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 In-home Services	**August 23, 2018**
OPENING DATE AND TIME	PROCUREMENT CONTACT
October 5, 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 In-home Child Welfare services.

Written questions are due no later than September 7, 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 St.; Omaha, Nebraska 68117
TELEPHONE NUMBER: 402.397.9866 FAX NUMBER: 402.397.1404
SIGNATURE: [signature] DATE: 10/03/2018
TYPED NAME & TITLE OF SIGNER: Director, Child Welfare GN

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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 In-home Child Welfare 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	August 23, 2018
2	Last day to submit written questions	September 7, 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	September 20, 2018
4	RFI opening	October 5, 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 RFI reside with the DHHS. 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 RFP. 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 "In-home Services RFI 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. RFI responses should reference the request for information number and be sent to the specified e-mail address. 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 as a separate document. The separate document must be clearly marked PROPRIETARY. Vendor may not mark their entire Request for Information as proprietary. Failure of the vendor to follow the instructions for submitting proprietary 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 vendor 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 (CFS) provides services to sustain a child(ren) with parents in the family home, including Family Support Services, In Home Safety Service, Intensive Family Preservation, and Family Peer Support. These services are contracted with providers throughout Nebraska to provide stability for children, as well as support and education for parents who have become involved with CFS due to allegations of abuse or neglect.

CFS is seeking information for evidence-based model services that: promote safety for children in a home environment; support biological families in their homes in order to parent their children and ensure their children's safety; and meet the expectations of the Families First Prevention Services Act, Pub.L. 115-123.

Services should increase a parent's protective capacity, link families to community supports and services, enhance their child's educational opportunities, and focus on their health and wellbeing.

B. SCOPE OF WORK

Provide comments or input on services that provide 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

In-Home Services

OMNI Inventive Care (OMNI Behavioral Health)

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

October 4, 2018

III. Project Description and Scope of Work

The vendor 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 (CFS) provides services to sustain a child (ren) with parents in the family home including Family Support Services, In Home Safety Service, Intensive Family Preservation, and Family Peer Support. These services are contracted with providers throughout Nebraska to provide stability for children as well as support and education for parents who have become involved with CFS due to allegations of abuse or neglect.

CFS is seeking information for evidence-based model services that promote safety for children in a home environment; support biological families in their homes in order to parent their children and ensure their children's safety; and meet the expectations of the Families First Prevention Services Act, Pub.L. 115-123.

Services should increase a parent's protective capacity, link families to community supports and services, enhance their child's educational opportunities, and focus on their health and wellbeing.

B. Scope of Work

Provide comments or input on services that provide both stabilization to biological families and education curriculum to ensure child safety and prevent recurrence of maltreatment.

Introduction:

In the United States, more than 800,000 children annually receive child welfare agency provided in-home services and another 230,000 children receive supervised out-of-home care and will be reunified to the home of a parent each year (U.S. Department of Health and Human Services, 2003). A sizeable proportion of these child welfare services (CWS) recipients, at least 400,000 a year (US DHHS, 2005), will participate in voluntary or mandated parent training. Parent-training programs are clearly a linchpin of governmental responsibility to provide reasonable efforts to preserve, maintain, or reunify families who become involved with CWS. (Barth, Landsverk, Chamberlain, Reid, Rolls, Hurlburt, Farmer, James, McCabe, Kohl, 2005).

In Nebraska 7,967 children were removed from their home and put into state custody or care through the child welfare of probation systems. Approximately 64% of children were removed due to neglect. (Foster Care Review Office, annual report 2018).

