In-Depth Technical Assistance (IDTA)

Final Report 2007-2012

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Executive Summary

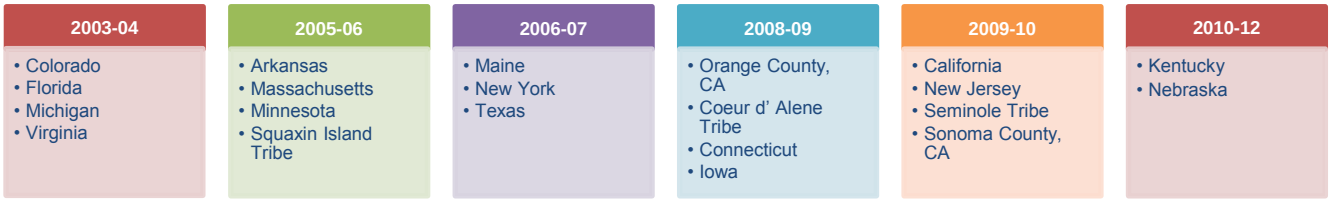
Introduction

The National Center on Substance Abuse and Child Welfare (NCSACW) provides In-Depth Technical Assistance (IDTA) that strengthens collaboration and linkages across service systems and family courts to improve outcomes for families with substance use disorders who are involved in the child welfare and family court systems. The 18-month program provides substantial support and expertise through a unique technical assistance model that matches a site's strengths, needs and priorities with a senior level consultant for approximately 32 hours per month.

IDTA is provided in a systematic, phased approach, with specific timeframes associated with each phase.

- Phase 1: Site Outreach and Engagement
- Phase 2: Site Team Development and Orientation
- Phase 3: Collaborative Action Planning and Product Development
- Phase 4: Implementation, Evaluation and Sustainability Planning
- Phase 5: Re-engagement and Institutionalization

Launched in 2003, IDTA provided assistance to 21 State, county and Tribal jurisdictions:



Impact on Children and Families

Combining evidence-based program strategies, the technical assistance provided through IDTA, and each IDTA site's individual needs and priorities, IDTA sites accomplished the following:

- **Memoranda of Understanding for Working Across Agencies**—addressed underlying values in developing collaborations that resulted in formal MOU or working agreements.
- **Recovery Specialist Models**—implemented, expanded or enhanced a recovery specialist model to expedite access to treatment services, increase rates of children remaining or reunified with parents and decrease time in out-of-home care.
- **Cross-Systems Workforce Development**—developed and/or implemented cross-system training plans, including adopting the NCSACW Child Welfare Training Toolkit and online tutorials
- **State Administrative Changes**—implemented changes such as prioritizing parents with child welfare involvement for substance abuse treatment admission, contracting requirements, state certification of provider organizations, and policy changes related to Medicaid reimbursement and Medication Assisted Treatment (MAT).
- **Screening Protocols**—developed, implemented and refined screening and assessment protocols to eliminate redundancies and increase referrals to appropriate agencies.

- **Parent Partner Models**—developed and implemented parent partner programs to increase rates of service plan engagement
- **Family Dependency Drug Courts**—implemented Family Drug Courts or incorporated therapeutic approaches into their Dependency Courts
- **Data Informed Systems**—used cross-system data collection and mapping processes to inform policy, program and practice decisions.

Lessons Learned and Major Themes

The IDTA program provides NCSACW with several key lessons that are used to further refine the program and facilitate sustainable systems-level change. Following are lessons learned over the last five years, drawn from the successes, challenges and efforts of the CLs and NCSACW staff. The lessons are grouped into four primary themes: 1) Project leadership: Engaging and sustaining partners in the process; 2) Identifying opportunities for change: Being problem focused and data driven; 3) Establishing shared outcomes and joint accountability; and, 4) Implementing and sustaining system-level changes.

1. **Project leadership: Engaging and sustaining partners in the process**
    - Define the incentives for each partner to invest in collaboration
    - Discuss underlying values
    - Clarify expectations of each system with agency leaders
    - Identify essential partners early in the process
    - Include pilot sites to test changes
    - Involve key decision-makers
    - Plan for the inevitable and challenging changes in leadership
2. **Identifying opportunities for change: Be problem focused and data driven**
    - Identify a specific need, concern or issue
    - Gather baseline data
    - Emerging issues and crises may provide opportunities for change
    - Use diagnostic tools to clarify the problem statement
    - Use diagnostic tools to identify opportunities for change
    - Connect with existing outcome measurement initiatives
3. **Establishing shared outcomes and joint accountability**
    - Start with a clearly defined logic model
    - Outcomes must be both short-term and long-term
    - Determine how outcomes will be measured
    - Plan for unintended consequences and misconceptions
    - All partners must be accountable for identified outcomes
    - Connect workgroup activities to the identified outcomes

4. **Implementing and sustaining system-level changes**
    - Leverage resources across systems
    - Establish timelines and expectations for implementation
    - Document outcomes and implications for system-level change
    - Maintaining a high level of visibility
    - Connect to related collaborative projects

Purpose and Background

The National Center on Substance Abuse and Child Welfare (NCSACW) program of In-Depth Technical Assistance (IDTA) has had a far-reaching impact on States, Tribal governments and communities, now having served 21 sites—16 States, 3 Tribes and two Counties. These sites continue to develop exemplary practice models for cross systems collaboration. Work products from their activities are posted on the NCSACW website. Sustainable system-level policy, program and practice changes require sufficient time to implement and measure the impact of those changes. Sites that participated in IDTA often return to NCSACW to request additional follow-up technical assistance. This report provides an overview of the IDTA program model, the sites served and their accomplishments, as well as lessons learned in facilitating systemic change at the State, Tribal and county levels.

IDTA Program Model

The IDTA program uses proven change management strategies to build the capacity of States, Tribes, counties or regions to collaborate and promote systems change to improve child and family outcomes. The IDTA program provides strategic, intensive TA to jurisdictions that are struggling but are committed to achieving improved outcomes for these families. IDTA is provided in substantial depth and duration to produce lasting change, incorporating cross-agency involvement and multi-source support as necessary elements of the design.

The IDTA program is designed to help governmental jurisdictions (States, Tribes and large counties) manage the challenges inherent in developing a collaborative approach to the issues of familial substance use and mental disorders among the child welfare and dependency court populations. As a result of the IDTA, participating sites achieve meaningful improvement in the way these families are collectively served by the lead entities. The NCSACW enlists three specific entities to provide leadership for the IDTA-related initiative, while also encouraging the inclusion of the numerous other organizations, systems, disciplines and stakeholders that touch the lives of the families that comprise the target population. These three entities are:

> *Dependency Court Systems* – with jurisdiction in cases of child abuse and/or neglect and include both the judicial officers and the attorneys who represent parents, children, social workers and the State in court processes
>
> *Child Welfare Systems* – with primary responsibility to ensure the safety and well-being of the child, which includes addressing the child's need for a permanent and loving home within twelve months of case opening for children placed in out of home care. The system is also charged with the legal responsibility to make reasonable efforts to reunify the family
>
> *Substance Abuse Treatment Services Systems* – with primary responsibility to address substance use disorders, guiding the client to sobriety and recovery. They also have a legal mandate to report suspected child abuse or neglect

The IDTA program provides a multi-faceted approach to facilitating system change that is based on a framework of collaborative linkages and policy tools that have proven effective in the provision of IDTA over the last ten years. The participating sites benefit from a constellation of interventions tailored to the site that focus on cross-system collaboration and are designed to create lasting change. These interventions are enriched by an increasingly broad resource and knowledge base that is readily available on the NCSACW website to promote the goals of NCSACW and support the sites in achieving their objectives.

The IDTA approach to guiding change is planned and structured, but also takes into account the reality that systems-level change rarely unfolds in a straightforward, linear fashion. IDTA is provided in a systematic, phased approach, with specific timeframes associated with each phase. The program's intensity and duration position each site to begin the process of realigning the policies and practices of its multiple systems, developing a plan for ensuring that the changes are sustainable and supporting the progressive interdependence of the three lead systems. During this contract, the site teams were guided through the following phases to establish joint outcomes, develop collaborative agreements, identify and prioritize cross-system strategies, and develop new policies and protocols that lay the groundwork for broad practice-level change.

Phase 1: Site Outreach and Engagement (3-6 months pre-IDTA)—Phase 1 establishes the relationship between NCSACW and the potential IDTA site. Activities during this stage form the foundation for successful engagement and include: (1) outreach and marketing; (2) assessing sites' strengths, capacity and readiness for change; (3) analyzing sites' context, needs and resources; (4) identifying and nurturing a site's "change leader," who will likely become the key project liaison; and (5) establishing an informal relationship with other key representatives. At the end of Phase 1, sites that meet the established criteria and are approved by the Contracting Officer's Representative (COR) are invited to submit a formal application to receive IDTA for an uninterrupted 15-month period (Phases 2 through 4).

