State of Nebraska Department of Health and Human Services
REQUEST FOR INFORMATION

RETURN TO:
DHHS - Procurement
301 Centennial Mall South, 5th Floor
Lincoln, NE 68508
Phone: (402) 471-6082
E-mail: dhhs.procurement@nebraska.gov

SOLICITATION NUMBER	RELEASE DATE
RFI Combined Services	**May 9, 2018**
OPENING DATE AND TIME	PROCUREMENT CONTACT
June 12, 2018 2:00 p.m. Central Time	**Michelle Thompson**

This form is part of the specification package and must be signed in ink and returned, along with information documents, by the opening date and time specified.

PLEASE READ CAREFULLY!

SCOPE OF SERVICE

The State of Nebraska (State), Department of Health and Human Services (DHHS), is issuing this Request for Information (RFI) for the purpose of gathering information for a service that includes Agency Supported Foster Care, Family Support, Supervised Visitation, and Parenting Time services.

Written questions are due no later than May 17, 2018, and should be submitted via e-mail to dhhs.procurement@nebraska.gov.

Bidder should submit one (1) original of the entire RFI response. RFI responses should be submitted by the RFI due date and time to dhhs.procurement@nebraska.gov.

RFI responses should be received in Department of Health and Human Services by the date and time of RFI opening indicated above.

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request For Information form, the bidder guarantees compliance with the provisions stated in this Request for Information.

FIRM: OMNI Inventive Care (OMNI Behavioral Health)

COMPLETE ADDRESS: 5115 F. Street; Omaha, Nebraska 68117

TELEPHONE NUMBER: 402-397-9866 FAX NUMBER: 402-397-1404

SIGNATURE: _____ DATE: 06/11/2018

TYPED NAME & TITLE OF SIGNER: Jamie L. Monfelt-Siems, LIMHP, Director, Child Welfare Services

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I. SCOPE OF THE REQUEST FOR INFORMATION

The State of Nebraska, Department of Health and Human Services (DHHS), is issuing this Request for Information (RFI) for the purpose of gathering information for a service that includes Agency Supported Foster Care, Family Support, Supervised Visitation, and Parenting Time services.

ALL INFORMATION PERTINENT TO THIS REQUEST FOR INFORMATION CAN BE FOUND ON THE INTERNET AT: http://das.nebraska.gov/materiel/purchasing.html

A. SCHEDULE OF EVENTS

The State expects to adhere to the tentative procurement schedule shown below. It should be noted, however, that some dates are approximate and subject to change.

	ACTIVITY	DATE/TIME
1	Release Request for Information	May 9, 2018
2	Last day to submit written questions	May 17, 2018
3	State responds to written questions through Request for Information "Addendum" and/or "Amendment" to be posted to the internet at: http://das.nebraska.gov/materiel/purchasing.html	May 29, 2018
4	RFI opening	June 12, 2018 2:00 PM Central Time
5	Conduct oral interviews/presentations and/or demonstrations (if required)	To Be Determined

II. RFI RESPONSE PROCEDURES

A. OFFICE AND CONTACT PERSON

Responsibilities related to this Request for Information reside with the State Purchasing Bureau. The point of contact for the RFI is as follows:

Name: Michelle Thompson
Agency: DHHS Procurement
Address: 301 Centennial Mall South, 5th Floor
Lincoln, NE 68508
Telephone: 402-471-6082
E-Mail: dhhs.procurement@nebraska.gov

B. GENERAL INFORMATION

A subsequent Request for Proposal (RFP) may not be issued as a result of this RFI. There will not be a contract as a result of this RFI and the State is not liable for any cost incurred by vendors in replying to this RFI. If an RFP is issued, the information provided will assist the State of Nebraska in developing the Request for Proposal. This RFI does not obligate the State to reply to the RFI responses, to issue an RFP, or to include any RFI provisions or responses provided by vendors in any RFP.

C. COMMUNICATION WITH STATE STAFF

From the date the Request for Information is issued and until RFI opening (as shown in the Schedule of Events), contact regarding this RFI between potential vendors and individuals employed by the State should be restricted to written communication with the staff designated above as the point of contact for this Request for Information.

The following exceptions to these restrictions are permitted:

1. Written communication with the person(s) designated as the point(s) of contact for this Request for Information;
2. contacts made pursuant to any pre-existing contracts or obligations; and
3. State-requested presentations, key personnel interviews, clarification sessions, or discussions.

Violations of these conditions may be considered sufficient cause to reject a vendor's response to the RFI. No individual member of the State, employee of the State, or member of the Interview Committee is empowered to make binding statements regarding this RFI. The State of Nebraska will issue any clarifications or opinions regarding this RFI in writing.

D. WRITTEN QUESTIONS AND ANSWERS

Any explanation desired by a vendor regarding the meaning or interpretation of any Request for Information provision should be submitted in writing to the DHHS Procurement and clearly marked "RFI Number Combined Services; Combined Services Questions". It is preferred that questions be sent via e-mail to dhhs.procurement@nebraska.gov.

It is recommended that Bidders submit questions sequentially numbered, include the RFI reference and page number using the following format.

Question Number	RFI Section Reference	RFI Page Number	Question

Written answers will be provided through an addendum to be posted on the Internet at http://das.nebraska.gov/materiel/purchasing.html on or before the date shown in the Schedule of Events.

E. ORAL INTERVIEWS/PRESENTATIONS AND/OR DEMONSTRATIONS

The State reserves the right to conduct oral interviews/presentations and/or demonstrations if required at the sole invitation of the State.

Any cost incidental to the oral interviews/presentations and/or demonstrations shall be borne entirely by the vendor and will not be compensated by the State

F. SUBMISSION OF RESPONSE

The following describes the requirements related to the RFI submission, handling and review by the State.

To facilitate the response review process, one (1) original of the entire RFI response should be submitted. RFI responses should be submitted by the RFI due date and time.

A separate sheet must be provided that clearly states which sections have been submitted as proprietary or have copyrighted materials. RFI responses should reference the request for information number and be sent to the specified address. Please note that the address label should appear as specified on the face of each container. If a recipient phone number is required for delivery purposes, 402-471-6082 should be used. The Request for Information number must be included in all correspondence.

