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System Transformation in the Context of Building an Integrative System in the Child Welfare System in Allegheny County through Child and Adolescent Needs and Strengths Assessment

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SYSTEM TRANSFORMATION IN THE CONTEXT OF BUILDING AN

INTEGRATIVE SYSTEM IN THE CHILD WELFARE SYSTEM IN

ALLEGHENY COUNTY THROUGH CHILD AND

ADOLESCENT NEEDS AND STRENGTHS ASSESSMENT

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ABSTRACT

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In the last decade, the Allegheny County constituents could witness the transformation of a widely criticized system of divided services into a single Department of Human Services. As an attempt to improve service planning DHS moved to a common assessment (*CANS Comprehensive*) shared across the child-serving offices/systems that would lead to a shared service plan and an overall integrated service delivery process. The primary goal of the CANS is to support communication between systems and, in the end, help the integration process within DHS.

This study describes what CANS is and how it became a central point in Human Services in Allegheny County. On the other hand it looks at the dynamics of implementing this new assessment across offices with a focus on the challenges different systems face, while implementing the new tool.

ACKNOWLEDGMENT

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

AC DHS - Allegheny County Department of Human Services

CANS/ CANS Comprehensive - Child and Adolescent Needs and Strengths Assessment

CASPI - Child and Adolescent Severity of Psychiatric Illness

CYF – Child Youth and Family Office

DHS - Department of Human Services

MR/DD – Mental Retardation / Developmental Disabilities

OBH – Office of Behavioral Health

OIM – Office of Information Management

OMHSAS - *Office of Mental Health and Substance Abuse Services*

SAMHSA - Substance Abuse and Mental Health Service Administration

TCOM – Total Clinical Outcome Management

USDHHS – U.S. Department of Health and Human Services

I. INTRODUCTION

This research is a study of the new Child and Adolescent Needs and Strengths Assessment tool in the Allegheny County Human Service Department (ACDHS). This thesis is an attempt to analyze the organizational change within the department from a system change theory approach. The goal is to point out the variables that stand as base for system transformation to an integrated system approach, a vision embedded in the ACDHS' philosophy.

The reason ACDHS has decided to adopt the CANS assessment and integrate its offices under one communication tool is their continuous concern to improve the outcomes for children and meet their families' needs, which has always been a core focus of any human service department within the United States. In the past several decades the conclusion has been that poor communication among agencies from the child welfare system puts children's life at risk and is failing at rendering meaningful services that benefit the families.

It is well known that children and youth and their families are involved in multiple systems including child protection, juvenile justice, mental health, substance abuse, health and education. In many instances, children and youth are involved with several systems simultaneously. Each of these systems has different legal mandates, policy objectives and funding requirements, making it difficult to integrate care for children and youth across multiple systems. There is growing statewide and national recognition of the need to establish a unified system of care, which addresses the needs of children and youth in a more holistic, integrated manner. For this purpose, the DHS Executive Office has a systems integration team that has been working to implement the

integrated systems philosophy throughout the DHS offices by using a Common Assessment Tool – CANS.

Therefore, the study describes what CANS is and how it became a central point in Human Services in Allegheny County. On the other hand it looks at the dynamics of implementing this new assessment across offices with a focus on the challenges different systems face, while implementing the new tool.

Research Questions

1. What is the novelty of the CANS assessment tool and how is it different from previous tools?

2. Did the philosophy of Allegheny County Department of Human Services change in relation to human services delivery after adopting the CANS tool?

3. What are the factors that determine progress in implementing change in the context of system transformation?

II.   LITERATURE REVIEW

A. Historical background of human services in the American society. Reasons for change.

Historically, the focus of child welfare agencies has been to achieve safety and permanency for maltreated youth. The Safe Families Act of 1997 expanded child welfare goals to include a specific responsibility for the well-being of maltreated youth. Despite this expansion, the term well-being has yet to be carefully defined, leaving child welfare agencies without specific direction about how to achieve this goal. By working to create safe and stable families for maltreated children, child welfare agencies contribute significantly to children's well-being. The concept of well-being, however, is broader than just safety and permanency. Health, education, and mental health are important facets of child well-being that are extremely relevant for children in the child welfare system, as these needs are often neglected. Therefore, the child welfare system should work to ensure that children's health, education, and mental health needs are identified, that children are linked with the appropriate service providers, and that the needed services are actually provided. To facilitate this process, child welfare agencies must establish productive collaborations with health care systems, schools, and mental health systems (Wulczyn, Barth, Yuan, Jones-Harden, & Landsverk, 2005). Even though a broad concern for child well-being is now part of the legislative mandate for child welfare agencies, it is not clear how the system can support specific activities toward this purpose such as initial identification of youth in need of health or mental health assessments (Leslie, Kelleher, Burns, Landsverk, & Rolls, 2003;Wulczyn et al., 2005).

There were evidenced many problems in the current child welfare system. Funding for these services is an overarching problem. In addition, many personnel are already overworked. They often lack time to conduct a needs assessment and make referrals, especially during the early stages of an investigation when the priority is child protection. Furthermore, personnel may not perceive their role as identifying these needs and ensuring that the needs are addressed appropriately. They also lack training on how to accurately and appropriately identify youth in need of services. Given these issues, it is not surprising that recent research demonstrates that approximately 75% of investigated children with mental health problems are not likely to receive treatment (Burns et al., 2004). Even higher rates of unmet needs are found among children who remain at home following an investigation (Burns et al., 2004). Rates are also high among those who are found to be victims of neglect and among very young children (ages two to five years; Burns et al., 2004). Although rates of unmet needs among youth in foster care have not been estimated, one report shows that in the mid-1990s, only 27% of children placed in foster care received mental health services (USDHHS, 1997). The author argues that as children and families seek assistance in addressing problems that arise, the first step of helping involves assessment. In the same line, C. Durkin once said that "assessment is the cornerstone of good social work practice." The purpose of the needs assessment is to establish an initial framework for a comprehensive, long-range master plan to better meet the needs of children and youth.

John Lyons in his book "Redressing the Emperor - Improving Our Children's Public Mental Health System" touches on the concepts of the youth's and the family's voice in the system of care. With this analysis he builds a foundation for his concept of

total clinical outcome management. He devotes a chapter to an expansion of the variables that impinge on children's mental health by discussing many social factors that are critical to building healthy communities and then proposes innovative strategies for mobilizing communities to create jobs and take charge of social institutions, allowing all parents and youths to feel ownership in their communities.

A common practice in human service systems across the U.S. was the requirement from states or other funding entities to require measurement for performance monitoring and/or management purposes (Lyons, 2009). In these situations, measures simply represent a documentation/ reporting function required to get paid. This type of application generates a couple of significant challenges. First, providers naturally resent the time and expense of completing the tool. Second, there is no value to the provider except to ensure payment. Therefore, the contingencies of these measures place natural pressure on respondents to attempt to report what they believed the funding source would like to see. That's why it is logical not to trust some diagnosis or data sets because they were simply generated to insure payment. Lyons points to the State of Indiana and the reason for the failure of its application of standard assessment prior to their decision to implement the CANS. The initial measure served only to ensure funding and became a burden on providers while providing no meaningful information to the state. That culture was one of the primary reasons Indiana decided to shift to the CANS and a Total Clinical Outcome Management (TCOM) strategy (Lyons, 2004).

Therefore, until recently, the instruments used for assessment were designed primarily for fiscal reasons, they did not have a clear clinical organization or orientation. They tended to be a checklist of items, sometimes quite long and complex, with the main

goal of resource rationing. Organizing and conveying this information in an understandable manner was burdensome and challenging to clinicians who were reluctant to use such tools, even when the tools were available. Also, initial instruments such as ASAM, PAT, MATRIX and others (Deane, Huzziff, & Beaumont, 1995) had only a few defined categorical levels of care. Over time, these categorical levels of care have changed meaning. For example psychiatric hospitalization in the 1980s tended to be weeks and aimed at treatment, while recent trends focus on risk reduction and tend to be a few days. In addition, most instruments were designed for adults.

The Child and Adolescent Severity of Psychiatric Illness (CASPI) (Lyons, Mintzer, & Kisiel, 1998), one of the few instruments designed for children, was initially used in assessing the need for residential treatment, and later expanded to consider all levels of need. This instrument considers the dimensions of symptoms, risk behaviors and caregiver capacity. The recommended levels of care consider milieu intensity and service intensity. The Child and Adolescent Needs and Strength instrument (CANS) was patterned after the CASPI and has demonstrated concurrent reliability in field testing, and has been used to evaluate service use within public mental health and juvenile justice systems (Lyons,Griffith,Quintenz, Jenuwine,&Sasha, 2003; Lyons et al., 2004).

Therefore, the growing attention to the development of systems of care for children's care highlights the importance of documenting the experience and results of an evolving service delivery system (Stroul, McCormack, & Zaro, 1996). Progress has been made in identifying appropriate outcome indicators and designing methodologies for evaluating individual, program and system outcomes. The potential value of using clinical outcome measures to enhance the quality of services and the accountability of

service providers has been recently recognized. This has led to the development of a number of approaches to measuring outcomes (Burns, 1996; Rosenblatt, 1993; Sederer, Dickey & Hermann, 1996). For measurement strategies that rely on the reports of clinicians and other service providers, inter-rater reliability is a critical characteristic of the measure.