For several years, Nebraska's Foster Care Review Office (FCRO) has recommended that child welfare stakeholders collaborate to innovate system improvements that leave more children safely in their homes while ensuring that those children whose safety cannot be assures are placed in temporary foster care. At the current time, however, research would not indicate, confidently, that the decrease in the number of children in out-of-home care is a reflection of an improved system. The FCRO identified the following ongoing concerns through their most recent annual data (2018):

- NDHHS-CFS data indicates that approximately the same number of children are coming into the child welfare system, however more families are receiving non-court voluntary services. On its face, this can be a positive change, wherein families do not unnecessarily penetrate the system, and access specific services, providing by NDHHS-CFS, can

alleviate safety concerns. However, the FCRO is unaware of any specific policy changes that would lead to more families receiving non-court voluntary services. Simultaneously, we are not aware of any stakeholder input on these shifts.

- One of the most common concerns expressed by the FCRO by stakeholders throughout the State is the lack of services and service providers, especially in the rural areas. To our knowledge, there has not been an increase in services or service providers for court involved families, so it is unclear what services are being offered to non-court families.
- In addition, there is no external oversight for the screening process used to decide if families are best served by the court or non-court system, and there is no external oversight for non-court cases. If a family enters the court system, the courts provide oversight to NDHHS-CFS and the FCRO provides oversight to the child welfare system as a whole. The oversight does not occur in non-court cases. While FCRO is not prepared to recommend that all non-court cases receive the same level of oversight as court cases, with a complete understanding of the policy shifts it is impossible to assess if this change best serves Nebraska families.
- There is some indication that at least part of the decrease in population is due to the concerted effort on the part of NDHHS-CFS to find permanency for children in out-of-home care 2 years or more. The average days in care for children who achieved permanency during the Fiscal Year 2017-2018 was longer than the average days in care for children who achieved permanency in Fiscal Year 2016-2018 (508 days and 488 days respectively). Even though the number of days in care was longer, there was no increase in the number of children leaving foster care without a permanent family in place.

Children are removed from caregivers typically due to some form of maltreatment. Child maltreatment "*includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence, and commercial or other exploitotion, which results in actual or potential harm to a child's health, survival, development, or dignity in the context of a relationship of responsibility, trust, or power* "(World Health Organization, 2016). The legal definitions of child maltreatment and the exact terms used to refer to it vary from one jurisdiction to another, which partly explains why the reported incidence of child maltreatment also varies. According to the most recent national data, 9.1 children in every 1,000 in the United States are victims of maltreatment every year, based on Child Protective Services (CPS) reports (United Stated Department of Health and Human Services, 2018).

Maltreatment is typically the function of multiple factors including but not limited to caregiver/familial mental health, caregiver/familial substance use, poverty, lack of resources, and/or community fragmentation. In Nebraska, underlying conditions for removal are commonly identified as drug use, violence in the home, and parental mental health (Foster Care Review Office, 2018). According to a study completed by Lanier, Kohl, Benz, Singer and Drake (2014), parents who have the following characteristics have a higher risk of maltreating their children: less education (as compared to average parent), more severe symptoms of depression, history of CPS involvement, parents themselves who were maltreated as children, low family income, experience high levels of stress, display overall impaired psychological functioning.

Regardless of function, parents who maltreat their children are often described as placing unrealistic expectations on their children, perceiving their behaviors as a provocation, and

applying more coercive, punitive parenting practices than the general population (Sanders & Pidgeon, 2011).

Maltreatment may also be the product of instability within family systems. Instability in families is created by multiple inter-related factors and may include both individual facets and familial facets which need consideration. For example, parents of children with behavior problems often experience disturbances in their own personal adjustment, including but not limited to, elevated levels of parenting stress (Anastopoulos et al. 1992), depression, anxiety (Cummings and Davies 1994), and low parenting self-efficacy (Sanders and Woolley, 2005). Negative parent-child behavioral exchanges are likely to elicit unpleasant emotions in parents that undermine supportive supportive parenting behaviors (e.g. Dix et al 2004), or feelings of anger and frustration may intensify cognitive judgements about the intentionality of negative child behaviors, leading to harsh parenting practices (e.g. Dix et al. 1990; Joiner and Wagner, 1996). Similarly, parents who believe that they are incapable of managing difficult child behavior may adopt helpless or inconsistent parenting behaviors. For caregivers whose youth demonstrate oppositional of defiant behaviors, a cycle of inconsistent or unpredictable parenting practices begin when children react (with noncompliance) to inconsistent, unpredictable parenting practices. Parents then react to the noncompliance by increasing the degree of coercion (Patterson 2002) which can lead to the use of violence and hence may lead to physical abuse (Chaffin et al 2004).

