that and not confuse the two-- not assume that going to the hospital equals safety, not assume going to the hospital equals healing, not assume going to the hospital equals getting to the essence of the crisis, and not assume going to the hospital means better when they get discharged.

OK, so we are going to do our role play now. I told you earlier today we're going to do an immersive role play. It's the easiest role play you've ever done because all you have to do is move. I'm going to be doing the talking, and you're going to be just moving. There are a couple of ways you can do this.

If you can do it in terms of your speaker and your physical space that you're in, I think it's very useful to stand up for this exercise and to give yourself space to move forward and backward several steps. After I show you one more slide, you won't have to look at the screen at all. If it does not work for you to stand up, then instead, you can rock forward and backward in your chair. Please do add some physicality to this exercise.

In this exercise, I'm going to be the treater, and I have four brief scenarios where you are the parent. And I'm going to read a little scenario, and then I'm going to ask you questions and make some statements. And I'd like you to pay attention to your gut reaction as I ask you those questions and make those statements and determine at a gut level-- don't overthink it. Determine at a gut level, was that statement or question productive or counterproductive?

If it's counterproductive, meaning it makes you mistrust me, it makes you disengage, it makes you not like me, it makes you angry, you have salty thoughts about me, anything like that, take a step backwards. If, on the other hand, I say something that you're trusting-- you're either trusting me or trusting this intervention, it feels engaging, it feels calming, it feels harm improving, anything that feels good, take a step forward. And if it's neutral, stay where you are. You will be going back and forth quite a bit. So give yourself room to do that if you are standing.

The most important part of this exercise is that you take your treatment provider hat off and put it aside. If you don't do that, then I'll ask a question, and your parent gut will say, that's terrible, step backwards. But then your treater hat will come on and say, but that was a really important question to ask. For this exercise, our treater opinions don't matter. We want to try to immerse ourself in the experience that parents have during our interventions.

If you are in a situation where you have a hard time considering the parent point of view because that's not a lived experience you've had, for example, it's helpful to make it as personal as possible. And so for example, you might think about a child that you fiercely love and would do anything for. And imagine these exercises on behalf of that child. Or imagine the parents of those kids that you fiercely love. Try to make it as personal as you can in doing this.

So here's the first scenario. You are a parent of a 16-year-old daughter, who has been skipping school, staying out past curfew, and using drugs and alcohol. This is newer behavior for her, and it has resulted in a lot of sleepless nights for you. You are exhausted, and you're feeling helpless about your ability to reinforce rules.

It seems like you have lost control at home. If that feels productive, step forward, counterproductive, step backward. It feels like you have lost control at home. It sounds like it's been exhausting. Are you consistent with your discipline as a parent?

What has concerned you or surprised you most about her behaviors? What has been the hardest part about this for you? Is there alcohol in your home? It's time to get tough. You need to take away her keys and her cell phone. Does it go better some nights than others? Have there been any strategies that work better than others?