Concurrent with the site's application process, a Consultant Liaison (CL) is assigned to each site selected to participate in the IDTA program, based on a needs assessment that matches the CL's skills and knowledge to the unique needs and priorities of the site. The CL facilitates the development of the Scope of Work (SOW) and corresponding work plan, and assumes lead responsibility for facilitating the implementation of the work plan and required technical assistance.

Phase 2: Site Team Development and Orientation (IDTA months 1-3)—NCSACW, the CL and the sites work together during Phase 2 to establish and orient the site team, define the structure within which the IDTA effort will operate, and engage additional stakeholders. This phase also involves collecting and analyzing data from each system to develop recommendations that inform joint priority-setting and the eventual development of a work plan, which guides IDTA activities. Phase 2 activities have included:

- Establishing the Core Team and the Oversight Committee
- Conducting a Cross-Site Orientation Meeting
- Launching the IDTA activities in an on-site Kick-Off Meeting
- Conducting multi-system data collection and analysis
- Engaging in joint visioning
- Establishing a set of cross-system values and guiding principles
- Identifying mutual priorities
- Inviting key stakeholders to participate on the Advisory Committee
- Administering a Collaborative Capacity Instrument

The IDTA program involves a fairly prescribed team model for project leadership and management. This project structure is designed to facilitate sustainability, communication, and

broad-level buy-in for the project and the systems change that it promotes. The figure below highlights the structure and roles for the IDTA team, comprised of the following entities:

a) **Oversight Committee** – Displayed at the top of the figure below, the Oversight committee is comprised of the top executives in each of the lead entities. This Committee oversees and designates the Core Team, facilitates the policy changes and identifies and works to remove system barriers.

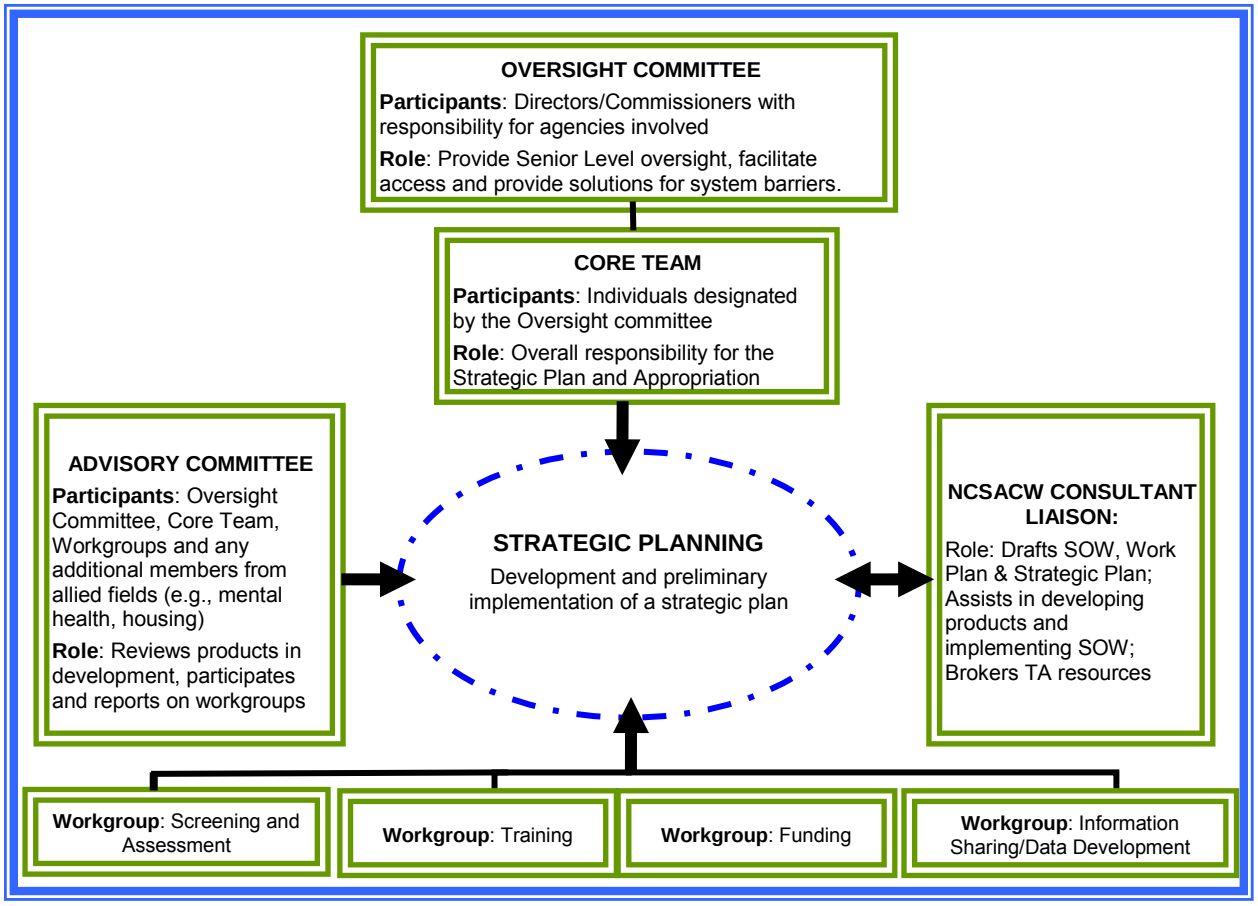
b) **Core Team** – Designated and led by the Oversight Committee, the Core Team is comprised of mid-management level representatives from each of the three lead entities, in addition to representatives of additional select organizations (ideally consisting of no more than 6-8 individuals). The Core Team is charged with the overall responsibility for the Strategic Plan and carrying out the policy changes at the organizational level.

c) **Advisory Committee** – Comprised of Oversight Committee, Core Team, members of the community and key stakeholders, the Advisory Committee reviews products in development, participates and reports on workgroups and contributes to the Strategic Planning.

d) **NCSCAW Consultant Liaison** – This NCSACW staff member is responsible for drafting the Scope of Work, Work Plan and Strategic Plan; assists in developing products and implementing the Scope of Work; and provides technical assistance to the team.

e) **IDTA Workgroups** – Comprised of team members from the Core Team and Advisory Committee, the work groups are determined by the priorities and work products of the IDTA project.

As depicted in the figure below, each of the five entities listed above works together and feeds into the Strategic Planning, which consists of the development and preliminary implementation of a strategic plan for the IDTA project. Having this specific project structure in place accommodates: 1) *Sustainability* through the authority and endorsement of the Oversight Committee; 2) *Communication* through the system of accountability that is implicit in the hierarchical relationships as well as the peer-to-peer relationships; 3) *Regional broad-level buy-in* through the participation and investment of the diverse stakeholders that make up the Advisory Committee; and, 4) *Internally supported change* through the investment and commitment of multiple systems to achieve defined outcomes.



The discovery process incorporated into Phase 2 accommodates collaborative visioning based on information and data analysis that leads to establishing a set of articulated shared values, guiding principles and attainable goals. This process also provides important contextual information that determines which stakeholders need to be engaged to ensure that joint outcomes can be realized.

Benchmark activities designed to guide the site through this phase include: 1) a *Cross-site Meeting*, which brings multiple IDTA sites together to exchange ideas, introduce their proposed products, share their experiences, and meet the key Federal and NCSACW staff involved in the IDTA program; and, 2) the *Site Kick-off Meeting*, which is a two-day strategic planning meeting that engages the site's full team of stakeholders, provides and orientation to the IDTA Program and introduces the site's goals as identified in their application. This meeting also provides participants with basic knowledge of the organization, vocabulary, resources, and challenges of each of the partnering systems, and culminates in establishing the collaborative priorities and desired outcomes for the TA. The activities in Phase 2 set the stage for defining necessary deliverables to be included in the site-specific scope of work and detailed work plan, which is fully developed during Phase 3.

Phase 3: Collaborative Action Planning and Product Development (IDTA months 4-10)— After identifying the site's priorities and generating joint recommendations to address those priorities based on a Ten-Element Collaborative Framework, Phase 3 is focused on developing those recommendations into a detailed scope of work and corresponding work plan that defines the IDTA objectives, project deliverables and responsible party, needed resources and desired

outcomes. The Work Plan serves as the site's "roadmap" throughout the period of IDTA, providing guidance to the workgroups assigned to complete specific products and tasks. Both the scope of work and work plan are approved by the COTR which helps ensure that the site's plan is well-thought out and will yield meaningful results. To support long-term sustainability of the outcomes of the IDTA, the CL and the Core Team work closely with the Oversight Committee to integrate the work plan into an overall change management plan that can be incorporated into the existing strategic plans of the lead systems.

The specific products and deliverables, and the process for accomplishing those, are tailored to fit each site's unique characteristics, strengths, needs and resources. Expected deliverables include:

- A set of protocols, guidelines, and/or a toolkit that facilitates front-line collaborative practice;
- A training delivery plan that supports joint training efforts of the lead systems;
- A data development plan that establishes strategies for addressing gaps in cross-system information collection and reporting; and
- A collaborative funding plan that supports sustainability by identifying opportunities for sharing resources and leveraging available funding streams in innovative ways.

