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"PROTECTING CHILDREN – THE JOURNEY MUST CONTINUE"

21ST ANNUAL REPORT OF

THE STATE FOSTER CARE REVIEW BOARD

2003

Submitted Pursuant to

Neb. Stat. Chapter 43, Section 43-1303(4), R.R.S.

State Foster Care Review Board

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"PROTECTING CHILDREN – THE JOURNEY MUST CONTINUE"

21ST ANNUAL REPORT OF THE NEBRASKA STATE FOSTER CARE REVIEW BOARD

THE BOARD'S ANALYSIS OF THE NEBRASKA CHILD WELFARE SYSTEM AS REQUIRED BY STATUTE

CHILD WELFARE SYSTEM PERFORMANCE MEASURES, continued...

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"Be of service. Whether you make yourself available to a friend or co-worker, or you make time every month to do volunteer work, there is nothing that harvests more of a feeling of empowerment than being of service to someone in need. "

Actress Gillian Anderson

The State Foster Care Review Board

would like to express its appreciation to

Board Chair Kay Lynn Goldner

and the other members of the Board

who edited this annual report.

In Memoriam

Foster children lost a champion, and the Board lost a distinguished member who spent her life caring for others, when State and Local Foster Care Review Board member **Carole Douglas** passed away in March 2004.

Nothing that we write could be as fitting a tribute to our deeply missed colleague as her own words. The following is a reprint of an article Carole wrote after her diagnosis that exemplifies her extraordinary view on life.

Results, Resolve and Resilience

These words have renewed significance for me recently. The journey of the last few weeks has given me a new and deeper perspective of the value of these attributes for keeping us in the fray for health women, children and families.

As some of you know, on March 21 [2003] I was diagnosed with a serious cancer of the liver. What a surprise as I am feeling quite well and symptom-free at this time.

We are often conscious of our resilience in the days and months immediately following events that put a major roadblock in our plans. But too often we forget that resilience is not only what takes us through the immediate crises but also what keeps us on track and looking for the best options for years later. How we cope with our new realities and keep our eye on the results we have dreamed of achieving depends on how resilient we are from day to day.

I am much more conscious of the opportunity of each day these past weeks. While I obviously believe in a strategic approach to life, I am finding a need to have more respect for the options that present themselves each day. I mentioned to my oncologist that I felt healthy, optimistic, and very aware that today is the only opportunity any of us can depend on. Also, I was aware that either one of us could be killed driving home from work today. Her response, with a grin, was "none the less, we will both drive home carefully tonight."

So, without recklessness, with strong information (data) and firm resolve I challenge all of us to look to the opportunity of today. For today, try doing something a new way or make a new relationship to make your city a little safer and healthier for your family, you neighbors, your coworkers and the mothers, children, and families in your community. Spend today fully so that you anticipate the tomorrow waiting for you with the next sunrise.

PROTECTING CHILDREN - THE JOURNEY MUST CONTINUE

A COMMENTARY

Protecting Children – The Journey Must Continue

by Carolyn K. Stitt, M.S.W.

"The ultimate test of a country is how it protects its children."
Andrew Vachss, author, columnist, attorney

In the last 18 months, the State of Nebraska has become aware of challenges and failures in the child protection system. Much of this knowledge resulted from research on child abuse deaths conducted by Foster Care Review Board staff at the Governor's direction.

The Foster Care Review Board commends Governor Johanns and the Nebraska Legislature, particularly Senators Wehrbein, Brashear, Landis, Aguilar, Stuthman, and Bromm, for taking the first critical steps on the long but necessary journey toward creating a more responsive child protection system. Actions taken in the 2004 legislative session included:

- Appropriating $3.5 million+ for additional CPS workers[1],
- Increasing funding for skills development for child abuse investigators, and
- Funding to allow child protective services and law enforcement to have better access to each other's computer systems to obtain needed information on the families.

Under Governor Johanns' leadership, HHS has responded to these challenges by reinstating a supervision mechanism, putting in place an internal accountability plan, adding additional staff approved by the legislature, and meeting with the Board to address numerous child welfare system concerns. These efforts are critical and the Board commends all involved, including HHS Director Nancy Montanez and Administrator for Protection and Safety Todd Reckling.

Notwithstanding these efforts, in order to create a more responsive child protection system it is essential that system improvements continue so that every Nebraska child will have the best possible future. At a minimum, CPS and law enforcement must be more attentive to reports of abuse, especially for children age birth to five, who are at the greatest risk of injury and/or death from abuse. Reports must be given greater scrutiny, investigations must be timely, and the decision on whether or not to investigate must be subject to supervisory review.

In this journey, the Board envisions that, ideally, reports of abuse will be investigated thoroughly, that children in out-of-home care will have safe, stable, and nurturing placements, and that permanency (exits from the foster care system) will be achieved in a timely manner.

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[1] CPS is a division of the Department of Health and Human Services responsible for response to reports of child abuse.

To realize this vision for Nebraska's children and to build on the important improvements already underway, the Foster Care Review Board recommends that Nebraska implement the following initiatives.

Next Steps in the Journey to Ensure Children's Safety and Well-Being

1. **Designate a lead agency responsible for a consistent response to child abuse and neglect reports.**[2] A lead agency would be responsible for ensuring that:
   - Calls alleging abuse and neglect will be correctly screened, accepted, prioritized and assigned;
   - Qualified individuals will investigate child abuse reports in a timely manner;
   - Supervisors will examine every decision and address any pertinent issues immediately to ensure child safety; and,
   - Investigations will provide the county attorney with all of the information necessary to file a proper petition with the court.

   Key facts supporting the recommendation:
   - The CPS hotline receives 17,000+ reports of abuse and neglect every year. The hotline currently screens out (eliminates) many reports of children in danger, some reports are not labeled correctly for priority investigations, and other reports are assigned or referred to law enforcement without all the pertinent information needed. Each of these scenarios often leaves children at serious risk.
   - Law enforcement also receives calls reporting alleged abuse and neglect. These calls are often not documented or shared with CPS.
   - Law enforcement is first responder, but the officers who respond have little training in assessing the risk to the children in the home. Even in areas like Lincoln and Omaha where there exist special juvenile units it is usually a street officer with little training who responds due to the number of calls received.
   - The current response "system" encompasses two unrelated entities (local law enforcement agencies and CPS) who do not consistently collaborate and coordinate efforts or internally manage their aspects of investigations.

2. **Intensify Prosecutions for Serious Abuse.** Increase prosecution of caregivers accused of the most serious allegations leading to children being removed from the home. This would enable the court to act on the conditions that placed a child in jeopardy.

   Key facts supporting the recommendation:
   - **In juvenile court cases,** courts can only order services to address the items in the petition that were proven at the adjudication hearing. **With insufficient or inadequate evidence, the petition cannot fully address all conditions that brought the child into care.**

[2] See response to abuse reports section beginning on page 21 and investigation issues on page 23.

- Prosecutions can be hampered by poor investigations that provide insufficient or incomplete evidence.
- Plea-bargaining that reduces or drops serious case concerns (e.g. sexual abuse) places children at risk for future harm since courts cannot address issues that are not in the petition.

3. Reconsider who transports children and who monitors their visitation.

Contractors transport approximately 1,600 children each week[3]. For some children this can be a positive experience, but for many it is a negative experience as shown in the key facts below.

Therefore, **the Board recommends that the State hire permanent case aides to provide transportation, using funds to be available from the elimination of private contracts.**[4] The case aides need to be assigned to particular workers and particular cases, have training and expertise, and be required to communicate with the case manager each time they provide transportation and/or monitor visitation. Eliminate contracting out this vital component of case management.

Key facts supporting the recommendation:

- Reunifications are seldom successful if the parent doesn't show up for the visitation sessions or if the parent is inappropriate during visitation. Therefore, case managers need to either observe first-hand the interactions between parent and child or have clear, regular communication with those who do.
- Under the current contract system, children often must deal with a new driver each time they are transported. This adds unnecessary stress for children who are already highly stressed by the removal from the home and who suffer the attaching/de-attaching that often happens with each visitation or therapy session.
- If a case manager always worked with the same case aide on a case, children would suffer less stress, plus the aide would know the case and what key observations to communicate with the caseworker and/or foster parent.
- Currently there are too many communication gaps that affect children.
  - The Board has reviewed cases where children were transported for weeks without the caseworker or foster parent being made aware that the parents were not attending scheduled visits.
  - In other cases, contractors report that when they tried to communicate serious concerns to caseworkers, their calls were not returned and their reports were not considered, especially if their report contradicted the caseworker's plan.
  - One provider currently contracted by the State will not allow visitation specialists to document negative interactions because the parents must sign-off on these visits.
  - HHS does not always receive documentation from providers in a timely manner and it is often difficult to read.

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[3] 30% of children reviewed in October 2004 had contractors providing their transportation. 30% of the 5,522 children in care would be 1,657 children.

[4] See case management issues on page 37 and contract issues sections beginning on page 41.

- There have been numerous concerns regarding contractors engaging in unsafe practices, such as
  - Not having car seats, including for babies unable to hold up their heads,
  - Having non-contractor staff in the cars,
  - Smoking while driving children who have serious asthma or respiratory illnesses, and
  - A few reported instances of drivers having non-contractor employees actually transporting the children.
- Using the same dollar amount now spent on contractors, the State could hire enough case aides to provide consistency and safety in transportation.

4. **Create coordinated prevention efforts in every part of the state.**[5] Include home visitation programs, such as the programs Vermont and Hawaii programs that have been successful in substantially reducing abuse and neglect, and those that the Centers for Disease Control found reduced abuse by 40 percent or more.

   Key facts supporting this recommendation:
   - Nebraska has one of the highest national per capita ratios of children in foster care as compared to the number of children in the state,[6] primarily due to a lack of prevention programs that could identify and address many family issues before they were so critical that removal was necessary.
   - 10,140 Nebraska children were in foster care for periods of between 1-365 days in 2003.

5. **Create special units within HHS that focus on creating stability[7] for all children under age six**[8] who have special vulnerabilities due to their developmental levels. Assure that adequate supervision and mentoring exists for workers in these units. Begin planning similar units for children age 6 –12.

   Key facts supporting this recommendation:
   - 1,194 of the 5,522 children in out-of-home care on 12/31/2003 were under age 6, the group most vulnerable to permanent damage from abuse and unstable living situations.
     - 38.0% had been moved to 3 or more different placements - a level of instability that experts find can itself cause damage (453 of 1,194 children).
     - 21.4% had been in 4 or more placements (255 of 1,194 children).
     - 7.9% had been in 5 or more placements (94 of 1,194 children).

[5] See page 85 for additional information on prevention.
[6] U.S. Dept. of Health and Human Services, Child Welfare Outcomes 2001.
[7] Stability includes reducing the number of placements children experience, increasing the appropriateness of their long-term plan, and reducing the length of time they spend in care.
[8] See section on young children beginning on page 29.

6. **Write clear, appropriate case plans with services, goals, and timeframes that reflect why the children entered care.**[9] Conduct better assessments of the families. Focus reunification efforts on families who have expressed a desire to change, assuring that these families receive the needed services. For families that do not show a willingness to change, expedite permanency. Eliminate the current practice of wasting resources and time attempting reunification with families that clearly cannot or will not safely parent their children. Carefully document parental compliance/non-compliance with the plan so that, if the parents are non-compliant, evidence is gathered and alternative permanency can be pursued.

   The Board continues to be greatly concerned that about 25 percent of the children in care have suffered extreme abuse, yet their case plan goals remain reunification in spite of the high statistical likelihood of repeat abuse. When caseworkers are asked why they chose to write a plan of reunification, the answer if often that there is a "strength-based" philosophy. Strength-based decisions can work in many cases, but they should not outweigh the safety considerations for the child.

   Caseworkers also fail to utilize provisions of the Adoption and Safe Families Act that allow exception hearings for certain cases of severe or chronic abuse. At the exception hearings a judge can rule that making efforts to reunify does not apply in the case due to a specific condition at removal.

   The bottom line is that safety considerations are given a lower priority than conformity to a concept that does not work in at least 25% of the cases. It is imperative that, when planning for a child's future, there be a clear and thorough look at the damage done to the child, the likelihood of parental rehabilitation, and the likelihood of serious abuse recurring if the child is returned to the parents.

   Key facts supporting this recommendation:
   - The Board and the Federal Children and Families Services audit have both found that too many children had no current plan and that too many children have "cookie cutter" plans rather than plans tailored to the individual circumstances.
     - 30.3% of the children reviewed either had no current plan or the existing plan was incomplete in essential areas, such as services or timeframes (1,247 of 4,116 children).
     - 25.2% of the children reviewed had inappropriate plans (1,040 of 4,116 children).
   - Families are typically not involved in planning at removal or when developing and updating case plans. A window of opportunity to work with the families when they are most likely to change is being lost.
   - Families with no current plan or one that is incomplete do not have the opportunity to begin working towards goals. Therefore, months can go by before progress or lack thereof can be documented. This hinders permanency for the children involved in these cases.

[9] See page 71 for additional information on children's plans.

- Nebraska has not developed a "fast track" to assure that children who have suffered serious or chronic abuse can have their cases expedited following the guidelines in the Adoption and Safe Families Act.
- Inappropriate plans, incomplete plans, and a lack of planning all contribute heavily to the excessive length of time children spend in care.

7. **Increase the number of placements available and develop specialized placements**[10] for children needing treatment for sexual abuse/sexual acting out, violent behaviors, emotionally disturbed children, children with dual diagnosis (such as substance abuse and mental health issues), pregnant girls, and children with severe behavioral issues. This would reduce the high number of children with multiple placements.

   Provide oversight by supervisors of decisions to move children, develop transition plans, and assure that foster parents receive needed supports.[11]

   Key facts supporting this recommendation:
   - Children who experience four or more placements are likely to be permanently damaged by the instability and trauma of broken attachments, yet this is now a normal experience for nearly half of the children in out-of-home care.
     - **49.7% (2,747 of 5,522) of the children in out-of-home care on 12/31/2003 had experienced 4 or more lifetime placement disruptions.**
     - Some children experience even more disruptions with 33.6% having six or more, 15.2% having 10 or more, and 3.0% experiencing over 20 placement disruptions.
   - Many children are placed where a bed is available rather than in a placement that is best equipped to meet their needs.
   - Good foster parents are sometimes overlooked.
   - Necessary transitions between placements are often not well-planned or done in way to minimize the trauma for the children.

8. **Better screen and monitor children's placements.**[12] Assure that training prepares foster parents for the tough issues they are likely to face. **Evaluate the foster parents abilities and expectations during the screening and training processes and do not license those that cannot cope.** Provide the support needed to address issues before they affect a child's safety. Assure adequate communication of any issues regarding a foster home or day care used by foster children. **Monitor children's placements and immediately act on any safety concerns.**

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[10] See page 55 for additional information on placement needs.
[11] See page 35 for additional information on transitions plans.
[12] See page 45 on contracted placements and page 55 on other placement issues.

Key facts supporting this recommendation:

- Caring for a foster child is substantially different than caring for one's own child, and many foster parents have not been adequately prepared or have unrealistic expectations. This lack of screening and training sets up many to fail and contributes to safety issues if the foster parents are unable to cope.
- Foster parents often do not understand the following key facts when children are placed in their homes:
  - Many foster children exhibit tough behaviors like sexually acting out, fire starting, food issues, smearing feces on the walls and furniture, regressive behaviors, and/or aggressive behaviors.
  - Foster children can display defiant behaviors due to deep grief for broken relationships. Punishment is not an appropriate response to these behaviors, and the children may exhibit these challenging behaviors for weeks or months. [Children injured in foster placements are often injured due to frustration over these types of behaviors.]
  - Intensive supervision of foster children is essential to ensure the safety of the family and the foster child(ren).
  - Many foster children have physical or mental challenges and/or learning disabilities, and the care of these children often requires additional training.
  - Flexibility is the key to success. Foster parents must be prepared to deal with biological families, changing visitation schedules, foster children's pre-and post-visitation behaviors, and their own children's reactions to sharing their parents with children who need a lot of attention.
- PRIDE training[13] for foster parents varies significantly depending on the presenter. Supervision needs to be in place to ensure all foster parents receive adequate training.
- Communication issues can put children at risk. Foster parents for about 10 percent of the children reviewed (398 of 4,116) had not been given medical information about the children. In addition, many placements report they were not given behavioral information needed to ensure the safety of the child and others around them.
- The mixture of other children in the home and their needs is often not considered when placing foster children, yet it is essential to assuring their safety.
- Resource development (specific workers who recruit foster homes) and the caseworkers who place the children often do not coordinate their efforts. This is further hampered by using contract agencies who are to recruit and monitor their placements.
- Some foster homes have multiple types of licenses. If one license is "on hold" or suspended, the caseworkers involved in the other types of licenses are not informed. Likewise there is no cross-reporting for foster parents who are also licensed day care providers.
- When problems arise it is difficult to determine who knew what, when they knew it, and if they appropriately shared it with all concerned parties. Supervision is lacking.
- Serious concerns with some agency-based placements have not been addressed in a timely manner, if at all.[14]

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[13] See page 48 for more information on PRIDE training.

[14] See contract issues on page 45.

9. **Minimize Restraints.** Restraints include physical restraints (also called takedowns), chemical restraints, confined isolation, and prolonged depravation of food. Some children are subject to more than one type of restraint, and many have had multiple episodes. Many of the children who were restrained have limited intellectual functioning, and thus are very vulnerable to abuse by adult caregivers.