Although the aforementioned maltreatment can lead to removal, national statistics indicate that 95% of children who enter the CWS for maltreatment remain in their home of origin. In Nebraska, data indicates that approximately the same number of children are coming in to the child welfare system, however more families are receiving non-court voluntary cases. Approximately 96.5 % of children are receiving services in a "family-like" settings (FCRO, 2018).

This RFI requests information with relation to in-home services. However, it is important to include those services provided to youth in foster homes as part of the in-home service dynamic. Changes necessary for all youth and families served through child welfare programming requires more holistic treatment .

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 also placement disruption in foster homes also affects 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). In addition, the involvement of older youth in their planning needs attention. According to the Foster Care Review Office (FCRO), just 12.4% of older youth participate in their planning and attend court hearings (FCRO, 2018).

The use of evidence-based community interventions for children in foster care, their families, and child welfare programming in general 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).

Stabilization of Biological Families:

It can be theorized that familial instability may yield increased risk for maltreatment. In order to increase stabilization in families, focus needs to be shifted to services that focus on parent training and assessment of individualized needs for youth and family members. Such needs may include multiple services such as mental health therapy, skill training, and community support and identification of community resources. Further discussion of parent training methods is provided in subsequent categories of this RFI.

In correlation to parent training, there also needs to be increased focus on Family Engagement and the provision of Family Driven Care. Family engagement requires a strength based approach and family centered decision-making. Family centered decision-making gives family members "voice and choice" in their treatment and case planning. The intention of engagement is to empower families, maximize family resources, and increase kinship/informal connections. Various approaches are used to achieve consensus on key decisions related to removal, placement, and permanency while simultaneously enhancing capacity, strengthened competency, and promoting family growth and development. For purposes of policy and practice, "the family" is broadly defined to include parents, children and youth, extended family, related kin, and others.

Without engagement of parents, services are not likely to bring about meaningful change in family functioning (Littell, 2001). Early engagement is critical to establishing the helping relationship to address the family's issues. Engagement is demonstrated in many forms including parental acceptance of a need for help; attendance or availability in services; retention, compliance, and cooperation, and adherence to service plans. Both caseworker behavior and the behavior of service providers are critical for family engagement. For example, caseworkers and providers who set mutually agreed upon goals provide family-centered driven services, emphasizing skill development and provide the family with needed resources can positive impact family engagement (Dawson & Berry, 2002).

Engagement services should be a three-step process. The first step of engagement is to elicit conversation with families. Conversation should include a brief explanation of programming, reason for the referral to programming, and identification of the goals and needs according to the family. To initiate engagement services, caseworkers and/or providers may provide a "Quick

Engagement Intervention"; which allows a caseworker to ask an open-ended question about family needs. The caseworker uses the family's answer to (i) identify an opportunity to help; (ii) identify a solution that can be accomplished; and (iii) demonstrate follow through with a solution. (Ingram, Cash, Oats, Simpson, and Thompson, 2015). This simple, yet effective engagement strategy can lead to further provider alliance and engagement between the family and the caseworker/service provider.

The second step of engagement is to begin a family-centered assessment of current strengths and limitations that may be affecting the family. Children and families require a comprehensive program of services. Said program of services starts with a comprehensive assessment of family's 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 viewed 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(s) 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 career is fostered and the carers receive practical help in understanding and managing difficult situations (Staines, Farmer, Selwyn, 2011).

Family centered assessments focus on the whole family; the assessment itself values family participation and experience, and respects the family's culture and ethnicity. The assessments are designed to be comprehensive and provide overall conceptualization of a family's individualized needs. Family-centered assessment helps families identify their strengths, needs, and resources and develop planning that assists them in achieving and maintaining safety, permanency, and well-being. Planning may include but is not limited to child welfare programming necessary for family success, economic assistance, mental health/substance abuse treatment needs, community/peer supports.