Phase 3 includes a mid-point self-assessment to examine efforts and progress to date, and employ midcourse corrections as needed. It also provides explicit reinforcement that the IDTA, while extensive, is time-limited and that the site is ultimately accountable for its progress. During Phase 3, sites also engage in ongoing marketing and communication about the project's goals and strategies to enlist statewide support and buy-in. The resources, tools and product templates developed by NCSACW and the sites in previous IDTA sites are leveraged to assist new IDTA sites move efficiently through this Phase.

Phase 4: Implementation, Evaluation and Sustainability Planning (IDTA months 11-15)— In this phase, sites focus on developing concrete steps for broad-based implementation, including the identification of resources to both evaluate the impact of their effort and institutionalize and sustain those activities that result in positive change. In this context, evaluation applies to measuring a site's progress with cross-systems collaborative development, as well as its capacity to implement the work plan and achieve the desired results.

Using the principles of *rapid-cycle testing* to accommodate implementation-specific evaluation, sites are encouraged to pilot their change strategies at the local level to obtain feedback about what works and what does not, to ensure that the project's outcomes reflect the improvements that were envisioned. While this feedback loop on product use and improvement is expected to be continuous, the key benchmark of Phase 4 is the finalization of products for broad dissemination, including nationwide distribution via the NCSACW website. The 15-month period of IDTA ends with a site-wrap up meeting at the end of Phase 4, which offers the opportunity for NCSACW representatives to meet with the site's top level leaders in conjunction with the entire Site Team to present accomplishments and discuss challenges related to sustaining the collaborative system-level change that has been achieved.

Phase 5: Re-engagement and Institutionalization (up to 6 months post-IDTA)—To support the site in addressing any remaining challenges, follow-up TA is made available for a limited time to those sites that request it and can justify the additional allocation of NCSACW resources. A new SOW and work plan is developed, using a process similar to the one used to

develop the SOW in Phase 2. The SOW describes the allocation of resources by NCSACW and the site to accomplish the measurable goals, as well as any specific deliverables needed to resolve challenges and support site progress. Follow-up TA might include: establishing a jointly funded site coordinator position, providing targeted TA for local implementation efforts, or conducting cross-system training activities.

Phases 4 and 5 conclude with a final site evaluation of the TA services they received from NCSACW, including the opportunity to provide feedback on how to improve the IDTA program for future sites. Additionally, sites that have received IDTA will be offered the opportunity to participate periodically in NCSACW-sponsored leadership academies, where their capacity to serve as mentor sites to new IDTA recipients is supported.

Role of the Consultant Liaison

The CL facilitates the development of the scope of work and work plan for each site and assumes lead responsibility for facilitating the implementation of the work plan and required technical assistance. The CL works with a site for an average of one day (8 hours) per week, combining his or her professional background, skills and experience in facilitating system-level change, familiarity with public financing, knowledge of promising practices and access to nationwide resources with an independent perspective to serve as an effective catalyst for change. This time is utilized for both off-site and on-site technical assistance. On-site visits occur on an average of every 8-10 weeks.

CLs are senior-level professionals with extensive experience and knowledge in the areas of child welfare, substance abuse treatment, and dependency courts. Most have worked at multiple tiers in at least two of the three lead systems, from the frontlines of community-based organizations to executive-level experience in governmental agencies. They possess the necessary technical expertise that allows them to knowledgably communicate on multi-systems issues. The CL's responsibilities include:

- Facilitating the development of the SOW and work plan
- Determining and coordinating the technical assistance needs of the site
- Fostering cross-system communication and collaboration
- Providing a neutral perspective on issues and problem-solving
- Conducting research and assisting with product development, material preparation, review and feedback
- Supporting collaborative leadership development
- Maintaining an outcome-driven focus for the site team
- Disseminating resources on model programs, evidence-based and promising practices, and emerging research
- Reporting to NCSACW and its CORs on site-specific progress, barriers, and lessons learned

The CLs also broker additional resources to harness NCSACW's continuum of training and technical assistance services and network of national experts to support each site's success. The sites are provided with access to experts via teleconference, web-based and in-person meetings on topics such as Family Drug Courts (FDC), NIATx process improvement, substance

abuse specialists in child welfare and court settings, funding and sustainability, confidentiality and substance exposed newborns. Sites are also provided support in integrating Child and Family Service Reviews and Program Improvement Plan goals into the IDTA SOW.

By providing guidance, facilitation, and content expertise, in addition to leveraging each site's existing strengths and resources, the CLs and IDTA support:

- A new way of communicating among professionals across systems on policy, program and practice issues.
- Increased sensitivity among diverse stakeholders, from courtroom to agency to provider about differences in system language, mandates, values, and priorities that must be recognized and incorporated into a new way of doing business.
- A platform for creatively combining, redesigning, reallocating, redirecting or identifying new sources of support by reviewing the capacity of all three systems to address the needs of families collectively rather than as fragmented, uncoordinated efforts.
- Better understanding about the most pressing needs of the distinct communities within a given jurisdiction, as well as the gaps in available resources, through improved communication with a broad array of stakeholders at the local level.
- The collection and synthesis of data and critical information across all systems that allows stakeholders to set priorities and make informed decisions regarding those priorities.
- The capacity of stakeholders to maintain their commitment to cross-systems collaboration while adapt and respond to significant contextual events that demand the attention of one or more of the agencies.
- Strategies that facilitate sustainable change.

Collaborative Policy, Practice and Diagnostic Tools

The Ten-Element Collaborative Framework is used for both diagnosis and tracking in each of the IDTA sites to illuminate needs and priorities, guide the identification of individual and system stakeholders needed to create a team capable of developing effective policy and practice change, and assist each site in assessing its unique strengths, collaborative culture, and untapped resources. To support this collaborative framework, NCSACW uses several diagnostic, policy and practice tools (detailed below) that help sites improve their practice and policy responses.

These tools spotlight practices and policies that link agencies in new and effective ways in responding to the needs of children and families affected by substance use disorders and child maltreatment. Each of these tools have been revised and tested against the realities of collaboration, and each has been welcomed by its users to improve their collaborative capacities.

Collaborative Practice Framework	
Framework and Policy Tools for Improving Linkages between Alcohol and Drug Services, Child Welfare Services and Dependency Courts	Explains a framework for assessing the components of collaborative efforts to address the substance abuse issues among families in the child welfare and dependency court systems. This ten-element framework is a tool for assessing collaboration across systems, specifically the identification of benchmarks for improving system linkages, which are fundamental to improving outcomes and long-term well-being for families in the child welfare system with substance use disorders. http://www.ncsacw.samhsa.gov/files/NewFramework.pdf
The Collaborative Practice Model for Family, Safety and Stability	The *Collaborative Practice Model* is a publication by CCFF that compiles in one document the tools and models that have been used by collaborative teams at state and local levels throughout the nation. The *Collaborative Practice Model* uses the ten system linkage elements that child welfare agencies, substance abuse treatment providers, family courts, and other agencies can use to collaborate with each other. This publication defines and provides examples of sites from around the nation who have implemented significant policy and collaborative practice changes in each of the ten system linkage elements. http://www.ncsacw.samhsa.gov/collaboration/default.aspx
The Matrix of Progress in Building Linkages Among Alcohol and Drug Agencies, Child Welfare Services, and the Dependency Court	The Matrix of Progress is a tool for assessing collaboration across systems, and identifies benchmarks for improving system linkages by specifying the fundamentals of improved practice, good practice, and best practice for each of the ten elements in the framework. http://www.ncsacw.samhsa.gov/collaboration/collaboration-matrix.aspx

Diagnostic Tools for Enhancing Collaborative Practice	
Collaborative Capacity Instrument (CCI)	The CCI is a free online self-assessment survey developed by CCFF. Members of State, Tribal, or local collaborating organizations can use this tool to rate the group's progress in each of the ten system linkage elements. Partners can use the results to assess needs, set priorities for their collaborative work, monitor their progress over time and provide information to stakeholders and policymakers on how well the key systems collaborate. There is a second CCI that partners can use to assess their collaborative capacity to address domestic violence, mental health and primary health care. http://www.ncsacw.samhsa.gov/collaboration/collaboration-capacity-instrument.aspx
Collaborative Values Inventory (CVI)	The CVI is another free online survey instrument developed by CCFF to uncover the underlying values and beliefs that each partner brings to the group. Respondents use this tool to rank their level of agreement with a series of statements about values and beliefs. CCFF provides survey results to the group in PowerPoint format with analyses of the levels of agreement and disagreement for each statement and includes subgroup analyses, such as results by discipline. Groups use the CVI to identify differences that could block the group's progress unless partners discuss their differences and decide how to address them, as well as areas of agreement that can form the basis of developing written principles to guide their work. http://www.ncsacw.samhsa.gov/collaboration/collaboration-values-inventory.aspx
Drop-Off Analysis	The Drop-Off Analysis is a method used to assess linkages among child welfare, treatment agencies and courts. The method helps to identify connections that families need to make between systems to obtain services and achieve their child welfare case goals. At each stage of the families' "hand-offs" between the systems, agencies using drop-off analysis collect data to determine how many families drop out of the systems. For example, agencies might use this approach to identify parents who received an emergency response and were subsequently screened for a substance use disorder, the number of parents referred for an assessment after the screening results were available and how many of these parents completed the assessment. Several agencies and systems have used drop-off analysis to focus their attention on the parents that were not moving on to the next stages of assessment, treatment and recovery as well as to understand the reasons for these drop-offs. http://www.ncsacw.samhsa.gov/collaboration/default.aspx#tools
Virtual Walk-Through of the Systems	A system Walk Through is a process designed to assess the effectiveness of a system in achieving its desired results or outcomes, such as reunifying families, successful treatment completion and ensuring children are living in safe and stable environments. The primary purpose of the Walk Through is to provide key stakeholders with: • An understanding of the system as it currently exists; • Identification of any problem areas and barriers, such as inconsistency of referrals, delays in accessing treatment, lack of services/involvement from critical stakeholders, problems with engagement and retention; and, • An opportunity to generate ideas for improving organizational processes.