   The Board recommends that HHS ensure that placements do not rely on restraints as their primary means of controlling children and youths' behaviors, instead relying on de-escalation and child development models, and using restraints only as a last resort.

   Key facts supporting this recommendation:
   - Some providers appear to base their program on a policy of using restraints as the primary method of behavioral control instead of using proven behavioral de-escalation techniques.
   - Some placements do not have programs to effectively deal with children's behaviors before an incident occurs, or, if programs exist, staff is not adequately trained.
   - 217 of the children reviewed had information on file that restraints were used on them within the 6 months prior to the review. Since there is inexplicably no requirement to report these incidents, the actual number of children is likely significantly higher.

Basis of the Recommendations

The Foster Care Review Board is a state agency created to oversee children in out-of-home care in our state. Typically, children's cases are reviewed every six months by one of the 59 community-based volunteer local boards. After careful review and research, a board itemizes their concerns and provides recommendations for the ongoing care and safety of the child.

Findings are then forwarded to the judge and other legal parties (i.e., guardian ad litem, attorney) who are responsible for the child's care and well being. The findings and updated statistical information subsequently are entered into the Board's computer system for analysis.[15]

The Board bases its analysis and recommendations in this document on the collected results of the **6,503 reviews** that were conducted on the cases of **4,116 children** during 2003, and on its 21-year history of analyzing the Nebraska child welfare system.

It is important to recognize societal changes that have greatly affected the foster care system. Throughout this commentary are references to conditions that existed 5, 10, 15, or 20 years ago. Negatively impacting the child welfare system over the past two

[15] A more complete description of the structure of the Board and the case review process is found in the special section on the Foster Care Review Board.

decades, and children's lives today, are: the proliferation of substance abuse among parents and teens, increased violence in homes and communities, families lacking stability, economic pressures, other societal ills, and changing cultural norms.

Economic realities have affected the system's ability to respond to changing societal conditions. **In recognition of the State's current financial difficulties, the Board has concentrated its recommendations on what is necessary and fundamental for children to thrive.** Many of the recommendations in this report call for a change in the way that current dollars are spent, rather than requiring additional funds. Some recommendations could actually save money.

Goals of This Report

The Nebraska Legislature created the Foster Care Review Board as a quality assurance measure to:

- Serve as an independent voice that informs policy makers and the public on issues related to how Nebraska responds to child abuse and neglect;
- Identify the successes of programs and individuals;
- Identify deficiencies in individual cases reviewed;
- Offer its experience-based knowledge and expertise on how to improve the system so that children who have suffered abuse or neglect have the maximum opportunity to have safe, productive lives and to recover from their trauma.

This report is written in the hope of improving the system so that more children have the best possible futures. It presents a statewide vision of what could be achieved by making the recommended changes; thus, it includes concise descriptions of obstacles to safety and well-being, and gives the Board's recommendations for reducing or eliminating the obstacles. Elements of the Board's vision include that:

1. Every Nebraska child who should be in out-of-home care is appropriately removed from the home of origin;
2. Every child who is in out-of-home care is in a safe, stable, nurturing placement where he or she receives the services needed to deal with past traumas; and,
3. Every child under the State's jurisdiction has a unique and tailored permanency plan for the future that is the best for that particular child and his or her set of circumstances.

The Board actively seeks to work together with policymakers and agencies on the issues presented here, in a concerted effort to improve children's lives.

How the Journey Began with Research and Findings on Nebraska's Child Deaths Due to Abuse

With all the efforts and progress made to improve the lives of Nebraska children, it was with heavy hearts that the Board has became aware of the number of Nebraska children who have died due to abuse, neglect, or violence. The following describes the Board's research findings on cases of children who died due to abuse, neglect, or violence, and demonstrates the Board's continuing efforts to improve the child protection system.

Recognizing the increase in child deaths due to abuse or neglect over the past few years, the Board researched the cases to determine if these children had been reported to Nebraska's child protection system. **From this research the Board found the following facts about 32 child deaths from 1997 to August 2003:**

- **26 of the 32 children killed (81%) were newborn through five years old.**
  - The Board continues to recommend that reports of abuse involving young children be prioritized.

- **14 of the 32 children killed (44%) were not known to the system before their death.** Either their abuse was not identified, or it was identified but not reported.
  - The Board recommends that proven prevention efforts need to be implemented statewide to ensure that fewer children suffer abuse. The Board continues to recommend that the state and communities work together toward educating the public on how those involved can identify abuse, the public's duty to report abuse and who to contact if abuse is suspected.

- **18 of the 32 children killed (56%) had been reported to either child protective services or law enforcement, or the perpetrator had other violent offenses,** yet either no investigation took place or the investigation was seriously flawed.
  - The Board recommends that the child protection system be revamped so that children's safety is the highest priority.

- **3 of the 32 children killed (9%) were state wards at the time of their death.**
  - The Board continues to recommend that there be greater oversight and monitoring of placements, and that foster parents be given greater accessibility to support services and training.
  - The Board's recommendations to improve system response, improve oversight, and assure appropriateness of placements and services for children placed out of the home are interwoven throughout this report.

For each of the tragic deaths summarized above there were countless other children who did not die but needlessly suffered broken bones, burns, welts, bruises, torture, or sexual exploitation, or whose basic survival needs were

ignored – either because the adults around them did nothing to intervene or because the system failed to protect them. Sadly, some children and youth currently in the foster care system were not spared this level of abuse prior to their removal from the home.

While child abuse will never be totally eradicated from our society, Nebraska can make changes that would reduce the number of children abused and the severity of the abuse, and improve system response to child abuse and neglect.

Therefore, after the first research was completed, **the Board took immediate action to draw attention to systemic failures in an attempt to aid children who remain at risk.**

Armed with the Board's research, its knowledge of the child welfare system, and its understanding that children at certain stages of development are more vulnerable to abuse, **the Board met with a number of policy-makers, (including the Governor, members of the Legislature, the Attorney General, HHS officials, members of the child welfare system, advocates, and the media)** to describe the urgency of the problem and to present practical recommendations for system improvements.

Public officials responded aggressively to the unarguable need to improve the child abuse investigation system.

Commendations for Leaders of the Journey

1. **Governor Mike Johanns** is commended for
   - Publicly examining the problems in the investigation system,
   - Prioritizing the needs of abused and neglected children and educating the public on those needs,
   - Minimizing budget cuts to the child welfare system,
   - Significantly increasing the number of child protection caseworkers, and
   - Funding computer enhancements to improve communication between child protective services and law enforcement.

2. **The Nebraska Legislature** is commended for prioritizing the safety and well-being of children by funding, in the midst of serious budget difficulties, 120 new caseworker positions, funding computer enhancements to improve communication on cases of child abuse, and minimizing other budget cuts to the child welfare system. This speaks to the commitment of Nebraska lawmakers to protecting Nebraska's most vulnerable children.

3. **The Department of Health and Human Services** is commended for expressing an openness to identify problems and to move towards solutions. HHS is also commended for increasing the number of cases with written plans, for involving the Board in its quality assurance, and for responding to concerns expressed in the Federal Child and Family Services Audit.

4. **The Judiciary, especially in Douglas and Lancaster Counties,** is commended for providing additional information that helped assure children that had not been reported by HHS were not lost in the system; due to these efforts these children were tracked and able to receive timely reviews. The judiciary is also thanked for helping the Board develop procedures that increased effective communication with the courts. The Board also thanks the many judges who have co-sponsored education programs with the Board or presented programs for local board members.

5. **Attorney General Jon Bruning and his staff** are commended for prioritizing prosecution of child abuse cases.

6. **The Nebraska Foster and Adoptive Parents Association** (NFAPA) is commended for its mentoring and educational programs, and for distributing information through an excellent newsletter and website.

7. **Foster Parents and Placements** are commended for showing their concern and dedication by providing children the nurturing attention needed to overcome the children's past traumas.

The Board strongly believes that **the work of the above individuals and groups can be built upon to assist the system to better serve all children**.

General Questions About the Foster Care Journey

How Many Nebraska Children Are in Out-of-Home [Foster] Care?

There were 5,552 Nebraska children in out-of-home care on Dec. 31, 2003. During 2003, there were 10,140 children who were in out-of-home care for periods ranging from 1 to 365 days.

Why Are So Many Children in Out-of-Home Care in Nebraska?

There are a number of issues that affect how many children are in out-of-home care and their foster care experience. Many children are affected in more than one area. The following is an overview, with each issue explained in greater detail later in this report.

1. Nebraska lacks prevention programs that could address problems before they are so severe that the child must be removed from the parents.
2. Some children could be safely at home if there were easily attainable services across the state to assure their safety and well-being, and if these services were provided in a reliable, communicative, and coordinated system. Such a service network could both prevent some removals and support a return to the parents.
3. Nebraska does not take advantage of the highest of window of opportunity for parents to change – that is the period immediately following a removal.
    a. There is a lack of timely intervention when families first come to the attention of the system.
    b. There is often no early assessment of parental abilities and needs.
    c. There is often no early match of parents to services to address the issues that led to children being in care.
    d. Suitable relatives and non-custodial parents are frequently not identified early in the cases.
4. Contractors providing transportation and visitation monitoring often do no communicate case concerns effectively to case managers, delaying children's permanency.
5. Poor investigations lead to poor petitions, and thus the grounds for terminating parental rights are not formulated.
6. In some cases paternity is not determined until a child has been in foster care for some time, often not until it is clear the mother cannot safely parent. Then the lengthy process of reunification attempts often begins again with the father, who may be a virtual stranger to the children. It is only after this process is exhausted the process towards adoption or guardianship can start for children for whom neither parent is a suitable caregiver.
7. Case plans are often inappropriately for reunification, even when it is clear that the parents cannot or will not safely parent. These children cannot safely go home and their cases are not moving on to adoption or guardianship.
8. Many children do not have current, written case plans, so there is no means for parents, case managers, or legal parties to accurately measure progress.

9. Nebraska does not utilize provisions of the Adoption and Safe Families Act that allows certain cases (serious abuse, sexual abuse, chronic abuse) [16] to move to immediate adoption or guardianship without making sure-to-fail reunification efforts. There are no special units to move these cases to a quick resolution.
10. While parental response to visitation is a key indicator of whether reunification could be successful, the level of communication between caseworkers and the contractors who now assume this part of case management is often poor. Thus, caseworkers do not develop evidence for terminations or identify cases where a reunification with the parents could be successful.
    a. In addition, children already traumatized by abuse are further stressed by having a changing group of strangers with them during the highly stressful time pre- and post-visitation.
    b. Children are also stressed when repeatedly transported to visitation sessions that do not happen.
11. Many caseworkers do not incorporate the observations of foster parents, family support workers, contracted transportation workers, contracted visitation monitors, physicians, or therapists, into their decision-making. As a result, some serious red flags for child safety have been missed and inappropriate plans have been developed or continued.
12. Caseworker turnover can cause significant delays as the new caseworker attempts to learn these complex cases while simultaneously dealing with cases in crisis.
13. There is a lack of therapeutic services and a lack of stabilization while in care.
    a. The system moves children too often between foster homes, increasing their behavioral issues.
    b. Children's needs are not met, so they are not able to reunify with the parents, complete an adoption, or complete a guardianship.
14. Unlike 36 other states, Nebraska law does not specify that parental failure to maintain regular visitation, contact or communication with the child can be a grounds for termination of parental rights.[17] The Kansas statute also includes a "lack of effort on the part of the parent to adjust the parent's circumstances, conduct or conditions to meet the needs of the child."

Regardless of which area(s) above are flawed, a problem in any one can cause a child not to reach permanency. However, with resolve Nebraska can make changes to improve the system for its abused and neglected children.

[16] The Adoption and Safe Families Act provides that efforts to reunify are not required for parents who have subjected the children to abandonment, torture, chronic abuse, or sexual abuse, or for parents who have killed or severely injured a sibling, or for parents who have had previous terminations of parental rights [Nebr. Rev. Statute §43-283.01(4)].

[17] Kansas statute §38-1583 is one example.

Why Are Children Removed From Their Homes?

The summary table that follows shows why children reviewed during 2003 were removed from their home of origin. During the reviews, up to ten reasons for entering out-of-home care may be identified for each child. These are predominant reasons. Table 5 contains additional details. Many children enter care due to multiple issues (example: physical abuse, neglect, and parental substance abuse).

% Children Reviewed	Condition	Important Facts
56.5%	Neglect[18]	Neglect has serious consequences. Nationally, almost as many children die each year from neglect as from physical abuse.[19] Neglect includes failure to provide basic and necessary medical care and hygiene, failure to supervise children enough to keep them safe, engaging in criminal activity in front of the child, abandonment, and related inattention to the child's needs. Parental substance abuse and mental health issues often contribute to neglect.
24.9%	Inability to cope with children's behaviors	Many child and youth behaviors stem from unrecognized abuse or neglect.
22.9%	Physical Abuse	This can include bruises, lacerations, broken bones, concussions, and brain damage.
17.7%	Unsafe or substandard housing	Parental substance abuse and mental health issues often contributes to housing issues.
16.4% (or 20.7%, if including disclosures made after removal)	Parental Substance Abuse	Parental substance abuse is likely seriously under-reported as a reason for removal as it is often the root of the above problems (e.g., the child comes into care due to physical abuse, but the physical abuse happened during a substance abuse episode). In recent years, the methamphetamine epidemic has substantially increased the number of children in out-of-home care who come from families highly resistant to change.
7.8% (or 16.0%, if including disclosures made after removal)	Sexual abuse	Sexual abuse is often not disclosed until after the children are in care. 7.8% of reviewed children had sexual abuse recognized as an initial reason for entering care, with another 8.2% disclosing sexual abuse after entering care.
12.9%	Abandonment	

According to the National Clearinghouse on Child Abuse and Neglect, in 2000 nearly two-thirds of child victims nationwide suffered neglect, while nearly one-fifth suffered physical abuse, and about one-tenth suffered sexual abuse.

[18] If a child has not been provided for physically, medically, and/or emotionally, it is considered neglect.
[19] National Clearinghouse on Child Abuse and Neglect, www.calib.com/nccanch/, July 2003.

Regardless of the specific reason that led to removal, in most cases the parents were unwilling or unable to give children the care which is necessary to grow, thrive and be safe, so the children were placed in a foster home, group home or specialized facility as a temporary measure to assure the children's health and safety. It is the child welfare system's charge to reduce the impact of the abuse whenever possible.

What Did Local Boards Find On Key Child Welfare Indicators?

Individuals involved in Nebraska's child welfare system worked hard trying to meet the needs of the 10,140 children who entered out-of-home care during 2003. However, as the following chart shows, considerable work remains to be done if safe, appropriate placements, appropriate plans, and access to needed services are to become the norm for all children.

System Working for the Children	**Work to Be Done to Improve System**
Complete, Written Plans 69.7% (2,869 of 4,116) of children reviewed in 2003 had a complete permanency plan as required by Nebraska statutes. .	Incomplete or No Current Written Plans 30.3% (1,247 of 4,116) of children reviewed in 2003 did not have a complete plan as required by Nebraska statutes.
Less Than 2 Years in Care 50.1% (2,062 of 4,116) of children reviewed in 2003 had been in care for less than two years at the time of their last review.	Over 2 Years in Care 49.9% (2,054 of 4,116) of children reviewed in 2003 had been in care for more than 2 years at the time of their last review.
No Prior Removals from the Home 60.7% (2,898 of 4,773) of those entering care during 2003 had been placed in out-of-home care only one time and had not suffered a premature reunification.	Previous Removals from the Home 39.3% (1,875 of 4,773) of children entering care had been placed in out-of-home care at least once before. Note: The effect of an HHS interpretation of the reasonable efforts clause (when it became standard practice in HHS to pursue reunification in all cases, regardless of severity) can be seen in the following comparison statistics from before this change: • 2.1% of children entering care in 1989 had been in care previously • 13.9% of children entering care in 1992 had been in care previously.
Stable Placements 50.3% (2,775 of 5,552) of children in out-of-home care at the end of 2003 had experienced one, two, or three placements.	Multiple Placements (moves) 49.7% (2,747 of 5,522) of children in out-of-home care at the end of 2003 had experienced four or more placement moves.

What are the Most Frequently Cited Barriers to Permanency?

Ideally, the child welfare system would help each of the children in out-of-home care to successfully deal with past abuse and the effects of separation from the parents, and then would move children swiftly into safe, permanent living arrangements. These living arrangements would ideally include the following components:

1. The intention of lasting until the child's maturity;
2. A sense of commitment and continuity – "a permanent family is a family forever";
3. A sense of belonging; and,
4. A respected social status as a "real" member of the family.

However, this type of permanency is not always the case. At each review, local Board members can identify up to ten barriers that remain to the achievement of safe, permanent homes for the children.[20] The chart below summarizes major barriers.

3 Most Frequently Identified Parental Barriers to Permanency

1. Parental unwillingness or inability to safely parent their children
   - 33.6% (1,385 of 4,116 children reviewed in 2003)
2. Past histories of abuse, neglect and violence
   - 23.0% (950 of 4,116 children reviewed)
3. Parental substance abuse
   - 21.3% (876 of 4,116 children reviewed)

3 Most Frequently Identified System Barriers to Permanency

1. Length of time in care, with reduced likelihood of successful permanency
   - 17.5% (721of 4,116 children reviewed in 2003)
2. Lack of current, written plans for the child's future
   - 12.8% (525 of 4,116 children reviewed)
3. Lack of case progress
   - 10.5% (434of 4,116 children reviewed)

Why Did the Foster Care Review Board Initiate Project Permanency and What Does it Involve?