There are many phases and types of family centered assessments, including screening and initial assessment, safety and risk assessment, and comprehensive family assessment. In many comprehensive assessments, additional assessments are embedded within. One such assessment is the North Carolina Family Assessment Scale (NCFAS). The NCFAS is used to assess family strengths and stressors that are predictive of child maltreatment and removal, and is completed by the family caseworker after interviews and observations of the family. (Ingram, Cash, Oats, Simpson, and Thompson, 2015). Currently in Nebraska, this assessment is only

utilized within intensive programming (such as Intensive Family Preservation and Intensive Family Reunification services) but could be expanded to other in-home services.

There is a need for increased utilization of family centered assessments and to communicate their results and recommendations with the multi-disciplinary team. Typically these assessments are completed by providers, but their results are often overlooked by funders. Results are also not typically shared with families. The lack of transfer of knowledge minimizes the assessment process and overall utility. In order to increase engagement as well as transparency, it will be important to provide assessment results both at intake and case closure.

The final step of the engagement process involved case closure planning (also known as after care planning). This step is focused on helping the family sustain the use of newly acquired skills and continue development and utilization of resources and supports that have been identified during the life of the case. The aftercare planning should "piggy back" on the strengths and needs identified by the family assessment. Case closure activities involve review of the overall successes of the case creating a safer, functional, and permanent environment for the child and family. The aftercare plan should identify the family's resources, skills and supports to establish to sustain progress and extinguish CWS involvement. Case closure also includes recommendations for any ongoing services which may be necessary to meet the overarching goals of extinguishing CWS involvement.

In addition to engaging families and providing a comprehensive assessment, there has to be a means to measure the problematic areas in which families are often viewed as "unstable". Typically, this involves observations and reports from caseworkers, service providers, as well as family member report. Measurements of motivation with children and families, decreased life satisfaction, strain of caregivers, and therapeutic alliance. These measurements are necessary to provide further insight and conceptualization of family dynamics; family needs, and further service programming. The Peabody Treatment Progress Battery (PTPB) is an integrated set of brief, reliable, and valid instruments that can be administered efficiently at low cost and provide systematic feedback for use in service planning. The PTPB includes eleven measures completed by youth, caregivers, an/or clinician that assesses clinically relevant constructs. Such constructs include symptom severity, therapeutic alliance, life satisfaction, motivation for treatment, hope, treatment expectations, caregiver strain, and service satisfaction The measures, especially with their repeated use, offer clinicians and others the opportunity for systematic feedback on their clients, both individually and in relation to other clients served. Such feedback provides rich clinical material for treatment planning, particularly for those clients who are not improving as expected. The PTPB is intended for use with youth aged 11-18 years, in varied service settings and clinical programs including outpatient care, in-home treatment, and foster care. (Reimer, Athay, Bickman, Breda, Kelly, and Vida de Andrade, 2012). Results from multiple and repeated testing identifies that each of the 11 measures are psychometrically sound, and provide necessary feedback for youth, families, and their multi-disciplinary teams.

Another important factor to consider when increasing stability is the utilization of a greater Multi-Disciplinary Team (MDT). Family involvement within the MDT is a core component of a complementary learning system in which an array of family members, providers, school, and non-school supports complement one another to create an integrated set of community-wide resources that support learning and development from birth to young adulthood. In such a system, family involvement is one of several pathways for supporting young people in many

places and contexts in which they grow and learn. Westmoreland, Bouffard, O'Carroll, and Rosenberg (2009) identified three elements in particular combination to form a pathway of interactive and ongoing family involvement and MDTs:

1.) Family involvement is a shared responsibility in which schools and other community agencies and organizations are committed to reaching out to engage families in meaningful ways and in which families are committed to actively supporting their children's learning and development.
2.) Family involvement is continuous across a child's life and entails an enduring commitment but changing parent roles as children mature from birth to young adulthood.
3.) Effective family involvement cuts across and reinforces learning in multiple settings where children learn-at home, in prekindergarten, in school, in after school programs, in faith-based institutions, and in the community.