Impact on Children and Families

Combining evidence-based program strategies, the technical assistance provided through IDTA, and each IDTA site's individual needs and priorities, IDTA sites accomplished the following:

- **Memoranda of Understanding for Working Across Agencies**—15 IDTA sites (68.0%) addressed underlying values in developing collaborations that resulted in formal MOU or working agreements: Arkansas, Colorado, Connecticut, Florida, Iowa, Kentucky, Maine, Massachusetts, Minnesota, Nebraska, New Jersey, New York, Squaxin Island, Texas and Virginia.
- **Development of a Recovery Specialist Model**—11 IDTA sites (50%) implemented, expanded or enhanced a recovery specialist model in their State, county or Tribe: Colorado, Connecticut, Coeur D'Alene Tribe, Florida, Iowa, Massachusetts, Minnesota, New Jersey, New York, Orange County, CA, Seminole Tribe. Some outcomes include:
    - In 2009, the State of Connecticut implemented a Recovery Specialist Voluntary Program (RSVP). From May 2009 to May 2011, 142 parents received RSVP services. Program evaluation results indicated 46% of parents in RSVP accessed treatment within 0-5 days, and 80% within three weeks. The program reports 88% of RSVP families are reunifying at 12-months.
    - In 2007, Minnesota piloted the use of recovery specialists in Itasca County as part of their Children's Justice Initiative (CJI). Pilot testing results indicated the Recovery Specialists program led to increases in percentage of substance abuse treatment completion, negative drug test results and children remaining or reunified with parents, as well as decreases in children's total time in out-of-home care.
- **Implementation of Cross-Systems Training Plans**—15 IDTA sites (68%) developed and/or implemented cross-system training plans: Coeur D'Alene, Colorado, Connecticut, Florida, Iowa, Kentucky, Minnesota, Nebraska, New Jersey, New York, Orange County and Sonoma, CA, Seminole Tribe Florida, Texas and Virginia. Highlights include:
    - 3 IDTA sites (13.6%) have adopted or are in the process of adopting the NCSACW Child Welfare Training Toolkit: Connecticut, New Jersey and Nebraska.
    - 9 IDTA sites (41%) provide a link to the NCSACW Online Tutorials for Child Welfare, Substance Abuse and Court staff and encourage staff and providers to take these courses: Colorado, Connecticut, Iowa, Kentucky, Nebraska, New Jersey, New York, Orange County, CA and Texas.
    - The New Jersey Division of Mental Health and Addiction Services requires all substance abuse providers to take the NCSACW Online Tutorial as a condition of their contract.
- **Implementation of State Administrative Changes**—7 IDTA sites (31.8%) implemented state administrative changes, including contracting requirements, state certification of provider organizations, and policy changes related to Medicaid reimbursement and Medication Assisted Treatment (MAT): Colorado, Florida, Iowa, Michigan, Nebraska, New Jersey and Virginia. For example:
    - In 2011 New Jersey's Department of Children and Family Services adopted MAT policies and associated practices that allow for parents to be enrolled in clinically

appropriate and effective methadone or other MAT without facing removal of their children.

- In 2012 a funding policy was released by the Nebraska State Division of Children and Family Services and Division of Behavioral Health ensuring payment was not a barrier to treatment for child welfare involved families.
- Connecticut prioritized parents with child welfare involvement for substance abuse treatment admission and significantly expedited treatment admission for child welfare involved parents to within five days.

- **Development of Screening Protocols**—11 IDTA sites (60.0%) developed and/or implemented screening protocols: Arkansas, Coeur d'Alene Tribe, Colorado, Connecticut, Florida, Kentucky, Maine, Massachusetts, Michigan, New York and Texas. 4 other sites are in the process of developing and/or piloting screening protocols: Los Angeles, Nebraska, New Jersey and Pennsylvania.
  - Connecticut refined their screening and assessment protocols to eliminate redundancies. Connecticut eliminated the requirement for a Project SAFE Evaluation in cases where the parent was already in treatment, admitted to needing treatment, or had a positive GAIN assessment result. This change eliminated unnecessary redundancy, resulted in an estimated savings of $100,000 annually from redundant assessments and significantly expedited treatment admission for child welfare involved parents.
  - Since Maine's pilot testing in 2005 and implementation of a universal screening tool in 2006, referrals to substance abuse treatment have doubled over their pre-IDTA referral numbers.
- **Development of a Parent Partner Model**—2 IDTA sites (13.3%) developed parent partner models. Orange County, CA provides parent partners at the first court hearing leading to increased rates of service plan engagement. In Minnesota, the parent partner model was formalized in a parents' manual increasing parent participation in court processes and case planning; the program description was published by the American Bar Association.
- **Operation of Family Dependency Drug Courts**—15 IDTA sites (68%) operate Family Dependency Drug Courts (FDCs): California, Colorado, Florida, Iowa, Maine, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, Orange County, CA, Sonoma County, CA, Texas and Virginia. Though Kentucky and New York have recently eliminated FDCs, both states continue to incorporate therapeutic approaches into their Dependency Courts and the Administrative Office of the Courts in these states continue to be active in IDTA.
- **Data Informed Systems**—6 IDTA sites (27%) used a drop-off analysis, system walk-through, case reviews and other cross-system data collection and mapping processes to inform policy, program and practice decisions: Los Angeles, Kentucky, Nebraska, New Jersey and Sonoma, CA.

Sites and Phases of Change

Between 2007-2012, NCSACW provided IDTA across all five phases to 17 sites—11 States, four counties and two Tribes. The table below provides a list of all sites that received IDTA since the program launched in 2003, specifying which phases of IDTA each site received during this 2007-2012 contract period.

	IDTA Site	**Phase 1**: Site Outreach (3-6 months pre-IDTA)	**Phase 2**: Site Team Development & Orientation (IDTA months 1-3)	**Phase 3**: Collaborative Action Planning & Product Development (IDTA months 4-10)	**Phase 4**: Implementation, Evaluation, & Sustainability Planning (IDTA months 11-15)	**Phase 5**: Follow-up & Aftercare/Site Re-engagement (6 months post-IDTA)
Round 1 2003-2004	Colorado					
	Michigan					
	Florida					•
	Virginia					
Round 2 2005-2006	Arkansas					
	Massachusetts					•
	Minnesota					
	Squaxin Island					
Round 3 2006-2007	Maine					
	New York					•
	Texas				•	•
Round 4 2008-2009	Orange County, CA	•	•	•	•	•
	Coeur d'Alene Tribe	•	•	•	•	
	Connecticut	•	•	•	•	•
	Iowa	•	•	•	•	
Round 5 2009-2010	California	•	•	•		
	New Jersey	•	•	•	•	•
	Seminole Tribe	•	•	•		
	Sonoma County, CA*	•	•	•	•	•
Round 6 2010-2012	Kentucky	•	•	•	•	
	Nebraska	•	•	•	•	
Pre-IDTA	Alaska	•				
	Los Angeles, CA	•	•	•	•	
	Nashua, NH	•				
	Pennsylvania	•				

*Sonoma County, CA received IDTA through contract funds outside of NCSACW. NCSACW funds supported the Phase 5 follow-up IDTA received by Sonoma.

Of the 11 sites that participated in the IDTA program during Rounds 1, 2 and 3 (2003-2007), four sites received Phase 5 follow-up IDTA—Florida, Massachusetts, New York and Texas. Ten sites applied for and were approved to participate in IDTA between 2008-2012—Orange County, CA, the Coeur D'Alene Tribe of Idaho, Connecticut, Iowa, California, New Jersey, the Seminole Tribe of Florida, Sonoma County, CA, Kentucky and Nebraska. Four sites also received pre-IDTA Phase 1 site outreach and engagement—Alaska, Los Angeles, CA, Nashua, NH and Pennsylvania. All 17 sites received a customized program of IDTA designed to identify and implement key policy and practice changes based on their readiness to change and

progression through the phases of IDTA. The *Site Summaries* provide a detailed summary of the IDTA provided to each site during the 2007-2012 contract years, outcomes achieved and future direction. Following is a brief overview of each site's major accomplishments.