G. PROPRIETARY INFORMATION

Data contained in the response and all documentation provided therein, become the property of the State of Nebraska and the data become public information upon opening the response. If the vendor wishes to have any information withheld from the public, such information must fall within the definition of proprietary information contained within Nebraska's public record statutes. All proprietary information the vendor wishes the state to withhold must be submitted in a sealed package, which is separate from the remainder of the response. The separate package must be clearly marked PROPRIETARY on the outside of the package. Vendor may not mark their entire Request for Information as proprietary. Failure of the vendor to follow the instructions for submitting proprietary and copyrighted information may result in the information being viewed by other vendors and the public. Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, vendors submitting information as proprietary may be required to prove specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive. Although every effort will be made to withhold information that is properly submitted as proprietary and meets the State's definition of proprietary information, the State is under no obligation to maintain the confidentiality of proprietary information and accepts no liability for the release of such information.

III. PROJECT DESCRIPTION AND SCOPE OF WORK

The bidder should provide the following information in response to this Request for Information.

A. CURRENT AND FUTURE ENVIRONMENT

Currently, the Division of Children and Family Services (DCFS) provides an array of services that includes Foster Care, Family Support, and Parenting Time/Supervised Visitation. These services are contracted with Providers throughout the State of Nebraska to provide placement and permanency for children, support and education for parents, as well as supervised visitation for families whose children have been removed from the parental home due to abuse and/or neglect.

DCFS is seeking to create a new single service for families that: provides safety for children in a home environment; supports biological families, and; when appropriate, offer a permanent family home to a child(ren) who need permanency.

This service should include capacity to provide stabilization to biological families and parent education curriculum to ensure child safety and prevent recurrence of maltreatment.

B. SCOPE OF WORK

Please provide comments or input on how DCFS can create a Foster Care service that provides both stabilization to biological families and education curriculum to ensure child safety and prevent recurrence of maltreatment.

Form A

Vendor Contact Sheet

Request for Information Number Combined Services

Form A should be completed and submitted with each response to this solicitation document. This is intended to provide the State with information on the vendor's name and address, and the specific persons who are responsible for preparation of the vendor's response.

Preparation of Response Contact Information	
Vendor Name:	OMNI Inventive Care (OMNI Behavioral Health)
Vendor Address:	5115 F Street Omaha, Nebraska 68117
Contact Person & Title:	William E. Reay; President and CEO
E-mail Address:	breay@omnibh.com
Telephone Number (Office):	402-397-9866 ext. 103
Telephone Number (Cellular):	402-616-3838
Fax Number:	402-397-1404

Each vendor shall also designate a specific contact person who will be responsible for responding to the State if any clarifications of the vendor's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Vendor Name:	OMNI Inventive Care (OMNI Behavioral Health)
Vendor Address:	5115 F. Street Omaha, Nebraska 68117
Contact Person & Title:	William E. Reay, President and CEO
E-mail Address:	breay@omnibh.com
Telephone Number (Office):	402-397-9866 ext. 103
Telephone Number (Cellular):	402-616-3838
Fax Number:	402-397-1404

Request For Information (RFI)

State of Nebraska Department of Health and Human Services

Combined Services

OMNI Inventive Care (OMNI Behavioral Health)

William E. Reay, President and CEO
Jamie L. Monfelt-Siems, LIMHP

June 11, 2018

III. Project Description and Scope of Work
The bidder should provide the following information in response to this Request for Information.

A. Current and Future Environment.
Currently, the Division of Children and Family Services (DCFS) provides an array of services that includes Foster Care, Family Support, and Parenting Time/Visitation. These services are contracted with Providers throughout the State of Nebraska to provide placement and permanency for children, support and education for parents, as well as supervised visitation for families whose children have been removed from the parental home due to abuse and/or neglect.

DCFS is seeking to create a new single service for families that: provides safety for children in a home environment, supports biological families, and when appropriate, offers a permanent family home to a child (ren) who need permanency.

This service should include capacity to provide stabilization to biological families and parent education curriculum to ensure child safety and prevent recurrence of maltreatment.

B. Scope of Work.
Please provide comments or input on how DCFS can create a Foster Care Service that provides both stabilization in biological families and education curriculum to ensure child safety and prevent recurrence of maltreatment.

Introduction:
Recent reports provided by US Department of Health and Human Services indicate there is approximately 500,000 youth in foster care. (Adoption and Foster Care Analysis and Reporting System; US Department of Health and Human Services, 2017). Although entries into foster care across the nation identify a 19% decrease, the overall trend over the past 10 years in the US has demonstrated an increase of children entering the foster care system.

In Nebraska, currently 4,772 children are in out of home care, which includes foster care placements, kinship/relative placements, and residential facility placements (Nebraska Foster Care Review Office, second quarter report, 2018). Of these youth in out of home care, 109 youth re-enter Child and Family Services no less than three times. Child (ren) enter care for multiple reasons; the most prominent and current reason in Nebraska is related to neglect, followed by parental drug use, domestic violence, housing, physical abuse, parental incarceration, parent mental health, and child's behavior (Foster Care Review Office, 2018).

Children involved in foster care are vulnerable to multiple risks including difficulties with emotional and behavioral development; brain and neurobiological development; social relationships with parents and peers; and educational problems. Emotional and behavioral development is identified through mental health problems in children of foster care. Mental health problems for children in foster can include an array of mental health disorders associated from severe and persistent mental illness (e.g. major mental health disorders such Major Depressive Disorder; to diagnoses of less severity (e.g. Adjustment Disorders). Conduct Disorder is also included within mental health problems for children in foster care. Regardless of diagnoses, children may demonstrate a host of cognitive distortions, emotional dysregulation

issues, and behavioral disruption. Behavioral disruption may include but is not limited to verbal/physical aggression, property destruction, non-compliance, self-injurious behaviors, elopement, substance use, and suicide.