OK, shake that one off, and get yourself reset for the next one. OK, this time, you're the parent of a 14-year-old son who has been increasingly impulsive and is quick to get angry and aggressive. He runs around the house. He throws things around. And he chases his siblings.
You have two younger children in the home who get scared when this happens. Trying to verbally talk him down only makes things worse. So instead, you try to keep the younger kids out of the way, and you pray that nobody will get hurt. The safety plan says that you are supposed call 911 when this happens, but you are afraid of what the police officers will do to him.
Sometimes you have to do what you don't want to do. This is about your son. The police officers won't hurt him. They will calm them down and get him to the hospital. I'm surprised you haven't heard from DCF. Your other children are at risk. You need to follow the plan. You need to call 911 when he gets aggressive.
It sounds like you have a safety plan that doesn't work for your family. Are there options other than calling 911 that you would be more comfortable with? You have a gut feeling that calling 911 is a bad idea. It's important to pay attention to your instinct.
I'm curious. Why is it a bad idea? What are the risks for your child or family of calling 911. Can you think of any circumstances when even given the risks you just described that you would choose to call 911? I'm telling you calling 911 what is the best thing you can do for your family.
OK, shake that one off. And here is number three. You are the parent of a 10-year-old boy recently diagnosed with severe depression. He's very embarrassed to be the focus of so much attention, and he does not want to have to go to counseling sessions or take the medicine that's been prescribed.
It's a struggle to get him out of the house and into the car. He cries and begs to not have to go, and you often end up crying yourself. You have canceled a number of sessions at the last minute when it's clear you will not get there. As a parent, you have been beating yourself up wondering whether you are the cause of your son's sadness.
It's really important that he doesn't miss any appointments. I'm wondering if it's time for you to have therapy. It looks to me like your heart is breaking for your son. What has the experience been like for you as his parent? Your son's depression is a big deal for you and him. It's OK and natural to be upset about it.
If you were to guess, what do you think he's having the toughest time with? Let me show you how to put together a reward system for him. He can earn sticker's when he goes without complaining. If you aren't able to get him to cooperate, we'll have to put him in the hospital. Then he won't have a choice about taking his medicine.
OK, shake that one off. We have one last one. Your daughter Angela has been cutting herself superficially for the past several months. She has been seeing a counselor. But you had kept this information private. You haven't told family members, friends, or school personnel. However, this morning, your daughter told a friend that she was cutting and sometimes thought about suicide. That friend told her mother, who, fearing that Angela might be in immediate danger of killing herself, called 911.
Three police cruisers and an ambulance arrive at your home, sirens blazing. All of the neighbors came over, wanting to know what was happening as Angela was loaded into the ambulance and taken to the ER for an evaluation. At the hospital, you are livid, embarrassed, and ashamed. This could have been

handled in a different way. Why didn't this other mother call you instead of 911? Now everybody will know-- family, neighbors, classmates, and teachers.
It's important that you focus on your daughter This isn't about you. It's Angela's safety that's the priority here. I'm sorry that it happened this way. I understand it was not your choice to bring her here. You're right. The other parent could have handled this in a different way. It is a big deal, and the feelings you're having are legitimate.
What is the hardest part about this for you? Thank goodness she told a friend she was feeling this way since you didn't know about it. Looking back, do you think there were signs that she was suicidal? The doctor will do a mental status exam and decide if she will be hospitalized. You will have a chance to meet with the doctor in about 30 minutes. Is there anything you need to take care of in the meantime?
It sounds like everything happened very quickly at home. Would you like some time alone to catch your breath? Or would it be helpful to you to talk out loud as you plan for the meeting with the doctor? Do you have thoughts about what you hope will happen today? Are there things you want to be sure to address when you meet with the ER doctor?
OK, shake that one off, and have a seat. Easiest role play ever, right? The kind where you don't have to talk. But now of course, let's do some processing. So just kind of first thoughts. What was that exercise like? Feel free to unmute and talk about it or put some notes in chat. What was that experience like standing in parent shoes? Viv?
AUDIENCE: Nauseating.
KAPPY MADENWALD: Because you were moving back and forth so much or something else?
AUDIENCE: No. I think like being a parent and embodying being a parent and caring for your kids so much to have to go through those experiences. Like an emotional tug of war roller coaster.
KAPPY MADENWALD: Wow.
AUDIENCE: I felt like the actual act of moving toward you or away from you really helped illustrate the gravity of the statements you were making, I guess, and how they were affecting how I felt about our connection and what I was thinking.
KAPPY MADENWALD: Yes. I agree. I think the physicality is very useful and instructive to us.
AUDIENCE: It also felt so clear to me where questions were sitting in an expert stance and telling me as opposed to asking, and then having the opportunity to step back or forward with agreement or disagreement felt really clear.
KAPPY MADENWALD: Wouldn't that be interesting if we knew that-- if we could see that happen every time? It would be so instructive to us, wouldn't it? To help us get more precise with our game. A couple of people are commenting that they recognize some of the things that they've said but suddenly standing in parent shoes, experience them as negative. And some of you may have felt the same, that you've said some of these things in the past.
As you think about the things I asked you and said to you, do you think I said things that no parents have ever heard? Or do you think parents hear these things? Yeah, this is sort of everyday kind of conversation that teams have with parents. I've said most of them myself. I ripped them from my own headlines, hopefully mostly in the past, in fact mostly when I was more back in expert mode.
So these are not unfamiliar questions. So that means these kind of questions and approaches are kind of normalized. And we don't really recognize the impact. We don't appreciate what it's like to be asked the question and how provocative some of the questions are, the iatrogenic effect of some of those