2007-2012 IDTA Program Sites

California

- Completed an environmental scan of FDCs throughout the state using an on-line survey and site visits to 16 FDCs across the state, conducted by teams representing the project partner agencies. The findings captured information about local program standards, practices, operations, goals, caseloads and capacity, and revealed a wide variety of models, caseloads, capacities, cost, and effectiveness across the state.

Coeur D'Alene Tribe

- Created a Tribe-specific cross-system model of service provision that uses a wraparound approach and includes: a cross-system case staffing protocol that incorporates community and family input; regular team meetings; consensus driven decision making, and a formal orientation process for multidisciplinary membership

Connecticut

- Developed the Recovery Specialist Voluntary Program (RSVP), a recovery specialist and coaching program that was implemented in three sites, successfully redirecting existing resources to develop the program without new funding.
- Created a Memorandum of Agreement (MOA), which established a clear vision of shared values and expectations involving all three systems and facilitate successful information and data sharing practice.
- Refined their screening and assessment protocols to eliminate redundancies. Connecticut eliminated the requirement for a Project SAFE Evaluation in cases where the parent was already in treatment, admitted to needing treatment, or had a positive GAIN assessment result. This change eliminated unnecessary redundancy, resulted in an estimated savings of $100,000 annually from redundant assessments and significantly expedited treatment admission for child welfare involved parents.
- Prioritized parents with child welfare involvement for substance abuse treatment admission and significantly expedited treatment admission for child welfare involved parents to within five days.

Iowa

- Developed and implemented a drug testing protocol and a Family Support Model. The Family Support Model uses peer mentors to increase engagement and retention of families in services, and includes protocols and guidelines that define best practices for cross-system collaboration.
- Piloted joint protocols and procedures, screening tools and a joint release of information in two counties.

Kentucky

- Developed a statement of shared values and principles, which was signed by all three agencies, and a Memorandum of Understanding (MOU) to place the continuing IDTA work in the State Interagency Council (SIAC) and institutionalize the collaboration.

- Piloted the UNCOPE as a universal screening tool, and is exploring implementation of the GAIN-SS to be consist with the Kentucky Medicaid State Plan Amendment
- Piloted merging data between the child welfare, substance abuse and court databases, and developed a MOU and an information sharing desk guide to build the capacity to exchange data between the child welfare and court data systems.
- Changed Medicaid rules during the course of the IDTA program. In 2012, Kentucky enacted a budget that funds Medicaid substance abuse services. Prior to the enactment of this budget, Kentucky was one of only seven states that do not offer substance abuse treatment through their Medicaid program.

Nebraska

- Improved identification of families affected by substance abuse in the child welfare system by adding the UNCOPE substance abuse screen to the early investigation stage of the child welfare process, adapting the UNCOPE for Nebraska's Home Visiting Program, and adding questions to the child abuse and neglect hotline regarding identification and reporting of drug or alcohol exposure for newborns.
- Increased the timeliness of referrals to treatment and expanded access to treatment by resolving treatment payment barriers, reducing screening redundancies and minimizing assessment delays
- Increased available housing options for parents/caregivers with substance use disorders and their children, allowing families to remain intact during treatment rather than placing children in out-of-home care.
- Designed an innovative family treatment model for implementation in Sidney and Omaha. The Sidney model is funded through a blend of Medicaid and Indian Health Services (IHS) revenue.

New Jersey

- Examined contract monitoring practices and explored opportunities to realign contracts to fund a Recovery Specialists program. New Jersey is drafting a plan to implement a Recovery Specialist program.
- Pilot tested sharing child welfare and substance abuse treatment data to track treatment entry, treatment completion and child welfare reunification outcomes, developed a MOU to share data across the systems that is pending approval from each agency's attorneys.
- Developed a child welfare policy for responding to and tracking substance-exposed infants identified by the Children Abuse and Prevention Act (CAPTA) requirements. The policy includes protocols on how to appropriately respond to pregnant and parenting women participating in Medication Assisted Treatment (MAT) programs.
- Developed a comprehensive cross-system training package that incorporates the NCSACW online tutorials, the NCSACW Child Welfare Training Toolkit and a Fact Pattern summary. The Fact Pattern is a composite profile of a "typical" child welfare involved family who is affected by parental substance use and has been used as a training tool in over 20 states.

Orange County, California

- Enhanced access to services by developing a streamlined centralized approach to distributing “real-time” information about existing services and resources readily available in the community
- Improved engagement and retention of parents in services, by developing and implementing a Family Support Workers/Mentor Parent model, creating a My Action Plan (MAP) form, and publishing the Parents Guide to the Juvenile Dependency Court Process.
- Revised the existing contracting mechanisms to a more client-centered” fee-for-service model.”
- Piloted data and information sharing opportunities to improve communication and referral processes.
- Integrated the collaborative practice work into the ongoing work of the County Blue Ribbon Commission. The IDTA team reports their continued work and results to the Blue Ribbon Commission.

Seminole Tribe

- Created a flowchart, procedural manual and multi-party consent form for the Child Protection Team (CPT), which includes Children’s Mental Health, substance abuse treatment providers, tribal child welfare and the Seminole Police Department.
- Developed an Abuse Hotline referral process and form that tracks cases from the initial point of referral to the Seminole Police Department, through the CPT and to the appropriate service providers. This protocol allows all tribal program partners to track cases from initial point of referral through services to ensure the needs of tribal families are being met.
- Developed a multi-party consent form and a Child Protection Team Protocol and Abuse Hotline Form.

Follow-up IDTA—Re-Engagement and Institutionalization

Florida

- Developed a child welfare investigation re-design paper with recommendations on strengthening linkages between child welfare and substance abuse treatment, which was submitted to the Secretary of the Department of Children and Families.
- Developed a services integration model that incorporates substance use and mental health issues and strategies into a child welfare, family-centered practice model.
- Piloted and implemented the UNCOPE as a universal substance use screening tool by child welfare investigators at the local level.

Massachusetts

- Built upon and re-engaged the IDTA Family Recovery Collaborative (FRC) project to support the development and implementation of their Regional Partnerships Grant site.

New York

- Engaged counties in the State to adopt and implement *Gearing Up to Improve Outcomes for Families: A Collaborative Practice Guide for Managers and Supervisors in*

Child Welfare, Chemical Dependency Services, and Court Systems, which the IDTA team authored in 2008.

Texas

- Connected collaborative efforts of the State level Texas IDTA Partnership with the local level innovations of the three Children's Bureau funded Regional Partnership Grant (RPG) sites and the development of Family Drug Courts (FDCs) in Texas.

Pre-IDTA—Site Outreach and Engagement

Alaska

- Collaborated with the Western Pacific Implementation Center to highlight the needs of families affected by substance abuse who are involved with the family courts by coordinating the provision of training and technical assistance across multiple existing initiatives.

Los Angeles County, California

- Developed and piloted Project SAFE (Screening and Assessment for Family Engagement) in two areas. Project SAFE uses the UNCOPE as a screening tool during the child welfare emergency response process. Project SAFE is a standardize screening and assessment process to aid in determining child safety in the context of parental or caregiver substance use, rather than relying on the results of a drug test alone in making a determination. An evaluation report of the pilot using a comparison group is anticipated at the end of August 2012.
- To support Project SAFE, Los Angeles developed a MOU between child welfare and substance abuse treatment outlining the responsibilities of each system in the pilot implementation, including client confidentiality, evaluation and fiscal provisions.

Nashua, NH

- Adopted the UNCOPE as part of their new Child Welfare Safety and Risk Assessment
- Initiated monthly case reviews with substance abuse treatment staff and invited substance abuse treatment representatives to participate on the Child and Family Services Reviews Program Improvement Plan team

Pennsylvania

- Developing plans to pilot the UNCOPE with three pilot counties and use lessons learned from the pilots to develop the broader guidance for the other counties. Pennsylvania intends to build upon existing initiatives in the state, such as systems of care, and to implement their pilot county effort in the spring or summer 2013.
- Drafting sections of a comprehensive practice guide that would be provided to the pilot and other counties as a tool to guide the development of county-specific protocols.

Lessons Learned and Major Themes

The IDTA program provides several key lessons that are used to further refine the program and facilitate sustainable systems-level change. Following are lessons learned over the last five years, drawn from the successes, challenges and efforts of the CLs and NCSACW staff. The lessons are grouped into four primary themes: 1) Project leadership: Engaging and sustaining partners in the process; 2) Identifying opportunities for change: Being problem focused and data

driven; 3) Establishing shared outcomes and joint accountability; and, 4) Implementing and sustaining system-level changes.