Stabilization of families must include differentiating "levels" of service structure. Such services may include community peer supports, family Support, and intensive family preservation. The term "family support" is sometimes used as an umbrella term for an array of child maltreatment interventions, which might include "family preservation" or "peer support". However, it more often refers to community-based services broadly intended to promote family and child wellness, safety, and stability.

According to the National Evaluation of Family Support Programs (2003), programs that had the best outcomes across eight categories (child cognitive achievement, child social, and emotional development, parenting behavior, child physical health and development, child safety, parental mental health or risk behaviors, parenting attitudes and knowledge, and family functioning and resources) had the following program characteristics:

- Programs that focus on children with special biological needs or those that have parent self-help or self-development as a primary goal have larger effects on a variety of outcomes.
- Programs that both work with parents of children with special needs and provide opportunities for peer support have greater effects on parents' attitudes towards knowledge of childrearing and child development.
- Programs for families with children with development delays or behavioral problems that use professional staff to work with parents in-group settings rather than through home visits have greater effects on child social-emotional development.
  Programs that use professional staff to provide parent education are more effective in improving parental mental health and physical health, while those that provide opportunities for parents to meet support groups are more effective in producing positive attitudes about parenting, increasing parenting knowledge, and improving overall family functioning.
- The one program characteristic most associated with positive results is having a primary goal for the parent to be self-development. The positive effect is on parents may "trickle down" to their children. Such programs resulted in improved child social-emotional development.

Furthermore, it is equally important to acknowledge changes in familial aspects with regard to children placed into foster care. 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.

Family Driven care, and increased family engagement is necessary in order to successfully provide any service provision, and promote family stability. Parents, youth, and families and their multi-disciplinary team will be involved with informing all aspects of the therapeutic and service processes. Service models should embrace the philosophy of family driven care, according to the National Federation of Families:

1. Families are given accurate, understandable, and complete information necessary to set goals and to make choices for improved planning for individual children and their families.
2. Families and youth, providers and administrators embrace the concept of shared decision making and responsibility for outcomes with providers.
3. Families and youth are organized to collectively use their knowledge and skills as force for transformation.
4. Families engage in peer support activities to reduce isolation, gather, and disseminate accurate information, and strengthen the family voice.
5. Families provide direction for decisions that impact services, treatments, and supports.
6. Provides take the initiative to change practice from provider-driver to family-driven.
7. Administrators allocate staff, training, support, and resources to make family driven practice work at the point where services and supports are delivered to children, youth, and families.
8. Community attitudes change efforts focus on removing barriers and discrimination created by stigma.
9. Communities embrace, value, and celebrate the diverse cultures of their children, youth, and families.

10. Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes.

Family engagement will also require family-centered case planning and case management. Family centered case planning ensures the involvement and participation of family members in all aspects of care planning, so services are best tailored to address the family's needs and strengths. Family centered case management includes communication and planning with multiple service systems (i.e. multi-disciplinary team) to ensure provision of appropriate services and assess service effectiveness and client program.

Critical elements for family case planning:

1. Meet the family where the family is: engagement is more likely when a client is in a familiar setting, and engaging on their own terms.
2. Build on strengths: families are more likely to be engaged if they feel their strengths are recognized.
3. Family empowerment: engagement is more likely when family members feel that they are affecting the change process.
4. Steps to success: engagement is more likely to result when child welfare professionals understand and convey to families, that the processes of change happens in small steps.
5. Client involvement in assessment, planning, and decision-making: Engagement is more likely when the family has all the information necessary to address concerns.
6. Hope expectancy: engagement is more likely when the child welfare professionals convey hope, and an expectation that the family is capable of succeeding.
7. Honoring and connecting with cultural resources: a family will be more likely to engage if the family's cultures ways of knowing, communicating, and nurturing are recognized as strengths, and when the culture of the family is valued.
8. Concrete services: families will be engaged best when the needs they identify can be met.
9. Skill-based: engagement results from teaching of specific skills such as motivational interviewing.
10. Honest communication: child welfare professionals need to communicate with honesty, integrity, respect, cultural competence, and authenticity.