questions. And Gabriel says, I took bigger steps back when something raised mistrust. That's a big deal. You want to say more about that Gabriel? No pressure. But if you would like to.
AUDIENCE: Yeah. The size of my steps were like matching how I felt. So when I felt trustful, I would take steps forward. When something made me feel really good, I would take bigger steps forward and--
KAPPY MADENWALD: I like that. And was there anything particular that struck you, Gabriel, when you stepped backwards, like something that you were surprised it really made you mistrust me?
AUDIENCE: Yeah, when I felt I didn't have any control. So when you were saying, this is how it's going to be.
KAPPY MADENWALD: That's a really great example of it. And we saw that in the exercise with Stephanie as well. When I took all the control from her, we can see that reaction. So let's look at some other comments here. Enlightening to view it from a parent viewpoint. Uncomfortable at times. Hmm. Rebecca says, I'm a parent, so put it into perspective for me if the crisis were to happen. Yeah. It's interesting how some things that sound like they can be comforting might not be when you are experiencing it from parent shoes. This exercise really shows the difference between how effective we think we are and how parents are experiencing.
That's the difference between my view of care and the quality of my care and the family's care experience. And sometimes there's a really significant gap there that we're not aware of. In general, when you were stepping back, what was happening to the relationship between you and me when you were stepping back?
AUDIENCE: More distant.
KAPPY MADENWALD: Yeah. So it's creating a distant relationship between us literally and figuratively, like an emotionally distant kind of relationship. The relationship is deteriorating. What's happening to your crisis data as a parent when you're stepping back? It's going up, right? It's escalating. How long did it take you to step back, to decide to step back?
AUDIENCE: Pretty quick.
AUDIENCE: Yeah, pretty fast.
KAPPY MADENWALD: This is really instructive. It's very fast, right? Our limbic system is gauging the safety immediately before I'm even putting conscious thought to it. So it's an instant feel. It's an instant feel. We sometimes feel like we don't have much power in our roles. But this exercise shows just how much power we have.
But we're like a power tool. We can do good cuts that create a step forward, and we can do bad cuts that step backwards. So we have a lot of power there. Did any of you find yourselves having salty thoughts about me or wondering about my credentials, wondering who the heck I thought I was? You're way to kind, Michelle. I've heard some F yous sometimes in this training. Like, who do you know who you are? You're a far more polite group.
AUDIENCE: Maybe I just knew that it was a role play, too.
KAPPY MADENWALD: That's it. That's it.
AUDIENCE: [INAUDIBLE] being polite then. [INAUDIBLE] I think, and there were moments where I was like, they lack compassion and integrity. And I think speaking to Gabriel's point earlier is it's so easy to move forward or back when it's involving somebody you really care about. So it had me-- it wouldn't be hard that if I knew the person was attuned to what I was experiencing for me to lean back in. But if I didn't see that that person was attuned to the impact of what they're saying, I would just continue to go back.