Project Permanency is a collaborative initiative that originated with the Foster Care Review Board in 2003 and was implemented across the state during 2003-2004. The goal of Project Permanency is to ensure that the child welfare system recognizes the unique needs of children age birth through five.

[20] See Table 4 for more information on identified barriers to permanency.

The Project was created to secure safe and appropriate permanency for children in the foster care system as swiftly as possible; to assure that foster children's physical, emotional, and developmental needs are met; and to minimize the number of moves children experience while in the State's custody.

As part of this effort:

1. The Board has trained members of local boards to visit the foster homes of young children as part of the review process to ensure that children are safe and to provide foster parents additional information on child development and supports available.
   a. Many foster parents have reported to the Board that the information given them at the visits has been very useful for them as they deal with the children's daily care and interactions with the foster care system.
2. Information gathered about the home from the visits is included in the Board's findings on the appropriateness and safety of the placement. Any safety concerns found are conveyed to HHS and the children's guardian ad litem.
3. During implementation in each geographic area of the state, the Board has provided educational programs on children's needs for bonding and stability for child welfare professionals, including court officials, caseworkers, and foster parents.
4. Optimal practices are being encouraged on a systems level, including:
   a. Specialized caseloads for young children,
   b. Intensive, accessible services to families,
   c. Early identification of paternity and any potential relative placements,
   d. Timely assessments of parental ability and willingness to parent, with plans reflecting parental willingness and ability to parent,
   e. Expedited court hearings, and more intense court supervision,
   f. Thorough petitions and investigations,
   g. Recruitment of specialized foster placements,
   h. Increased communication between the parties, and
   i. Stability of children's placements, and transitions, if absolutely necessary, that are planned to minimize children's trauma.

The Foster Care Review Board is collaborating on Project Permanency with the Department of Health and Human Services, the Judiciary, County Attorneys, Guardians Ad Litem, the business community, and advocates, in order to ensure broad support for the initiative and to increase the number of children with successful outcomes.

This is an ambitious project, but necessary if young children are not to be further damaged while in the foster care system.

Major Activities of the Foster Care Review Board During 2003

- Completed 6,503 reviews on 4,116 children, an increase from the 6,378 reviews on 4,292 children completed in 2002.
- Issued 45,521 case specific reports with recommendations to the courts, agencies, attorneys, guardians ad litem, and county attorneys, an increase from 44,646 reports issued in 2002.
- Facilitated local board members volunteering 36,417 hours of service.
- Utilized the authority derived from legal standing statutes to appear in court over 980 times during 2003, with the courts addressing the Board's concerns in over 75% of the cases. Also advocated for additional children through team meetings, meetings with legal parties, special correspondence, and the like.
- Tracked 10,140 children who were reportedly in out-of-home care during the year.
- Researched and verified the out-of-home care status, and then closed the cases of, approximately 511children whose cases had been closed without HHS issuing a report.
- Researched problems in the CPS (child protective services) system after the failure of the system to respond to safety concerns regarding foster children. Brought those concerns to the attention of the Governor, HHS Director, and Legislature. The Governor subsequently named the Board's Executive Director Research Chair for the Children's Task Force. With the leadership of Governor Johanns and key senators, the following was enacted in the 2004 Legislative Session:
  - $3.5 million was appropriated for additional workers.
  - Additional training for law enforcement is funded.
  - Funding was secured to improve computer access for law enforcement and CPS.
  - Seven child advocacy coordinators were to be hired.
- Began Project Permanency, where trained local board members visit the foster homes of young children (birth-five) to assure safety and to provide additional information on behaviors common to young foster children.
- In conjunction with Project Permanency held trainings for child welfare professionals across the state on young children's needs for stability, typical behavioral indications of stress in foster children at different developmental levels, and how to plan to best avoid putting further stress on the children.
- Developed a new report format based on judicial input, and modified the data the Board collected on outcome indicators.
- Entered into discussions with Federal Health and Human Services regarding their insistence that the Board's tracking system be put on the HHS N-FOCUS platform, regardless of state statutes requiring independence and continued high rates of error and omission on the N-FOCUS system.

- Cooperatively worked with the Department of Health and Human Services (HHS) Director, Service Area Administrators and other top HHS staff on:
  - A memorandum of agreement regarding HIPAA
  - The HHS Performance Improvement Plan (PIP).
  - Concerns with case management in the Omaha area.
  - Concerns regarding a contractor that had advised its foster parents not to speak to the Board, whereas the Director advised the contractor that was contrary to their agreement.
  - Staffing individual cases of concern.
  - CPS concerns.
- Sponsored educational events on Bonding and Attachment, termination of rights, and precision in report language. Co-sponsored an educational program on a Model Mental Court, with over 200 in attendance. Presented at the Judicial Education Program for District, County, and Juvenile Court Judges. Allowed some staff to attend the National Council of Juvenile and Family Court Judges regional training in Kansas City.
- Had several staff attend comprehensive multiple day trainings on the state's new accounting system, and modified practice to conform with the new standards.
- Greatly increased the Board's presence in court hearings.
- Organized a joint release of the Annual Report with Governor Mike Johanns.
- Worked to compensate for omitted or inaccurate reports from HHS to the Board's Tracking System.
- Made numerous presentations on the Board and on the status of children in out-of-home care to focus groups, community organizations, college classes, and foster parent training classes.
- Provided statistical and other information to researchers, grant seekers, and child advocates.
- Developed means of coping with major budget cuts made in light of an economic downturn.
- Toured facilities to assure that individual physical, psychological, and sociological needs of the children are being met.

Where the Journey Starts – Responding to Child Abuse or Neglect Reports

How Many Child Abuse Reports Are Received Per Year?

In a 12-month period studied by the Foster Care Review Board, there were over 22,000 reports received, and about 17,000 of those reports were on children in dangerous situations.

What Happens When a Child Abuse Report is Received?

Background information: Most calls to report child abuse go to CPS, either through calls to the hotline (the toll-free number) or to a local HHS office, with most being answered by hotline staff. When a child abuse report is received the CPS "intake" process (the process of assuring that the call is answered, screened, accepted, prioritized, and assigned), must work well or there may not be an investigation.

Findings/Rationale for Recommendations: The Board has examined the CPS response to child abuse reports through:

- The Board's research on child deaths due to abuse.
- The Board's attempts to access the CPS system regarding foster children's safety.

The Board has found that within CPS there are a number of supervisory and practice issues that negatively affect response to child abuse reports. These include:

- **Too many child abuse reports are "screened-out,"** that is not accepted for response and not recorded on the computerized family history for future reference. This includes many calls from medical and other professionals, calls from multiple sources, and calls involving children who due to age or disability are extremely vulnerable.
- **Even if a call is "accepted" that does not mean that any further action will be taken to ensure the safety of the child.**
- There appears to be no supervisory review of hotline decisions to accept or not accept a report, and there appears to be no supervisory review of whether any further action is taken on calls that are accepted. Supervision levels vary across the state, so even within CPS there are significant differences in response.
- CPS attempts to do evaluations over the phone during receipt of the abuse report rather than focusing on getting enough information to know how to prioritize in-person investigations. It is unclear how a thorough safety evaluation can be completed without seeing the child.
- CPS does not effectively compile all the information they have about a family while screening the calls, or assure this is readily available on the computer.
- Cross reporting from CPS to law enforcement does not always occur.

Some child abuse reports are made directly to law enforcement. The Board is aware of some problems in this area as well, including:

- Law enforcement dispatchers are not always trained in making safety assessments to prioritize the calls that they receive, or on confidentiality issues.
- Cross reporting from law enforcement to CPS does not always occur.
- Communication across law enforcement jurisdictional lines, which has historically been problematic, is uncertain (e.g., communication between the State Patrol, Sheriff's office, and local law enforcement agencies, who may have all had interactions with the family).
    - For example, the law enforcement computer system, JUSTICE, does not include safety checks or investigations that do not result in a petition, so other agencies would not have this information at the time of their investigations.

Structurally, **the current system diffuses responsibility for decision-making** between the CPS hotline, the 65 local offices of HHS, and the 200+ law enforcement agencies (over 200 city law enforcement agencies, 93 sheriff's offices, and 6 offices of the State Patrol). As a result, there continues to be serious problems in take and investigations, a wide variance in response by area. The investigation part of this issue is described in more detail in the next section.

Children's lives depend on who answers the phone; whether they decide there should be an investigation, and who knocks on the door. A lead agency, with clear lines of authority and accountability, would ensure that each of these essential processes works with optimal efficiency.

Recommendations:

1. Name a lead agency to be responsible for ensuring that calls are correctly recorded, screened, accepted, prioritized, and assigned. [Other roles of the lead agency can be found in the section on investigations.]
2. Put in place supervision of all critical decisions regarding children.
3. Assure that the persons receiving the reports are well-trained professionals who are assigned this function based on expertise.

Which Road to Follow – Investigating Reports of Abuse or Neglect

Who Investigates Child Abuse and How Well Trained Are They?

Findings/Rationale for Recommendations: Investigation quality can literally make the difference between life and death for children, and can also dramatically affect the children's quality of life and future productivity. Nebraska created a split system, with investigation of child abuse allegations done by local law enforcement agencies and, perhaps, a subsequent safety assessment done by CPS. In Nebraska's current system, these are areas where there are consistent failures due to a lack of supervision, training, and structure.

The first responder to a child abuse report is usually one of the law enforcement officers from the 200+ law enforcement agencies (over 200 city law enforcement agencies, 93 sheriff's offices, and 6 offices of the State Patrol). **As first responder law enforcement officers must assess a child's immediate risk of harm, yet their expertise is in determining if a crime has already occurred, which is a very different skill set.**

Law enforcement training is a significant issue. Officers from small town departments may have had no training in investigating child abuse calls or may be hampered by relationships to the alleged perpetrators. Only four hours of training is offered during the officer training programs for Lincoln and Omaha police departments. Many officers are not well equipped to handle investigations involving preverbal or handicapped children, or the subtler forms of child neglect. Juvenile units, such as in Lincoln or Omaha, have more training, yet even if there is a juvenile unit due to the volume of reports the first responder may be a street officer who has had little specialized training on child abuse investigations.

There have also been issues regarding which law enforcement agency (local city, sheriff, or state patrol) has the jurisdiction and responsibility for individual investigations, delaying the response to the children's urgent situations. There has also been a lack of cooperation by some law enforcement departments to CPS requests for investigations.

Currently, investigations vary from a thorough investigation with a face-to-face contact with the child, to someone going to door, getting no answer, and not returning.

If there are problems with a law enforcement agency not responding or with the quality of an investigation, there are limited avenues for correcting the situation. The same is true of CPS.

Few investigations involve both law enforcement and CPS, yet this collaboration is essential for a number of reasons, including:

1. Children may need immediate protection and services. Law enforcement has the authority to make an emergency removal and CPS can minimize the trauma of that action for the child.
2. Some families need services to address chronic issues. Having the family history of prior CPS and law enforcement contacts is necessary to assure the plan for addressing the safety of the child is adequate.
3. CPS workers may need the protection of a law enforcement officer in some cases involving children who are abused by violent or unstable persons.
4. Child abuse is a criminal activity requiring the collection of admissible evidence.
5. The families may also be involved in criminal activities outside of the child abuse report, such as domestic violence, other acts of violence, or substance abuse.
6. It is essential that CPS and local law enforcement shares reports of child abuse that each may receive independent of the other so what is known can be considered when determining risk.
7. It is also essential that there be dialogue between prosecutors and the law enforcement and CPS workers who gather the evidence that will form the basis of court's ability to address the problems that brought the families into the system. In the current system, no one is in charge of calls, investigations, and actions to keep children safe.

Why Have "1184" Teams Not Solved Investigation Problems?

The Nebraska Legislature thought when it passed LB 1184 in 1992 (child abuse investigation teams) that it had created a system to ensure that there were joint investigations. The Legislature did not anticipate that in some areas CPS would pull out of investigations, and that CPS would screen out (eliminate) many priority calls.

Some have suggested that a way to address the above issues would be to augment the 1184 teams; but the Board does not agree with this assessment. **Building on the 1184 teams,** many of which still do not meet the legislative intent or mandate 12 years after their formation, **will not correct structural deficiencies** in the system for a number of reasons, including:

1. The teams were not designed to have a leader with authority to compel immediate corrective actions on behalf of a child or to handle crisis situations.
2. The teams were not built to handle the volume of abuse reports received.
3. The teams cannot impact law enforcement jurisdictional issues, nor law enforcement or CPS staffing issues.
4. 1184 Teams have been in place on paper since 1992, but many barely function. About one-third of the teams do not meet, others meet but do not discuss cases, and others have no front-line investigators on the teams.
5. Investigation protocols are in place, but there is no mechanism to assure these protocols are followed.

In a related matter, when the Board and Voices for Children hosted caucus groups to develop a blueprint to improve child protection for Governor Johanns in 1999, there was discussion of the role of child advocacy centers. The Board agreed with the other participants that child advocacy centers have a vital role in facilitating interviews of child victims. The Board continues to support the centers in fulfilling this important mission.

Coordinator positions were recently added to the centers under a contract with HHS. The coordinators are to review the child abuse reports received, but they lack direct supervisory authority over law enforcement or CPS, so the **coordinators will not be able to compel change on behalf of an individual child or impact the structure of the system** unless they communicate through a county attorney or HHS supervisor who takes subsequent action.

The quality of the investigations affects what prosecutors can put into the petitions to the court that will form the basis of intervention on behalf of the children. There are other prosecution issues as well, including the number of part time prosecutors, budget constraints, and the like.[21]

Why Does the Board Recommend Creating a Lead Agency?

Findings/Rationale for Recommendations: What is lacking is a lead agency where there would be someone in charge of promoting and facilitating collaboration, assuring that the disciplines work in tandem, and assuring focus would be on child protection.

The lead agency would act much like prosecutors do when leading drug investigations. The state is broken into regional drug task forces to coordinate response to drug problems based on regional strengths, expertise, and demand. Similarly, the lead agency the Board proposes would review every intake, would assign cases for investigation (with the more serious being assigned to one or more investigation specialists), and would provide direction throughout the process.

The lead agency would be in charge of creating a consistent, appropriate, timely response in the following aspects of every child abuse case, and would determine:

- Whether abuse reports are correctly collected and evaluated;
- Whether there will be an investigation, who to assign to the investigation, and how quickly the investigation occurs;
- Whether or not the investigation gathers sufficient evidence for the prosecutor to be able to file charges; and
- Whether a safety plan is in place if a child is not removed from the home.

[21] See page 79 for more information on prosecution issues.

Recommendations:

1. Create a lead agency in charge of assuring that qualified individuals complete child abuse investigations in a timely manner. The lead agency should have authority to make decisions and assure quality investigators are assigned.
2. The National Center for Prosecution of Child Abuse recommends that prosecutors take a leadership role in the child abuse investigation process, so that should be considered when naming the agency.

How Can Problems with Initial Response to Reports and Investigations Impact a Child?

Some children's cases, unfortunately, involve failures in many different systems. The following are some of the failures found in the case of a toddler who died from abuse. The toddler was only 1½ years old at the time of her death. In her case:

1. Her family had been involved with CPS from before her birth. Her older siblings were in foster care and had been returned.
2. She was placed in care at birth due to testing positively for maternal drug exposure. The child spent over a year in foster care and had bonded with her foster parents.
3. Her mother did not want her. Her mother was apparently told that she needed to take this child back or she would lose the other children. The mother was pregnant.
4. The mother's failed random drug screenings were not provided to the court.
5. The family support worker had serious concerns with how visitation was going.
6. The caseworker wrote the plan for reunification, even with all the contrary evidence.
7. The court placed her back with the mother, under the supervision of HHS.
8. Shortly thereafter the grandmother called CPS multiple times to report the mother again being under the influence.
9. A month before her death, relatives called the case manager to report bruises on her face and a cut lip. The worker asked the mother to take the child to the doctor, but there was no follow-through.
10. Four days before her death, the CPS worker made a home visit and observed blood on the child's nose, a fat lip, and a fading black eye. An older sibling also had a black eye. The worker requested the mother (the potential perpetrator) take the child to the doctor.
11. The worker was unaware that since the child was still a state ward she could have removed her immediately.
12. The police contacted CPS for placement, as the child was in the hospital with bruising, bumps, cuts, and healing bruise over the eye. The hotline worker contacted the caseworker.
13. There was a shift change and the second shift did not have the report.

14. The police officer asked the doctor if the mother had caused the injuries. The doctor said he didn't know who the perpetrator was, citing liability issues. The doctor failed to add "but it doesn't matter, this child needs to be in protective custody now." The police released the child to the mother.
15. Two days later the child was brought to the hospital unconscious. She died of Shaken Baby Syndrome (the violent shaking of the 1 ½ year child causing brain injury).

This toddler's case illustrates why there is a need for a lead agency and clear lines of authority and communication. One can only speculate how different the outcome might have been:

- If there had been a supervisory review of the decision not to investigate the first report of maternal drug abuse.
- If there had been supervisory review of the worker's case plan for reunification and if the worker had been instructed to change the plan.
- If the supervisor had instructed the worker to inform the court of the mother's continued drug use.
- If there had been a joint law-enforcement – CPS investigation where the full family history could have been considered.
- If there had been a review of the decision of whether or not to leave the child in the home.

Because of the above issues, the Foster Care Review Board recommends that the State create a lead agency to increase supervision of decisions at each stage.