The Child and Adolescent Needs and Strengths for children and adolescents (CANS) represents a novel approach to outcomes measurement. Rather than emphasizing traditional psychometric properties such as internal consistency or factor structure in order to identify a parsimonious set of items that add to a total score, the CANS approaches measurement from a communication perspective (Lyons, 2000). Specifically, the CANS selects items based on treatment and setting decision-making and designs the anchors on these items so that they relate directly to clinical decision-making. This results in a measure that emphasizes the rater's ability to completely but concisely describe the characteristics of the youth and his/her family in a way that is directly translatable into service planning even without any "scoring." However, for this to be feasible, inter-rater reliability, even at the individual item level is required. The CANS presents an advantage over other instruments. While this assessment approach is associated with other common measures among children it has a demonstrated relationship to service planning and level-of-care decision-making (Kisiel et al., 1999).

In the same sense, the President's New Freedom Commission on Mental Health[1] emphasizes both the importance of individualized plans of care, and the application of

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[1] President George W. Bush established the President's New Freedom Commission on Mental Health in April 2002 as part of his commitment to eliminate inequality for Americans with disabilities. The President directed the Commission to identify policies that could be implemented by Federal, State and local governments to maximize the utility of existing resources, improve coordination of treatments and services,

evidence-based practice. This is very significant because long-term meaningful improvements in outcomes for children with serious mental health challenges and their families will depend on a coming together of these two important approaches (Friedman and Drews, 2005). Same authors state that there were relatively few instances identified where there had been a systematic effort to integrate evidence-based practices with individualized care. In most cases, the policy emphasis in a local community was either on promoting the development of systems of care and individualized care, or on promoting the use of evidence-based practices. The good news is, however, that there were some very positive examples of such an integrated approach in the systems that have adopted the CANS Common Assessment Tool.

Cross-system barriers

Children and their families often enter public systems during a period of crisis. This crisis may be exacerbated as they face a fragmented and at times overlapping and conflicting array of services. Families, legal guardians, probation officers, judges, case workers, and other parties find these systems complex and difficult to navigate. The complexity might be overlooked if the systems were well coordinated, but often they are not. As each system focuses on a particular aspect of child's action, it fails to address the family's needs in an integrated and comprehensive manner. The typical cross-system barriers that impede the ability to reach an integrated care are:

and promote successful community integration for adults with a serious mental illness and children with a serious emotional disturbance. http://www.mentalhealthcommission.gov/

Service system- services are provided only in the system the child/family enters, despite the family's having multiple issues.

Finger-pointing – systems state that particular system is not responsible and that another system should be taking over the care of the child.

Uncoordinated care- care is not coordinated for the multiple needs of the child and family.

Monitoring – services are not uniformly monitored for quality assurance.

Thus, the reasons for change in child welfare from a systems perspective are the following: inadequate range of services and supports, failure to individualize services, fragmentation of system when children and families had multi-system needs, children with special needs are in many systems, lack of clear values/principles for system, lack of clarity about population of concern, inadequate accountability, and lack of adequate responsiveness to cultural differences.

Furthermore, the expectations from a system of care nowadays are based on some key principles and values: it should be based on needs of child and family and include a system of ongoing evaluation and accountability; it should promote partnerships between families and professionals. It should involve collaboration between multiple agencies and service sectors, and promotes individualized supports and services based on strengths and needs in multiple domains while promoting culturally responsive supports and services.

B. Total Clinical Outcome Management (TCOM)

1. What is TCOM

The TCOM framework is best understood as a philosophy, a strategy, and a set of tactics. The philosophy of TCOM is that the needs and strengths of the client/patient

should drive the process of care. The optimal means of achieving this goal is through the use of structured, evidence-based assessments. This means that standard assessment processes drive decision making at the individual child and family level, the program level, the hospital level, and ultimately, the system level. The articulation of TCOM principles represents an important shift in how services are managed now at DHS. Until recently the case worker would decide what the family needs and plan the services; however, the new idea is that now the family empowered to tell the system what its needs are and how would the family members like to address them.

In this context, the primary tenet of TCOM is that effective services in complex child serving systems require a focus on a shared vision of the children and families receiving services. Complex systems require the collaboration of multiple partners each with different mandates, agendas, and priorities and this implies that it is necessary to facilitate the communication among all system partners, including youth and families. Despite differences in cultures and language of different offices, all partners share a commitment to serving children and families and that should hold them accountable to the child and family at all levels.

2. TCOM- A practice/system management approach

In Redressing the Emperor, Lyons (2004) proposed an "expansion of traditional outcomes management approaches to a full practice/system management strategy". He termed this approach Total Clinical Outcomes Management (TCOM), a title designated to imply the following:

Total means that it is embedded in all activities with families as full partners.

Clinical means the focus is on child and family health, well-being, and functioning. That focus on recipients should be a focus on their needs and strengths[2].

Outcomes means the measures are relevant to decisions about approach or proposed impact of interventions. The idea is to maintain the focus on those aspects that represent the goals of the treatment, service or intervention.

Management the term implies that the information collected is used to make decisions in real time about how services and programs are staffed and managed. Other words the collected data will be used for management decision-making in all aspects of managing the system from individual family planning to supervision to program and system operations.

To put this concept into practice, to better serve people with behavioral health needs, it is first important to know what they need. This knowledge is a shared understanding between the person and the provider. Next, a decision must be made on what intervention approaches are indicated to address the identified needs. Then, it is important to be able to manage the human service offices with information about the degree to which the individual's needs have been met. If the needs are not met then a different intervention approach is recommended. In all cases the challenge of the organization is to keep the work focused on the understood needs of the individual or family in care. Thus the philosophy of TCOM is that the system, at all levels, should always make decisions based on the needs and well-being of the people served.

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[2] Traditional quality improvement efforts have focused on the functioning of services (e.g., how soon an appointment is made following hospital discharge, how long a phone call is answered, how long the wait time prior to an appointment). While such quality indicators may be meaningful for service management, a clinical focus means shifting these measurements processes away from the services and toward the people an agency is attempting to serve.

Philosophy

The TCOM approach is grounded in the concept that the various perspectives in a complex service system create tensions. For example, the person providing the treatment often has a different perspective than those responsible for paying for the treatment. Within treatment teams, people from different disciplines often see the treatment process differently. The conflicts that result from these tensions are best managed by keeping a focus on common objectives - a shared vision of the child and family. By creating systems that have the capacity to always return to this shared vision, it is easier to create and manage effective and equitable systems.

Strategy

Creating a system that remains always about the shared vision requires an approach that supports the communication of this shared vision throughout the system of care. Since the shared vision is the person (or people) served, it is necessary to effectively represent these individuals through the human service system. To accomplish this objective, a common structured assessment is used to communicate the shared vision throughout the system and to directly affect service/intervention planning.

3. TCOM and Organizational theory

In his work on organizational theory, Max Weber (1947) distinguished a bureaucracy (i.e. a rational legal authority) from two other forms of authority – traditional (leadership by tradition) and charismatic (leadership by charm). In a rational-legal authority, people in leadership follow a legally established order and must act within established rules or face legal jeopardy. Weber described bureaucracy as the most

evolved form of rational legal authority. According to Weber, an ideal bureaucracy has these key characteristics:

- Fixed areas under the jurisdiction of the authority exist and the boundaries of responsibility are clear.

- Within a fixed are required duties are assigned to individuals whose training or expertise is consistent with their responsibilities.

- A clear division of labor exists among individuals.

- A hierarchical system is created where higher officials govern lower officials and communication is standardized and regulated.

More recently, Perrow (1967, 1993) has argued that Weber's model of bureaucracy is idealized and, thus, not suited for real world applications mainly because bureaucracies are designed to handle routine and stable processes; it discourages change, in fact change is a threat to the routine the bureaucracy intends to create.

Evolving from the original theory of bureaucracy, contingency theory stated that organizations with different products or processes develop differently (Galbraith, 1973). In other words, the purpose of the organization will influence exactly how it becomes organized. In a technological era every organization incorporated this element and from this point of view, now we can see routine technological organizations (i.e. building cars) that require formal and centralized structure. Craft technological organizations (i.e. art) require a decentralized, less hierarchical structure with flexible decision making. And non-routine technology requires more of a matrix structure with multiple points of centralization and this best conceptualizes a human services system. In the context of organizational theory, the DHS organization is a bureaucracy using non-routine

technology to assess the needs of its clients and plan service. Until now, the offices, providers and agencies of ACDHS have used their own native technological system, but under the new philosophy of integration and the creation of a common data base, they need to adapt to new challenges and change. The fact that there is a shared vision of helping children that is common to nearly everyone in the system provides a critical opportunity for leveraging system change. TCOM, in fact, is a moral mechanism for change. Any changes that are justified based on clear benefit to children and families are far easier to implement across the board than are any other changes. Identifying the "right thing to do" is the moral mechanism for change. (Lyons, 2004)

An effective change within an organization will happen if we create a learning organization culture. Quoting Senge (1990), Lyons states that in order to create the kind of environment that supports effective change, we need to change our mindset. One should not get too caught in the current status of things, but instead focus on the process that brought them where they were and the processes that can move them forward. Awareness of and sensitivity to points of leverage in an organization and a system is fundamental to the effective management of that organization or system.

C. Introduction to Communimetrics – communication as measurement.

The field of communication is broad and diverse and often is organized along disciplinary lines which then struggle to share common theories and approaches (Anderson, 1996; Donsbach, 2006). However, over the past several decades communications has evolved as a field of inquiry. One of the early models of communication can be characterized as transmission theories. These models date back to

the 18th century British Empiricists. In transmission theories, communication is the process by which information is transferred from one person's mind to that of another (e.g., Rothenbuhler, 1998). It is the process by which a message may be sent and received. In this way of thinking, the study of communication focuses on how information is created and packaged and sent and then received and processed. Metaphorically, transmission models are much like understanding the postal service. Letters are considered, written, addressed, mailed, delivered, received, opened, read, and processed by a second party.