KAPPY MADENWALD: Yeah. Yeah. Like, I don't even-- the stuff that should make me step forward, I don't even trust it anymore. And in the short exercise, Diff says, I question your skills and integrity. Like, my gut is telling me, she doesn't quite know what she's doing here. This is a big deal how powerful this is. What was the experience like stepping forward?
AUDIENCE: It's interesting. I want to say very briefly that a couple times-- and I don't remember the questions-- but I had the feeling that, you know what? If I already have been through a situation with you-- like, let's say it's an MCI person and this is like the third time we've been doing an evaluation. Or let's say it's like the school social worker or IHT that's-- like, if there was already relationship, a couple of times I felt like, you know what? I could be OK with this question. Like, in my head, it came up like, is this totally new? Is this the first time I'm meeting you? And then I'm like, I'm backing away, or I'm having a response.
KAPPY MADENWALD: That's a really good point, Helen.
AUDIENCE: Yeah. What's the relational frame that might exist already?
KAPPY MADENWALD: So we already may have a very good psychologically safe relationship, and some of those questions are easier. Or I might be meeting you for the first time. It's also possible that-- think about this in your early days of working with the family. It's possible that they come to us in step back positions to begin with because of past experiences, because 85% of their time has been spent self-protecting in the past. They come with the wall up and expecting it to go bad again. So they're not coming and starting in a neutral place like you were in this exercise.
What was the step forward like? What was that experience like? Comforting, compassionate. I felt grateful for being-- or for being understood. It was validating.
AUDIENCE: I had a little bit of trouble whether-- differentiating if I was taking a step forward because I'm a provider, and I know those questions are helpful, and they're being put in a positive way, or if I'm doing it because I'm not really a parent or if I'm doing it because it will be helpful for the parent. So I had a little bit of trouble with it. But I think I did an OK job of differentiating when it was a negative-- from a negative standpoint to a positive.
KAPPY MADENWALD: Yeah, it is tricky. And you're right. If you haven't had this particular lived experience, like, how do I build an understanding of what that parent bear role would be? It's useful to think about, who am I fiercely protective of? A sibling, a niece, a parent. And how would I experience it when it's that personal? Because it is very different, as you're saying, Maria, than it is from the professional point of view. We just don't have that much at stake. This is the child and parent's life. It's a really big deal. So yeah, thank you for sharing that.
AUDIENCE: I think one of the questions that you asked kind of, like, threw me off, and I was like, I don't know if I'm in the middle. It was when you said-- it was a negative standpoint, and I know it was. But it was when in one of the examples, you said about keeping your child safe, kind of like dismissing the parents. How I saw that was kind of dismissing the parent's feeling and focusing on the safety of the child. And I was like, yes, that could be helpful as a provider to mention to a parent. But at the same time, it's kind of provocative because you're dismissing that parent's feelings, and they have the right to feel whatever way they're feeling. You know what I mean? So that was like the hardest one that for myself to kind of like see myself in the shoe of a parent.
KAPPY MADENWALD: Yeah. Was that the last one where I said, this is about your daughter. It's not about you.
AUDIENCE: Yeah, it was the last one about the child of [INAUDIBLE] suicidal ideations.

KAPPY MADENWALD: Yes, yes. Yeah, I think that's a really good example of that. And then I said, it's your daughter's safety that's most important here.
AUDIENCE: Yeah.
KAPPY MADENWALD: And as if I have to tell you that, as if a parent that's not already top of your mind. Yeah, I think that's a very, very good insight there, Maria. Yeah, absolutely. So it just feels like, of course I am. Of course she's top of my mind. But it's also OK for me to have my feelings, too.
That intervention, that particular scenario came out of a real life experience. I was doing coaching with the team, and a clinician burst in the room. She came from the emergency department and described that scenario and said, I just have to get coaching right away because I'm working with this parent.
And she is the most selfish, self-centered parent I've ever met. All she cares about is image management. And she just keeps going on about how everybody knows now, like it's going to ruin her reputation. This isn't about her. This is about her child. And the clinician was so upset and appalled by the parent's behavior.
So we really-- so I'm glad she came in. So we had to spend a lot of time to stand in parent shoes and imagine the surprise of three police cruisers and an ambulance pulling up to your home on a topic that was so personal for you and your daughter. What would that experience be like? And what are the reasons that you don't want-- why were you protective? Why weren't you telling neighbors and teachers? Was that just [INAUDIBLE] management?
AUDIENCE: No.
KAPPY MADENWALD: Personal. There's all kinds of consequences. These are private matters, and these are issues around stigma. And we do want child and parent to be able to control their own narrative and gauge when and where to tell. And there can be consequences even in the neighborhood of kids who can't come over to play anymore or schools that are now considering this as their writing college recommendations and making decisions about classroom assignments and all kinds of things. There are big implications here.
We did two law enforcement response ones. That other one I'm sure was also loaded for people. You need to call 911. You need to call 911. Now when we are talking to kids and families about safety planning, really essential that we take time with things like that. Call 911 is on a lot of safety plans.
But how many have you found yourself stepping back when I said you need to call 911? You need to follow the plan. The police officers won't hurt him. They'll just gently take him to the hospital in those handcuffs in that cruiser. It's very loaded. And if we just say call 911 because it makes us feel better as a treatment provider, it can create an iatrogenic reaction in the family and particularly for people that are persons of color.
And if I'm a white person telling a Black person to call police, and for them, that is a big and loaded issue for that particular family, it's a big emotive issue, I can very easily be viewed as not getting it at all, not safe for the family to have me in their home. It's a big deal. I will say to all of you thank you very much for this very active participation. And then I am-- as I said, I'm going to move through the rest of these slides just so we have them recorded for everybody.
So there are three approaches that-- and you might have noticed this during the exercise. And a few of you made some comments about the approaches that helped and the approaches that didn't. These three approaches are just-- you can just expect that the most common reaction is going to be