1. Project leadership: Engaging and sustaining partners in the process

Project leadership includes engaging and sustaining participants on the Core Team to develop and implement the IDTA SOW and execute policy, program and practice changes. The Oversight Committee provides administrative oversight, facilitates access to resources and provides or endorses the Core Team's solutions to system barriers. Engaging and sustaining partners in the cross-system collaborative process begins with a clear understanding of expectations, roles and responsibilities of each agency and constantly re-engaging partners in the face of changing priorities and administrative turn-over.

- **Define the incentives for each partner to invest in collaboration**—Beyond a fundamental belief that collaboration will improve outcomes for children, youth and families, each partner must be able to articulate the policy, program and practice benefits they expect to gain as a result of improved collaboration. This entails an understanding of why collaboration is important to each system—not just what one system needs from the other. While most sites recognize the benefit to the child welfare system and agree that improved access to treatment services for families involved in child welfare and the courts is directly related to improved safety, permanency and well-being, it is often more difficult, at least initially, for substance abuse treatment, mental health and other partners to recognize the benefits to their systems. Sites that have mutually engaged and committed partners are able to identify other system outcomes such as improved treatment compliance, completion rates and discharge outcomes.

- **Discuss underlying values**—Many collaborative groups begin the process of collaboration without understanding the underlying values that can impede the group's progress. NCSACW uses the CVI to provide sites an opportunity to engage in a discussion of underlying values and beliefs of partner agencies. NCSACW presents to the site a summary of the CVI scores and an analysis of the results. After reviewing the results, it is important for the site to discuss the areas of common agreement and divergent views. That discussion should lead to a consensus on principles that the collaborative members agree can form the basis of state or local priorities for implementing practice and policies changes, leading to improved services and outcomes for families. In this way, the values discussion becomes an ongoing process rather than a one-time event. This ongoing discussion of values and beliefs is particularly important as sites progress to a deeper level of collaborative practice. It is at this point that they often face greater challenges and conflicting opinions about services to children and families, such as how each system views and responds to relapse or Medication Assisted Treatment.

- **Clarify expectations of each system with agency leaders**—Over the course of IDTA, partners in each site may have varying levels of commitment and varying capacities to commit in the face of competing priorities. While being sensitive to these issues, and allowing for varying levels of commitment, it is imperative that agency leadership understand the level of commitment expected to successfully identify, develop and implement policy, program and practice changes. Identifying opportunities for change and developing cross-system collaborative strategies requires a significant level of effort from designated participants on the Core Team and work groups. There may also be direct financial commitments needed to implement and test out policy and practice

changes. Agency leadership, at the Oversight Committee and Core Team levels must also communicate how IDTA fits within the context of other priorities and initiatives. Clearly articulating expectations of each system from the beginning and throughout the IDTA process supports ongoing investment from partners. This also involves understanding and engaging in a direct conversation about the political and environmental context in which each agency is operating and how impending changes in leadership, reorganization, and the political will to address the issues may facilitate or hinder the process.

- **Identify essential partners early in the process**—Essential partners for beginning IDTA are child welfare, substance abuse treatment and family courts. Depending on the identified issue and the organizational structure of the site, other key partners may include mental health, Managed Care agencies, the privatized Child Welfare Agency, hospitals, public health, home visiting providers, Medicaid and Temporary Assistance for Needy Families (TANF). During this contract two sites involved the Medicaid Director or designee in the IDTA program. This allowed the Core Team to quickly address barriers to accessing services such as ensuring that parents don't lose their Medicaid coverage when their children are temporarily removed from their care. In the other site the Core Team advocated successfully for the inclusion of substance abuse treatment as a covered benefit in the state's Medicaid plan. The majority of sites reported serving families with co-occurring substance use and mental disorders, intergenerational trauma and domestic violence; requiring the involvement of the Mental Health System. Additionally, as many states and counties realign substance abuse treatment and mental health services under the behavioral health umbrella, many sites already have both substance abuse treatment and mental health represented as critical partners in IDTA. Sites often begin IDTA with a narrow definition of essential partners and project objectives. As the CL facilitates discussions of needs, concerns and issues, sites are guided towards defining and engaging needed partners.

- **Include pilot sites to test changes**—State, regional or county level teams must have identified 2-3 pilot sites to test proposed changes in policies, programs and practices. These pilot sites must be brought on early in the process to ensure the identified changes are feasible. Pilot sites provide valuable feedback on how to adapt proposed changes to the local level, challenges that may arise, and important considerations for broader implementation. Pilot testing also generates evidence of success that can be presented to agency leadership and used to justify broader implementation. State level IDTA projects that have not fully engaged pilot sites are less likely to implement proposed changes or to sustain changes over time.

- **Involve key decision-makers**—At the Oversight Committee and Core Team levels it is imperative to actively involve and inform leaders who have decision-making authority. Without their involvement, decisions are stalled and it will be almost impossible to affect significant change. This is partly established in the initial conversations that outline expectations, roles and responsibilities. It is also critical to continually assess the group's progress and participation. Throughout the course of IDTA, initial members may be leave or disengage and new members may be difficult to identify or may be assigned even though they lack decision-making authority. In these cases the CL works with the site to suggest a change in leadership or partners.

- **Plan for the inevitable and challenging changes in leadership**—Turnover at all levels makes it difficult to continue and sustain the work. Oversight Committee members

must be prepared to assign new members to the Core Team. Core Team members must be prepared to assign new members to the Advisory Committee and Work groups. Planning for leadership changes at the Oversight Committee level requires a concerted effort throughout the course of IDTA to maintain the commitment to the project. This involves keeping the project highly visible, including periodic presentations to high level stakeholders such as agency leaders, legislators, Boards of Supervisors and judges. This also involves celebrating small successes early on to maintain the momentum, including pilot testing a tool and showing the results or formalizing a MOU for how the systems will work together through this process. Two sites presented their IDTA program findings to their State legislators and received legislative endorsements to sustain their efforts, which in one site included providing annual reports to the legislature on their progress. Conversely, sites that want to keep policy and practice changes at the mid-management level only are highly unlikely to realize any significant or enduring system reforms. While changes in leadership are inevitable, the subsequent impact on the project can be minimized when the remaining partners work together to sustain their efforts and gain the trust and commitment of new leadership. Every IDTA site served during this contract period was impacted by the loss of key leaders and stakeholders and the turnover of Core Team members. Though work was sometimes delayed while new leaders or members were oriented, sites with a strong commitment from all partners persevered despite these setbacks. Other sites showed minimal progress or were forced to suspend their work.

2. Identifying opportunities for change: Be problem focused and data driven

In some cases, the opportunities for change are clearly defined at the outset of IDTA, often related to a recent crisis or as a result of using the Ten-Element Collaborative Framework and diagnostic tools. Through the course of providing IDTA, CLs are often presented with opportunities for change that emerge in the context of facilitated discussion. Being problem focused and data driven ensures that system level policy, practice and program changes are based on a clear mutual understanding between partners of the underlying issues and needs. Without this process, partners are often working from their own assumptions about issues and needs.

- **Identify a specific need, concern or issue**—Initial discussions with key partners need to focus on a clear identification of need, the specific issue they are trying to address and what data they are currently using to determine the prevalence of the issue (e.g. substance exposed newborns, child fatalities related to parental substance use or lack of treatment capacity). There may be several misconceptions underlying each partner's understanding of the primary issues that need to be addressed through increased collaboration. Taking time to clarify and agree on the primary presenting problem(s) will enable the group to focus on concrete solutions with the ultimate goal of broader systems level changes that "move the needle" for children and families. One site focused on barriers to getting parents into timely and appropriate treatment. While the immediate problem was accessing treatment, the team agreed that the ultimate goal is ensuring children remain in or quickly return to safe and stable families.

- **Gather baseline data**—Gathering baseline data establishes the scope of the identified issue in the context of the overall system. It should clarify why this issue is important and how it affects each system. Recognizing that data is not always readily available on the prevalence of children and families affected by substance use disorders in the child welfare, family court or substance abuse treatment systems, sites must begin by

accumulating whatever data is available to illustrate the problem. This often requires identifying proxy data, such as number of cases where parental substance use was a reason for removal. Gathering baseline data is also used to discuss how the collaborative group will measure progress over time. If and when policy, program and practice changes are put in place, the group must determine how to use existing data to measure progress or what new data must be collected to demonstrate progress.

- **Emerging issues and crises may provide opportunities for change**—While high profile cases, crises and emerging issues often involve negative media and community attention, they can also provide the impetus to examine existing policies and protocols and encourage stronger collaborative efforts. In one site a substance use related child fatality led to the intensive examination of the State's protocol for screening parents for substance use and mental disorders during the initial child welfare investigation process. This process then led to substantive changes in tools and practices, with input from key stakeholders, followed by appropriate cross-systems training.