The following sections describe issues that are faced by children removed from the home.

Assuring Children Can Continue Life's Journey - Young Children's Issues

How Are Children Under Age Six Particularly Affected by Abuse or Neglect and Foster Care Experiences?

National Research: Research on children's physical and emotional development indicates that, especially for the preschool population, it is critical to have stability and continuity of care. Children in this age group are developing the physical connections of the brain. In their research, Drs. T. Berry Brazelton & Stanley Greenspan identified the essentials needed if children are to develop higher-level emotional, social and actual abilities:

Fundamental Building Blocks for Children[22]

1. *Ongoing nurturing relationships.*
2. *Physical protection, safety, and regulation.*
3. *Experiences tailored to individual differences.*
4. *Developmentally appropriate experiences.*
5. *Limit setting, structure and expectations.*
6. *Stable, supportive communities and culture.*
7. *Protection for the future.*

Research has also shown that when young children must cope with prolonged or multiple stressors, these vital connections can fail to form properly, resulting in temporary or permanent changes in the children's ability to think, to develop positive inter-personal relationships, and to process future stressors. High levels of stress hormones occurring during the period of ages newborn through three have been found to create life-long problems with impulse control, anxiety, hyperactivity, and learning disorders.[23]

Findings/Rationale for Recommendations: As discussed in the section on prevention, the Board is concerned that too many Nebraska preschool children are being abused or neglected. In the section on response to child abuse reports and investigations the Board expressed its concerns regarding response to child abuse reports. The concerns with the system do not end there. There are a number of system deficiencies that affect children once they have been removed from the home. While these affect children of all ages, these deficiencies especially have an effect on young children due to their developmental needs as listed above.

It is critical that a young child's attachments needs are considered in decisions about his or her care, since attachment is necessary for:

- The attainment of full intellectual potential,

[22] Brazelton, Dr. T. Berry & Greenspan, Stanley, "Our Window to the Future," Newsweek Special Issue, Fall/Winter 2000.

[23] Sources include Karr-Morse, Robin, and Wiley, Meredith S. in Ghosts From the Nursery, c. 1997.

- The ability to think logically,
- The development of a conscience,
- The ability to cope with stress and frustration,
- The ability to become self-reliant,
- The development of positive relationships,
- The ability to handle fear and worry, and
- The ability to correctly interpret and handle any perceived threat to self.

As Dr. Urie Bronfenbrenner, then a psychologist at Cornell University, said many years ago in the videotaped lecture, *The American Family: Who Cares*, all children require the same thing: "the enduring, irrational involvement of one or more adults. Someone who is crazy about the kid...a love affair that lasts a lifetime."[24]

Unfortunately, after children are removed from the home, many experience multiple placements and/or failed reunification attempts with their parents, and thus have a lack of the ongoing nurturing relationships (attachments) needed to grow and thrive.

- On an average day about 1,200 children ages five and under are in foster care in Nebraska. By any standard, this number means that a lot of preschoolers have been abused or neglected to the point of needing removal from the parental home.
- It could be expected that a child have a maximum of two placements (an emergency placement and then an on-going placement.) Every move beyond those two can be considered excessive and damaging.
- The Board commends efforts by child welfare professionals to ensure that the majority of preschool children do not experience excess moves, yet the Board remains concerned that 453 (38.0%) of the 1,194 preschool children in out-of-home care on Dec. 31, 2003, had been in more than two foster homes and 255 (21.4%) had been in more than three foster homes.
- 155 (13.0%) of the 1,194 preschool children who entered foster care during 2003 had been removed from the home at least once before.

The Board is concentrating on young children, because they are most vulnerable to abuse and because they show the greatest permanent effects from abusive situations. The following quotes from national research sources echoes these concerns.

> Federal researchers have found *"The risk of maltreatment is highest for children under four years of age. Moreover, children with a prior history of victimization were more than three times as likely to experience recurrence compared with children without a prior history."*[25]
>
> Nationally, *"over half of the babies who come before dependency [juvenile] court have significant cognitive, language, and developmental delays stemming from the neglect and mistreatment they have experienced."*[26]

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[24] Quoted in the first annual report of the Nebraska Foster Care Review Board, 1983.
[25] National Clearinghouse on Child Abuse and Neglect, www.calib.com/nccanch/, July 2003.
[26] A Scientific Approach to Child Custody, National Public Radio broadcast, March 3, 2003.

The preceding statistics and findings are especially troubling because research shows that childhood stressors such as broken attachments and prolonged grief can cause serious, possibly irreparable, damage to children's brains affecting normal growth and development.

The system itself and our current society can compound these difficulties. In addition to the issue of multiple placements, the Board has also expressed concern with the number of foster homes where both parents work outside of the home and the foster child is placed in daycare.

For young foster children who have already had so much turmoil in their lives, the additional stress of changing caregivers between daycare and foster care each day can be overwhelming and detrimental. From the point of view of a young child who has been removed from his or her parents and is then cared for by one set of strangers during the day and a different pair of strangers at night, it can easily appear as if no relationship is ever secure. For many children, of course, this is by far the lesser of two evils since they cannot safely return home, but it falls short of fully meeting the child's development needs.

Similarly, it can be difficult for foster children when foster parents provide home daycare to many children, since this limits the time available for the foster parent to bond and interact with each child.

Recommendations:

1. Provide intensive services to parents with the intent to assess their long-term willingness and ability to parent. Ensure that, rather than merely measuring "compliance," every assessment of the parents' on-going progress measures true behavioral changes.
2. Minimize placement disruptions by recruiting and working with foster care families for infants, toddlers and preschool children and identifying appropriate relative placements (e.g. aunt, grandmother) early in the child's case.
3. Provide specialized training on the importance of bonding and attachment to parents, foster parents, case managers and supervisors.
4. Work with foster parents to minimize the amount of daycare for foster children, and ensure that foster children receive adequate amounts of the foster parent's attention.
5. Develop specialized units where highly trained professionals focus on providing permanency[27] for children who have been identified as unable to return home due to parental inability or unwillingness to provide long term care. Reduce the caseloads for these specialized case managers.
6. Increase awareness amongst foster parents of the mentoring program available through the statewide foster parent association.
7. Adopt legislation like that in other states that adds as grounds for termination of parental right a lack of effort on the part of the parent to adjust the parent's

[27] Permanency indicates that the child is in a safe, stable family situation. This could be with the parents, through adoption, or, for older children, through a guardianship.

circumstances, conduct or conditions to meet the needs of the child, and the failure to maintain regular visitation, contact, or communication.

Can Parental Visitation Schedules Harm Children?

Findings/Rationale for Recommendations: The Board finds that many young children reviewed show the negative effects of erratic or poorly planned parental visitation.

In addition, the high turnover rate for case managers, case aides, and contract employees who monitor visitation and provide transportation means that young children are expected to cope with an ever-changing group of strangers during the stressful time of reconnecting to their parents at visitation, and the traumatic time when separating from the parents at the end of the visit.[28] During this particularly difficult time, children need stability.

Recommendations:

1. Enable case managers to monitor parental visitation for young children and to act quickly if the visitation schedule unduly stresses the children. Eliminate the use of contractors for transportation and visitation monitoring. Put case aides in place are assigned to particular workers and particular cases, and who are required to communicate with the case manager each time they provide transportation and/or monitor visitation.
2. Require that visitation reports be provided to the judge.
3. Provide in-depth training or hire experts in child development to supervise visitation when mandated by the court.
4. Provide the same visitation worker for mandated supervised visits whenever possible.

[28] See page 41 for additional information on concerns with contractors providing children's transportation and visitation monitoring.

Road Blocks in the Journey – Separation and Grief Issues

How Are Children Effected by Separation from Parents or Trusted Care Givers/Foster Parents? What Additional Training Do Professionals Need in This Area?

Findings/Rationale for Recommendations: The Board finds that some professionals in the child welfare system, including some case managers, guardians ad litem, foster parents, and group home staff:

1. Do not understand that children form vital attachments to their parents regardless of how dysfunctional their families are.
2. Do not understand that it is normal for children to grieve for lost attachments to parents and/or foster parents,
3. Are unable to recognize common grief symptoms in children, and how these may be different from grief symptoms in adults.
4. Are unable to identify the serious consequences that can occur if children are moved from trusted foster parents or caregivers.

This knowledge is absolutely essential if children's best interests are to be met.

Grief over the broken attachments caused by removal from parents or trusted foster parents is as traumatic to children as if the parent or caretaker had suddenly died.

Dr. Elisabeth Kubler-Ross, author of *On Death and Dying*, found in her research that children take longer to go through the stages of grief than adults do. **The younger the child was at the time of the loss, the longer the grief period can be expected to take.**

A study of infants who were 18 to 24 months old when a loss occurred revealed that children were still displaying active grief symptoms 6 to 8 years *after* the loss. If children were older at the time of the loss, the time of active grief slowly became progressively shorter. It was not until the child experiencing the loss was an older teen that their grief approached the 1-2 years of active grief that is typical of adults.

Children of any age who are removed from a foster parent to whom they have attached will grieve the loss of the foster parents. They may also simultaneously need to revisit the grief over the separation from their parents or they could have more intense reactions to reminders of that grief.

Good transition plans can certainly help children better cope with the loss, but the need to grieve will remain.

How Do Children Express Grief?

Children's grief, like grief in adults, may be expressed in a number of ways depending on the individual circumstances, age, and temperaments of the children as well as the way the involved adults deal with the transition between caregivers. Typical grief reactions include:

- Regressive behaviors (e.g., return to baby talk, lapse of toilet training, bed-wetting)
- Distracted easily, thinking disorganized, memory lapses, learning difficulties
- Problems with judgment and cause/effect, increased mischievous behavior
- General anxiety, separation anxiety, alarm, panic, fears
- Food issues, including hoarding food or refusing to eat
- Abnormal displays of anger to normal situations
- Sadness, depression, despair, self-esteem problems, feeling they've been "thrown away," yearning and pining for the lost caregiver
- Sudden flairs of anger
- Physical symptoms such as sleep disturbances, rapid or irregular heart rates, and lower resistance to infection
- Blaming others or themselves for the situation
- Denial of events
- Avoidance of future relationships.[29]

Many children experience a recurrence of grief as they enter new developmental stages, and this must be taken into consideration. Many children are punished in school, foster homes and/or when returned to the parents for exhibiting these predictable reactions to grief, and the Board believes that more work must be done to inform providers, schools, and workers about these reactions.

Grief must be recognized and considered when deciding how to help the child so that behaviors are not misinterpreted (e.g. willfulness) **or misdiagnosed** (e.g. as physical or mental conditions with similar symptoms).

Recommendations:

1. Provide mandatory continuing education on:
    a. Findings of the latest research on children's attachment needs,
    b. Why children grieve for lost attachments, and
    c. How children show grief symptoms to the following: case managers, foster parents, guardians ad litem, county attorneys, law enforcement, and the judiciary.

[29] Numerous sources, including nationally known expert on children's attachments needs, Nancy Thompson, M.S.W., L.M.H.P.

How Can Necessary Transitions Be Done in Ways That Help Children to Cope with these Life-Changing Events?

Findings/Rationale for Recommendations: The Board has reviewed the cases of many children who have been moved to new foster homes or facilities without an effective transitional plan that considered the children's age, developmental stage, needs, and attachments. Often, children were given no preparation whatsoever for this major, life-changing event.

Research shows that young children can be hurt, possibly permanently, by a move to a new caregiver that is not well planned and that does not take into consideration their developmental stage and attachments.

If it is vitally necessary to move children from one foster home to another, research has shown that there are a number of ways of conducting the transition that will help the child better cope with the new situation. Transition plans should be carried out in the most child-friendly manner possible. Young children, especially, need a predictable routine and to be with someone whom they know and trust at all times.

The Board would like to thank Nancy Thompson, a nationally known expert on children's attachment needs and brain development who is based in Omaha, for providing the following list of ways to help children in transition.

Helping Children in Transition
By Nancy Thompson, M.S.W., L.M.H.P.

- Early in the transition process obtain a special object such as a blanket, teddy bear, etc. For older children this may be a clothing item, toy, or pillow. If it is impossible to secure the original item, replicate the item as closely as possible and as early as possible in the transition process.
- Encourage repetition of previous patterns for personal care, such as bedtimes with rituals, food preferences, types and times of bathing (shower or bath). Caretakers should note this information so it can be passed on.
- If possible, take Polaroid® or instant pictures of the previous family, the house, and the pets; otherwise, see if copies of photos can be obtained for the child to keep.
- Whenever possible, encourage transitions that include a visit at the present home, a visit at a neutral place (park, restaurant, etc.) and an overnight or daylong visits with discussions about the habits of the new household.
- Older children should take active part in packing and unpacking their own belongings and putting them away.
- Provide a duffel bag or other luggage for transporting the child's personal belongings. Do not use a plastic bag, garbage bag, or cardboard box.

- Whenever possible, arrange periodic contact by phone, visit, or mail with the previous caretakers. This becomes more important if the child is moving after a long period of time.
- Encourage new caretakers to exchange food information, and even recipes for favorite dishes, and prepare them early in the transition process and again when requested by the child.
- At the first visit before transition encourage new caretakers to give the child a token gift that goes with the child back to their current placement. The child can bring this gift with them at the next visit or upon permanent relocation.
- New caretakers should provide a secure place for the child's belongings and allow the child to adjust to the new placement before expecting sharing with other children in the home.
- Children under stress often show regressive behaviors. They need patience and kindness as they struggle to regain their normal developmental level. Tolerating whining, crying, and withdrawal along with thumb-sucking etc., will help the process move along and tolerance will be more effectual than consequences or criticism. Most children will regain their former skills within a few days or weeks.

Recommendations:

1. Case managers, foster parents, agencies responsible for contracted foster homes, guardians ad litem, therapists, courts, and other concerned parties should do everything possible to encourage a well-thought-out transition plan for any child that must move, especially if the child is pre-school age or developmentally delayed. The plan must be based on the children's age, developmental stage, needs, and attachments.
2. Minimize placement disruptions by recruiting and working with foster care families for infants, toddlers, preschool children, and other age groups, and identifying appropriate relative placements (e.g. aunt, grandmother) early in the child's case.
3. Increase awareness among foster parents of the mentoring program that is available through the statewide foster parent association, which can also help minimize placement disruptions.

Guide for the Journey – Case Management Issues

What Is the Impact of Case Worker Turnover?

Findings/Rationale for Recommendations: The Board finds that it is more common for children being reviewed to have had several different HHS case managers while in care than to have had stability in case management. During 2003, 2,455 (59.6%) of the 4,116 children reviewed had 4 or more different case managers during their time(s) in out-of-home care.

Children often pay the price of professional burnout and workforce issues when they linger in care while each new worker learns their case, if documentation is incomplete due to the turnover, and if their service needs go unmet because the new workers are not familiar with their circumstances or service availabilities.

Many case managers who resigned their positions cite that the case manager's job is nearly impossible to perform adequately due to the following:

- The need for more supervision and structure.
- Increasingly large caseloads.
- The time-consuming nature of entering required basic case information on the N-FOCUS CWIS computer system.
- The lack of placements for the children in their caseload.
- Children and youth being denied needed mental health services under managed care private contracts.
- Little time for pre-service training on domestic violence, which is a factor in many of the cases.
- The fragmentation of the caseworker position, where pieces of their duties are parceled-out to private contractors, and the caseworker cannot override contractor decisions.

The following case example illustrates how case manager turnover can impact children.

> *"Terri" entered care when she was 12 years old due to abuse. She has been in care almost 3 years now and has had at least six different caseworkers in that time. There was no case manager assigned to this case for almost 4 months in a row during 2003. For a few months she had a guardianship with a grandmother, but that quickly disrupted. The grandmother reported that she hadn't received support to continue the guardianship. Terri feels abandoned by her mother and grandmother, and is angry. The current plan is to place her in a group home until she ages out of the system.*

Recommendations:

1. Make caseloads equitable.
2. Increase levels of support and supervision for case managers.
3. Reduce computer time for case managers by utilizing data-entry personnel.
4. Provide continued and additional energy in the identification and removal of barriers to case manager effectiveness and productivity so that these professionals can serve children, youth and families across the state.
5. Look at how communication now takes place between case managers and contractors and examine communication breakdowns and frustrations.
6. Analyze the HHS Child Welfare budget and worker caseloads. This analysis must include the number of FTE's (full time equivalents) in each position. A common method of measuring caseloads needs to be adopted, along with a recommended caseload for each level of worker.
7. Analyze the training required for new case managers. The analysis should cover course duration, location and content.
8. Reduce supervisor caseloads so they have time to train and guide caseworkers.

Do Case Managers Maintain Contact With the Children?

Findings/Rationale for Recommendations: Face-to-face contact is necessary to accurately assess the appropriateness and safety of placements and services. It is critical for appropriate case planning. It also facilitates case managers' communication with the children's caregivers and other parties.

Contact is especially critical for pre-school children or the severely handicapped who may not have contact with adults who could report a possible concern with a placement and, thus, are more vulnerable to abuse or neglect.

The 2002 Federal Child and Family Services review found that "*the frequency and quality of face-to-face contact between caseworkers and the child and parents in their caseloads was often insufficient to monitor children's safety or promote attainment of case goals.*"[30]

The Board finds that this situation continues as some case managers have not had timely face-to-face contact with the children, as shown below:

- 179 (4.3%) of the 4,116 children reviewed during 2003 had documentation showing that no contact had taken place within 60 days of the review. This includes 52 children age birth to five.
- 347 (8.4%) of the 4,116 children reviewed during 2003 had no documentation regarding case manager/child contacts and thus likely did not have any contact. This includes 66 children age birth to five.
- 3,579 (87.0%) of the 4,116 children reviewed in 2003 had documented case manager contact within 60 days prior to the review.