Among communications theorists, this example of a linear process of information transfer is becoming increasingly quaint. While the example of a letter was a common experience congruent with the communication theories of the time, today most 18 year olds may not have even written, let alone mailed, a letter. New forms of communication such as email, texting and instant messages have reduced our reliance on letters as a form of communication. These new communication options also reveal the limits of transmission theories of communication.

Although transmission theories of communication remain common, recently some theorists have identified these models as conceptually flawed. Transmission theories tend to be simplistically linear as information (in our case knowledge) is viewed as moving from point A to point B and these theories struggle to include inputs from point B that might actually change the nature of information coming from point A (Carey, 1989). Some theorists (e.g. Deetz, 1994; Pearce, 1989) have proposed a constitutive model which conceptualizes communication as a meaningmaking activity.

The concepts of constitutive communication have been embedded into business world through the work of Tapscott and Williams (2006) on mass collaborative. A core concept within this work is the concept of collective intelligence (c.f. Weiss, 2005). Collective intelligence is the shared intelligence that arises from a network of collaborators or competitors reached through communication.

Going back to TCOM, a key challenge in its implementation was the choice of measurement strategy. In fact, the assessment strategy chosen was the foundation of the TCOM approach. To resolve the tension between measurement theory and TCOM related to how measurement was conceptualized and operationalized, Dr. Lyons (2009) proposed an alternative theory of measurement designed specifically for implementation in service delivery environments. He refers to this measurement theory as communimetrics because the primary reason for measurement in the TCOM approach is communication. And communication in Dr. Lyons' vision is not a linear process only between the client and the case worker, but also between agencies that are involved in a particular case. This multidimensional communication should render a collective information/intelligence that eventually will be used to master a better plan for the family in need.

D. The critical role of assessment.

Continuing on the line of rendering good services and integrating them under a comprehensive treatment plan, DHS had decided to do that through the process of assessment. A comprehensive clinical assessment is also a required process to provide diagnostic and other information needed for the person-centered plan. The assessment can be one particular assessment or a combination of assessments that are chosen to inform the provider about a particular individual. The kind of assessment chosen

determines who can conduct it. Moreover, the clinician uses the assessment results to make recommendations for the best treatment strategies or interventions to meet the person's needs. C. Durkin once said that "assessment is the cornerstone of good social work practice."

E. What is CANS?

One could describe the Child and Adolescent Needs and Strengths (CANS) as the first communimetric tool. But actually, the experiences taken from the development and implementation of the CANS led to the creation of the communication-based theory of measurement. As Dr. Lyons (2009) said: "the story of the development of the CANS is really the story of the evolution of the communimetric theory of measurement." This tool evolved from an early Child and Adolescent Severity of Psychiatric Illness (CASPI) (Lyons, Mintzer, & Kisiel, 1998), one of the few instruments designed for children. It was initially used in assessing the need for residential treatment, and later expanded to consider all levels of need. This instrument considered the dimensions of symptoms, risk behaviors and caregiver capacity.

The CANS assessment is a functional assessment that rates multiple domains: child's emotional and behavioral needs, functioning, risk behaviors and strengths and the caregiver needs and strengths. The CANS provides a common language, objective criteria to support decisions about intervention plans and intensity of services, monitors progress through outcome measures, and supports quality improvement initiatives. Information from the CANS will support decisions at multiple levels - direct services, supervision, program management, and system management.

An additional advantage of the CANS is its assessment of strengths. There has been an increased focus on the importance of strengths and on strength - based treatment (Cole & Poe, 1993; Powell, Batsche, Ferro, Fox, & Dunlap, 1997). Preliminary data indicate improved outcomes for children as a result of participation in strength-based programs (Bruns, Burchard, & Yoe, 1995).

CANS is an assessment designed from a communimetric perspective (Lyons, 2009) in which individual items are used to represent different treatment/intervention needs and the levels of each item directly translate into actions. The CANS is easy to learn and is well liked by individuals, youth and families, providers and other partners in the services system because it is easy to understand. Each CANS item suggests different pathways for service planning. There are four levels of each item with anchored definitions designed to translate into the following action levels. The next two tables represent how needs and strengths are scored.

Scoring Needs

	Score Level of Need	*Appropriate Action*
0	No evidence of need	No action needed
1	Significant history or possible need which is not interfering with functioning	Watchful waiting/ Prevention/ Additional assessment
2	Need interferes with functioning	Action/Intervention
3	Need is dangerous or disabling	Immediate/Intensive action

Scoring Strengths

	Score Level of Strength	*Appropriate Action*
0	Centerpiece strength	Central to planning
1	Strength present	Useful in planning
2	Identified strength	Must be Built /Developed
3	No strength identified	Strength creation or identification may be Indicated

Dr. Lyons' idea was that by using an action-oriented measurement process for the standard assessment, it is possible to create a measurement approach that is immediately and directly relevant to both clinicians and the people they serve. Further, the approach to creating the output from this assessment process is the first opportunity to establish shared meaning. The assessment process should be done collaboratively with people served and their families. It is not a diagnosis provided by an expert; it is a consensus on actionable needs and strengths among all parties involved in the care of the person and/or family.

Communication among partners in the human service system is critical. It is a fundamental aspect in the assessment of service needs and outcomes, system development initiatives to reduce fragmentation, and to increase joint service planning, development and coordination (Stroul, McCormack, & Zaro, 1996). A communication strategy is a priority in the use of the CANS; raters must all be "speaking the same language" if a communication strategy is to work. Similarly, implications for service planning must be comparable regardless of who is completing the tool: as such, inter reliability is essential.

Reliability

A number of reliability studies have been accomplished using the CANS-MH, including studies with a variety of practitioners and researchers. A total sample of more than 300 subjects has been included in these reliability studies. When clinical vignettes are used as the source of ratings, the average reliability across studies is 0.74. When case records or current cases are used as the source of ratings, the average reliability across

studies is 0.85. In a study in Iowa, the reliability of individual items was assessed between clinicians and researchers. The average reliability of individual items of the CANS-MH was 0.73 across 40 cases. A number of different types of individual have been trained to use the CANS-MH reliably including mental health providers, child welfare case workers, probation officers, and family advocates (parents of children with difficulties). A minimum of a bachelor's degree with some training or experience with mental health is needed to use the CANS-MH reliably after training.

Validity

The validity of the CANS-MH has been studied in a variety of ways. In a study in Allegheny County, the CANS was found to be significantly correlated with an independently assessed CAFAS (Rautkis & Hdalio, 2001). In this study, the Caregiver Needs and Strengths total was found to be correlated with an independent measure of burden. In a sample of more than 1700 cases in 15 different program types across the State of New York, the total scores on the dimensions of the CANS-MH (e.g. Problems, Risk Behaviors) reliably distinguished level of care. In a comparison of CANS-MH level-of-care guidelines to clinical judgment, staff at Multnomah County, Oregon found that the CANS-MH informed level of care criteria agreed with the expert panel decision 91% of the time. It has also been used to distinguish needs of children in rural and urban settings (Anderson & Estle, 2001).

F. Building an Integrated System – a theoretical approach.

By the term "system" one may assume something like a collection of agencies (large and small, public and private) which are located in a particular area, and which provide a complementary range of services to children and families (Shields, 1989). A system of

care is "a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families" (Stroul & Friedman, 1986). It is an adaptive network of structures, processes, and relationships grounded in system values and principles that provides children and youth with serious emotional disturbance and their families with access to and availability of necessary services and supports across administrative and funding jurisdictions (Hodges, Ferreira, Israel & Mazza, 2006).

Other words, a system of care incorporates a broad, flexible array of services and supports for a defined population that is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and youth at service delivery, management, and policy levels, and has supportive policy and management infrastructure. And the role of system of care is to provide access to effective services for diverse population within a specified community.

However, Shields (1989) noted two decades ago that the reference to a service system can be misleading, particularly for those who are confronting special needs for the first time. The reason it can be misleading is that the word "system" technically refers to something that is a unified whole made up of interrelated and interdependent parts. In this literal sense of the term, most of the human services in the U.S. rarely belong to a collection of services that constitute a unified whole, nor are they really interdependent. Shields suggested that "network" may be a better term to describe many of these communities of agencies, since it implies relationship but not necessarily a high degree of interdependence.

"The irony of many human services is that they are created to respond to the needs of those they serve, yet often end up reflecting the needs of those who provide the services. Thus many hospitals end up being organized around the needs of doctors and nurses; many centers, around the needs of staff and administration"(Shields, 1989).

Shields argues that often the agencies are not as responsive as they might be to the needs of the people they serve and then the haphazard collection of agencies we refer to as the system is not apt to be any more responsive.

"The reality in many instances is that cooperation is not the best between agencies; that information does not flow as readily as it might…" (Shields, 1989).

Major calls for change since the mid-1980s have been made through the development and implementation of community-based systems of care.

On the issue of system transformation in the public sector the literature is not abundant and is merely about change theory. Caldwell (2003) sees a key inhibitor to the successful implementation of change theory as being the complex interaction that takes place between different change agents within an organization. It is no longer common for a single "hero leader" or "organizational development consultant" to be charged with implementing a linear change processes (Connolly et al., 2000; Siegal et al., 1996). Contemporary reality is that four distinct types of change agent may be involved in any particular change process: namely, senior leaders, middle managers, external consultants, and teams; each having different experiences and perspectives (Caldwell, 2003). Other authors have also pointed to the differing experiences of middle and senior managers and the complexity of their interactions as being a problematic factor in implementing

organizational change (Balogun, 2003; McWilliam and Ward-Griffin, 2006; Rouleau, 2005).