Family driven practices with the ability to "meet" families where they are, promote engagement of family members in all aspects of planning and services, as well as promote transparency throughout the multi-disciplinary team will have more successful outcomes related to stability and the preservation of the family unit.

<u>Education Curriculum to ensure child safety and prevent recurrence of maltreatment:</u>
In order to prevent recurrence of maltreatment, and provide services with Family Driven practice services, CWS must rely on effective parent training and support. Parent training is the primary intervention that child welfare agencies provide in trying to preserve or reunify families. Without effective interventions for families, there is no chance of operating an equitable child welfare system (Currie, 1997).

Historically, there have been many efforts to develop and deliver effective parenting interventions. Most notably, several decades of services included homemaker services, which worked directly with parents in their own homes to teach home economics skills and provide

assistance with parenting (Hutchinson & Sudia, 2002; Kadushin, 1961). Intensive family preservation programs, especially those utilizing the Homebuilder's model programs with their crisis oriented, home-based, and social learning-based interventions had relatively widespread use in the 1980s and 1990s. Their intended use is to teach enough parenting skills and coping strategies, within a month (or so) of intensive ecologically based services, to steer families out of their crisis and into a prolonged period of successful parenting. Yet the amount and model of parent training that occurs in intensive family preservation programs has been poorly documented. In any event, intensive family preservation programs have not shown robust effects in preventing the placement of children or reducting reabuse in the most rigorous statewide and national evaluations (Scheurman, Rzepnicki, & Littell, 1994; Westat, Chapin Hall Center for Children, & James Bell Associates, 2002). Intensive family preservation programs continue to be used across the United States, although with declining support. At the same time, federal funds for such programs are increasing, offering growing opportunities for institution more effective approaches. (Barth, Landsverk, Chamberlain, Reid, Rolls, Hurlburt, Farmer, James, McCabe, Kohl, 2005).

The search for effective parent-training programs for child welfare families has been long and slow. Berry's (1988) review of such programs includes no peer-reviewed studies of the general child welfare population. Berry (1988) finds a few promising efforts (Reid & Kavanagh, 1985) but argues that they lack "good fit" with the general CWS population because they require more resources and time than is generally available in child welfare agencies. A new generation of parent-training programs has emerged and warrants exploration. This analysis builds programs on recent reviews of the evidence base for parent-training programs with other audiences, primarily mental health providers working with conduct-disordered children (Brestan & Eyberg, 1988; Farmer, Compton, Burns & Robertson, 2002; Kazdin & Weisz, 1988; Nixon 2002 as identified in Barth, Landsverk, Chamberlain, Reid,, Rolls, Hurlburt, Farmer, James, McCabe, Kohl, 2005). More recently, evaluating parenting programs for use in CWS requires the choice of standard for determining which have an evidence base for effectiveness or, at least, which are efficacious enough to be promising programs. Many and varied criteria are being used by the scientific community to denote evidence-based from nonevidence-based interventions.

There are three commonly held, but rarely tested assumptions and values in the field of parent training. The first assumption is that the instruction in child development is not only necessary, but also sufficient, to ensure parental behavioral changes. This assumption may be the outgrowth of research suggesting maltreating parents have inappropriate behavioral expectations of their children (e.g. Tolliver et al. 1998). Although a focus on teaching child development knowledge is a logical response to such findings, intervention research from a wide variety of health outcomes indicates that changes in knowledge does not guarantee changes in parenting behaviors.