[30] Final Report, Nebraska Child and Family Services Review, U.S. Dept. of Health and Human Services.

From this chart it can be inferred that 526 children were likely not seen by their caseworkers within the last six months of their care (the 179 where it was clear there no contact plus the 347 with no documented contact). This includes 118 very young children (birth to five) who would be very vulnerable if abuse was occurring in their placements.

Recommendations:

1. Reduce caseloads and encourage case managers to maintain and document their contacts with the children.
2. Respond to concerns, if any are noted, in visits conducted by guardians ad litem, CASA workers (Court Appointed Special Advocates), or the Foster Care Review Board.

5,522 Nebraska children were in out-of-home care on Dec. 31, 2003.

Barriers to Successfully Completing the Journey - Transportation & Visitation Contract Issues

What Are the Concerns Specific to Contracts for Transportation or Visitation Monitoring?

Background information: In some instances the same contractor provides both transportation and visitation monitoring, in others there are separate contractors. In cases where visitation is not monitored, contracted transportation workers may be the only ones who know whether the parents attended the visitation or not, since they are take the children to and from the arranged contact with the parents. Contractors also transport some children to and from school and therapy appointments.

In a sample of children's cases being reviewed in October 2004, about 30 percent of the children were being transported or having visitation monitored by a contractor. This would mean that contractors would have transported approximately 1,657 of the 5,522 children in care on Dec. 31, 2003.

Findings/Rationale for Recommendations: The following summarizes the Board's findings of major problems with contracted transportation for children.

A. **Children often must deal with a new driver each time they are transported.** This adds unnecessary stress for children who are already highly stressed by the removal from the home and the attaching/de-attaching that happens with each visitation or therapy session.
   - Contractors do not assign the same person to drive a particular child. Some simply put out a message to all their drivers saying they need a child picked up at location "x" and delivered to location "y" at a particular time, and whichever driver responds first will be the one to interact with that child.
   - When foster parents have asked drivers to come a few minutes early to get acquainted with children who have particular difficulties with strangers, they have been labeled "uncooperative" and drivers have threatened to contact caseworkers recommending a placement change.

B. **Some contractors have engaged in unsafe practices.**
   - Drivers have arrived without car seats for children under age 6, even for babies who could not yet hold up their head.
   - Drivers have had other persons in their cars when transporting the children.
   - There have been a few reported instances of drivers having non-contractor employees transporting the children.
   - Drivers have smoked in cars with children with asthma and respiratory illnesses.

- Drivers have failed to pick up children at the placement and at the visitation or therapy site.
- Drivers have dropped off children at their foster home early without ascertaining that there were any adults at home.

C. Drivers do not know the child's case and thus cannot accurately describe the child's behaviors before and after visitation or therapy sessions. Drivers are not trained on how to comfort children at these stressful times.
   - Drivers usually are not trained on what information to give to foster parents or caseworkers and how to relay that information.
   - Many foster parents have not known that parents did not show up for visits, and thus they had a difficult time interpreting children's post-transportation distress, especially for pre-verbal children.

D. There is no incentive for drivers to report when parents do not show for visitation.
   - The Board has reviewed cases where children were transported for weeks without the caseworker or foster parent knowing that the parent was not attending scheduled visitations.
   - Not only is this unnecessarily stressing on the children, but it could also result in the development of inappropriate plans of reunification with parents who show no interest in parenting their children and incorrect information being given to the courts.

E. Contractor scheduling difficulties have resulted in no transportation being available.
   - Many drivers are college students. When college classes stopped this May, in Omaha many parental visitations were cancelled due to a lack of drivers.

F. Contractors are being paid considerably more for this service than would be the cost, including benefits, of hiring full-time case aides to do the same task with better results.

G. Contracting has added a layer of bureaucracy between the case managers and the children, increasing the likelihood that critical information is not shared and increasing the chances of poor outcomes for the children. In addition, there are insufficient means of oversight to ensure children are safe and are actually receiving services that are being billed to the state

Additional problems can occur once the child has arrived at the visitation site.

Monitoring the appropriateness and consistency of parental reactions to the children during visitations is at the core of casework, yet in some cases it is being delivered by persons with very little training or understanding of the dynamics involved.

One of the best predictors of whether a child could at some point be safely returned to that parent is whether the parent visits the child regularly and the quality level of interactions during visitation. Thus, it is very important that the interactions be well documented and correctly interpreted.

It is critical that the persons delivering this service understand the difficulty the child may experience leaving their parents again after visitation is concluded. They must also understand the emotional trauma that children experience where visits do not occur as planned or are disrupted, and how children of different development stages may express this distress.

Whether visitation is monitored or not, pre- and post-visitation transportation workers are often the only ones with the children during some very traumatic moments, yet they are frequently unwilling or ill prepared to comfort the children, especially if they are virtually strangers. Since some of the children are transported over considerable distances, there may be no one to help them deal with visitation issues for quite some time, if at all.

For the children's sake, visitation incidents must be appropriately reported to the children's foster placement so the placements can correctly interpret children's behaviors and can help children deal with situations regarding visitation. Often this does not happen.

Recommendations:

1. Hire permanent case aides to complete visitation.
2. Provide case aides extensive instruction on how to correctly interpret parental actions, how to interpret the children's reactions at visitation, and how to help children deal with the trauma of moves to new facilities/homes.
3. Require immediate communication to the foster placement and the caseworker of whether the parent(s) attended a particular visitation session, and expedite reporting to caseworkers on parental non-attendance.
4. Liaison with the Foster Care Review Board on a quarterly basis to address the Board's transportation and visitation concerns.
5. All the oversight recommendations from the previous "all contracts" section above also applies

On Dec. 31, 2004, there were 1,041 Nebraska children placed in group homes or facilities.

Stops Along the Journey – The Need to Better Monitor Group and Agency-Based Foster Placements

What Are the Concerns Specific to Contracts for Placements?

Background information: Agency-Based Foster Care contractors are private organizations that contract with HHS and are responsible for recruiting, assessing, screening, training, supervising, and providing 24-hour support for many foster homes, therapeutic foster homes and group homes. Some facilities do an excellent job of providing care, but systemic deficiencies need to be addressed so that all agencies are held to appropriate and consistent standards of care.

Findings/Rationale for Recommendations: Through reviews the Board has found the following troubling situations:

A. Case managers for some reviewed children could not identify where the children were placed—only that the children were in the custody of a particular contract provider. Some case managers did not know which other children were placed in the same home or how the other children's needs and behaviors could impact the child being reviewed. Without all this information safety cannot be assessed.
B. Serious abuse (severe burns, broken bones, concussions) has occurred in some agency-based placements as a result of a lack of supervision and misuse of restraints.[31]
C. Even after a clear pattern of abuse or neglect has been detected in certain agency-based placements, agencies have continued to place the child and/or other children in the questionable placement without resolving the placement problems.
D. Many agencies fail to develop child-specific placements geared to meeting the physical, emotional, or behavioral needs of an individual child.
E. Some children in out-of-home care have experienced several placement moves while in agency-based care without the knowledge or consent of the case manager, guardian ad litem, or Court. Again, the abdication of control is significant, and any progress is too often reversed.
F. In many reviewed cases, case managers did not have a copy of the agency-based foster home's home study—important background information needed for assessing appropriateness. In other cases, the agency's home studies have been seriously outdated (e.g., over 20 years old). Often, case managers have not reviewed the home studies.
G. In some cases, case managers have never met the agency-based foster family.
H. Procedures for licensing have been problematic. HHS has granted some licenses for agency-based foster homes without a review of the home study.

[31] See page 67 for more information on restraints.

I. Some agency-based foster homes have too many children placed in their care. No one appears to monitor the number of children in many agency-based foster homes.
J. The agency receives payment for its agency-based foster homes at a significantly higher rate than for standard foster homes, yet in many cases the benefits are not getting to the children.

Experience with the current structure of agency-based foster homes, group homes, and residential facilities shows that there is insufficient oversight of the agency-based system. This lack of oversight in some placements has resulted in poor care, and the lack of quick and effective response to this situation continues to put children at unnecessary risk in many of these facilities.

Recommendations:

General Recommendations

1. Increase oversight of private agencies' decisions concerning the placement and services for children.
2. Provide a method of evaluating the effectiveness of agency-based placements.
3. Give incentives to assure that children transition to lower levels of care in a timely manner (without a placement change, if possible), but only when safe and appropriate for them to do so.
4. All the oversight recommendations from the previous "all contracts" section above also applies
5. Liaison with the Foster Care Review Board on a quarterly basis to address the Board's placement concerns.

Recommendations Specific to Group Homes

1. Conduct regular, unannounced, on-site visits to all group homes, and stagger such visits so that they occur in the evening and overnight, as well as day shifts.
2. Review staffing ratios in conjunction with the number, sex, age, and behaviors of the youth placed in each particular group home.
3. Ensure that supervision is adequate and that effective emergency procedures are in place in case of injury.
4. Discourage the use of restraints as the primary behavioral control strategy.
5. Assess the skill levels and training of the staff.
6. Review all background checks of staff hired by the group homes.
7. Review the standard of care being provided to the residents.
8. Assist the agencies in establishing and providing the services necessary for the youth placed in the group home.
9. Regularly review all allegations and reports of abuse or neglect involving a group home or its employees.
10. Liaison with the Foster Care Review Board on a quarterly basis to address the Board's placement concerns.
11. Provide a method of evaluating the effectiveness of agency-based placements.

Recommendations Specific to Agency-Based Foster Homes and Agency-Based Therapeutic Foster Homes

1. Follow existing HHS policy and conduct home studies prior to placing children or at least within 30 days in an emergency situation. HHS should file the home study in the child's permanent record or in another easily accessible location where information would be available for caseworkers and for review of the case by the Board.
2. Assure any home studies completed by another entity are provided to HHS in a timely manner and included in the child's permanent file.
3. Conduct criminal background checks on all potential foster parents, including those from agency-based placements. Like home studies, this information should be readily accessible for caseworker review.
4. Assure that adequate background checks are being completed, and that the home studies are complete and up to date.
5. Eliminate the use of any foster home previously found to be unsuitable.
6. Cross-check all providers against prior allegations of abuse, including those involving providers who are/were also day care providers. Do this on initial application and on renewal.
7. Examine the number of children placed in the foster homes, and assure that the home is not simultaneously providing care for dependent adults or others not listed in the home studies.
8. Assure that the foster care providers are being given adequate support and training by the contractor agency. Agencies should be required to show that they provide foster parents support and education on specific physical or mental health needs that an individual child may present.
9. Provide a method of evaluating the effectiveness of agency-based placements.
10. Since agency based foster homes and therapeutic foster homes receive children with more difficult behaviors, at minimum agency-based foster parents should be required to demonstrate proficiency caring for children with one or more of the following issues
    - children needing extraordinary amounts of assistance with behavioral management and modification,
    - children who are physically aggressive,
    - children with sexualized behaviors,
    - children requiring intense supervision,
    - children with attachment disorders, depression, anxiety, or suicide ideation,
    - children with sleeplessness,
    - children requiring medication for physical and/or mental health issues.

What Problems Have Been Identified in How Contractors Provide the PRIDE Training Program for Foster Parents?

Background information: The State of Nebraska purchased the Foster PRIDE/Adopt PRIDE parent resource information development education curriculum from the Child Welfare League of America. Many other states use this curriculum and this is now the 27-hour competency based training Nebraska uses for foster parent training.

This curriculum is not related to other community service programs that use the PRIDE acronym. In this context, we refer solely to this particular curriculum.

Contractors are providing the PRIDE training for foster homes licensed through the state (whether traditional, relative, special needs adoption, or special placements). Contractors provide this training for their own agency-based foster parents, and some provide this for non-contract foster parents as well.

The curriculum is for nine sessions of three hours each. Instructors for some of the contractors report that this is a very full agenda with a large volume of information being presented. Instructors are to have completed a "Train the Trainer" program prior to providing this program.

Findings/Rationale for Recommendations: It has been reported that some contractors are not providing the full nine sessions at three hours each and completing the curriculum, cutting the classroom time by an hour or more per session. Well-trained instructors have had doubts about the ability of any instructor to complete the courses in less than the required time and still provide quality training.

Also, instructors have reported that no one checked to be sure that they had completed the full train the trainer program.

It appears there is no oversight on the contact hours provided, the quality of the instruction, or whether the instructors have completed the train the trainer programs.

Recommendations:

1. Assure that PRIDE training is for the full number of contact hours and that the instructors are qualified.

How Are Allegations of Abuse by Contractor Staff and Others Recorded on the Central Registry?

Findings/Rationale for Recommendations: There are problems related to the central registry, which is the HHS list of persons accused of abuse, whether a contractor staff person, foster parent, parent, relative, friend, daycare provider, or stranger to the child. Certain employment positions require a background check of the central registry.

Currently there are five categories on the registry, and some of the names shown in the chart below, are confusing.

Term	Meaning
"Court substantiated"	A District, County, or Juvenile Court ruled the abuse or neglect occurred.
"Petition to be filed"	A County Attorney filed a petition with a District, County, or Juvenile Court, but the Court hearing has not yet occurred.
"Inconclusive"	Evidence indicates that it is more likely than not that abuse or neglect occurred, but court adjudication did not occur (e.g., proof that abuse or neglect occurred, but insufficient evidence to prove who exactly caused the abuse or neglect so no petition can be filed).
"Unable to locate"	After trying at least once, the alleged perpetrator was unable to be located.
"Unfounded"	Anything not in the other categories. It does *not* mean that the abuse did not happen.

Alleged perpetrator's names only go on the registry if the case is labeled "Court substantiated" or "Inconclusive." If the case is labeled "Inconclusive" the alleged perpetrator can file to get his or her name expunged, or removed from the list.

The classification system is problematic because some terms have a definition that is very different than what is implied, especially for "inconclusive" and "unfounded."

In regard to contractor staff, current HHS practice is to label allegations as "unfounded" when the contractor disciplines the staff person involved, when the child is moved from the placement, or when the child is transferred to a new day care. If there is a good likelihood that abuse occurred, this person should be labeled "inconclusive" so the name goes on the central registry. If there are future allegations regarding this person, having a central registry entry will be important historical information to consider. It could also prevent a perpetrator from getting employment where they could harm other vulnerable children or adults.

Recommendations:

1. Examine the case classification system on the Central Registry.
2. Change "Inconclusive" to a more descriptive term such as "Likely, But No Court Action Possible."
3. Eliminate the current practice of closing investigations as "Unfounded" when the contractor disciplines the staff person involved, when the child is moved from the placement, or when the child is transferred to a new day care. Follow the HHS policy of placing persons on the central registry, even if the contractor took disciplinary action.
4. Assure that all perpetrators are appropriately placed on the central registry, so that if future reports of abuse are received the history of allegations is known and so the perpetrator is not hired for positions involving contact with children or dependent adults.
5. Record all allegations against an individual or facility on the N-FOCUS CWIS computer system in such a way that they are easily accessible.
6. "Unfounded" encompasses too many conditions, and implies that the incident(s) did not happen, even though there could be suspicions. "Unfounded" should be broken into the following categories:
    - "Suspected" when it appears something did occur, but there isn't enough proof to be "Inconclusive."
    - "Fixed" or "Situation Changed" for cases where the allegations involve a group facility and the situation is changed with the resignation of the employee in question or the move of the child to a different facility.
        Note: These should be reviewed to see if they really fit the category "Inconclusive" and thus should be subject to inclusion on the central registry. This category should not apply if there is reason to believe the abuse did occur.
    - "Unlikely" where there is a plausible explanation other than abuse or neglect and the situation is unlikely to occur again.
    - "False" where the reporter apparently knowingly made a false claim.
7. Reduce the number of expungements granted (purging of a person's name from the abuse registry).

Barriers to the Journey – Oversight & Safety Issues With Contracted Services

How Does the Current Contract Structure Affect Children?

Findings/Rationale for Recommendations: The majority of the children in care are affected by contracts for transportation, visitation, or placements. The Board finds that these core case management duties have been contracted out to the private sector without putting adequate safeguards in place.

Contracting has added a layer of bureaucracy between the case managers and the children, increasing the likelihood that critical information is not shared and increasing the chances of poor outcomes for the children. In addition, there are insufficient means of oversight to ensure children are safe and are actually receiving services that are being billed to the state

In many cases the quality and quantity of services has deteriorated; and many children and youth are not receiving the services they need. This practice has put children at risk in a number of ways, such as:

1. Critical information is not being communicated or not easily made accessible between the case manager and all the contractors in a case. This communication gap exists both from the case manager to the contractor and from the contractor to the case manager.
2. In some cases, contracted staff have the only contact with the children, yet have few contacts with the case managers, and case managers often discount their observations. Contractors have reported having difficulty getting phone calls returned, which appears to be endemic.
3. The cost of contracting with for-profit organizations limits the funds available to provide permanent case management for the children's cases.
4. Children's cases do not achieve stability in a timely manner.