As regards the broader context within which managers have to implement change, Doyle et al. (2000) suggest that public sector managers have much less satisfactory experiences of change than their private sector counterparts. They attribute this largely to the nature of public policy which they describe as "based upon ministerial edict (combined with threat), highly controversial in substance, tight and non-negotiable timescale, no planning window, no consideration of the logistical and political implementation issues."

Moreover, politics and power struggles exist in any department or organization. Bolman and Deal (1997) outline the following political assumptions:

1. Departments and organizations are coalitions of individuals and groups.

2. There are enduring differences among coalition members in values, beliefs, information, interests, and perceptions of reality.

3. Most important decisions involve the allocation of scarce resources—who gets what.

4. This gives rise to conflict, making power the most important resource.

5. Thus, goals and decisions emerge from bargaining, negotiation, and lobbying for a particular kind of change amongst the various individuals and groups.

Many departments have a hierarchal, top-down structure where every person knows where they fall on the ladder and who makes the important decisions. This kind of dynamic can cause a wide division between those who make decisions and those who execute them, which in turn leads to dissatisfaction and mistrust among those who

execute decisions. Many times, these employees will openly rebel against the leaders or decide to covertly undermine their authority, looking for a way to gain power. In a system such as Human Services, dissatisfaction may arise on the part of providers not agreeing with decisions taken by DHS alone. It is really important to integrate providers into the process of change because they may have control of the funds for services and they connect service providers to families.

In contrast to the above-mentioned traditional structure, a different organizational model is presented in the book The Web of Inclusion (1995), authored by Helgesen. This text describes how departments can instead have models that are "web-like," with leaders placing themselves at the center of the department instead of at the top. To refer to the metaphor of the human body, if the structural frame is the bare bones of a department, then the cultural frame is the soul. Bolman and Deal (1997) state "Peak performance emerges as a team discovers its soul."

In line with leadership change and championship, organizational models, Rino J. Patti (2000) proposed a model for organizational change. The first step is to create a sense of urgency among staff regarding the need for change. As much is possible, existing data should be used to demonstrate the urgency of change. Secondly, develop an action system, and a large-scale system-integration change initiative should be guided and overseen by a "change coalition" that has representatives from all key stakeholder groups with specific delegated roles. Thirdly, there is a need to clarify the change imperative. The visions and desired outcomes should be refined and widely communicated throughout the organization. Next, the organization should assess its readiness for change by looking at the staff competencies, organization's culture, and the state of existing

processes and regulations. After the situation is analyzed, people are involved, and change management processes are in place, strategies and processes can be initiated to implement the change. Teams can be designated to engage in detailed problem solving and design new processes. Quoting Proehl (2000), Patti recommends "acting quickly and revising frequently," to ensure that the new system has the desired results, or is modified as needed. Finally, any changes made should be assessed to ensure success and the need to be institutionalized.

   If we refer to the implementation of CANS as an engine for change from a systems perspective, there are usually three basic approaches to implementation (Lyons, 2009): immediate widespread, planned incrementalism, individual/gradual.

   The *immediate widespread* form of implementation is easiest from an administrative perspective and the greatest challenge is to actually succeed in widespread effective use of the tool. The main problem with immediate widespread implementation is that the process of supporting training and good utilization is very difficult to do evenly, and the process of cleaning up the implementation can lead to what could be called implementation fatigue. Sometimes, failures in implementation get blamed on the tool itself, when the problem is actually a challenge with training or operations.

   The *individual/gradual* implementation strategy is entirely voluntary and looks more like a marketing/sales strategy. Someone is exposed to the tool, uses it, likes it, and then talks to someone else about it. Frequently individual/gradual implementations set the groundwork for system-wide implementations. Sometimes it is possible to use an immediate/widespread implementation strategy with planned incrementalism. In this strategy, the completion of the tool is immediate and widespread; everyone starts

completing it at the same time. Applications of the tool are then implemented incrementally. This approach is quite useful when there is a strong history of people using a prior tool for advocacy rather than accuracy. In other words, if people have been completing a prior tool in a certain way to guarantee a certain outcome (e.g., funding for a specific service), it is valuable to use a two-stage process to break this destructive habit. First, you get people used to using the new tool and emphasize the accuracy with which they used it. Then, after you've worked to establish a culture of accuracy, you implement those applications that have been historically driven by covert agendas, such as funding or other considerations.

On the other hand, it is believed that building an integrated system equals *planned incrementalism*. Planned incrementalism is a paced approach to implementation that tries to roll out a tool in a sequential fashion that establishes its utility and effectiveness first in smaller settings before encouraging its use more broadly.

As an example, the Illinois Department of Children and Family Services (IDCFS) is using the CANS throughout its system. The first implementation was in 2002 as a planning and outcome tool in their foster care stabilization program. Then in 2004, it was begun to be used in the residential treatment system to monitor outcomes for children and youth in the most intensive and extensive placements. Next, in 2005, the CANS was implemented in the Integrated Assessment, which occurs for all children and youth at entry into IDCFS custody. The next implementation occurred with the Child and Youth Investment Teams (CAYIT), which are used to make decisions about placement if a child or youth is thought to need something beyond regular foster care. In 2009, it began to be

used at the Administrative Case Reviews that occur for all children and youth every 6 months during their stay with IDCFS.

The advantage of planned incrementalism is that it provides a natural process for adjusting and evolving the tool to make sure it supports the work. Feedback from early experiences can be used to adjust either the tool itself or the process by which it is used. Planned incrementalism also can reduce resistance by building positive experiences that can be used for later implementations. The disadvantage is, if you have segment of the system that is highly resistant, an incremental approach may lead to a long overall struggle against this type of entrenched resistance. Despite this challenge, Dr. Lyon's experience suggests that planned incremental approaches have greater long-term sustainability (Lyons, 2004).

We have to acknowledge that sometimes there will be competing pressures arising from the incompatible or opposing goals and objectives of different offices that push or pull the system in opposite directions, and that there are structural aspects of the system that cannot be eliminated; however, it is important that these aspects are understood and managed[3].

Additionally, The Research and Training Center for Children's Mental Health at the University of South Florida[4] has developed a model of implementation factors that contributes to the development of effective system of care. The Center's model includes 14 implementation factors (please see Annex nr. 1). The model builds on, and is consistent with the earlier system of care research, and places a greater emphasis on development and interaction of the system's components.

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[3] Redressing the Emperor, Lyons 2004 (pg. 31)

[4] Report available at www.nirn.fmhi.usf.edu. Retrieved on March 4, 2010.

To summarize the core elements of an effective system-integration process we have to stress again the importance of leadership and constituency building, effective collaboration, partnership with families and youth, cultural competence, effective communication, conflict resolution, mediation, and team-building mechanisms, and of course a positive attitude. Moreover, it is important to be strategic: this includes a strategic mindset, a shared vision based on common values and principles, shared outcomes, clear goals, objectives, benchmarks, and trigger mechanisms—being opportunistic, opportunity for reflection, and adequate time.

Challenges

The overall challenge of the system of care will be reflected into issues of real integration and not just building bridges; to bring together values and principles, needs of the population of concern, system structures and functions, individualized care, family choice, performance measurement, and evidence-based treatments, all under one umbrella; and to create a system that is able to adapt to changed needs and conditions, engraving in periodic data-based review and reflection for the purpose of continuous improvement.

The challenge of the working team might lie in building a strong foundation for the system of care through effective partnerships, clear values and principles, a strong theory of change, sound performance measurement, and regular review of progress for purposes of improvement; identifying areas of strength and areas in need of strengthening; examining alternative strategies for improvements, where needed, including the expanded use of evidence-based treatments; continue the iterative process of system development

in which data are collected and used to assess the impact of changes, and the overall progress toward the achievement of system goals.

III.   THE INTEGRATIVE PROCESS IN THE ALLEGHENY COUNTY DEPARTMENT OF HUMAN SERVICES.

Before we can understand how the Allegheny County Human Service Department decided to change its philosophy and adopt an integrative approach throughout its offices, we must first examine what it represented in the past and how its offices interacted.

Until mid 1990, Allegheny County delivered a wide range of human services to its citizens through a network of independent county agencies and departments. Critics of this multi-siloed system observed, "while many individuals received services from several departments to address related challenges, there was little or no coordination of or coordination among these programs[5]". Up until that time, there was also no mechanism to track who was receiving services or what impact those services had on the lives of children and families. Therefore, one of the major change became the establishment of an overarching Department of Human Services (DHS). The system of care in Allegheny County was transformed from six County Departments into five DHS program offices: Area Agency on Aging, Office of Behavioral Health, Office of Children, Youth and Families, Office of Community Services, Office of Mental Retardation/ Developmental Disabilities. It also consolidated internal support ("Back Office") functions by creating:

 • Office of Administration - provides administrative support services for the entire DHS, including fiscal, human resources, and management.

• Office of Community Relations (OCR) - offers internal and external communications, including media relations, public events and education, and donations. Also handles consumer concerns/complaints.

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[5] According to the case study on Allegheny County that was prepared by Michael Smith of Stewards of Change titled "Building an Interoperable Human Services System How Allegheny County Transformed Systems, Services and Outcomes for Vulnerable Children and Families" (2008).

• Office of Information Management (OIM) - assists in the research and informational needs and evaluation processes for all DHS program offices.

• Office of Data Analysis, Research and Evaluation (DARE) – supports and conducts research to produce community-ready information about the work of DHS.

In 2005, the Allegheny County Human Services Department was awarded the Innovations in American Government Award from Harvard University's Kennedy School of Government for its unique approach to working with people who have behavioral health diagnoses as they are released from Pennsylvania penitentiaries. These awards are known as the "Oscars" for governance excellence.