- **Use diagnostic tools to clarify the problem statement**—The use of systemic change diagnostic tools both clarifies the problem and justifies the necessary investment from all partners. These tools include the drop-off analysis and a virtual walk-through of the systems, which can be used in conjunction with case reviews. The use of both process and outcome data is highly effective in illuminating underlying issues, generating interest among partners, underscoring each partner's role and identifying the challenges and barriers they may face in attempting to improve policies, programs and practices.. In one site, the drop-off analysis uncovered a significant gap in policy and practice. While current policy and practice ensured all parents involved in the child welfare system were being screened for potential substance use disorders, only a small percentage were receiving assessments and entering treatment. With the process and outcome data highlighting a clear gap in policy and practice, the partners committed to make the necessary system level changes.

- **Use diagnostic tools to identify opportunities for change**—The drop-off analysis and virtual walk-through involve clearly identifying gaps, barriers and redundancies in the systems that prevent families from accessing services. Both of these diagnostic tools also involve the partner agencies brainstorming potential measureable solutions, with the CL facilitating a dialogue to reach group consensus of which strategies to test out through pilot scale implementation. In three sites the virtual walk-through illuminated the fact that each system conducted their own drug testing, resulting in duplication of efforts with sometimes conflicting results. Developing a consistent Drug Testing Policy which includes sharing results across systems yields savings as well as consistency of response for clients and agencies.

- **Connect with existing outcome measurement initiatives**—The Child and Family Services Reviews (CFSR) monitors State child welfare services to help States achieve positive outcomes for children and families, and the National Outcome Measures (NOMs) system tracks and measures outcomes for people in recovery from mental health and substance abuse disorders. Using the CFSR process and NOMs system can ensure the identification of issues and solutions that are relevant for all partners. One site examined the rate of re-entry into out-of-home care for children of substance abusers, identifying barriers to families getting into services and how removing those barriers could impact the re-entry rate.

3. Establishing shared outcomes and joint accountability

Enduring systems change takes time, is complex, usually happens incrementally and may involve starts and stops. It is essential to identify goals that can be completed within the IDTA timeframe, tracking additional systemic change goals that may emerge during the course of IDTA, while also maintaining realistic expectations of sites. IDTA is typically one of many critical and often competing responsibilities for these sites. It is unrealistic and overwhelming to take on too many issues and tasks all at once, especially in the early stages when the need is still being defined. For example, some sites attempt to develop a training plan before identifying what the training will instruct participants to do differently. Clearly defining expected outcomes at the beginning ensures the proposed policy, program and practice changes will be connected to the intended outcomes. Teams must agree that the goal of IDTA is systems reform that results in improved outcomes for children and families for which all agencies are jointly accountable.

- **Start with a clearly defined logic model**—All system partners must agree on how success will be defined and measured, both for individual children, youth and family outcomes and for the process of cross-system collaboration. A clearly defined logic model informs the group of how implementing proposed changes will involve distinguishing between and evaluating both process and outcomes.

- **Outcomes must be both short-term and long-term**—By defining both short and long-term outcomes the group is charged with articulating how improved collaboration and changes in policy, programs and practice will ultimately affect the children and families in concrete and measureable terms. Providing a safe and stable family, improved parental capacity and improved child and family well-being may be long term goals. Short term goals can include timely access to treatment, ensuring treatment received matches level of need, successful treatment completion, and screening all children for developmental delays. The Core Team and workgroups must define indicators of success for each system and all partners must assume joint accountability for those indicators. Sites that focus only on process level outcomes such as cross-systems training are less likely to realize improved outcomes for children and families.

- **Determine how outcomes will be measured**—Ensuring there is a process for collecting and sharing data is critical, and one of the most important pieces that must be done early on in the process. Acknowledging that data is often not readily available, based on a review of the baseline and drop-off analysis data, the Core Team and workgroups must determine how to track and measure the identified short-term and long-term outcomes. New data elements may be needed, and part of the implementation of policy, program and practice change may involve pilot testing new data elements. Alternatively, partners may agree to have one agency collect data to measure outcomes assuming that the information will be shared. This requires additional effort to establish the formal or informal agreements necessary to ensure information is shared while protecting confidentiality.

- **Plan for unintended consequences and misconceptions**—In one site, policy and practice changes were stalled as the substance abuse treatment agency expressed concern that early screening for substance use disorders in child welfare would result in a high number of parents attempting to access an already overwhelmed and underfunded treatment system. This is a common concern that does not often come to fruition. While screening may result in increased referrals, without additional strategies to engage families in services, the increase in referrals does not necessarily translate to

increased numbers of parents accessing treatment services. In either case it is crucial to use the initial baseline data and to have a plan in place to track and measure referrals to determine if appropriate or overwhelming increases do occur, and if any increases result in improved outcomes for families through accessing and completing services.

- **All partners must be accountable for identified outcomes**—Identified short-term and long-term outcomes must be connected to the mission and mandates of each partner agency. While individuals can agree on the benefits of safety, permanency, well-being and recovery, individuals must still report progress and outcomes to their agency leadership in a way that justifies their continued investment and collaboration. Each system is accountable to their own mandates and outcomes, which must be directly connected to the anticipated outcomes of the proposed policy, program and practice changes. Two outcomes each agency can claim as a success are: 1) cost savings, demonstrating how the expense of enhanced services is off-set by, for example, savings in out-of-home care costs; and 2) improved engagement and retention in treatment services by, for example, consolidated drug testing and therapeutic interventions.

- **Connect workgroup activities to the identified outcomes**—The IDTA program provides the process and the structure to identify necessary policy, program and practice changes. The workgroups often naturally gravitate toward four key topic areas: 1) Practice protocol development; 2) Data and information sharing; 3) Training and staff development; and, 4) Funding and sustainability. Process achievements, such as the development of a cross-system training plan or an information sharing protocol, are intermediary strategies for achieving improved outcomes for children and families. For example, the training plan should include guidance on what professionals will do differently, and the Core Team and training workgroup should be able to track how training results in changes in practice that can then be connected to improved outcomes for children and families.

4. Implementing and sustaining system-level changes

The IDTA program is intended to result in sustainable policy, program and practice changes that are institutionalized across systems. While a substantial portion of the IDTA program is devoted to strategic planning, as previously mentioned, State, regional or county level teams must have identified 2-3 pilot sites to test the recommended changes. Pilot level implementation allows sites to see and discuss the feasibility of broader implementation and troubleshoot any challenges that may arise. Pilot level implementation, documenting results and revising proposed changes as a result of feedback received from partners during the initial implementation are key aspects of ensuring sustainable system reforms.

- **Leverage resources across systems**—Implementing changes typically involves a discussion of what resources are needed and available across the systems to conduct pilot testing, and what will be available to sustain system-level changes. Resources include labor, such as staff to develop resources and tools, implement changes, evaluate the effectiveness of those changes, and provide reports to agency leadership. If for example enhanced screening leads to increased referrals and higher numbers of individuals accessing services, then the funding sources for those services must be negotiated. These discussions must include agency leadership, developing their support for initial expenditures, identifying potential cost off-sets, keeping them apprised of successes and challenges, and justifying a continued investment in collaboration and system reforms. This also involves reaching out to partners who have a financial stake in

the issue. In one site, involving the Medicaid office ensured that families who were Medicaid eligible maintained their eligibility even when their children were temporarily removed, thus enabling them to access treatment services.

- **Establish timelines and expectations for implementation**—Effective implementation, at the pilot or broad scale, begins with a clearly defined strategic plan that outlines roles, responsibilities, expectations and timelines. Setting expectations includes detailing the roles and responsibilities of the Core Team and workgroup members, providing training for pilot sites, issuing new policy and practice protocols, referring back to the logic model to ensure the planned changes are connected to measureable outcomes, confirming that the data collection plan is in place to evaluate the effectiveness of the changes, establishing a venue to gather feedback on challenges that arise and enabling individuals to make necessary corrections during the course of the initial implementation.

- **Document outcomes and implications for system-level change**—Showing how children and families benefit as a result of collaboration is essential to maintaining momentum, broad implementation and institutionalizing policy, program and practice changes. This involves demonstrating to agency leadership how proposed changes save money (e.g., reduction in out of home care); improve system processes (e.g. court dockets, case closures, reductions in relapse and re-entries) or allow front-line staff and supervisors to be more effective (e.g. access to timely and critical information; shared expectations of and follow-through with participants; increased and timely access to services). One site's housing model is intended to result in reduction in out of home care costs, a reduction in residential treatment costs, and ensure child welfare workers are able to meet reasonable effort requirements. While documenting outcomes achieved through pilot scale implementation, the collaborative group should also document challenges that may arise in broader implementation, identifying whether a system can effectively implement changes at the system level, or if the proposed changes will remain on a small scale.

- **Maintaining a high level of visibility**—Demonstrating and celebrating successes with broader stakeholders and the Advisory Committee is critical to maintaining involvement from all systems and sustaining the work over time. All partners must be able to see what is possible and what can be accomplished when they work together. The ultimate goal is to memorialize changes in policies, programs and practices so they are institutionalized and not dependent upon key people.