Foster children have also been found to be at elevated risk for disruption in key areas of brain development. Foster children experience deficits in a variety of neurocognitive functioning including poor visuospatial processing, poorer memory skills, lower scores on intelligence tests, and less developmental in language capacities (Pears & Fisher, 2005). Deficits likely affect children's performance in school and their cognitive development, as well as impulsivity in decision making abilities. (Leve, Harold, Chamberlain, Landsverk, Fisher, Vostanis, 2012). Experience of maltreatment and placement in foster care might have enduring brain and neurobiological vulnerabilities that could affect their ability to succeed in home, school, and other social contacts (Fisher & Stoolmiller, 2008).

Socially, children who have who experienced maltreatment and behavioral disruption may have greater difficulty in achieving and maintaining positive social and peer relationships. Children with institutional or foster care histories tend to be indiscriminately friendly towards others (Leve, Harold, Chamberlain, Landsverk, and Fisher & Vostanis 2012), which places them at greater risk for vulnerability and poor decision making in a social atmosphere. Emotional and behavioral dysregulation might also extend to other social contexts, including difficulties establishing and maintaining positive peer relationships, as well as having meaningful engagement with their community.

The aforementioned problems can afford children with difficulty in both placement stability and reunification to their biological homes. Placement disruption occurs in foster care for variety of reasons. Most prevalent, the breakdown can be a result of the emotional and behavioral difficulty demonstrated by foster children, but can also be due to a lack of training and education provided for foster caregivers on the specific needs of foster children. Foster parent and relative caregivers are not likely to be provided with the adequate information and instruction on behavioral management techniques, let alone practice and feedback on behavioral management. In addition, children labeled as "difficult" tend to induce negative reactions and responses in their caregivers, which can lead to placement breakdowns.

Placement disruption has negative consequences for children's emotional and behavioral development, with each change in foster home involving repeated discontinuity in caregiving experiences as well as social instability (school and peer changes). These factors are recognized as promoting negative psychological outcomes for foster children (Rubin et al. 2007). Equally challenging, foster children with backgrounds of abuse and neglect and/or disordered attachment have shown increased physiological reactivity during attachment tasks with their foster caregiver. This indicates that the quality of relationships with current caregivers might be comprised by experiences of prior neglect that impede children's abilities to regulate emotions in the context of environmental stress (Leve et al. 2012).

Placement disruption and/or placement instability often arises from a breakdown of the child-foster caregiver relationship, but can also result from administrative needs and policies. Studies indicate the main reasons of dissatisfaction for foster parents include a lack of understanding of the foster child; an inability to help foster parents manage difficult behaviors; and not taking

the foster parents' views seriously as primary reasons for dissatisfaction with services and are likely rationale for placement disruption (Staines, Farmer, Selwyn 2011).

Furthermore, not only is placement disruption problematic based on the aforementioned issues, but placement disruption in foster homes also impacts reunification or longer term placement. Children labeled "difficult" based on issues with externalizing behaviors, poor cognitive processing, and social/educational difficulty are identified through studies to be less likely to reunify with primary caregivers timely. Further studies have indicated children with externalizing behavior problems have been found to be one-half as likely to be reunified as children without problems, even after controlling for background characteristics and type of maltreatment (Landsverk et al. 1996).

Frequent placement changes and infrequent contact with biological families that high risk youth face may limit the interpersonal relationships that are developed and decrease the chances of forming a connection with an adult that is likely to lead to permanent placement (Lockwood, Friedman, & Christian 2015).

Children experience delayed reunification when the risks of parent and family problems are combined with child behavior problems. Since families in which these children are living may have limited ability to provide the level of care needed, continued alternative placement (i.e. foster care, relative/kinship care) or residential treatment may seem like the only option. However, extensive research has shown that housing extremely high risk children with their peers is a questionable intervention strategies. Children in group care situations reported much lower levels of supervision and consistent consequences for behavior than did the adult staff charged with caring for these children. Nevertheless, in the US, Europe, and elsewhere around the world residential treatment for highly troubled youths is still an extremely prevalent approach to treatment (Fisher & Gilliam, 2012).

The general response to frequent and constant placement disruptions is to place youth in residential facilities. There is a history and current rationale for the utilization of residential treatment facilities. The rationale for the use of residential placements is intuitively appealing. By removing troubled youth from their families and communities and placing them in a setting in which the level of restrictiveness appears quite high, it should be possible to maximize their functioning and safety. There is reason to believe that children and adolescents with disruptive behavior problems, such as antisocial and aggressive symptoms are among the most difficult populations to treat in a residential settings and that they tend to benefit the least when compared to other groups of non-antisocial counterparts in care (Zoccolillo & Rogers, 1991). A possible set of explanations for this notion is the placement of such youth together in group settings actually increased their rates of problem behaviors possibly through mechanisms such as modeling and direct reinforcement of aggression (Fisher, Chamberlain 2000). Furthermore, the least amount of evidence exists for residential services, where in fact the majority of funding dollars are spent (Burns, Hoagwood & Maultsby, 1998).

For the most difficult to treat youth, significant improvements in outcomes are likely to require practice level changes that involve the provision of effective treatments and supports within the

framework created by systems of care. Most of the current effort (within systems of care and beyond), focuses on how to develop, evaluate, and disseminate evidence based treatment. (Farmer, Burns, Wagner, Murray, and Southerland, 2010). But implementation of such evidence-based treatment is lacking.

Community based services are frequently provided for children in foster care to address their complex and multifaceted needs and to prevent placement in more restrictive environments outside of the community. These interventions are often delivered in the contact of a system of care in which a team assesses, plans, and coordinates care for children and families. Inclusion of foster parents in these interventions occurs in some parts of the country and the potential to increase their involvement needs attention (Landsverk, Burns, Faw-Stambaugh, Roll Reutz, 2009).

The use of evidence-based community interventions for children in foster care has the potential to additionally decrease the widespread disparities in health and mental health outcomes, improve placement stability, and increase the likelihood of children achieving permanency. A vast body of evidence documenting poor outcomes among children in foster care has led to numerous calls to action to document characteristics risk factors more effectively and to develop programming and policy to address the needs of this population (Fisher, Chamberlain, and Leve 2009).