The second assumption is that manualized programs, which have historical connections with empirically supported therapists (Westen et al. 2004) produce better outcomes than programs without a curriculum. Thus, programs utilizing a manual or curriculum would report larger effect sizes than programs, without a standardized protocol.

A third, and most strongly held assumption in the field is that "more is better"-that is, providing families with more services will lead to better outcomes (e.g. Lundahl and Harris 2006). Parent training programs often include other supplemental services, such as anger or stress

management, substance abuse treatment, or job skills training. Although the provision of a larger array of services might lead to changes in other parent or gamily outcomes (e.g. abstinence from substance use, improved economic circumstances) we assert that these ancillary services are less likely to manifest in proximal, immediate changes in parenting or child behaviors than program component directly targeting parenting skills. Such additional services may present an overwhelming burden or impede parents' ability to focus on and mastering parenting skills. (Wyatt Kiminski; Valle, Filene, Boyle 2008).

Keeping in mind the aforementioned assumptions, development and implementation of parent training programs must rely on diverse functions that are typical of a CWS population. Services and training must provide for multi-morbid mental, physical, and behavioral health issues as well as provide for educational issues. Services are expected to demonstrate improvement in parenting, while negotiating rules and policy between governmental policy and judicial systems. The success of a parent training program to achieve this triad is likely to be key in their dissemination and implementation.

In recent years, 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.

One such evidence based treatment is Parent Management Training (PMT). Developed by Robert Kazdin, PMT is one of few identified evidence based practices for producing change in parenting dynamics. PMT is now among the most well established EBI's for child mental health problems, with proven benefits in the treatment for child disruptive behavior in a large number of controlled trials (Dretzke et al 2005).

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 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.

In conjunction with Parent-Management training and often embedded in programming is the utilization of the "How To" Manuals. The "How To" Manuals, also known as the Pro-Ed Series. are written in an easy to understand, accessible form. The series is made up of sixteen manuals addressing training from selecting reinforcers to how to use a token economy and point systems. Each manual gives a basic, user-friendly overview of how to apply the particular behavioral technique for either increasing an appropriate behavior or decreasing an inappropriate behavior. Each "How To" manual starts with a brief introduction to the procedure and an overview of situations in which it can be effective. The manual then systematically leads

the reader through the development and implement process for the specific procedure. Each manual demonstrates how to develop data collection forms for the techniques and how to evaluate the interventions effectiveness. At the completion of each section of the manual, there is a series of questions that ask readers key questions regarding the information have read. The manual also provides additional references and further reading sections for the manual's users. The "How To" series does provide a valuable resource for consultants, a supplement for training and a source of new intervention strategies for practitioners. (Hall, Hall, 1998).

Parent-Management Training and the "How To" Manuals, typically make up the most common arsenal of materials utilized for in-home programming. Such programming includes services such as Family Support, Intensive Family Preservation (IFP), and Intensive Family Reunification (IFR). Again, it is important to note the need for individualized programming, therapeutic intervention, and skills coaching (skill building). The need to utilize and promote individualized services, versus "commodity" based services is necessary to not only build successful programs, but also create successful families.

Increasing knowledge, awareness, and effective child welfare programming also requires a change in mindset with regard to the inclusion of biological families in foster care programming. Worldwide, 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.

Once the comprehensive assessment of youth and family need is completed 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 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. 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 parents allows the child's individual needs to be addressed on an ongoing basis.

In addition, program staff provide support and consultation to the family. This includes weekly contact related to data collection, strengths of the youth, and any particularly challenging behaviors identified. 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). Program staff work in collaboration with teachers and school officials to develop and implement a behavioral support plan that mirrors the planning in the 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).

Program staff empower 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, program staff try to prevent anything from happening that undermines the parent's reinforcing roles or relationship with the youth. This includes occasionally protecting parents from unpopular decisions that might have to be made (limiting contact with certain peers). The stratification of authority helps the parent stay in the role of youth advocate and puts the program supervisor squarely in the line of fire.