- **Connect to related collaborative projects**— Connecting the accomplishments of IDTA to related collaborative projects circumvents the need to compete with other priorities by finding ways to complement and enhance existing initiatives. Building on existing collaborative projects, implementing changes on a large scale, or imbedding new practices across the continuum of services involves leveraging knowledge and resources. For example, the collaborative group may align their work with existing collaborative groups, such as the Blue Ribbon Commission on Children in Foster Care, Children's System of Care, home visiting, differential response, or transition age youth. These connections can be made early on, or can be created as opportunities present themselves. In one site, as the group began to discuss universal screening for substance use disorders in the child welfare system, they discussed incorporating this screening into home visiting programs as a way to identify high risk families. This site adding screening questions regarding parental substance use and co-occurring

disorders in the context of home visiting programs to ensure that families are referred to needed services.

Moving Ahead: New Directions

As a result of lessons learned over the last five years, and the collective experience developed from work in all sites, the next cycle of IDTA will incorporate several adjustments and enhancements:

- **Focus on a renewed objective**—NCSACW understands the need to recognize and provide services to treat the underlying issues of trauma, substance use and mental disorders to ensure positive outcomes in safety, permanency, well-being and recovery for children, youth and families. With clear statements of the problem, and defined outcomes, NCSACW will ensure the IDTA program generates measureable progress in sites that receive IDTA. The NCSACW's renewed objective is to provide IDTA that enables States, Tribes, counties or regions to make measurable progress in system reform that reduces barriers to adoption and implementation of trauma-informed, evidence-based services for parents and children that enhance child and family well-being.

- **Refinement of the phased approach**—The phased approach to IDTA frames tasks, activities and milestones that continue to serve as an important structure for the IDTA program. Recognizing the need to focus on measurable outcomes, NCSACW will use short-term and long-term training and technical assistance (TTA) to build relationships with sites through outreach and other TTA activities, allowing the formal IDTA program to be problem focused and data driven. NCSACW examined the current phasing of IDTA, adjusting the anticipated tasks, activities, milestones and timeframes to ensure the IDTA process makes the best use of NCSACW and site resources.

    - *Pre-IDTA: Recruitment of sites (Up to 1 year)*—This phase establishes the relationship between NCSACW, the CL and the potential site and clarifies expectations of all parties prior to formal acceptance and participation in IDTA. Sites that meet the established criteria and are approved by the COR are invited to submit an application to receive Phase 1 and 2 of IDTA for a period of time not to exceed one year.

    - *Phase 1: Assessment of Need and Readiness for Change (Up to 6 months)*—Activities during this stage are designed to assist the sites in clearly defining their needs, the issue(s) they intend to resolve and their capacity to do so through this process. CLs will administer diagnostic tools as indicated. This phase also forms the foundation for successful engagement and retention of partners, policymakers and other critical stakeholders.

    - *Phase 2: Strategic Planning and Capacity Building (Up to 9 months)*—Using the data and information gathered during the first phase, CLs and the sites will work together during Phase 2 to develop mutual priorities for practice and policy changes. Phase 2 activities include specifying the program, practice and/or policy changes and deliverables to be achieved. The sites will develop a strategic plan for pilot testing these changes in Phase 3. Updates and changes to the strategic plan are documented by the Core Team when changes are requested or made.

- *Phase 3: Implementation and Evaluation/Pilot Testing Program, Practice and Policy Changes (Up to 6 months)*—This phase is focused on pilot testing the program, practice or policy changes identified in Phase 2, evaluating and making the necessary adaptations and adjustments needed. The key benchmark of Phase 3 is the development and testing of products for broad dissemination. Participants in Phase 3 demonstrate knowledge of and ability to make cross-system changes and institute collaborative practice(s).

- *Phase 4: Dissemination, Evaluation and Sustainability Planning (Up to 6 months)*—In this phase, sites focus on developing concrete steps for broad-based dissemination, including the identification of resources to continue to evaluate the impact of their effort and institutionalize and sustain those activities that result in positive change. Participants in Phase 4 demonstrate the ability to monitor their progress against baseline measures and plan for moving from pilot to systems change.

- *Phase 5: Follow up, Monitoring and Aftercare (up to 6 months post-IDTA)*—This phase is time-limited and designed to ensure the work developed during the IDTA process is being sustained. Sites will also be expected to provide status reports, to include follow-up data.

- **Evaluate site's readiness to progress to the next phase**—Each site experiences a unique set of successes and challenges based on their individual economic and political environments. The IDTA program seeks to support sites to work through any challenges that arise to implement system-level policy, program and practice changes, and document measureable outcomes that improve the lives of children, youth and families. At times, some sites experience significant challenges that require more time and resources than the IDTA program can commit, and often require the site to re-examine their ability to commit to participating in a strategic planning process that seeks to implement system-reform changes. Sites that have achieved goals and objectives for Phases 1 and 2 will develop a SOW for Phases 3 and 4 (Implementation and Evaluation) to be approved by the COR. Developing a SOW reengages the site and charges each partner to commit to piloting and eventually implementing system-level changes. Sites that are unable to make substantial progress in Phases 1 and 2 may receive other levels of TTA through the NCSACW and may re-apply for IDTA at a later date.

- **Allow for varying levels of commitment**—The multi-faceted IDTA approach to facilitating system change will be used with up to six selected sites per year. Whereas the IDTA program was previously a 15-24 month engagement in which a senior level consultant is assigned for up to 32 hours per month, future versions will allow a CL to work with a site for 8-40 hours per month, as agreed in writing. Both in terms of the length of time and the level of effort invested by the CL, NCSACW will commit to providing IDTA in sites according to their own capacity to commit, readiness to change and SOW. The participating sites will benefit from a constellation of interventions that focus on cross-system collaboration and engagement of key stakeholders designed to create lasting change. IDTA sites may also receive short-term TA as additional needs arise.

- **Apply Collaborative Policy, Practice and Diagnostic Tools**—The consistent use of collaborative policy, practice and diagnostic tools throughout the course of IDTA provides sites with objective measures of strengths, needs, and values and provides

NCSACW with a systematized approach. The CL uses these tools to facilitate thought-provoking and change-oriented conversations with partners. NCSACW will continue to use tools and products developed for the IDTA program during the 2002-2012 contract years and will continue to develop new tools as needed.

- **Engage Policy Academies**—NCSACW will explore opportunities to invite IDTA sites to participate in Policy Academies. Engaging sites in Policy Academies will provide an alternative to hosting Cross-site meetings, which were previously a required milestone for IDTA. Policy Academies will strengthen the knowledge and skills of substance abuse and mental health treatment agencies, child welfare agencies, the courts and other critical stakeholders with the planning, implementation and evaluation of policies that support the complex needs of children and their families affected by substance abuse, co-occurring disorders and trauma through collaborative practices. In addition to creating sustainable policy and practice changes, Policy Academies provide an invaluable opportunity to develop peer-to-peer networks among sites that are engaging in significant system-level change initiatives, and can be held either in-person or developed as a series of virtual web-based meetings.

Final Thoughts

CLs closely monitor accomplishments and challenges during the course of IDTA, gauging completion of critical components that serve as essential foundations for other tasks. NCSACW staff and CLs also monitor environmental factors such as budget crises, changes in political and administrative leadership and shifting priorities that can significantly impact IDTA. In the last five years, tracking the impact of Health Care Reform, Home Visiting programs, Family Drug Courts, prescription drug abuse, Medication Assisted Treatment, and collaborative approaches to drug testing became critical tasks for most IDTA teams. Sites express concern regarding the future of residential treatment, especially for parents with young children, and more states are moving to privatize child welfare services and contract with managed care organizations for behavioral health services. Such shifts in service provision required IDTA teams to continuously redefine and broaden their core and advisory teams and to adjust their goals and objectives to address these changes. Shifts in service provision, advancements in the field and current challenges also require NCSACW to serve as a clearinghouse for evidence-based and promising practices, new initiatives, emerging trends and Federal or State level and changes in funding or policies that impact the work of IDTA sites. This clearinghouse function ensures NCSACW, CLs and IDTA sites have timely and consistent information and resources at their disposal.

In the face of these ever-changing environments, the skills, knowledge and experience of the CLs include several intangibles that allow them to recognize opportunities for change that present themselves during the course of planning and implementation efforts. Sites often take for granted that there are certain parts of the system that can and cannot be changed. The CL's role is to recognize, acknowledge and challenge those assumptions, appropriately probing leaders, managers and direct service providers to illuminate real and perceived barriers. This requires a level of flexibility and astuteness to facilitate a group discussion that may have begun with detailing the one opportunity for change but ends with detailing new targets of opportunity. Focusing on these targets of opportunity that present themselves, and that represent true barriers to collaboration and effective services, often challenges that group to think beyond the partners who are currently at the table. The CL's role involves again recognizing, acknowledging, and charging the group to engage necessary partners. Through the CLs, the IDTA program is a process that effectively balances content, facilitation and guidance, all while remaining focused on improving outcomes for children, youth and families.