II. Education and Curriculum:

There has been an increased emphasis on dissemination and implementation of evidence-based treatments in children's mental health over the last decade. Much of this work has focused on the challenges and factors associated with increased likelihood of successful implementation of empirically supported approaches. Such efforts suggest that successful implementation is difficult but possible, and that organizational factors (e.g. readiness, leadership, receptivity) play an important part in treatment. However there is relatively little attention to just how much work is required and what types of issues are encountered from both the treatment developer/disseminator's perspective, and from the perspective of the implementing agency (Murray, Culver, Farmer, Jackson, and Rixon 2013). Parent focused interventions currently delivered to families in child welfare and most foster family training do not use treatment strategies with solid empirical support (Hurlburt et al. 2007; Barth et al. 2005). In part, the lack of utilization is based on a minimized list of evidence-based treatment strategies from which to choose. As elicited, there are several practices and models of training that are utilized with foster families, however there are few that have been repeatedly tested and replicated to determine their effectivity across multiple domains.

In order to provide effective interventions it is also important to acknowledge the intricate relationships between a foster parent and foster child. Interventions for foster care families are unique in several regards, predominantly because the children in care have been exposed to neglectful and/or abusive parenting from a former caregiver, but not from the current foster caregiver who would be involved in the intervention and who is currently parenting the child. This alone establishes a different "parent-child" relationship in which the child may react and respond differently. The differences in relationship although may be more positive, may also elicit negative responses from children as well (e.g. testing limits, noncompliance). Interventions

that decrease child behavior problems and increase foster family attachment and feelings of belonging might reduce the effect of behavioral problems; and increased caregiver support might reduce the number of placement disruptions (Leve, Gordon, Chamberlain, Landsverk, Fisher, & Vostanis, 2012). It is further identified that foster parents who are emotionally involved, well-trained, and supported by their agency and matched in temperament to the child are more likely to create a stable placement (Lockwood, Friedman, Christian, 2015).

As identified, foster children are more likely to exhibit constellations of behavior, neurological, and relationship vulnerabilities that pose unique challenges to caregivers. Thus, standard parenting interventions might not be sufficient or appropriate for foster families (Leve, Harold, Chamberlain, Landsverk, Fisher, Vostanis, 2012). Foster children may have historically experienced use of harsh discipline, a lack of positive reinforcement, and failure to provide adequate supervision, surveillance, and monitoring. Therefore the need for effective discipline, reinforcement, and supervision are necessary key targets of intervention (Fisher and Gilliam, 2012). Rather than remove the children from a "naturalistic environment", and place them into residential care, more home and community based treatment is necessary to avoid residential placement.

Many programs for interventions have roots in Social Learning Theory that was promulgated by Gerald Patterson and colleagues at the Oregon Social Learning Center, beginning in the 1960s. (Fisher and Gilliam, 2012). Interventions focusing on foster children, their caregivers, and their socialization have gained momentum in the last decades. Once such program is Multidimensional Treatment Foster Care (MTFC). MTFC is an alternative intervention to treating youth in aggregate care settings that is based on Social Learning Theory, and aims to capitalize on the potentially positive socializing influence of family. MTFC "mirrors" normative life (Leve & Chamberlain, 2007). MTFC originated in the state of Oregon and to date, is the only evidence-based curriculum identified to effectively reduce problematic behavior with youth in foster caregiving environments. MTFC has many derivative programs, such as Project KEEP (Keeping Foster and Kin Parents Skills and Supported); Together Facing the Challenge (TFTC); Family Connections (FC); and the Incredible Years (IY). MTFC studies have been replicated and found to be effective to serve foster youth of multiple ages (early childhood, middle childhood, and adolescents), as well as foster youth with co-morbid issues (e.g. mental health, developmental delays, substance use).

The intensive nature is specifically designed to provide levels of support and supervision necessary to maintain such youth in the community settings. Subsequently, the program was adapted downward developmentally to serve school aged children and children in pre-school age range who were on the cusp of beginning primary school (Fisher& Gilliam 2012). The current ages served through MTFC are children ages 3-18.

There is consideration on the fact the most children served in foster care have several behavioral problems and significant histories of trauma and maltreatment. They may have spent very little time and had very little experience with typical family environments. As such, they may require a considerable period of adjustment before they begin to behave in accordance with the expectations of the families with whom they are placed. This is one of the reasons that the program provides such extensive support to foster families and care for the foster children. The stress on children and foster parent during this period of adjustment can be considerable,

and it is unrealistic to expect that individuals (both foster youth and foster parents) will be successful on their own.

Therefore, foster parents are trained on specific targets to promote and increase particular strengths and needs. Targets of training include: Reinforce normative and prosocial behavior; Provide the youth with close supervision; Closely monitor peer associations; Specify clear and consistent limits and follow through on rule violations with nonviolent consequences; Encourage youth to develop positive work habits and academic skills; Decrease conflict between family members; and Teach use of new skills for forming relationships with positive peers and for bonding with adult mentors and role models.

Services are delivered in the context of specially trained and highly supervised foster parents, and with intensive collaboration of a greater multi-disciplinary team (e.g. foster parent, biological/adoptive parents, relatives, school officials, family and individual therapists, skill coaches, and professionals). The goals are to make it possible for the child to function in family and school settings over the longer term. Services are delivered in a proactive manner. Rather than waiting until children's problems reach a point where their placement may be compromised, program staff and the greater multi-disciplinary team work collaboratively with foster parents to prevent problems from escalating (Fisher & Gilliam 2012).