counterproductive. And that's any time that treatment provider uses communication that indicates any kind of blame or criticism of the youth or the caregiver, any time we use deficit-based language.
And indicates blame or criticism, it can be things like, are you consistent with your discipline as a parent? Or is there alcohol in the home? Any time we use deficit-based language-- let me show you how. Let me show you how to put together a sticker chart. Or have you thought about counseling for yourself? Anything that gives this impression that I see you as less than capable of.
And then any time the treater's directive and makes decisions independent. You need to call 911 in an emergency. Or the doctor will be here shortly, and the doctor will decide what happens next. You can just expect that those approaches are more likely counterproductive. And so if we can change our language, it'll make a difference.
From the treater point of view, notice the absence of bad intentions. I wasn't meaning to create iatrogenic harm. It's easy for me as a treater to not know I'm doing it. I'm asking these questions frequently. And because I don't have the big stakes in it, I'm not recognizing the risk.
I've given you two-- oh, one other thing. Imagine what happens if I cut out all of the step backward questions. Then you would have gone forward, forward, forward, forward, forward, forward. And how cool would that be? Relief, relief, relief, relief, relief. So that's what we're going for.
Our care here is much more about precision-- forward, forward, forward-- than it is about length of time or intensity of service. It doesn't matter how long I've worked with the family. If I'm asking a step backward stuff, it's not going to get better. It's our precision that makes a difference. And someone noted that earlier in the chat. This actually allows for recovery much sooner, and that is right.
I've now given you two physical ways to think about your work. The first is, where am I oriented? Am I coming at this from down here, this expert point of view? Or am I up here with the parent or the child, whoever's the focus my attention? And it's really easy-- because it takes intention to stay up here, it's easy to slip down into my natural sort of Kappy way of thinking about things.
So I have to purposefully get myself back up there when I can feel that slip has happened. So you can have this conversation in supervision as well. When you were out there today, how much time do you think you spent up here? How much time do you think you spent down there?
And then the second physical thing is, was that an approach that was productive, step forward, or counterproductive? As I imagine going out and the approach I'm going to take, immerse myself in parent shoes for a minute. How would I experience that? Would that is a step backward for me or a step forward? So two different ways to think about this that bring a physicality into it that just adds some dimension as we're talking about getting more precise with this work.
The last few slides are really about safety planning and recognition that safety planning itself introduces iatrogenic risk that would not otherwise be there. There is no harm-free-- risk-free, I should say, safety planning. It always introduces the risk of iatrogenic harm, kids or parents who are turned off by it, don't feel heard about it, that we come up with a plan that they don't particularly like or they weren't ready or interested in planning. There are a lot of elements there.
Good safety plans come out of kind of good harm reduction focused safety planning. And we get there by using approaches that lead to an increased empathic understanding of what's happening. Imagine with Louie and Louie's parent and Louie's school if we collectively-- if there's a new empathic understanding of what's happening with Louie, if there's a reframe from a deficit story to a more strength-based story about Louie, if there's greater understanding of the nature of Louie's distress.