The Board has found that when a health or safety issue involving a service from a contractor is disclosed, children are often caught in the following no-win situation:

- When a placement concern arises, it is difficult to know whether it is best reported to the CPS hotline, to the case manager, or to resource development, since HHS has not designated a single point of authority for these matters.
- When the Board has reported concerns to these HHS staff members, a common response is "did you call the [other party]." That is not acceptable, *per se*.
- Even when Board staff members have contacted all three parties, there is often no investigation to correct the situation.
- While this is happening, the contractor may not take corrective action as it could be viewed as admitting fault.
- Until the situation is resolved, children often remain at risk.

Recommendations:

Discontinue the Use of Contracts

1. Review the cost-effectiveness, efficiency, and wisdom of contracting for essential case manager duties, including the impact on children.
2. Based on what the Board has determined regarding high costs but poor quality, eliminate the use of private contracts for case management and increase the number of case managers. Get more value for the dollar by using state employees for these services.
3. Define a reasonable caseload for HHS caseworkers.

As Long as Contracts Remain in Use, Significantly Increase Internal Oversight

1. HHS oversight of contracted services must be increased. Recommit to aggressively monitoring the services and placements that are currently contracted to private agencies.
2. Implement immediate, proportional consequences for agencies that fail to meet strict guidelines regarding children's safety.
3. Clearly identify who within the system is to investigate concerns regarding contractors and who has the authority to take action to correct the concerns.
   a. A cornerstone of effective investigation is the objectivity of the investigator; therefore, contractor administration should not be the sole investigator for any incidents/complaints.
   b. State law should be followed and all reports of abuse or neglect investigated by trained HHS workers.
4. Clearly identify the lines of supervision and means of monitoring that needed investigations of allegations regarding contractors take place in a timely manner.
5. Clarify all existing service provider contracts to include clear expectations regarding performance, lines of authority, and communication. Look at how communication now takes place between the case manager, the agency, and the agency-based provider. Examine communication breakdowns, and monitor performance.
6. Review communication protocols and procedures for use when a child is injured in an agency-based service.
7. Withhold pay from service providers until their reports are provided to the case managers.
8. **Allow case aides to assist case managers with entering information on N-FOCUS CWIS so case managers can do the work they have been trained to do.**

Provide a Formal Outside Oversight Mechanism

1. Based on the lack of responsiveness to issues with contracts, provide a formal oversight mechanism outside of HHS but within state government for contracted services, and assure it utilizes social work, accounting, and legal experts.
2. Responsibilities of this group/office would include:
   a. Examining the RFP process for new contracts.
   b. Assuring a thorough performance review has taken place prior to reissuing any contract, including a thorough review of all allegations regarding the contractor, and supervising the contract renewal process.

c. Confirming that there is proper monitoring of contractor performance throughout the duration of the contract, that services paid for are received, that payment is withheld for service providers who do not provide reports to caseworkers, and that service received meet minimum quality levels.
d. Implementing immediate, proportional consequences for agencies that fail to meet strict guidelines regarding children's safety, including the ability to immediately suspend contracts with agencies found to have major safety violations.
e. Assuring that the case manager for every child in the placement or using the service where the alleged incident occurred is promptly advised of the allegation and the subsequent results of the investigation. Ensuring communication with foster care caseworkers, HHS resource development, the contractor agency, and day care licensing and oversight when the incident involves a foster parent who is also a day care provider or worker.
f. Confirming that HHS tracks allegations regarding contractor staff both by the individual and by the contractor agency.
g. Using its authority to immediately move children to safety, revoke licenses, address any additional health and safety issues, and ensure that investigations of any allegations of abuse regarding contractor services take place appropriately. [This would be similar to the way the old Department of Health assured physical safety of the elderly in nursing homes].
h. Assuring that HHS implements supervisory oversight of all issues connected to children's safety and well-being, and recommits to aggressively monitoring the services and placements that are currently contracted to private agencies.
i. Reporting at least yearly to the Governor, HHS management, the Legislature, other state agencies, and the public its findings on contract monitoring by HHS child welfare.

Clarify Contract Provisions

1. Present and future contracts must include provisions that:
    a. Describe how children's safety will be maintained.
    b. Specify minimal performance standards.
    c. Clarify who has authority to act if problems arise.
    d. List results-oriented penalties, including monetary penalties or immediate cessation of contract, for agencies that do not comply with safety or care standards.
    e. Set protocols and standards and describe penalties for failing to meet these standards.
    f. Set communication protocols and procedures for use when a child is injured in an agency-based service.
    g. Set protocols for other communication, (e.g. if children are transported to visitation and the parent does not show; if parents are inappropriate during supervised visits; if agency-based foster parents are noting new behaviors of concern, etc.).
    h. Provide standards for documentation.

i. Clarify that the FCRB has statutory authority to visit facilities, review facility files, and review home studies.
j. Specify training requirements for the employees that have child contact and how this is to be monitored.
k. Allow for on-site review and inspection of services at any time during the contract.
l. Specify that there will not be automatic renewal of contracts.
m. Prohibit contractors from suing caseworkers, FCRB staff, or other professionals if they report concerns about contracted services or placements to appropriate parties as part of their work duties.

2. Clarify all existing service provider contracts to include clear expectations regarding performance, lines of authority, and communication. Look at how communication now takes place between the case manager, the agency, and the agency-based provider. Examine communication breakdowns, and monitor performance.

Develop Specialized Placements to Better Serve Children Needing Group Care

1. Develop specialized placements in order to:
    a. Give children the treatment they need to overcome the abuse and neglect they have endured or to function in society.
    b. Reduce some of the behavioral issues that have lead to some safety concerns.
    c. Make contract termination a viable threat, as there will be alternative placements for the children and youth.
2. Develop specialized facilities that provide dedicated treatments for the following needs:
    a. Children who have been sexually abused or are sexually acting out, including those learning appropriate boundaries and how to stop unwanted advances.
    b. Children who are dual-diagnosis (e.g. substance abuse and mental health issues).
    c. Children who are violent.
    d. Children who have mental health or behavioral issues.
    e. Children who have physical or cognitive challenges.
3. Require group facilities for troubled youth to house only boys or girls, not mixed populations.

Stops Along the Journey – Placement Issues

(excluding contract issues from the previous sections)

What Types of Additional Placements Need to be Developed?

Findings/Rationale for Recommendations: The Board finds that a lack of appropriate placements results in children being placed where beds are available rather than where their needs can best be met. These placements frequently do not meet the needs of individual children, causing difficulties, conflict, and eventual removal from the placement. This harms the child further, resulting in a child with even higher levels of needs and less likelihood of successful outcomes.

There are significant shortages of traditional foster homes, therapeutic foster homes, group homes, residential care facilities, and therapeutic placements for specific needs, such as violent youth, sexual perpetrators, young children who have been sexually abused, emotionally disturbed children, children with a dual-diagnosis (e.g., substance abuse and mental health issues), pregnant girls, and children with severe behavior problems. The shortfall is especially acute west of Grand Island.

Some children remain in an unsafe or inappropriate placement for some time before an appropriate placement can be found that can meet their needs.

Compounding the situation:

- Many children already in the system are denied services at the level of care needed due to financial reasons (managed care), denials of care by private contractors, and/or due to placement and service deficits.
- Even if a more intensive treatment level is approved, there may be long waiting lists. To find an available placement often means moving the child to a different area of the state, which makes parental visitation and family therapy more difficult.
- There are more children entering the child welfare system, and a larger number of the children display higher levels of treatment needs due to the chronic or severe nature of the abuse or neglect they have suffered.
- There have been many cases where the Board has disagreed with the placement decisions of the new managed care provider, Magellan.
- Many treatment placements closed or accept only private-pay placements due to the number of treatment denials by ValueOptions, the private company with which the State contracted for managed mental health care services for children and youth until HHS allowed its contract to expire in 2002.

In addition, the Board finds that the **mixture of children in some shelters, foster homes, and group homes often places very vulnerable children in the same environment** (possibly even the same room) as other children who have exhibited physically or

sexually aggressive behaviors. It would be difficult for any facility to keep children safe under such circumstances.

Some foster homes or agency-based foster homes also serve as emergency placements. When children are taken into custody and placed in emergency placements there is often very little information about the children available. Again, this makes it difficult to assure the safety of the children and caregivers in the home.

The following case example illustrates the problems the Board finds with the mixture of children in some foster homes:

> *"Ginger," age 14, has been in foster care twice. The most recent removal was due to the mother's failure to protect Ginger from sexual assaults by an older sibling. Ginger has been in more than 35 different foster homes over her lifetime. Her most recent move was to the treatment foster home of a first-time foster parent who has two biological children, ages 1 and 2. Ginger's guardian ad litem has expressed concern that the foster mother takes no active interest in Ginger. It is unclear how a first-time foster parent with two young children can meet the needs of this challenging teenager.*

Recommendations:

1. Increase HHS' focus on placement development to meet the following special needs:
    a. Therapeutic placements for violent or aggressive children;
    b. Treatment placements for sexual abuse victims or children sexually acting out;
    c. Placements equipped to handle disabled children;
    d. Therapeutic placements for emotionally disturbed or traumatized children;
    e. Placements that specialize in the needs of children who have committed law violations;
    f. Treatment placements for children with a dual-diagnosis (e.g., substance abuse and mental health issues);
    g. Placements able to handle the medical and emotional needs of pregnant girls and adolescents; and
    h. Placements for children with severe behavioral problems.
2. Diligently work to recruit and retain therapeutic foster homes, group homes, and residential care facilities, especially in the western part of the state. This goal is also in the 2001 HHS Nebraska Family Portrait Initiative.
3. Ensure that the mixture of children in foster homes, emergency shelters, and group facilities is considered prior to placements. Create programs that specialize so that children are not inappropriately mixed in facilities.
4. Explore the possibility of using state resources, such as using the Nebraska Center on Children and Youth (NCCY) campus as a child-caring facility.
5. Implement a clear plan for oversight of agency-based foster care to ensure that children are not at risk in an agency-based placement and that the placement is appropriate for the children's needs.

6. Improve consistency of licensing practices and standards to ensure safety for children in out-of-home care. This goal was also in the 2001 HHS Nebraska Family Portrait Initiative.
7. Assure that shelters are used appropriately, as short-term placements while a more permanent placement is being recruited or located.
8. Assure that a full investigative background check is completed on all applicants for foster care providers, including relative placements, to eliminate many problems with inappropriate caregivers.

What Do Foster Parents Tell the Board Regarding Support, Information, and Communication Issues?

Findings/Rationale for Recommendations: The Board finds that many foster parents who have provided many children quality care left the system because of the following issues:

- Support from case managers was unavailable when problems arose,
- Adequate background information was not given on children placed with them, and/or
- Sufficient respite care[32] was unavailable.

The Board finds that the fragmentation of the case manager's position, and the additional layers of bureaucracy created by the agency-based care system (discussed elsewhere in this commentary) have decreased effective communication between foster parents and caseworkers. This lack of communication must be addressed if children are to be safe and healthy in their placements.

Many foster parents also report that their case managers display an attitude that foster parents are not an essential member of the team assisting the children and families. These foster parents report that their case managers often do not inform them when there are changes in children's plans and that they are also not included in the planning process. In order to retain top-quality placements, this attitude must be changed to one of mutual respect.

When conducting reviews the Board is required to ask whether the children's foster parents had been given children's educational and health records. With the exception of a few recent emergency placements, this information should be provided to all foster parents.

The Board found that many foster parents were given this information, but many were not. For example, regarding medical records:

- **398 (9.7%) of the 4,116 children reviewed had foster parents or placements that reported they had not been given medical records about the child.**

[32]Respite care is limited time away from the children in order to complete actions where the children cannot or should not be present, such as when foster parents attend continuing education classes.

- In an additional 643 children's cases it was not possible to determine whether the foster parents/placement had received medical records.
- Only 2,910 (70.7%) of the 4,116 children reviewed had foster parents or placements that reported they had received the medical records for the child.
- 135 of the 1,053 children age 0-5 had foster parents who indicated they had not received medical information about the young child in their care. It was unable to be determined for another 140 young children.

In regard to educational records:

- 3,580 children were reviewed who were age 2 or older (and therefore were either school age or possible for early childhood education programs) and who also were not over age 16 and either a dropout or high school graduate. For this population it would be expected that educational records should be provided.
- **343 (9.6%) of the 3,580 potentially school-aged children's foster parents or placement reported they had <u>not</u> been given educational records.**
- For another 606 of the 3,580 children it was unable to be determined if the placement had been given educational information.

Communication gaps do appear, and can lead to serious consequences. The Board has reviewed cases where the foster parents were not informed of children's allergies to common medications or other serious medical conditions. Potentially life-threatening events have occurred as a result. Many foster parents also report that children's immunization records have not been provided, leading to difficulty with preschool and school enrollments.

In addition, foster parents need to be given background information on the children placed with them in order to ensure the safety of themselves, their own families, the children being placed with them, and other children entrusted to their care. This is especially true for children who are exhibiting physical aggression, sexualized behaviors, or destructive behaviors as a result of the abuse or neglect they have endured.

The Board has had similar findings to the 2002 federal Nebraska Children and Family Services review which found that "*In cases in which foster family placement disruptions occurred, there was no indication that the NHHSS caseworker had made efforts to prevent the disruptions.*"

Fostering abused children is significantly different than caring for one's own children. As discussed in the section on grief, these children bring with them some difficult grief behaviors, need to learn a "new normal" of what is expected in the household, and frequently believe that they are unlovable. Foster parents need specialized training in dealing with these difficult behaviors and challenges, and open lines of communication between themselves and the children's case manager.

Foster parents need to understand why a child's "emotional age" may not be near the chronological age, and what needs to happen to bridge this gap, such as allowing children to talk about the negative events in their lives.

Foster parents have not always been able to obtain requested additional training in behavioral management for children with attachment disorders or children who had experienced severe or chronic abuse or neglect. The behaviors associated with these conditions can be very frustrating, so information that these are expected behaviors and tips on how to manage the behaviors could be very beneficial.

In addition, many foster parents find it difficult to talk to children and youth about the youth's romantic relationships and sexual behavior, even though the foster parents may have concerns about these areas.

The Board supports the efforts that the Nebraska Foster and Adoptive Association is making to help provide support, training, and mentoring on pertinent issues to foster parents across the state.

Foster parents also have indicated significant concerns with transitional planning for children. Children changing foster homes are often not given the opportunity to develop a relationship with the new foster parents prior to their placement, and children are often removed from foster homes with very little chance to say "goodbye" or retain important relationships.

Recommendations:

1. Recognize that foster parents are a vital component of the system.
2. Place a medical cover sheet at the front of every child's file so that essential information can be easily consolidated and shared with all appropriate parties as necessary. This is a procedure that HHS in Grand Island has implemented at the Board's request, and it appears to be working well.
3. Implement well-supervised procedures to ensure that foster parents are given essential background information on the children being placed with them, including health and education records.
4. Provide foster parents with training to address the more complex problems being presented by children today, and give them the support and respite they need. (The HHS Nebraska Family Portrait Initiative includes plans for training the trainers and in-service training for foster parents and staff. The Board supports these goals).
5. Continue exploring the creation of "professional foster parents" that is, foster parents who are provided enough in wages so that at least one parent remains in the home providing daily care for a limited number of children in a home setting.

How Many Children Do Not Experience Stability in Foster Care and What are the Ramifications?

Findings/Rationale for Recommendations: Experts recognize that it is reasonable to expect children to have a maximum of two placements, such as an emergency shelter where an assessment can be made to determine the most appropriate placement, and then the appropriate placement can be secured. Unfortunately, over half of Nebraska's children in out-of-home care do not experience this type of continuity of caregivers.

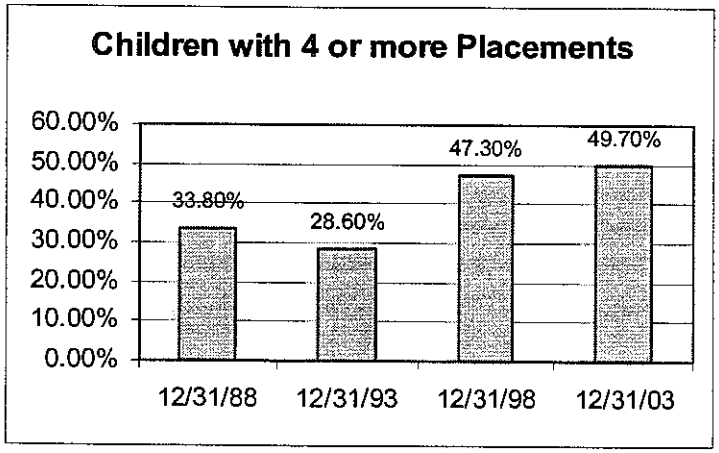
The Board finds that 49.7% (2,747of 5,522) of the children in care on Dec. 31, 2003, had experienced four or more placement disruptions and 33.6% (1,867 of 5,522) had experienced six or more placements during their short lifetimes. Many experts believe that children who experience four or more placement disruptions can be irreparably harmed by the multiple broken attachments.[33]

As one young man who grew up in foster care said,

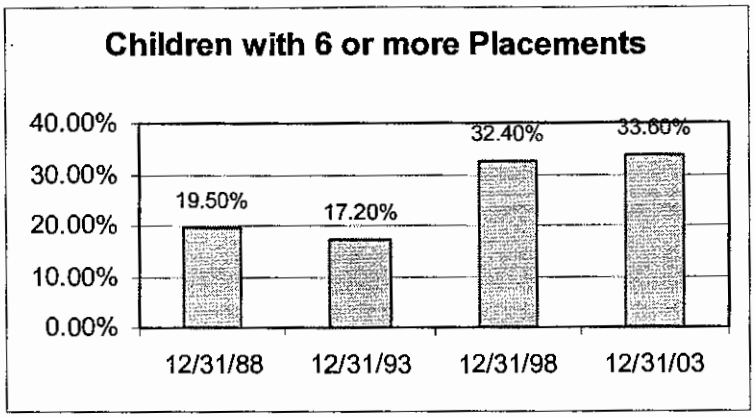
> ***"Every day I would come home from school and see if my stuff was packed. That was the first thing I would check."***[34]

It is hard to imagine how this young man was able to concentrate at school when he didn't know if he would have a home or not at the end of the day. This young man and society at large pays the price for this type of insecurity.