As reported, the collaborative team of foster parents, biological/adoptive parents, relatives of the youth, school officials, therapists, skill builders, and the foster care agency compromise an extensive collaborative and multi-disciplinary group. In addition, professionals such as the youth's prescribing physicians (such as for health and psychiatric needs) are necessary additions to the team. Having staff operate within their defined roles increases the ability to both support and discipline the youth. There is little to no overlap in the responsibilities of team members. Within the team, there are multiple layers of staff involvement with the youth, biological/adoptive family (or longer term caregivers), and the foster family. The intensive nature of the programming is specifically designed to provide levels of support and supervision necessary to maintain such youth in the community settings (Fisher & Chamberlain 2012). It is imperative that foster parents be considered part of the treatment team. Foster parents are viewed as paraprofessionals and seen as the "primary agents of change" and must meet key characteristics. Key characteristics of foster parents should include: a desire to make a difference in the child and the child's family life; to work as a member of a coordinated team; willingness to participate in the program's activities, which include frequent contact with biological/adoptive families (or identified longer term caregivers); more frequent contact with the collaborative team, and implementing behavioral support plans for the youth placed in their home (Chamberlain (2003).

Foster parents are trained rigorously on specific parent management training techniques, which include behavioral management models (that are specific to the age and developmental level of the children in the age group they intend to have in their home). Considerable emphasis during the training is placed on providing children with positive support for prosocial behavior. This includes the use of concrete reinforcement strategies. Foster parents are also trained in basic identification of the functionality of behavior and data collection associated with assessing behavior. Foster parents participate in "in vivo" trainings with program staff who model and practice skills with the foster family. Foster parents may also attend and participate in family therapy with a family therapist as necessary. (It is important to note that the youth may also

participate in individual therapy, and family therapy with the biological/adoptive or longer term caregivers). Foster parents participate in weekly phone calls and data collection with foster program staff on the treatment progress of the youth placed in their home. A support group for foster parents is also offered weekly. During weekly support groups foster parents have the opportunity to present particular situations that were either challenging or positive to the group. This allows for additional peer support and problem solving. During the weekly support group program staff provide child care.

As indicated, foster parents are viewed as the "agents of change", with regard to the daily "front line" observation, data collection, and modeling done with foster youth. Foster parents are often requested to model, practice and participate in teaching and training activities where they are demonstrating and modeling skills to biological/adoptive/longer term caregivers. There is a need for foster parents to be able to communication and build alliances with biological/adoptive and/or longer term caregivers in order to produce more sustainable change.

For children in foster homes, the child receives a comprehensive program of services. Said program of services starts with a comprehensive assessment of their strengths and needs. Dr. Sam Meisels (1996) in "Charting the Continuum of Assessment and Intervention" identifies the importance of valued assessments. "... *that for young children, assessment and intervention are intricately linked and must abridge by the principle of "contextualization" which includes the understanding the stressors affecting the lives of the children and their parents. Assessment and intervention tools such as the family portfolio serve to identify the family's perceptions and goals as well as identify the child's strengths and a purposeful collection of the child's work. Assessment and intervention are interdependent and should be not be viewed as separate, distinct, functions* (Roberston, 2006).

The comprehensive assessment is seen as being part of the systemic therapeutic approach, in that it is carried out with the child and caregiver(s) together over a number of sessions and is dynamic. Therapists are expected to be active in responding to issues as they emerge such as ensuring that medical/organic causes for problems have been ruled out. In theory the assessment is not primarily about a young person's suitability for therapy but is a means by which a therapeutic environment is created, based on the placement, with the relationship between the young person and the caregiver being given central importance. It is intended that the young person has the necessary help with issues leading to problematic behavior that could potentially jeopardize their placement, the relationship with the carer is fostered and the carers receive practical help in understanding and managing difficult situations (Staines, Farmer, Selwyn, 2011).

Once the comprehensive assessment is completed, foster youth are placed on a behavioral management system that is developmentally appropriate for the child's developmental age, and based on strength and need. For adolescents, a behavioral management system might be based upon a "level" system where privileges and desired reinforcement are earned. Behavioral programs for younger children and children who have cognitive and/or developmental delays are provided a simpler program than a level system. Often simpler programs involve more immediate forms of reinforcement such as stickers, a "star chart", or other desired agreed upon reinforcements. The over-arching expectation is that foster parents will maintain some sort of

concrete reinforcement program with children in their care for the duration of time the children are in the program. Behavioral programs will be continually adjusted and will need modification over time in order to meet the individual needs of the child. Foster parents provide input to the program staff related to any challenging behaviors and methods of reinforcement that are especially effective. Focal issues will change over the course of time that the child is in the program, but the high degree of contact between program staff and foster parents allows the child's individual needs to be addressed on an ongoing basis.

Foster care program staff provide support and consultation to the foster family. This includes weekly contact related to data collection, strengths of the youth, and any particularly challenging behaviors identified. Foster care program staff also provide behavioral support to the child's school. This may include direct consultation with teachers and staff, as well as meetings (i.e. Individualized Education Planning meetings). Foster care program staff work in collaboration with teachers and school officials to develop and implement a behavioral support plan which mirrors the planning in the foster home. Program staff also provide support for emergency and crisis situations at all times (24/7; 365 days per year). The idea that someone is always available to help with difficult situations is a critical component of success. By being proactive about crisis management, the foster parents and staff are able to prevent foster parents from feeling overwhelmed and alone when dealing with difficult circumstances, which likely contributes to low disruption rates (Fisher & Gilliam 2012).

Furthermore, foster care program staff empower foster parents and give them the skills and supervision necessary to make smart decisions about the use of daily contingencies in their interactions with youth. For example, Foster Care Program staff try to prevent anything from happening that undermines the foster parent's reinforcing roles or relationship with the youth. This includes occasionally protecting foster parents from unpopular decisions that might have to be made (limiting contact with certain peers). The stratification of authority helps the foster parent stay in the role of youth advocate and puts the program supervisor squarely in the line of fire.

Foster youth participate in therapy, both individual and family. Individual therapy focuses on mental health needs (as identified), adaptive functioning, and highlighting strengths. Each therapist-youth dyad generated provides multiple definitions of problematic life areas and selected emotional/behavioral areas to focus on. Family therapy with the youth's family (which includes foster family) focuses on identifying prosocial and problem behaviors occurring within the family context defining structured responses to these behaviors (Leve & Chamberlain, 2007). Additionally, family therapy assists to enhance parent-parent collaboration between the foster family and the biological/adoptive/longer term caregivers.