Need for further change

Even though many accomplishments were made since the reformation of DHS, further progress was still needed in the CYF Office, particularly related to preventing a child's placement out-of-home or re-entry into care. There were 5,678 children and youth in out-of-home placement in all of the systems: child welfare, juvenile services, and mental health and mental retardation at some point in 2006. In child welfare, AC DHS's rate of reentry into care within 12 months is 27%. The vast majority are adolescents. The challenge before DHS is to reduce these numbers by creating a well trained, sustainable workforce skilled at building on strengths of families and their natural supports, and providing services and evidence-based practices that empower individuals and families.

The paper already reflected in the beginning that children and their families are often involved in more than one public service system. Families often describe the service delivery system as a maze with poor access and confusing accountability for

services. On the issue of need for change, among major complaints of families were duplicative and conflicting services. Additionally, multiple caseworkers coming to families and asking the same questions over and over (in part caused by turnover in the ranks of psychologists and psychiatrists caring for a child, which also led to lots of wasted time repeating information), all this adding to the stressful situation the family was already in. Families feel confusion about what is best for the child and family when multiple professionals are involved and are not talking to each other.

Children and adolescents with serious emotional disturbance are commonly served by multiple systems including mental health, juvenile courts, public schools, and child protective services. Historically, these systems have developed separate jargon, missions, and services. This type of "silos" of services has resulted in communication barriers between the systems and fragmentation of services. Therefore, from the systems point of view there was an acknowledged lack of coordination among human services agencies which was also noticed by insurance companies when different providers asked for funding to compensate same kind of services for the same client.

With the Department of Human Service's desire to integrate the delivery of services and expand the understanding of the population being served, the ability to un-duplicate and match individuals becomes an increasingly important task. Eleven years ago, the computer systems used by Allegheny County's Department of Human Services were a mess. Ninety-six different applications couldn't 'talk' to each other. Workers didn't know how to find information in any of them. Clients were entered into the systems multiple times, so officials couldn't figure out anything about the people they served - or even how many there were. The creation of a comprehensive view of clients

across DHS is a difficult task due to the number of existing information systems within DHS. These systems comprise many unconnected data repositories that require special efforts to present a holistic view of clients needed to support policy decisions. So, DHS's vision is to achieve integration by designing a system where, regardless of the point of entry, every individual will receive a comprehensive assessment of needs, leading to a service plan that accesses resources from all appropriate sources across systems to meet the needs of the child and family. DHS seeks to do this in a way that is strengths-based, individually tailored and empowering for consumers. The goal was also to integrate data through the creation of a data warehouse like a central repository of human services data to support clinical and policy decision-making and also allow sharing the information.

In 2007, after Pennsylvania abandoned plans to launch a statewide child welfare data system, the Allegheny County DHS initiated adoption of a Web-based child welfare system. That system, which will be tweaked to support other case-management functions and integrated with the Allegheny DHS payment system, was scheduled for completion in 2010. In 2008, Allegheny County DHS issued a request for proposals to develop an organizational structure and operations that would ensure effective management, leverage the department's ability to manage information, make data-driven decisions and implement relevant technologies. The goal, essentially, is to use all the tools now in place to their maximum individual and collective client and staff benefit.

As part of the Pennsylvania Department of Welfare's Integrated Children's Service Plan, DHS is now working to achieve full integration of all their service systems through a unified process that utilizes a single intake, single assessment and a single plan of care.

In other words, DHS is now working on the following:

• Build and sustain the foundation of growing interagency and family collaboration at the service delivery, policy, and evaluation levels.

• Implement a common assessment tool and quality outcome management processes (CANS) across Allegheny County's child service systems.

• Ensure clear interagency communication through a common language, common assessment tools/quality improvement processes.

• Use information from outcome quality management tool, CANS, and claims/encounter data to inform policy and planning decisions on a countywide interagency level.

In Allegheny County, the leader who pushed for change is Marc Cherna, director of the Allegheny County Department of Human Services (Journal Sentinel, 2009). In addition to gaining trust, the department has worked hard to cooperate with grassroots child welfare organizations and engage local business leaders. In 1997, 18 charitable foundations joined forces to establish the county's Human Services Integration Fund. Members of the foundations serve on the board of the fund, which provides money for innovative programs when the state budget can't. The fund is believed to be the only one of its kind in the nation. One of the initial projects was funded through the Substance Abuse and Mental Health Service Administration (SAMHSA) as a system of care site. Additional funding was received from the Richard King Mellon Foundation to revise and develop the information technology infrastructure, and Casey Family Programs funded the projects of improving the outcome for children by integrating the offices.

DHS has already illustrated that integrating services for children and their families is a continuous process of identifying, meeting and overcoming challenges. Developing a single assessment tool for children and their families was another of the major challenges to achieving integrated services. In fact, DHS introduced an assessment tool that provides an effective measure of the strengths and needs of the evaluated individual across all service areas or domains. In the present time, the Child and Adolescent Needs and Strengths (CANS) Comprehensive assessment tool is slowly being incorporated into the business practice at the various DHS entry points as part of the Improving Outcomes for Children and Families in Allegheny County.

Developing the CANS Comprehensive

DHS staff from the DHS Office of Behavioral Health (OBH) System of Care Initiative (SOCI) is well aware of the concept of a broadly applied assessment tool. Beginning in 1999 and continuing through 2007, SOCI staff worked with the tool's original designer, Dr. John Lyons, to adapt his earlier version into ones that would be suitable for use by different subsets of the child population in Allegheny County. Lyons (2009) describes his experience with Allegheny County as different from other projects due to the county's intent to use the CANS as an integrated assessment process. Allegheny County had very strong family representation and the effort was to develop a measure that could serve as a mechanism for creating shared meaning for families and service professionals in the service delivery process. Many referred to it as developing a common language. During the focus groups it was revealed that the traditional Likert-type rating scales of None, Mild, Moderate, and Severe didn't make that much sense for

parents, who preferred the alternative action levels described by Lyons in his presentation- No evidence, Watchful Waiting/ Prevention, Action and Immediate/Intensive Action. These ratings were not explicit aspects of the CANS at that time, just alternative ways of understanding the Likert ratings. Parents said that the action levels make immediate sense for parents, who often experience many assessments of their children and often do not know how to translate these assessments into what should happen next. Parents then struggle to hold providers accountable for following up on the findings of the assessment. Parents felt that the action levels made the relation between assessment and services planning and receipt transparent, and that was an outstanding value of the approach. Therefore CANS is a tool that can be tailored to different circumstances, including both needs and strengths in an effort to integrate competing conceptualization, and now is action-oriented in its item structure. So, the Allegheny County version of the CANS was the first full communimetric measure evolved through the shared meaning in the child-serving system between parents and professionals, and facilitates communication within the service planning process.

In June 2008, the draft version of the Allegheny County Child and Adolescent Needs and Strengths (CANS)-Comprehensive was created in collaboration and input from young adults, family, system partners, DHS staff, and community members; along with representatives from Allegheny County systems related to child and adolescent mental health, child welfare, drug and alcohol abuse, juvenile justice and mental retardation/ developmental disabilities joined together to contribute to the creation of an assessment tool that would bridge all these systems.

The purpose of the CANS-Comprehensive is to assist in the management and planning of services to children/adolescents and their families with the primary objectives of permanency, safety, and improved quality of life. This should serve as both a triage method for prioritizing services and a planning tool to help families develop action plans, identify supports, etc. Moreover, the tool had to be used not only across all age brackets of youth receiving services through OBH, but one that would be applicable and effective across all child-serving systems.

Introducing the CANS Comprehensive

The introduction of the CANS Comprehensive moved forward with great care through several phases. First, system partners and providers were gathered in casual information sessions to hear an explanation and promotion of the new assessment tool. Front-line staff, in particular those from the areas of behavioral health, mental retardation/developmental disabilities, child welfare, justice-related services and special education, were targeted in this phase. Secondly, an initial testing of CANS was performed though a pilot project. In the third phase, as hands-on testing of CANS increased, surveys were conducted to evaluate its acceptability and perceived utility among staff in the behavioral health and child welfare systems. The final phase, between June 2009 and August 2009, utilized all the feedback to create a final, more appropriate, CANS Comprehensive assessment tool.

One aspect that was not mentioned so far in the paper is that the CANS tool is flexible in rendering the possibility of having multiple versions of the tool that can address different kind of clients. DHS has three versions:

- CANS Early Childhood is an instrument customized to the needs of newborn children up until they are five.

- The CANS-Comprehensive is used for the needs of youth ages five to twenty five, and,

- CANS Short Form – was created at the request of Behavioral Health Office to meet its medical authorization needs.

The next chapters of the thesis will reflect on how DHS Offices implement and use CANS and what the process of infusion has been like, based on my research. First there will be described the methods used in the research, and then based on the findings I will make appropriate recommendations.

IV. RESEARCH DESIGN

For this research study 7 semi-structured interviews were conducted in March 2010 with representants from different DHS Offices that have been exposed to CANS. The respondents included the System Integration Specialists from Executive Office, Office of Behavioral Health (OBH), Office of Information Management (OIM), Mental Retardation/Developmental Disabilities (MRDD) and Behavioral Health Providers. They all were selected based on their involvement in developing and implementing CANS. I focused on each office's business process, their practices, and the perception regarding CANS. I encouraged respondents to reflect on the challenges the office faces in adopting CANS and making it a successful project.