As shown below, the percent of Nebraska children experiencing multiple placements while in foster care continues to increase. This means that the system has more children who have experienced an often-painful separation from their foster parents, and who may be growing more resistant to forming any type of normal attachments.



[33] See page 33 for more information on grief and broken attachments.
[34] March 29,2004, editorial by a member of Pew Commission as it appeared on www.tallahassee.com.



Children who experience a number of placement disruptions have an increased probability of depression, confusion, short-term memory loss, learning problems, and/or behavioral impairment.

Even under ideal circumstances, separations of children from caregivers to whom they are attached can cause negative impacts for many years, and can have life-long consequences.

> ***"Adults must remember that once new attachments are formed, separation from these substitute parents is no less painful and no less damaging to the child than separation from birth or adoptive parents."***[35]

Each placement disruption is likely to increase the children's trauma, distrust of adults, and negative behaviors, making future successful placements even more difficult and negatively impacting the children's normal growth and development.

The damage done to children by multiple changes in caregivers can be severe and life-long. Research shows that many of the adolescents and young adults who are violent, lack empathy, or are severely mentally ill started their lives as one of these children who experienced multiple losses. Conversely, research has shown that the presence of even <u>one</u> positive attachment figure can be a protective factor to promote resilience in children who suffer trauma or separation[36].

Anyone who has worked with livestock or pets knows baby animals that are moved several times in their early development period show behaviors indicating the stress, are more susceptible to illness, and sometimes die. The same phenomena holds true to young children who are in their developmentally vulnerable period.

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[35] J. Freud Goldstein and A. J. Solnit, Beyond the Best Interests of the Child, c. 1973.
[36] Susan Downs et al, Child Welfare and Family Services Policies and Practice, c. 1991, page 280.

With the negative consequences for these practices so clear, we need to ask why so many children, even little children, experience multiple moves to new caregivers. **Children are often moved because**:

1. The lack of appropriate placements resulted in a placement where a bed was available rather than a placement where the children's needs could be met.
2. Foster parents were unprepared for children's predictable grief reactions, and unaware that it is necessary and expected that children will grieve their loss whenever they are separated from either a parent or a foster parent to whom they have become attached.
3. Many in the child welfare system erroneously assume that young children are not impacted by placement changes and are unaware of research which clearly indicates that each movement has a lasting effect on children of all ages and that placement changes should be avoided as much as possible.
4. If the new placement is unable to handle the children's grief behaviors, children are often moved again rather than providing services or support to prevent a placement disruption. This sets up another grief cycle.
5. There is a misconception that anytime a relative is identified the child must be moved.[37]

Many placement disruptions could be eliminated through the recommendations detailed below.

Recommendations:

1. Identify relatives and non-custodial parents within the first 120 days of a child's placement so that delayed identification does not result in unnecessary moves.
2. Adapt the model Utah is using, in which children under age six must be placed into a prospective foster/adoptive home when they enter care to reduce children's placement disruptions should the case plan change to adoption.
3. Recruit, develop, and retain child-specific placements for young children, especially those with special physical, emotional, or behavioral needs.
4. Provide on-going specialized training to all foster parents, case managers and supervisors on the importance for children to bond and form attachments to their caregivers.
5. Implement foster parent retention steps such as:
   a. Recognition that foster parents are a vital component of the system;
   b. Access to round-the-clock immediate and effective support when issues arise;
   c. Provision of health and educational records to foster parents upon placement or within a few hours of placement;
   d. Provision of other background information, such as likely behaviors (e.g. sexual acting out, fire starting, rages) when children are placed in foster homes and facilities;
   e. Continuation of work to create "professional foster parents" that is, foster parents who are provided enough in wages and benefits to be in the home providing daily care for a limited number of young children in a home setting

[37] See page 63 for more information on kinship care.

and assure that the children can remain in this home as long as needed regardless of whether Medicaid will continue to pay for this level of care; and

f. Additional training offered on child development, bonding and attachment, and effective methods of behavior modification, with specialized training as needed.

6. Award grants or contracts with entities to provide Multidimensional Treatment Foster Care (MTFC). The objectives of a MTFC program are to provide children and youth who have serious and chronic behavioral problems with close supervision, fair and consistent limits, predictable consequences for rule breaking, a supportive relationship with at least one mentoring adult, and limited exposure and access to delinquent peers. MTFC is based on the philosophy that, for many children and youth who exhibit antisocial behavior, the most effective treatment is likely to take place in a community setting, in a family environment in which systematic control is exercised over the children's behaviors.
7. Assure that children with higher level needs can stay in placements as their behaviors stabilize so they are not penalized for getting better by being forced to move to a new environment.
8. Build the capacity of out-of-home placements to match the population of children, their location, and their needs.
9. Develop a sufficient capacity of shelter beds to accommodate all children entering out-of-home care, for a stay of up to 30 days. This would ensure a thorough assessment of the child's placement needs and increase the likelihood of an appropriate ongoing placement.
10. Monitor placement providers closely and consistently.
11. Develop placements for children and youth with multiple or specialized needs.
12. Implement guidelines designating who should make placement, treatment, and service decisions for children and youth in out-of-home care and put into practice effective means to monitor and review these decisions.
13. Require relative caregivers to pass the same standards as other foster care providers to ensure that children are safe and well cared for.
14. Recognize that while the goal is to reduce the number of placements that children experience, this should never be met at the expense of children's safety.

Why Are Some Children Moved From Stable Foster Homes to Relatives With Whom They Have No Relationship?

Definition: Some children in out-of-home care receive daily care from relatives instead of from non-family foster parents, in a practice known as **kinship care**. Kinship care was put in place to allow children to keep intact *existing and appropriate* relationships/bonds with appropriate family members and to lessen the trauma of separation from the parents.

Given what is known about children's brain development and their need to form and maintain close bonds to the primary adults around them, a quick determination of the appropriateness of a relative placement makes a great deal of sense. If the relative is an appropriate placement, the children suffer the minimum disruption possible and are able to stay with persons they already know who make them feel safe and secure. Thus,

kinship care is especially beneficial when children have a pre-existing positive relationship with a particular relative.

If relatives are not an appropriate placement, then an appropriate non-family caregiver can be secured for the children and the children can begin the process of adapting to their new environment. Kinship placements are not appropriate if the relative cannot establish boundaries with the parent, or is in competition with the parents for the children's affection, or if there is any indication that the relative has abused other children (or the child's parents) or allowed their abuse.

Findings/Rationale for Recommendations: The Board finds that many children are moved to relatives who are virtual strangers due to decisions that are based only on familial ties, not on the children's best interests. Many case managers have the misperception that *whenever* a relative is found, children must be moved to the relative's home regardless of the lack of a previous relationship with the relative, the length of time the children have been in care, the children's attachments to the current non-relative foster parents, or the likelihood the children may suffer significant trauma as a result of the move.

Another frequent misconception is that a relative placement must be used, even if the relative is a poor caregiver. The following case examples show the consequences for the children.

> Case 1. *"Harry" and "Joe," ages 5 and 3, have been in foster care twice. The second removal happened over two years ago. The boys had been placed in a stable foster home for eight months, where they appeared to thrive. Then the boys were abruptly moved to the out of state home of an aunt and uncle they had barely met. That placement lasted only 3 months, and the boys came back with bruising from suspected abuse in the aunt and uncle's home.*
>
> *The first foster parents no longer wanted involvement in the system, so the boys were placed in an available foster home. The department is considering moving them again to live with, and potentially be adopted by, another relative they have not met. The children are showing signs of stress and attachment issues, such as self-stimulating behaviors and hording food. "Joe" has delayed language development. After being in foster care for more than half their lives the children are no closer to permanency.*
>
> Case 2. *"Alison" age 5, and her siblings entered care due to their mother's abandonment. Alison is placed with her grandparents out of state, and the plan is for the grandparents to adopt her. Alison has lived with her grandparents for almost two years. Her two older siblings were placed with the grandparents when she was, but later removed due to sexually acting with each other and their cousins. The older siblings are disclosing consistent stories of incidents in the grandparents' home,*

including physical discipline. It is unclear how Alison's safety would be assured in this placement. Complicating this, an out-of-state therapist reports that Alison is doing well in this placement, but it is unclear if the therapist knew of what happened with the older siblings.

The Board has reviewed cases in which suitable relatives came forward at the beginning of a case, and they were either never appropriately evaluated as potential placements for the children or their evaluation was so delayed that the children had already formed bonds with their non-relative care givers.

The Board has also reviewed the cases of children who have been moved after living for years with suitable non-relative caregivers. As a result, bonds to caring non-relative adults that children have formed over a significant portion of their young lives are broken without cause, based on an inflexible, non child-specific policy regarding relatives. Furthermore, these moves are often made in a manner that further traumatizes the children by not providing for appropriate transitions.

Neither practice conforms to the language or intent of the Adoption and Safe Families Act (1998 Nebraska, based on 1997 federal legislation). The Act is clear that the health, safety, and well being of the child is always to be the overriding concern in decisions about the child, including placement decisions.

Recommendations:

1. Identify relatives at the beginning of each case and assess their previous relationship with the children and ability to safely care for the children.
2. Establish paternity quickly in the case of every child who must be removed from the home by encouraging county attorneys and HHS to work together on the issue so that paternal relatives can be identified and assessed quickly;
3. Provide on-going specialized training to all relative caregivers on the importance for children to bond and form attachments to their caregivers.
4. Provide relative caregivers access to round-the-clock immediate and effective support when issues arise, and provide them with health and educational records on a timely basis.
5. Ensure that a kinship placement is not selected simply because of biological connections, but rather because it is a safe, appropriate placement with someone the children already know and trust.

49.7% (2,747of 5,522) of the children in care on Dec. 31, 2003, had experienced four or more placement disruptions

Suffering on the Journey – Restraint Issues

Why Do Policies Allow So Many Children and Youth to Be Restrained? What Are the Alternatives?

Definition: Restraints include physical restraints (also called takedowns), chemical restraints, confined isolation, and prolonged depravation of food. Some children are subject to more than one type of restraint. Many of the children had multiple episodes of restraints, including some having more than one restraint per day.

Findings/Rationale for Recommendations: The Board found that 217 children of the 4,116 children reviewed had file information indicating restraints were used on them during the six months prior to the review. This is especially concerning given that **HHS has no requirement that a restraint against a child be documented.** It can reasonably be concluded the actual number of children being restrained was significantly higher.

Another concern is that **many of the children that had documented restraints have limited intellectual functioning, and thus are very vulnerable to abuse by adult caregivers.** These children, especially, need programs tailored to their specific needs and abilities that can keep them safe with minimal physical interventions.

Some of the 217 children restrained experienced more than one type of restraint, and/or restraints in more than one facility.

- 181 of the 217 children were physically restrained,
- 56 children were placed in confined isolation,
- 12 children were chemically restrained, and
- 10 children had documentation that mentioned a restraint, but did not specify which type of restraint occurred.

The Board finds that **restraints should be a very rare last option used only when all other forms of behavioral controls have failed and the children's or the staff's safety is in jeopardy.**

The Board acknowledges that some of the children and youth in care display some very challenging and aggressive behaviors. However, the Board is concerned that **some facilities now use restraints as the *primary* method of behavioral control** – even though other behavioral control methods have proven to increase the children's ability to control their own behaviors and decreased the number of acts of physical aggression that children see modeled as acceptable adult behaviors.

The Board has a number of concerns regarding excessive use of restraints. Restraints do little to teach children self-control and increase the children's anger and frustration.

Restraints increase the risk of injury to the children and staff, rather than decrease the risk.

Restraints convey the message that it is acceptable for those with power to use physical force to get what they want from those without power, which has alarming implications for those youth who go on to have families of their own.

In many ways excessive restraints are little different than the abusive treatment many were receiving in the parental home.

The Board notes that while there are protections against unnecessary restraints for the vulnerable elderly, there are no such protections for Nebraska's vulnerable foster children.

Based on review information it appears that restraints are more likely to occur because:

a. Some providers appear to base their program on an assumption of using restraints as the primary method of behavioral control instead of using proven behavioral de-escalation techniques.
b. Some placements do not have programs to effectively deal with children's behaviors before an incident occurs, or if programs exist, staff is not adequately trained.
c. The service and placement providers' contract currently states that HHS accepts the written program of the facility without change. Many of these written programs authorize use of physical, chemical, and/or isolation restraints for youth placed at the facility.
d. In some instances, lack of appropriate staffing levels and lack of staff training have led to the inappropriate use of restraints.
e. Throughout the system, there are problems with the decision-making process used when placing children at facilities.

In addition, group home providers report that they have an increasingly difficult time finding qualified staff for the wages they are able to pay. As a result, they hire younger, less educated, and less experienced staff, who in many cases are college students not much older than the youth for whom they are providing care. Group homes also experience a high rate of turnover with staff leaving for higher paying positions before they are able to develop any expertise in dealing with troubled young people. Thus, some group home staff are unable to de-escalate a troubled child's behaviors without resorting to physical measures.

There are reasonable alternatives to restraints. Research, and the experience of group homes that rely on de-escalation techniques, proves that even with the most violent youth, de-escalation techniques often greatly reduces the need for physical restraint. Some group homes have made an effort to incorporate these de-escalation techniques into expected staff behavior and training. In these facilities restraints are very rare. Some group homes have clear policies on how they monitor any restraints in their facilities, while others do not.

Further, **many of the behaviors that precipitate restraints could have been reduced if the children's needs had been successfully addressed at a younger age or if grief behavior had been understood.**

Recommendations:

1. Include clear expectations regarding the use of de-escalation techniques and a requirement for proof of training in prevention and de-escalation techniques in all contracts for service and placement providers. Review HHS standard contracts to address concerns regarding restraints. Develop restraint-free therapeutic care environments and programs with the intent to eliminate the use of physical restraints.
2. Develop, implement, and monitor a policy to ensure appropriate use of restraints. Develop uniform documentation of all restraints and review both internally and externally by trained professionals for safety and appropriateness. Subject every restraint incident to mandatory outside review.
3. Implement programs that address youth's behaviors.
4. Provide training to group home staff emphasizing alternatives to restraints, including comprehensive de-escalation techniques.
5. Set competitive salary guidelines and qualifications for staff dealing directly with children in group settings to attract quality staff.
6. Implement clearer guidelines for placement decisions, treatment decisions, and service decisions and put into practice effective means to monitor and review these decisions.
7. Implement the measures described elsewhere in this document to ensure that children's needs are met at a younger age.

30.3% of the children reviewed in 2003 did not have complete written permanency plans (1,247 of 4,116 children).

Road Map for the Journey – Planning and Service Issues

How Many Children Have Appropriate, Current, Written Plans? What are the Consequences for Children If They Do Not?

Legal Requirements for Children's Case Plans: The Foster Care Review Act of 1982, Neb. Rev. Stat. 43-1312, mandates that each child in out-of home care have a written plan and is to be updated at least once every six months. The plan should include:

- The long-range goal such as reunification, adoption, etc.;
- The purpose for which the child has been placed in foster care;
- The estimated time necessary to achieve the purpose of foster care placement;
- Goals and time frames with which to measure progress;
- A description of services that are to be provided in order to accomplish the purposes of foster care placement;
- The person(s) who are directly responsible for the implementation of such plan;
- A complete record of the previous placements of the foster child;
- Documentation regarding the appropriateness of the placement; and,
- The address of the placement.

Findings/Rationale for Recommendations: Case plans are the road map home for the children. If there is no plan, then there is no way for the parents, the case managers, or legal parties to the case to accurately measure progress. In the case of non-compliant parents, no plan can mean children remain in out-of-home care without permanency because the professionals cannot build a case for termination of parental rights. Parents who are trying to comply can be extremely frustrated because they do not know what is expected of them.

It is also important to recognize that if the parents cannot do what the plan states (i.e., if the services needed are not available in a geographic area or if the parents are too low functioning to ever comply) then the plan is not realistic and not truly "reunification." Rather, it is a plan for parents to fail and for children to remain in the system far longer than necessary. The above scenarios slow the progress of the child's case and lengthen a child's time in out-of-home care.

The Board finds too many children have do not have complete, written plans:

- 30.3% did not have complete written permanency plans (1,247 of 4,116 reviewed children).
  - 684 children had no current plan,
  - 563 children had incomplete written plans (missing one or more essential elements needed to establish what is to happen and how this will be accomplished).

In addition to not having plans, when plans are formulated they are often inappropriate.

- In 33.6% of the cases reviewed, the Board could not agree with the child's plan (1,386 of 4,116 children reviewed).
- Initially almost every child with a living parent will routinely be assigned a permanency goal of reunification, regardless of whether or not reunification is appropriate, and notwithstanding the intent of the Adoption and Safe Families Act (Nebraska 1998, federal 1997).