In addition to behavioral support planning, and data collection, there is also a need to support children through skills coaching. A Skills Coach is provided to teach problem solving and other prosocial skills to foster youth. A Skills Coach can model and practice multiple skills with youth based on the need for their particular developmental age and stage and particular need (e.g. social interaction, anger management, problem solving, organization skills, and communication). Skill Coaches can also work in multiple environments which include the youth's foster home, school, and community; as well as work with the youth within the biological/adoptive/caregiver home. Skills Coaches primarily focus on specific social skills by coaching or reinforcing foster

youth with adaptive ways to respond to specific situations. The Skills Coach attempts to help foster youth expand behavioral options through role play in hypothetical situations and real world contexts. Skills Coaches teach appropriate behaviors to prevent the youth from receiving negative consequences (e.g. loss of privileges) or to help the youth in earning a desired reinforcement. This approaches help to establish an alliance between the Skill Coach and the youth (Leve & Chamberlain, 2007).

While the youth is placed into foster, biological and/or longer term placement, resources are identified. (This may in fact be completed prior to placement in foster care). If the youth is unable to reunify to the biological/adoptive home, then longer term placement resources are sought and identified. Longer term placement resources might include other relatives for placement, and or alternative caregivers who can serve as permanent caregivers. Whoever is identified, the foster parent(s), and collaborative multidisciplinary team work with those individuals to teach them the same parenting and behavioral management skills that are being employed in the foster home. Biological/Adoptive/Longer Term Caregivers also learn the use of effective strategies to set limits around negative behavior without being overly harsh and coercive; while employing behavioral management strategies identified as essential to ongoing treatment and success. The identified long-term caregiver(s) works with foster parents to learn said skills, and to facilitate a parent-parent collaboration. This parent-parent collaboration is valued and strengthened by the therapist, skills coach, foster care program staff, and multidisciplinary team. The team supports the longer term caregiver throughout the youth's placement in foster care and throughout the transition to the longer term placement.

Throughout multiple replicated and independent studies, MTFC and programs thereof have been determined effective, efficacious programs that can serve multiple ages with multi-morbid conditions. The utilization of distinct staff with defined roles assists in providing both support and discipline to the practice. Team members work in collaboration with one another and the youth, with the foster parent being the primary agent of change. The youth's biological/adoptive or identified longer term caregiver is identified, and is also part of the larger collaborative team. All caregivers are provided the same training and behavioral modification to allow for both consistency and continuity of care. Studies have indicated that youth who participate in MTFC and like programs have decreased lengths of stay in the foster care system; have increased likelihood of reunification (or identification of longer term placement); and are more likely to be successful in therapeutic intervention.

Embedded within MTFC and like programming, is the evidenced based treatment Parent Management Training (PMT). Developed by Robert Kazdin, PMT is one of few identified evidence based practices for producing change in parenting dynamics. Problem Solving Skills Training (PSST), and Parent-Child Interaction Therapy (PCIT) are two additional practices which demonstrate efficacy. All three trainings share one common theme: highly focused interventions that teach parents a specific and targeted set of parenting skills.

PMT consists of interventions in which parents are taught social learning techniques to change the behavior of their children or adolescents. PMT is based on four distinguishing but interrelated components.

a.) A conceptual view about how to change social, emotional, and behavioral problems.
b.) A set of principles and techniques that follow from that conceptual view.

c.) Development of specific skills in the parents through practice, role play, and other methods of training; and
d.) Integration of assessment and evaluation in treatment and treatment decision making.

PMT interventions are based on numerous studies that have revealed developmental pathways to child and adolescent behavior and emotional problems to be strongly associated with ineffective parenting practices.

PMT has been shown to lead to therapeutic changes among children and adolescents in scores of studies. Randomized controlled clinical trials, regarded as the strongest basis for drawing conclusions about interventions, provide the basis for this claim. Such trials have been conducted in the context of treatment and prevention.

The effectiveness of PMT treatment has been evident in a wide range of symptoms and measures of adjustment of children and adolescents. Most studies focus on symptoms and functioning at home and at school, and include parent and teacher reports and direct observations of behavior at home and at school and include parent/foster parent and teacher reports and direct observations of behavior at home, at the clinic, in the community, or at school. In a few studies, measures of parent and family functioning (e.g. psychopathology, depression, and family relations) have been included and also reflect improvements.

Several studies have shown that the changes are clinically significant. The most commonly used measure has shown that at the end of treatment, performance is well within the range of a normative sample of children who have not been referred for treatment and who have not been identified for the problem behavior or deviance.

Most applications of PMT have been with children who are referred for oppositional, aggressive, and to a lesser extent, antisocial diagnoses. Adolescents too, have been the focus of PMT. In terms of diagnostics, the most common focus is children who are characterized by oppositional defiant and conduct disorder, although studies often omit information about diagnoses. PMT has been applied to children with mental retardation, learning disabilities, and pervasive developmental disorder. In these areas, PMT has had an impact on functioning. PMT and the principles on which it is based are considered the most promising psychosocial treatment for children. The content of treatment includes standardized treatment which focuses on PMT, an intervention designed to alter parent-child interactions in the home. The goal of the intervention is to alter specific child-rearing practices and to increase the pro-social functioning of the child at home, school, and in the community. PMT consists of a pre-treatment session; which provides explanation of treatment and initial information gathering, followed by twelve (12) distinct sections of training and practice focused on specific parenting practices including defining behavior, recording behavior, and learning specific interventions for reinforcement, planned ignoring, and problem solving, followed by sessions focused on compromising and generalization.

It is important to note that the PMT practices have been identified through research to be embedded within MTFC and its subsidiaries. According to a review of studies in which MTFC was utilized with PMT, the overall results were positive to produce change in parenting practices amongst foster caregivers as well as biological/adoptive and longer term caregivers.