At the DHS site, a combination of the cluster and snowball sampling methods was used, wherein a natural group was already evident and initial subjects recommended other possible respondents. The interviews were conducted face-to-face and inductive content analysis was used to identify the pertinent themes that emerged from the interviews. These themes include the overall knowledge of the Total Clinical Outcome Management and CANS, lobbying efforts in favor of adopting CANS and its promotion, business process accommodation and challenges that impede a smooth implementation.

The interviews provide the primary data to explore the main research questions of this thesis. Comparing the progress of implementing CANS in different DHS Offices, I aimed to determine what variables influence a successful system transformation, which can also serve as a theoretical perspective for other organizations.

Limitations

My first thought about limitations of this research lays on the unfortunate situation of not interviewing any of the Child, Youth and Family Office (CYF) which could give me an invaluable insight over their expectations and fears regarding CANS and the integrative approach. My attempt to settle an interview with the manager involved with CANS was not successful due to a busy schedule on the interviewee's part, in conjunction with the time limitation for data gathering for this research. Still, I managed to get a broad picture about CYF status on progress from all other interviews.

From the theoretical point of view, we recognize that the limitation 'accounts partial' from written reports when used for research purposes, and Floresch (2000) argues that these are overcome through an interview and participant observation methodology. Silverman (2001), however, argues that interviews are not straightforward reports either. Rather, interviews yield accounts of experiences that are constrained by the regimes of knowledge available to participants. This was important in my inquiry, as I was interested in the people's knowledge about CANS and the challenges it poses to the system they work in.

Generally, the main limitation of this research is that we cannot argue at this point whether Allegheny County is successful at integrating its services, because there are no clear results on the implementation of the CANS yet, and it is still early to discern any final conclusions regarding its infusion into DHS. The implementation is a long-term process that this research study cannot cover at the moment.

V.   DATA ANALYSIS FINDINGS

Implementing the CANS-Comprehensive

Allegheny County's CANS tools are being incrementally implemented across the child service systems. Putting the CANS Comprehensive tool to use across DHS poses its own challenges. Over time, each system will be encouraged to replace their current intake assessment tool with CANS comprehensive or some logical variation adapted to that particular system. The implementation process is still in its early stages and will continue as part of the ongoing Improving Outcomes Initiative.

Education

Since July 2008, 150 staff in Allegheny County have been trained in the draft CANS Comprehensive through an in-person training session. In the future, staff will be trained on CANS either by taking an on-line training course or attending an in-person training session. Participation in both the in-person and Web-based training will be free of charge. The training sessions have been invaluable as they have served dual purposes: became both training and an opportunity for feedback and discussion. These discussions have been extremely useful to the evaluation of the CANS thus far. Furthermore, users will have to take a practice test and score above .70 to be certified and ensure reliability of CANS.

Evaluating the CANS-Comprehensive

Since January 2009, several evaluation-related activities have been in process to explore when and how the CANS is used; whether or not family and staff find it useful; and if the tool was complete or in need of changes. Data was collected through various survey techniques, including web-based surveys (via "Survey Monkey"), phone

interviews, and feedback collected following trainings. Based on feedback received during these trainings, several changes and suggestions were made. Feedback from the Youth Support Partners identified items that were missing from CANS; specifically, the initial version did not adequately address transition-age youth needs. Additional suggestions were identified regarding the cultural domain and its need to be expanded to be more reflective of the High Fidelity Wraparound principles.

Staff from Family Links provided a different point of view as they currently receive a completed CANS with any of their children in shelter that are from Philadelphia. However, the Philadelphia version is slightly different than Allegheny County's CANS Comprehensive; it is used as a planning tool. The Family Links staff provided feedback on the necessity for a narrative to accompany the CANS score; they also confirmed the utility of the tool and how it assists them with the work they do with the children coming into shelter placement. This feedback affected the structure and elements of the tool.

System Engagement

In order to inform the many system partners and providers about the CANS, there has been an on-going engagement phase where brief informational sessions were held to encourage the understanding, utility and buy-in across the multiple child-serving systems. Although there was cross-system representation during the development of the CANS, outreach to a greater audience – specifically the front-line staff who would be administering the CANS – was needed. Multiple sessions were held with staff from Behavioral Health, Mental Retardation/Development Disabilities, Child Welfare, Justice Related Services, and some Special Education Providers.

These sessions have been useful in communicating the DHS mission to improve cross-system communication and improve the service delivery process for the children and families that DHS serves. As part of the engagement process, there have been discussions about using the CANS to replace existing system-specific assessments.

Office of Behavioral Health

OBH is the office which is pioneering the usage of CANS in DHS. Initially there was some resistance; however, respondents asserted that it was the most ready agency to accept change and they were the first one to engage in discussions.

OBH has already worked through the business process change. Due to the similarities of the CANS and Environmental Matrix (the tool currently used for assessment), they have initiated the replacement of the Environmental Matrix with the CANS. In February 2009, a subset of staff from the Office of Behavioral Health began to use the CANS and MATRIX together as a comparison to assess items, usefulness, and family reaction. All staff members using this version of the CANS were asked for feedback on their CANS experiences via a web-based survey on "Survey Monkey" and follow-up discussion groups held in March, April, and June of 2009. Their comments have led to the discussion and development of a CANS shortened version that would be used to submit for medical authorization.

This initial testing was done with six blended service coordinators who gave positive feedback, as staff expressed both the ease and usefulness of the CANS when working with children and families. Staff also provided critical feedback concerning the length of the assessment and sensitivity towards timeliness for medical authorization.

Because of these concerns, a crosswalk was done between the CANS and Environmental Matrix resulting in a shortened version that was submitted to and approved by the author, Dr. John Lyons.

In August 2009, a small pilot project was initiated with three behavioral health providers (Allegheny Children's Initiative, Human Services Administration Organization, and Mon Yough Community Services) to further compare the finalized CANS short form and the Environmental Matrix. Thirty-nine consumers had a CANS and Matrix completed by blended service coordinators. The data collection aspect of this pilot was completed at the end of September and submitted to John Lyons for his analysis. Using a predication model, Dr. Lyons analysis has led him to the conclusion that the Matrix score can be closely replicated with CANS data. The changes in the Behavioral Health Office are going to occur incrementally. The initial pilot will involve three agencies, one Service Coordination Unit (formerly known as Base Service Units) and two specialized children's blended case management agencies. Once the results are reviewed from the pilot, it will be expanded to the 12 agencies that provide service coordination to children and families in Allegheny County.

In future practice the CANS Short Version will be used for medical authorization in the first 6 units of face-to-face contact, and then followed up by the use of the full CANS assessment tool within 30 days of opening with Service Coordination/Case Management. The use of CANS data is then used by the staff, consumer and family in building a service plan from a truly collaborative approach. The more the consumer/family is involved in the assessment and service planning, the more the services are recovery/resiliency oriented and owned by the consumer and family.

In addition, in a somewhat parallel process, Adult Behavioral Health has become interested in the adult version of the CANS – the ANSA. Their interest has brought additional opportunity for consistency within DHS. A large portion of those OBH serves are transition age children who will age out of the child-serving systems and many times move into the adult system with a less than smooth transition. With the use of the CANS in both the child and adult systems, there is a potential increase in the continuity of care.

At this stage, OBH is working with the state (OMHSAS) and Community Care Behavioral Health to replace MATRIX with the CANS, and the waiver request has passed two stages of a three stage process and if approved, this would be a major step toward establishing a common tool that would replace current licensing requirements.

Office of Mental Retardation/ Developmental Disabilities (MRDD)

The majority of respondents agreed that MRDD Office is very willing to embrace the CANS into its business. As with OBH, MRDD prefers to do that with the replacements of current assessments. In fact MRDD is a state-driven agency and has to comply with many state regulations. The office uses the Home Community Service Information Service (HCSIS- a state web-based service) and any integration of the client data would have to be coordinated in a complex way with the State of Pennsylvania.

On another hand, clients involved in a multi-system process, including MRDD, usually are referred to this office from another agency, which means that a complete assessment was already done at that point. Therefore, MRDD will use the CANS only when children are released of hospitals. Another aspect worth mentioning is that MRDD is more interested in the ANSA (Adult Needs and Strengths Assessment) tool as most of

its clients are adults. However, currently, three Allegheny County MR/DD staff are trained to administer CANS. There are also a number of supports coordinators who may serve in this capacity.

One respondent shared that the decision to start the process with OBH in implementing CANS was a thoughtful one and that if OBH is successful in this process, MRDD will also follow that path.

Children, Youth and Family (CYF) Office

The CYF is a dynamic, fast-paced, intense, and hectic workplace. Unlike on a manufacturing assembly line, routine task completion and predictability are unachievable (Yamatani, Engel and Spjeldnes, 2009). The authors expressed their opinion about CYF in Allegheny County, slightly criticizing it for not managing the workloads for caseworkers. From the interviews for this paper, it was also obvious that CYF currently is in a tumultuous situation from different aspects, including learning the new information system KIDS launched in 2008 that created an overwhelming environment. It is fair to say that maybe CYF is not ready at this moment to absorb new change so recently after the last one. The initial discussions with child welfare representatives explored whether the CANS can replace the Placement and Treatment (PAT) scale. Additionally, during joint meetings the child welfare staff made some suggestions on the actual CANS tool; most of their feedback and discussion was about administering the CANS – when would it be most useful; who should administer the CANS; how do we ensure communication among staff using the CANS. However, so far, there were no final determinations as to where the CANS fits best within the child welfare business process. When asked what is

the biggest challenge with CYF, one respondent stressed the issue of staff turnover (further developed in the challenge section below).