All of that then can lead to more viable, sustainable strategies. If I try to safety plan when the school is angry and the parent's angry, and they're angry at each other, we're not going to get a good plan that's going to be useful to Louie. We might get a punitive plan from the school. And that's not a safety plan at all. So we want people to feel empowered, feel that change activation that Stephanie felt when we did that work there.

So I'm looking for evidence of that. The language that's used about the child or the parent of the school starts to shift. There's more clarity. We go from always never talk to sometimes talk. I see people taking initiative, motivated language, people jotting notes and ideas. That's all evidence that we've gotten the executive function part of the brain activated. So I want to document those kinds of shifts. And when I do that, we begin to lead to safety plans that are really sort of-- they come out naturally out of that work.

The last several sets of pages of the slides are some conversation starters. It's just some examples of some of the Socratic questions that I've been using throughout the day today that will yield those kind of step forward responses. And I've got a few kind of starter tips here. Nothing new to you. You use a lot of these approaches already.

Always helpful to begin, though, with my mindset. Manually feed my brain. I'm engaging a person who's credible, capable, intuitive and able to collaborate. That gets me up here. I believe that these people I'm engaging-- Louie, school, Louie's mom-- they're the ones that are best able to identify sustainable and effective solutions. It's my job to facilitate that.

I use open-ended questions. Those are the Socratic kind. They can't be answered by yes or no. And then I listen attentively. And I use very simple techniques to forward the conversation. Say more. What are your thoughts there? What's your gut telling you? And then I avoid any instinct-- sit on my hands-- avoid any instinct to interpret for others or to solve it for others or to rush to any kind of a conclusion.

So I may have a conversation with Louie-- Louie's principal and say, it sounds like things were really rough or scary over at the school, whatever that might be. I'm wondering if you can tell me more about what it's like to have Louie in your school. And so I might say things like, I'm curious. When did Louie first come to your attention? What was happening before Louie came to your attention?

I'm curious. What steps do you take when a student comes to your attention? This is going to start to let me kind of hear about the kind of resources they have in place or don't. Are there any particular resources available to you for students that come to your attention like this? What options do you have for collaborating with parents whose children are likely to have a crisis?

I've got some tips here about talking to foster parents or DCF. Maybe I'm doing crisis intervention out at the foster home. And so I can say to a foster parent, I'm curious, how is it that Susie got to your home? How is she experiencing being away from her home?

What does Susie struggle with the most? That's so different than, how does Susie behave here? What does Susie struggle with the most? I'm asking for sort of an empathic response from the foster parent without being quite so directive there. What parts of Susie's behaviors are you trying to sort out or struggling to understand?

And then I can switch tacks a little bit because I want to understand what the experience is like for the foster parent. How does it feel to you to have Susie in your home? When you feel that way, what are your options for seeking support? What would make it easier for you to continue to have her in your home? What strategies-- what options are there for a foster parent who's struggling with a child? So I have a number of those kind of questions in here.

And then I have a sheet that lets us go deeper on the use of some of these big interventions like calling 911. So I might say, has 911 ever been called because your child was having a behavioral health crisis? And then I go over to the right side. Was that your choice, or did somebody else make that decision? What happened when 911 was called? What was the experience like for your family? If it were up to you, would you choose to call 911 again? And I can follow that up with some of the exception questions we talked about today. Go down here, emergency department, mobile crisis team, what was that experience like?

And then I have a slide on addressing stances. Any time somebody got a hard stop, absolutely not or absolutely must, I recognize that as a strength, even if it's not pretty. And I go there. Could you say more about that? What are the good reasons? What concerns are you trying to address? What has your experience been with? And I listened until the person had a chance to catch their breath. And then I can come in and use some of the exception questions to make that work.

OK, thank you for indulging me for an extra 10 minutes. I'm sorry that I kept you longer than expected. But again, thanks for staying on. Ari and I will stay on here for a couple of minutes to make sure you all have all of your needs addressed in terms of CEs. Please feel free to make any final comments in the chat.

And thank you so very much for your participation today and all of these great comments that people put into the chat that just really enrich the experience for everybody. And you should see the Survey Monkey link, and you also should find it in your email if you don't get it here.