III. Stabilization and Permanency:

Studies have indicated the utilization of programs such as MTFC and PMT for foster youth and their families have increased the likelihood of a youth demonstrating stabilization of emotional and behavioral dysregulation, as well as obtaining permanency. Family focused interventions that emphasize parent management and monitoring can ameliorate depressive symptoms, even though these problems are not explicitly targeted. Programs may change common risk factors, or consistent with the failure model, preempt the onset or worsening of depressive symptoms by impacting problems behaviors that developmentally precede them (Gordon, Kerr, VanRyzin, DeGarmo, Rhoades, Leve, 2013). Although evidence indicates stabilization and permanency, these factors in many studies were proven to be secondary to the increased relationship, alliance, and supportive factors provided by foster families. Meaning, as the foster parent/caregiver relationship is strengthened there is a correlation with decreased emotional and behavioral dysregulation. As noted in one particular study, "Buffering effects of a positive family environment (indexed as higher levels of caregiver emotional involvement, positive remarks, and warmth) predicted improvements in psychotic symptoms and social functioning." (Poulson, VanRyzen, Harold, Chamberlain, fowler, Conone, Aresneault, Leve, 2014). Therefore it is important to bolster the relationship between foster parents and biological/adoptive/longer term caregivers in order to produce sustainability. There is also the notion that continued therapeutic intervention (therapy and skills coaching) may be necessary beyond the youth's placement in foster care and the transition to either reunification or longer term caregiver placement. Continued collaboration with the greater multidisciplinary team approach will also be vital to ongoing stabilization and ultimately permanency.

However, it is often assumed that, once parents (foster parents, biological/adoptive/relative) acquire a particular set of parenting strategies, they will utilize those strategies with other children in their care and continue to do so over time. Unfortunately, this assumption has rarely been tested. The extent to which foster and kin parents retain and generalize the behavioral management strategies they learn through training is not well known. The finding from a few studies suggest that generalization of newly acquired parenting skills to other children in the home can and often does occur (Arnold et al. 1975; Humphreys et al. 1978; Bresten et al. 1997; Brotman et al. 2005), but is largely unknown. (Price, Chamberlain, Landsverk, Reid, 2009).

Additionally, it is important to understand the dynamic of vulnerable parents. Vulnerable parents; those parents who are affected by a range of stressors including poverty, disability, disrupted family configuration, and a variety of emotional, social, or psychological difficulties (Mendoza, Katz, Robertson, & Rothenberg, 2003) often have extenuating circumstances that decrease and/or limit their abilities to provide stabilization long term. This will likely effect permanency as when a cluster of these challenges overpowers the parents' ability to raise their child, ultimately affecting their child's healthy development, then it is likely that the child, and the parents, will come to the attention of the child welfare systems, and the children may eventually be placed in foster care or other determined, longer term placement. Vulnerable

parents represent unique challenges to child welfare professionals and other service providers who work with them.

However, studies have indicated that when parents have access to additional information, resources, and relevant training, they are better able to meet their children's developmental, social, behavioral, and leaning needs and advocate for their child within complex educational or health care settings (Mendoza et al 2003; Robertson 2006). Thus, the ongoing direction to produce stabilization and permanency should be to increase the utilization of home-based and community resources, including the utilization of MTFC, PMT, and like services thereof. There should be a continued emphasis on parent-parent collaboration, support, and shared resources. Further continued therapeutic intervention practices that also support parent-parent collaboration and youth strengths and needs will be most beneficial.

Conclusion:

The primary conclusion from research is that when foster families receive support aimed at improving home-based experience that address behavioral and neurobiological underpinnings, and placement capacity, children do better. This research base has expanded substantially in the past decade producing compelling findings on research-based models of risk and resilience for foster children and evidence-based interventions with strong promise to improve child well-being (Leve, Harold, Chamberlain, Landsverk, Fisher, & Vostanis 2012). At the forefront of research is two evidenced-based practices, MTFC and PMT. Both practices can operate simultaneously and separate of one another. As identified, MTFC embeds PMT within its skill base.

MTFC utilizes the foster parent as the "agent of change" and also requires multi-layered, multi-disciplinary staff approaches; where roles and responsibilities are specifically defined. There is an ultimate important factor indicating the need to increase and bolster parent-parent collaboration; and enhance the relationship between the biological/adoptive parents/long term caregivers and the foster parents. Foster parents demonstrate and model effective parenting practices to biological/adoptive families. (When biological/adoptive families are not determined to be viable options for permanency, longer term caregivers are then defined; for which modeling is then done with those identified). Furthermore, MTFC relies on the multi-layers of staff who also compromise the vast multi-disciplinary team structure. MTFC staff have clearly defined and distinct roles and job obligations. The multidisciplinary staff is comprised of multiple professionals (e.g. foster parents, biological/adoptive parents or longer term placement persons, therapist, skills coaches, school officials, medical providers).

Research on MFTC identifies promising and effective results, both for increasing prosocial behaviors and relationships, as well as demonstrations of increased permanency and stabilization. Furthermore MTFC shows effectiveness (although in a secondary emphasis) on minimization of mental health and behavioral disorders. It has been proven to be an effective practice with variable ages of youth (ages 3-18), and with various psychosocial and developmental disorders.

PMT is utilized to teach, model, and train parenting skills into generalized practice. It requires training to be completed with the caregivers and the youth. Training is done through in vivo sessions where particular parenting skills are modeled by a trained individual (in the case of MTFC that trained professional may also be the foster parent). PMT is identified to be an

evidence-based practice that has shown efficacy increasing parenting skills as well as parental control, consistency, and structure.

It is important to note change requires commitment across time and across levels. With regard to changing the current structure and vision of foster care, and with regard to combined services within foster care, discussions and trainings with staff and foster parents need to be presented differently from the beginning and at each interaction along the way. This starts with leadership having a strong commitment to the change that is being implemented, a solid understanding of the material and the goal of full implementation, as well as strong leadership skills necessary to fully implement the changes over time. Buy-in from staff and treatment families is essential to the full scale implementation of a new approach. While it requires patience to go through the process of getting input from all relevant stakeholders in the organization as changes are being developed, it appears to create a sense of ownership and understanding throughout the organizations that facilitate implementation.