Moreover, the quote from CYF's Integrated Children's Services Plan 2009-2010[6], accurately explains the office's perspective:

"We are a big system. How do you go about business during a transition? How do you take pilots to scale? Taking concepts 'live' and actualizing our great ideas and pilots to full scale requires intense planning and a significant investment of both human and financial resources. We are also challenged by the need to transition to a new delivery system without interrupting current service delivery to children and families."

OIM - Information System

Before reflecting on OIM's input in the transformation process, it is worthwhile mentioning that this office has a support goal. It works together with child welfare offices to build the technological system and integrate the each office's data into one common database. DHS has decided to create a database to manage referrals, collect data and generate reports.

Its original intention was to develop an in-house data system. Planning for the database, in the discussion OIM team had with different providers, it became apparent that the agencies DHS contracted with had already their own native systems and they became resistant when DHS suggested using another one. This would imply the need for additional funding from both parts and also training of staff. To address the providers'

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[6] Retrieved on March 20, 2010 from the Official Website of AC DHS
http://www.alleghenycounty.us/dhs/children.aspx

concerns, the database system will be used through multiple points of entry and, thus, will require a separate application which can be accessed by these systems. The application will accept data through direct web-based entry or through routine and frequent batching of data, and the later choice seems to be more welcomed by providers.

Each system will need to either generate or receive reports based on the data in the CANS system (please see Appendix 3 to visualize a generated CANS assessment report). A common report will be the overall profile of the child and family using the profile developed for each version of the instrument. The level of care recommendation based on the profile will also be required reporting, and may be a part of the profile report or a separate report. This will enable a continuum of care for children: integrating behavioral health, MR/DD, as well as all other prevention and intervention services that lead to healthy development, safety and stability.

Since the CANS Comprehensive represents a major step in systems integration, there has been a strong focus on encouraging buy-in from the multiple child-serving systems. Now that DHS has gone through this process and the CANS was finalized, OIM moved forward and built the final software application (it will be used first by the OBH staff). This process involved a great amount of work around understanding the new business model, developing the information system for CANS data collection (data elements, function), and building reports from the data system. The CANS data will include demographic/identifying information for the child and family, and assessment data. The identifying information will allow matching of data from each system. Demographic information will allow each system to access previously collected data in order to reduce the amount of information required by each system from the family. The

assessment data will allow each system to either use an assessment recently collected by another system, to view historical progress for the child/family, or to enter a new assessment based on changes in the child/family situation.

Additionally, OIM is working together with an external company, Communimetrics Inc. which developed an on-line service for training purposes utilizing videographic technology. The web-site will also perform annual certification of users and keep their records.

Common System Challenges

One of the biggest challenges that DHS has to address is where the CANS fits within each system – determining the **business process**. This will be addressed with key stakeholders from each system. Recommendations will then be presented to the DHS Deputy Directors for their final approval.

Child welfare staff turnover is identified frequently by respondents as one of the greatest obstacles to implementing and sustaining a continuous and sustainable infusion of the new philosophy in the system. The child welfare field often is characterized by high staff turnover, which can lead to low staff morale, excessive workloads for those who remain, and most importantly, feelings of rejection and insignificance by the child or family. A particular challenge for strengths-based care cited by respondents is orienting new staff to the systems of care philosophy, values, and practices, which can be time consuming and frustrating when it must be done repeatedly as new staff members are hired.

Another concern worth mentioning is the **mindset and language of the system of care,** which is the shared understanding from which the system is developed. This

represents commonly held values and beliefs about what is important for children and families that are widely held within and across service sectors. The commitment across agencies is the idea that the needs of the child and family come first. However, every office in the system has its own culture and language. The "aftercare" concept in Behavioral Health doesn't necessarily mean the same in CYF. So respondents alleged that even though the agencies operate with the same terms, the notions and the language are different and sometimes they even contradict each other. The Executive Office realized this during the training sessions on CANS. Trainees would score the form items so differently from one agency to another, mainly due to the lenses they used to see and assess a case. The MRDD workers would see a case from the point of a crisis and score higher than the average trends and CYF people were more concerned with the risk implications. Therefore, creating a common language and a common mindset is challenging and we all should consider the time variable to allow offices to absorb the change.

Therefore, bringing together different service delivery systems into a unified, integrated system is, indeed, challenging. The systems that are part of our integration efforts have a variety of processes, differences in culture, and different goals. Collaboration among systems requires letting go of individual structures for a unified culture, and this can be difficult to achieve.

Information sharing with DHS's cross systems partners, as well as contracted partners who aren't part of the DHS system, is already an issue. DHS is working to determine what, if any, barriers to sharing information do exist, and if so, then policy and regulatory changes may be needed to enable implementation of an integrated service

model. Allegheny County will request technical assistance from the Commonwealth to clarify policies regarding information sharing among various agencies and systems, and if needed, seek to identify potential solutions regarding changing or allowing waivers of regulations. So far respondents have shared that there are two options in dealing with this kind of problem: the agency would have to request a release of information from the agency that has the information, a process which can be time consuming; or at intake the client would sign a waiver of confidentiality, which again is not perfect because it raises some questions regarding the length in time the waiver would operate and the language should be very specific. Clients usually are very reluctant when it comes to sharing information about their problems; therefore, the language of the waiver should be very specific in terms of what kind of information is allowed to be shared. On the other hand, one could argue that the issue of confidentiality can jeopardize the purpose of CANS, whose main strength is based on communication among agencies and sharing information to better address the needs of the clients in a holistic way. In conclusion, DHS will have to give a lot of thought to the confidentiality issue and even if the solution will not be as flexible as intended to be, instead people's rights will be protected. Some respondents have voiced that if CANS were to be used statewide there would be no issue with confidentiality as seen today, in the sense that there could be a uniform regulation enhancing the CANS philosophy.

During the interviews and at one of the joint meetings, participants expressed the concern regarding **continuous training** about CANS. As someone said "there is a tremendous need for education, because there is a tremendous amount of misinformation." Continuous training will serve the educational purpose and also ensure

the reliability of the tool[7]. Another respondent suggested continuous "refreshment" from the initial training and certification, until recertification. DHS considers having an on-line tutorial through the Communimetrics website; however, additional "refreshers" would be an asset.

The following concerns were also expressed in the interviews:

- Technological readiness of providers to adopt the new information system DHS is building. All systems will definitely incur additional costs to make the project feasible.

- The provider's accountability for the information they will have access to through the common information data-base. A mechanism is needed to make sure that one agency's staff will look for information directly related to their clients, to avoid and track conflict of interest cases.

- Another issue that arose up briefly in one interview is the concern that CANS not to become a fiscal tool, as many tools are misused currently[8].

Future Challenges

Having a completed version of CANS, future talks will be related to **algorithms** and **level of care determination**. The CANS instrument provides numerous data points that rate the child's needs within the domains of behavior/emotions, risk behaviors, and functioning as well as the child's strengths. An assessment of the caregiver's needs and strengths is also obtained. Using these data points to make a determination of the level of

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[7] Making reference to reliability of the tool, an issue might arise with personnel who fail to score high enough in order to be certified. The question is whether there will be a mechanism to address this kind of problem.
[8] Additional information regarding this issue was already addressed in the Chapter "Literature Review".

care needed by the child and family in order to achieve positive outcomes from services requires a rigid process that analyzes the data and provides this decision support.

Two major steps are required to develop this decision support methodology.

1. Levels of Care will be defined by a cross-systems workgroup. Members of this workgroup have been identified from the Executive Office and Office of Behavioral Health and the group has started meeting.

2. After the levels of care are defined, algorithms based on ratings of each item under each domain will be written. These algorithms will work with the data collection system to analyze the data and report the recommended level of care. Dr. Lyons will be involved in the process to define the rules for the algorithms.

The algorithms will allow the calculation of level of care recommendations that can be used by the systems for decision support. During the first year of implementation, refinement of the algorithms is anticipated as mental health providers begin to compare the recommendations with actual treatment decisions. A long term objective of this process is to use recommended level of care compared to implemented level of care as a quality measure for the system.

DHS considers instituting the status of "**Super Users**" in CANS. These will be champions from each agency or office who achieve a reliability score of .81 or higher on the test. They will be trained to support local implementation of the CANS –training, supervision, and integration into everyday practice. Through the Super Users and a web-based training and certification system, DHS staff and provider personnel will be trained and certified to use the CANS. Super Users will provide assistance to local staff with

online training certification, the content, and scoring of the information. The role of the

Super User will evolve to perhaps monitor certification of staff locally.

VI. CONCLUSIONS

In the last decade, the Allegheny County constituents could witness the transformation of a widely criticized system of siloed services into a single Department of Human Services based on innovative business concepts and integrated technology. Allegheny County DHS encompasses multiple services and systems including behavioral health, child welfare, and MRDD. Although each system has its own unique goals, perspectives, and requirements; together they share a common goal to better serve the children and families of Allegheny County. As an attempt to improve service delivery and ultimately outcomes for children and families, DHS decided to move towards a common assessment tool (*CANS Comprehensive*) shared across the child-serving systems that would lead to a shared service plan and an overall integrated service delivery process. The primary concept of the CANS is to support communication. Since the children's service system is diverse and complex, part of the concept is to support communication across different child-serving agencies and approaches. The CANS assessment tool is also intended to gauge the needs of the child through one assessment; in turn, the family does not need to go through multiple assessment routines. Demographic information and assessment data that can be accessed by any agency working with the child and family is expected to minimize the confusion and frustration of these families while also creating a bridge among the agencies.

There are three primary uses for the various CANS tools - decision support, quality improvement/assurance, and outcomes monitoring. Probably the most common application of the CANS is as a decision support tool for level of care and service planning purposes. As argued in the previous chapter, the ongoing challenge is to use

technology as a tool to increase accessibility to information and protect client privacy and confidentiality while ultimately improving outcomes for children and families.