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 the broader definition of family and may also include foster family) focuses on identifying

prosocial and problem behaviors occurring within the family context defining structured responses to these behaviors (Leve & Chamberlain, 2007).

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).

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.

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.

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 Child Welfare field must better understand what is currently expected with regard to stabilizing families; what is expected from parent-training programs; and what service providers are willing to offer, in time and resources. Answers to questions related to these expectations will transform the current approaches to something more effective. At this time, agencies may have one, two, three or more parent-training offerings. Almost every agency would seem to have basic classroom-centered parent training some also have home-based homemaker chore services although these are dwindling fast (Hutchinson & Sudia, 2002). Some agencies offer flexible and somewhat open-ended family-based services that mix systems therapy and case management; and some offer behaviorally oriented intensive family preservation training. If agencies are to implement more family driven (or family centered) programs, agencies will need to reallocate resources away from conventional parent training. Additional focus should be placed on the individual need identified by the comprehensive family assessment. Understanding that each family is unique and has unique needs is of the utmost importance and providing services that meet those unique needs to offer increased success. The intention

should be to minimize "commodity" service structures and promote individualized structure in programming.

The evolution of effective child welfare parent training will require several parallel efforts. One is to develop expectations in agencies and courts that parent training should meet the specific developmental and parenting needs of families and should be required and evaluation a case-by-case basis, accordingly. Basic training on parent training (such as Parent Management Training) should be provided to legal parties. A second is to develop the assessments necessary to determine the type of parent training that is optimal. A third is to create and test interventions that have the greatest likelihood of success with families and being adopted into agency practice. (Barth, Landsverk, Chamberlain, Reid, Rolls, Hurlburt, Farmer, James, McCabe, Kohl, 2005).

Another potentially fruitful avenue would be to consider how or where non-PMT parenting interventions fit into the multilevel system of mental health therapies (i.e. cognitive therapy, dialectical therapy). For example training in mindfulness useful as an adjunct to PMT in complex cases characterized by high levels of parenting stress. Such strategies, attending to not only child problems but also to parent functioning, and selecting PMT alone or in combination with other interventions as needed, would serve to the goal of providing the highest quality support to the greatest number of families in need. (Colalillo, Johnston, 2016).

In addition, increasing the utilization of contextualized feedback is necessary to determine most effective treatment and service planning. The ability to determine, assess, and measure such topics as satisfaction with life, satisfaction with services, feelings of hope, caregiver strain, therapeutic alliance and outcome expectations is greatly important. The outcomes and feedback from those measurements provide valuable information to providers and funders.

Furthermore, increasing the utilization of the multi-disciplinary team and enhancing the inclusion of both older youth and families is necessary. The need to increase and allow youth and families "voice and choice" greatly empowers the family as a whole, and provides them additional accountability to their own successes.

It is important to note change requires commitment across time and across levels. With regard to changing the current structure and vision of in-home services, discussions and trainings with staff, providers, and 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 caseworkers, 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 and family services 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 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.

OMNI is the only provider in Nebraska who utilizes and applies the Peabody Progressive Treatment Batteries (PTPB). The contextualized feedback system that incorporates PTPB provides vast and rich data collection with regard to motivation, engagement, and satisfaction with services as well as other factors that impact service successes for youth and families. It additionally provides insight on alliances and engagement that youth and families feel they have with their "direct line staff" (skill builders, therapists). PTPB also provides overall satisfaction and alliances with OMNI as an agency. Administrators within OMNI routinely utilize the PTPB to identify trends and satisfaction with services.

In addition, OMNI Inventive Care utilizes the "How To" manuals related to teaching and training behavioral management strategies and generalization. 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.

When reasonable and thoughtful effort is expended to invest in families, then the children, the families, the caseworkers, and the public all benefit. By providing concentrated and comprehensive services from the moment of referral, many families can be helped to work out their problems in minimally intrusive ways that strengthen family functioning, provide for an enhanced network of supportive resources, and reduce the likelihood of out-of-home placement, without endangering the lives of children. (Walton, 2001).

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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