It is equally important to develop a framework that is potentially creative and innovative to mount a parent-mediated, evidence-based approach directly on the service platform of the child welfare system. Typically, Child Welfare has a culture that thinks of safety and permanence as their direct responsibility, while viewing child well-being as achieved through referral to outside service sectors such as medical and mental health. For example, Child and Family Service Reviews measure accountability in safety and permanence by tracking whether children experience threats to their well-being who are referred to outside serve sectors. The solution proposed here is to actually mount the well-being intervention on the Child Welfare platform while simultaneously addressing the need for well-being and the more classic Child Welfare goals of safety and permanence.

Child Welfare Systems are heavily influenced by bureaucracy with strict timelines, multiple regulations, numerous stakeholders, and revolving contracts. Child Welfare is further distinguished by its focus on safety and its inherent and necessary involvement of multiple caregivers, foster and biological caregivers; and often times multiple providers (e.g. multiple changes in case workers, providers). Parent participation in Child Welfare Services is largely involuntary, characteristics are diverse in terms of age, race, education level, and income; and their needs are often multi-layered and extremely complex. There is a strong need for practitioners, researchers, and policy makers to work collaboratively on efforts toward change. It is only through these multidisciplinary and multicontextual efforts that children and families will receive better services. Children and their families require that foster care will live up to its promise to provide a better life for children who have experienced early difficulties (Fisher, Chamberlain, & Leve 2009). In order for foster care (and combined services) to provide better for children, it will require a change in the mindset and framework of current structure. It will require innovation, and providers that are knowledgeable of evidence-based and best practices as well as both physical and social determinants that are mitigating factors in both the lives of children as well as their families. Those organizations with a strong focus on development of new knowledge and understanding of best practices as well as the innovative strategies to deploy such practices will be absolutely vital for this endeavor.

OMNI Inventive Care (formerly known as OMNI Behavioral Health) is one such agency that promotes and effectively utilizes evidence-based practices in its daily operations and with the

multi-morbid population served. OMNI Inventive Care is an agency known to provide services to a rather vast, and multi-morbid population, and is known to serve the most difficult to treat individuals and families. OMNI Inventive Care's services utilize a menagerie of evidenced based practices. Most relevant to this Request for Information, OMNI Inventive Care utilizes PMT, rather universally with its clients. PMT is the training component utilized as an "add-on" to foster parents' MAPP training (and as seen necessary based on the youth's needs); and in services which require parenting training and practice. PMT has been observed in current service provisions to be a very effective method for parent training, and allows for modeling, feedback, and practice with parents, foster parents, and other individuals who are support youth in care and services.

In addition, OMNI Inventive Care utilizes behavioral management planning to provide planning and contracting for youth and individuals served in multiple services. Such behavioral management planning/behavioral support planning provides caregivers with the ability to have a blueprint for concrete reinforcements for prosocial behavioral demonstrations. OMNI Inventive Care utilizes not only behavioral management and support planning but also their evidence-based platform to track data on youth and individuals to provide further indications that that the implemented planning is "working" (meaning the plans are producing changes in behaviors of both the youth/individual and the family).

Furthermore, OMNI Inventive Care typically provides assessment and consultation with regard to the functionality of behavioral demonstrations and completes a detailed assessment and analysis of the strengths and needs of individuals served. Through analysis and observation, OMNI Inventive Care also is cognizant and recognizes physical and social determinants that compromise an individual's abilities; including the ability for a youth to be successful in an out of home placement; the ability for the youth to reunify to his or her family; and the multi-faceted issues that caregivers face providing care of challenging youth.

Epilogue

For the Child and Family Services Division to accomplish these provider and system reform measures, several system-wide adjustments would be advised. The most progressive and supportable research-based position that the division could take would include a strong commitment to building a Child Protection and Family Sustainably System approach to improving the quality and effectiveness of:

1. Program Development;
2. Implementation;
3. Data Collection;
4. Technical Assistance;
5. Advanced Data Analytics
6. Data-based Practice and;
7. Program Evaluation.

The ultimate aim for these activities would be to only provide funding to the delivery of systematic programs and organizations (evidence-based approaches) using methods that support successful implementation while at the same time being able to fill gaps in the collective knowledge as to which approaches or interventions are most effective and which persons. This would mean bringing more science to the practices used in the child protection and family sustainability force-force, including caseworkers and organizational staff members. The use of

traditional and less effective, and more costly approaches have hindered the State in meeting its mission.

The Division can move the system forward by adopting a program development approach that you initiate, is far less reactive, and can have far better long term benefits. This includes changing the system culture to support program implementation, using more advanced methods to support program implementation than traditional heavy human resource dependent technical assistance approaches. In addition, providing a more flexible, dynamic and responsive data collection system and more modern analytic approaches is called for at this critical period. To this end, the approach of all services to children and families must first start with obtaining an accurate understanding of the needs, preference, and prognostic possibly for any child and family, based on close attention to initial assessment, ongoing monitoring, and individualized feedback information, and which tailors interventions and support accordingly in line with the most up-to-date scientific evidence. Furthermore, this approach tailors service to the individual characteristic of each child, family, and context and specify what works for whom, under what circumstances, for how long. Along with this conceptual map, programs get managed by data driven decisions through precise measurement, feedback and integrating technology into everyday service.

It is vitally important to abandoning and moving on to the next "shiny new program" or idea when faced with system and program failures, but learning from all mistakes and persisting in a systematic and long-term developmental process. As a routine part of service, programs should be required to gather the information necessary to show if it was well implemented and if it produced the desired proximal and distal outcomes. These data could be used to determine if the program is well implemented and effective and if it should be used in other communities.

The training needs, at both the State level and provider level, are substantial. Although any approach to improving the system will clearly require ongoing feedback and program improvement strategies, there are fundamental core trainings that are required to move the child serving agencies closer to being better suited to take on a massive reform. Fundamental training needs include, but are not limited to:

1. Sustainability through Parent-Parent Relationships- communication with biological family and foster family is key for sustainable placements.
2. How to Utilize your Team as a Foster Parent;
3. Skills Coaching, Building alliances;
4. Improving families experiences with professional service providers;
5. Understanding the challenges of being poor

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