The research performed reveals that Allegheny County Department of Human Services is engaged in an incremental system change and chose Office of Behavioral Health to pioneer the transformation and serve as an example for other offices.

The thesis reflected on the challenges the system faces in the process of change (a research question posed at the beginning of research). These challenges include training issues, sharing of information from the confidentiality standpoint, staff turnover, and most importantly, changes of the mindset and culture of constituent agencies within DHS.

VII. RECOMMENDATIONS

Based on the research and conclusions stated above, I have two major recommendation: DHS should continue the implementation process using the incrementalism approach, and educate the system through continuous training.

Starting from the idea that large bureaucratic agencies inherently resist change and when the proposed change effectively reduces one's discretionary decision-making, the resistance increases dramatically; hence DHS should give the system enough time to allow it absorb the change. As the research notes, CYF is in the middle of accommodating a recent major change, and MRDD being a state-driven office, needs to rely on the OBH's successful implementation in order to fully engage in the process. Moreover, the biggest change is integrating the cultures of different offices within DHS, thus the issue is more sensitive. One cannot change someone's understanding, beliefs and "language" over night. A step by step process is needed.

Strebel (2009) recently wrote that "a smart implementation process and leadership capitalizes on and adapts to the forces of change and resistance. It doesn't try to battle needlessly against these forces. For example, big moves with a small window of time for execution demand faster implementation than those that leave more time for deliberate execution. Big moves that face strong resistance require a top-down process to break through the obstacles, whereas when people are able and willing to make the move, a bottom-up process creates commitment."

Secondly, it is recommended to always train new users of these measures in their proper application, because even though it hasn't been reiterated that CANS would have a problem of reliability or validity, given the fact that this communimetric tool is

different than most other measurements strategies in both their design and use, therefore staff needs more training to linguistically switch from one tool to another.

Moreover, the single best strategy to ensure that a measure is used with reliability and validity is to make sure that it is, in fact, fully utilized. This will be achieved when all staff and providers will acknowledge the utility of CANS and its philosophy. CANS should pass from a simple form, which case workers have to fill out because someone told them so, or a tool – something that helps them in their work, to a framework, where all the workers could recognize it as their work.

Finally, the majority of respondents agreed on the need to continue lobbying for the use of CANS statewide and be aware of the U.S. politics dynamic. If CANS were to be used statewide it would eliminate a lot of concerns in regard to free sharing of information caused by restrictive regulation. The success will not take too long because as Dr. Lyons said: "identifying the "right thing to do" is the moral mechanism for change."

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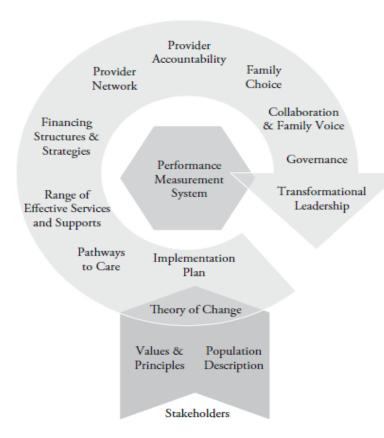
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Official Website of Allegheny County Department of Human Serivces

http://www.alleghenycounty.us/dhs/index.aspx

APPENDIX 1

Figure 1
Factors Contributing to Implementation of Effective Systems of Care

Provider
Accountability

Provider
Network

Family
Choice

Collaboration
& Family Voice

Financing
Structures &
Strategies

Performance
Measurement
System

Governance

Range of
Effective Services
and Supports

Transformational
Leadership

Pathways
to Care

Implementation
Plan

Theory of Change

Values &
Principles

Population
Description

Stakeholders

Source: The Research and Training Center for Children's Mental Health at the University of South Florida. Retrieved on March 20, 2010 from http://www.fmhi.usf.edu/institute/pubs/pdf/cfs/rtc/18thproceedings/18thChapter01.pdf

APPENDIX 2: A version of CANS Scoring Sheet
Source: Allegheny County DHS Executive Office

CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)

Please √ appropriate use: ☐ Initial ☐ Reassessment   **Date:** | M | M | D | D | Y | Y |
☐ Transition/Discharge

| m | m | d | d | y | y | ☐M ☐F

Child's Name   **DOB**   **Gender**   **Race/Ethnicity**

Current Living Situation:

Assessor (Print Name):   **Signature**

Caregiver Name: **Relation**

Provider Agency:

LIFE DOMAIN FUNCTIONING

0 = no evidence of problems   2 = help needed, moderate
1 = let's watch, mild   3 = immediate help, severe

		0	1	2	3
1	Family	O	O	O	O
2	Living Situation	O	O	O	O
3	School	O	O	O	O
4	Social Functioning	O	O	O	O
5	Recreational	O	O	O	O
6	Developmental	O	O	O	O
7	Communication	O	O	O	O
8	Judgment	O	O	O	O
9	Vocational	O	O	O	O
10	Legal	O	O	O	O
11	Medical	O	O	O	O
12	Physical	O	O	O	O
13	Sleep	O	O	O	O
14	Sexual Development	O	O	O	O
15	Natural Supports	O	O	O	O

YOUTH RISK BEHAVIORS

0 = no evidence of problems
1 = let's watch, mild
2 = help needed, moderate
3 = immediate help, severe

		0	1	2	3
26	Suicide Risk	O	O	O	O
27	Self-Mutilation	O	O	O	O
28	Other Self Harm	O	O	O	O
29	Danger to Others	O	O	O	O
30	Runaway	O	O	O	O
31	Gang Involvement	O	O	O	O
32	Fire Setting	O	O	O	O
33	Social Behavior	O	O	O	O
34	Bullying	O	O	O	O
35	History of Violence	O	O	O	O
36	Sexual Aggression	O	O	O	O

YOUTH BEHAVIORAL / EMOTIONAL NEEDS

0 = no evidence of problems
1 = history or sub-threshold, watch/prevent
2 = causing problems, consistent with diagnosable disorder
3 = causing severe/dangerous problems

		0	1	2	3
16	Psychosis	O	O	O	O
17	Impulsivity / Hyperactivity	O	O	O	O
18	Depression	O	O	O	O
19	Anxiety	O	O	O	O
20	Oppositional	O	O	O	O
21	Conduct	O	O	O	O
22	Adjustment to Trauma	O	O	O	O
23	Anger Control	O	O	O	O
24	Substance Use	O	O	O	O
25	Eating Disturbance	O	O	O	O

CAREGIVER STRENGTHS & NEEDS

O Not applicable - no caregiver identified

0 = no evidence of problems
1 = let's watch, mild
2 = help needed, moderate
3 = immediate help, severe

		0	1	2	3
37	Supervision	O	O	O	O
38	Involvement with Care	O	O	O	O
39	Knowledge	O	O	O	O
40	Organization	O	O	O	O
41	Social Resources	O	O	O	O
42	Residential Stability	O	O	O	O
43	Physical Health	O	O	O	O
44	Mental Health	O	O	O	O
45	Substance Use	O	O	O	O
46	Developmental	O	O	O	O
47	Accessibility to Care	O	O	O	O
48	Family Stress	O	O	O	O
49	Safety	O	O	O	O

APPENDIX 3: A sample of CANS assessment report
Source: Allegheny County DHS Executive Office

YOUTH INFORMATION			
Name			Referral date:
Date of Birth:		Gender:	CANS Specialist
DHS ID:			Date CANS Started:
DHS Program Analyst:			Date CANS Completed:

LIFE DOMAIN FUNTIONING			
ITEM#	SCORE	ITEM	JUSTIFICATION
1	3	FAMILY Please rate the highest level from the past 30 days	X was adopted by MGM when mother could not parent in 2002. Her older sister is in the home and they get along fine, according to SW. She went AWOL from home from 3.20/09-4/14/09. Adopted mother reports that X does what she wants and is resistant to adult direction, won't attend school and does not return home when necessary. Per reports, X is also not consistent with OP treatment and has refused to take prescribed medication. Adopted mother (MGM) is refusing to take X home at this time, X stated that she wants to eventually return home, but due to some conflict with caregiver, she is ready to go into care at this time. Rep X BM is "locked up again- I think, violation of parole." When asked how she felt about that – she indicated that it bothered her somewhat, but "it is just what it is".
13	3	SCHOOL BEHAVIOR Please rate the highest level from the past 30 days	Truancy and suspension concerns. 38 unexcused absences this year. 9 suspensions at this time. Issues include not obeying directions, having beepers, cell phones and other devices at school, trespassing and loitering, tardy to school or class, profanity use, fighting and threatening behavior and use of tobacco products. School has wanted her to go to a disciplinary school. SW recently re-instated her in school due to a suspension for fighting.
ITEM#	SCORE	ITEM	JUSTIFICATION
23	1	TALENTS/INTEREST Please rate the highest level from the past 30 days	X Reports that she has talent in writing.
24	1	SPIRITUAL/RELIGIOUS Please rate the highest level from the past 30 days	X reports that she goes to church.
ITEM#	SCORE	ITEM	JUSTIFICATION
44	2	DEPRESSION Please rate based on the past 30 days	DX of Bipolar D/O, as reported by adopted mother and X, X reported that she was diagnosed at Horsham clinic last year. SW reports that X has admitted to having mood swings. MGM reported that her mood in unpredictable, per SW. Psychological evaluation is scheduled for 4/23/09. Medications, Including EFFEXA, ZOLOFT and ABILIFY, were last prescribed in 7/08. X has refused to take the prescriptions.