Federal auditors were also concerned with how Nebraska develops plans for children's futures. The 2002 Federal Child and Family Services Review found that HHS had an *"inconsistency in developing case plans and involving parents in the case planning process."*[38]

Recommendations:

1. Insist that there be a complete and current permanency plan for each foster child. Insist that every case plan stipulate time frames and develop a system wide sensitivity to time frames for achieving goals.
2. Give case managers the support necessary to ensure that they have time to prepare complete permanency plans.
3. Provide additional training to all workers providing case management on how to write and administer complete permanency plans.

Can Reunification Attempts Put Children at Risk and How Can This Be Prevented?

Findings/Rationale for Recommendations: The Board found that 41.6% (2,211 of 5,321) of children removed from their home during 2002 had gone through at least one failed reunification attempt. This means these children have experienced unnecessary abuse, neglect, or trauma. As mentioned earlier in this report, the negative effects of multiple separations on brain development and children's behaviors are significant.

THE CYCLE OF FAILED REUNIFICATION ATTEMPTS

Child is abused or neglected
↓
Separation from their parents
↓
Effects of separation from the parents on child's development
↓
Adjustments to living in foster care
↓
Possible moves to new foster placements

[38] Final Report, Nebraska Child and Family Services Review, U.S. Dept. of Health and Human Services.

↓

Adjustments to living again with their parents

↓

Child is abused or neglected yet again…

The Board has identified the **major reasons that children return to care**:

1. Children are removed from the home, but the root cause of the abuse is plea-bargained out of the petition, so the court cannot order the parents to obtain services on those issues.
2. Children are removed from the home due to a situation that is never resolved, are returned home, then removed again for the same reason(s).
3. Children are removed from the home and reunification occurs prematurely, before the parent(s) is ready to reassume the responsibilities of parenthood.
4. Children are removed from the home and then reunified because appropriate placements cannot be found.
5. Young children who were in care act out later as adolescents, and subsequently are returned to care.
6. Case managers assume the standard is to attempt reunification with *all* parents, even when it can be predicted to be unsuccessful.

Failed reunification can cause serious, life-long harm to children and youth's ability to grow, develop, cope, and adapt. Children's interests are not served by the practice of attempting to reunify families in which the parents show little or no interest and/or ability in parenting. Of special concern are chronically violent families where the children's safety is at risk.

Since many children in care come from families highly resistant to change, the Board recommends that HHS investigate programs such as the one in the State of Washington where there are special units that work with these types of families. Efforts must be made to greatly reduce the number of children experiencing failed reunification attempts.

Recommendations:

1. Write clear, appropriate plans with services, goals, and timeframes and carefully document parental compliance with the plan so that if parents are non-compliant, alternative permanency can be pursued. Include biological families in the planning process and provide them and their attorneys a clear explanation of what the family must accomplish to get the children returned.
2. Conduct better assessments of the families and focus reunification efforts on families who have expressed a desire to change.
3. Eliminate the practice of attempting reunification with parents who cannot or will not parent in order to eliminate failed reunifications, further abuse, and repeat episodes in out-of-home care.
4. Provide appropriate remedial services to families who are identified as willing to work on new behaviors.
5. Continue implementation and monitoring of the guidelines outlined in the federal Adoption and Safe Families Act, where child protection and best interests replace family reunification as the primary guiding policy for child welfare agencies.

6. Follow the guidelines outlined in the Adoption and Safe Families Act where reunification need not be pursued in:
    - Cases of murder or voluntary manslaughter of another child by the parent,
    - Felony assault that results in serious bodily injury to a child,
    - Abandonment,
    - Torture,
    - Chronic abuse,
    - Sexual abuse, or
    - Previous involuntary termination of parental rights of a sibling.
7. Reduce the time given parents whose children are re-removed from the home to show significant progress before consideration is given to termination of parental rights[39] and moving the case to alternate permanency. This time should be reduced to six months and the system should move to ensure services are in place to accelerate this timeframe.
8. Prevent children who have been adopted or in guardianships from having to return to care in order to access services.

Why Are Many Children in Foster Care For Years Without Reaching Permanency?

Findings/Rationale for Recommendations: The Board finds that nearly half (2,054 of 4,116 – 49.9%) of the children reviewed in 2003 had been in care for at least 2 years without achieving permanency and 13.3% (547 of 4,116) had been in care for 5 years or more without achieving a safe, permanent home. Even though foster care is by definition to be a short-term solution, it is inevitable that many children are remaining in out-of-home for extended periods of time given the number of unresolved barriers to permanency.

The child welfare system has a duty to ensure that all abused and neglected children have the opportunity to grow up in safe, permanent homes with adult caregivers who care for the children and seek what is best for their development and well being. Further, because of the very nature of childhood and child development, it is critical that this happens in a timely manner.

Recommendations:

1. Provide intensive services to parents with the intent of assessing their long-term willingness and ability to parent.
2. Utilize provisions of the Adoption and Safe Families Act to move immediately to termination of parental rights in cases of serious or chronic abuse or where the parents lost their parental rights to siblings for the same condition.
3. Provide intensive case management for all young children (age 0-5 plus siblings) through additional case managers who would provide focused stability, services,

[39] The Nebraska Supreme Court has stated, "A child should not be left suspended in foster care and should not be required to exist in a wholly inadequate home. Further, a child cannot be made to await uncertain parental maturity." In *Re Interest of JS, SC, and LS, 224 Neb 234 (1986)*

and care for these young children. Each case manager should have a caseload not exceeding 15 children and each supervisor should have a staff not to exceed eight case managers.

4. Develop specialized units where highly trained professionals focus on providing timely permanency for school age children who have been identified as not being able to return home due to parental inability or unwillingness to provide long term care.
5. Create permanency units to serve children age six or older who have been in care for two or more years or who have suffered extreme abuse, and their siblings. Families would be evaluated, and if it were identified that the likelihood of a child being returned to the parents is small, these units would work to create permanency for that child.
6. Explore the use of family group conferencing, where the extended family works to help develop the safety plans for the children under certain circumstances. Assure that if family group conferencing is used that there is adequate supervision to ensure children's safety. (Family group conferencing was piloted as part of the 2001 HHS Nebraska Family Portrait Initiative).
7. Adopt legislation that will add to grounds for termination of parental rights the lack of effort on the part of the parent to adjust the parent's circumstances, conduct, or condition to meet the needs of the child, and failure to maintain regular visitation, contact, or communication with the child.

Are Services Readily Available?

Findings/Rationale for Recommendations: The Board finds that appropriate, effective services are not made available to many children, youth, and families. As shown in Table 3 of this report, all the services in the permanency plan were in motion for only 1,910 of 4,116 (46.4%) of the children reviewed in 2003.

Family reunification is more likely to occur if services are easily accessible, community-based, and delivered within six weeks; however, services are not even available in some parts of the state.

Even when the plan is no longer reunification, children may need a number of services to help them mature into responsible adulthood due to past abuse, neglect, or behavioral issues. In addition, children may remain in foster care for months without family issues being addressed while their parents are on long waiting lists.

Delays in the delivery of court-ordered services are of even more concern in the wake of recent federal and state legislation requiring that termination of parental rights be considered in cases where a child has been out of the home for 15 of the past 22 months.

The following cases illustrate a particular lack of service availability.

Case 1. *"Zane," age 10 is just about ready to be adopted. As often happens with children who have high levels of trauma in their early years he is acting out as the pending adoption draws near. Magellan, the managed care company that HHS uses to determine certain service eligibilities, denied Zane the certified teaching assistant he needed during school hours. His behaviors got worse and he was expelled for a semester. Magellan has approved him to go to day treatment, but will only do so for one week at a time. This has made it very difficult for his caseworker and his potential adoptive parents to plan his day-to-day activities and plan for his future. If Magellan denies him the day treatment program the school is compelled to offer educational services; however due to budget cuts they have stated they can only give him 45 minutes per day.*

Case 2. *"Mitch," age 16, has been in foster care 3 times. The last time he entered foster care due to suicidal ideation and statements, and intense conflict with his family. His parents voluntarily relinquished their rights. Throughout his lifetime Mitch has been in 44 placements. Many of the placement changes have been due to changes in approved treatment levels; that is, if his behaviors modify so that he doesn't need as restrictive an environment he gets moved to a new facility. This is a Catch-22. He needs stability to thrive, he gets services to address issues, he begins to make progress, his approved service level changes, he gets moved to all new workers and peers, he reacts to the instability and then is moved back to a higher level where the cycle begins again.*

Recommendations:

1. Assist rural and metro communities in developing treatment and services for children, youth, and their families, including:
    a. Substance abuse
    b. Anger control and Batterers' Intervention Programs
    c. Mental health treatments
    d. Alcohol/drug treatment
    e. Housing assistance
    f. Family support workers
    g. In-home nursing
    h. Family and individual therapy
    i. Educational programs.
2. Develop flexible funds for HHS service areas use to meet children's and families' needs.

How Can Youth Under the HHS Office of Juvenile Services (OJS) Be Better Served?

Findings/Rationale for Recommendations: The Board finds that youth under HHS-OJS often do not receive needed services and treatment placements, and that this means that the youth are often placed with more vulnerable children in homes or facilities that cannot be expected to fully meet their needs. Also, case files for OJS often lack complete permanency plans with time frames, goals, services, and related documentation.

OJS youth typically need services to address behavioral issues such as sexually acting out, aggression, violence, gang affiliation, chemical dependency, and anger management. Some need treatment for dual diagnosis (such as a low-IQ youth who need treatment for alcohol abuse and anger management).

HHS has a contract with a managed care company to approve any specialized services for these youth. The managed care provider does not fund services to address and/or control behavioral problems – only "medically necessary" services. Consequently, many delinquent juveniles are denied the appropriate services to treat their behavioral problems. "Medically necessary" would seem to be a term enabling managed care providers to deny treatment on financial grounds alone. The following case illustrates that point:

> *"Lynn," age 16, comes from a very dysfunctional background—domestic violence, unstable housing, problematic family relationship, and substance abuse by both parent and child. Although the family has been involved with child protective services for years, no action was taken on Lynn until he was ticketed for disturbing the peace while high on pot, and threatening to harm another youth and himself. He was also involved in an assault while at a shelter.*
>
> *When Lynn entered care he had not been living with his parents for some time. The managed care company used by HHS has denied Lynn the level of treatment needed three times in spite of three appeals by the case manager. This delayed his access to services as a different funding mechanism was explored. He needs chemical dependency in-patient and aftercare. therapy to deal with family issues, and treatment for depression and a conduct disorder.*
>
> *This is an angry young man that in about two years will age out of the system.*

Many of the youth committed by the courts to OJS had been in out-of-home care prior to committing a status offense. Case managers and parole officers who care for these youth need to seek out and assess the child/family history to determine appropriate services and placements.

Recommendations:

1. Develop funding for services and placements to meet the needs of OJS youth.
2. Develop uniform standards for case management staff caring for OJS youth.
3. Require case plans for all youth under OJS, including those at the Geneva and Kearney Youth Rehabilitation and Treatment Centers. (This goal was also in the 2001 HHS Nebraska Family Portrait Initiative).
4. Rewrite contracts with managed care to include payment for services for children and youth with a wide array of behavioral problems.
5. Cancel the managed care contract if rewriting is not possible, and return responsibility to HHS.
6. Provide youth with preparation for, and transition to, adult living.

Responsibility for the Journey – Prosecution and Court Issues

How Does Prosecution of Child Abuse and/or Neglect Affect Children's Cases?

Findings/Rationale for Recommendations: There are two separate tracks that cases involving child abuse or neglect can and should go through—juvenile court and criminal court.

1. Juvenile courts can either be a county court acting as a juvenile court, or in the larger metropolitan areas, a separate juvenile court. Juvenile courts focus on making orders on behalf of the child, such as placing the child in foster care, and/or ordering parents to services to address problems that led to court intervention. Juvenile court actions start with a concept that rehabilitating the parents, if possible, is best for the majority of children. Therefore, most cases start with a plan of reunification.
2. Criminal courts focus is on holding the parents accountable for their actions.

Both types of cases are important, and there are flaws in both systems. The Board finds that:

- Prosecution can be hampered by poor investigations that provide insufficient or incomplete evidence.
- Plea-bargaining that reduces or drops serious case concerns (e.g. sexual abuse) places children at risk for future harm since courts cannot address issues that are not in the petition.
- Newly elected county attorneys are often inexperienced with juvenile court issues, there is no requirement for them to obtain training in this complex area, and training has not been made readily available.
- There are economic disincentives to full prosecution due to the time-consuming, costly nature of child abuse prosecutions. This can result in children being left in dangerous and sometime deadly situations.
- In many instances, parents' cases are handled in Juvenile Court where there remains a mandate to rehabilitate no matter the circumstances.
- Parents who act without conscience, or who permanently maim children, need to have serious consequences for their crimes, and their children's case plans should reflect a permanency other than reunification.

In Nebraska, county attorneys are responsible for the prosecution of all child abuse and neglect cases in criminal court and the handling of all abuse and neglect cases in juvenile court. It is essential to establish a sound legal basis for intervening in families in juvenile court when child abuse and neglect occurred and to define the problem(s) in such a way that the issues are clearly identified, and holding the perpetrators criminally accountable for their actions.

In juvenile court cases, **courts can only order services to address the items in the petition that were proved at the adjudication hearing**. With insufficient or inadequate evidence, the petition cannot fully address all conditions that brought the child into care.

The same type of situation can happen with plea bargains, even though many plea bargains are done with the best of intentions. For instance, the county attorney may be concerned that that the child in question would be further damaged by the rigors of a trial. Depositions can take hours, and recounting the details of sexual or other abuse can be very painful. The child may be preverbal or otherwise unable to communicate, which can make prosecution very difficult. There may not be enough evidence on some of the abuse, or the county attorney may believe that the other proven conditions may be enough to keep the children in out-of-home care where they can be safe.

The Board acknowledges that it can be very difficult to prosecute when the primary witness is a child. This is especially true in light of the recent U. S. Supreme Court decision in the Crawford v. Washington case that affects the admissibility of children's testimony to law enforcement, medical personnel, and others outside of a court hearing.[40] Nevertheless, it is important for the safety of the child in question and other children that may have contact with the perpetrator that prosecutions occur. **Sound investigations are important because they are an essential building block of successful prosecutions.**

The following example, of the type that the Board frequently sees during local reviews, shows how items left out of the petition through inadequate evidence, plea bargains, or other causes can leave children at risk:

> *The petition regarding "Mona," age two, alleged domestic violence by her parents, but failed to include both parent's mental limitations and her father's physical illness. A psychological evaluation indicated that due to their low level of intellectual functioning and judgment problems, neither parent could safely care for the child without continual assistance. The adjudication is being appealed. If the adjudication on the domestic violence is overturned that will end the court's grounds for intervention and the court will have no choice but to return this child to the parent's care. Mona will likely suffer harm as a result.*

From children's perspective, it is important that prosecutions occur. **Without prosecutions the perpetrators bear few consequences for the children's suffering.** A resolution or closure to the abuse is needed as well as an assurance that it will not happen again. Numerous research studies have found both disabled and very young children are often capable of testifying in court if the people working with the children know how to proceed.[41]

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[40] Crawford v. Washington, #02-9410, Argued Nov. 10, 2003. Decided Mar. 8, 2004.

[41] Among the researchers making this finding was Dr. Patricia Sullivan, currently at the Creighton School of Medicine Center for the Study of Children's Issues, in Omaha Nebraska.

Recommendations:

1. The Board recommends that the state begin a program to put the responsibility for investigation and prosecution of child abuse under the auspice of the County Attorney in larger counties, or the Attorney General's office in non-metropolitan areas. This person would be the director of an Investigation and Prosecution Center, where specially trained and selected CPS and law enforcement officers would be housed. These Centers would facilitate communication between prosecutors and investigators, and should facilitate the better collection of evidence needed to file successful juvenile court petitions and prosecute child abuse.
2. Mandate training in child abuse prosecutions for newly elected prosecutors. Include in this training the technical aspects of prosecution of crimes against young children and a familiarity with the various other professionals who are involved in the cases and their roles.
3. Encourage county attorneys and judges to ask more questions of the worker regarding placements that trying to be court approved. In this report the worker should give a short synopsis of the plan for the child and the appropriateness of the placement or the judge should deny the placement change.
4. Examine why judges are not using the guidelines provided them to bypass reunification efforts on cases where reunification is not required.
5. Suggest that the County Attorney's Association remind county attorneys of the critical need to file supplemental petitions when new information arises so that the courts can address *all* the important issues in children's cases.
6. Allow the Attorney General's office to provide specialist attorneys who can file juvenile court cases to provide expertise for prosecutors. The Child Protection Unit of the Attorney General's Office has provided quality consultation and case assistance for felony child abuse cases throughout the state. The unit could be expanded or a similar unit established to provide assistance with child abuse and neglect prosecutions in juvenile courts. At the minimum, three attorneys, an investigator, and support staff are needed. This staff could also provide oversight and technical assistance to the child abuse investigation teams (a.k.a. 1184 teams).
7. Introduce legislation to replace the county attorney system with a publicly elected non-partisan district attorney system (for counties outside of Lancaster and Douglas Counties) with candidates for office who meet certain professional prosecution standards (such as five years experience prosecuting felony cases).
8. Increase accountability for prosecution of child abuse and neglect whether the state chooses to create a district attorney system or elects to augments the current county-by-county prosecution system.
9. Adopt legislation like that in other states that adds as grounds for termination of parental right a lack of effort on the part of the parent to adjust the parent's circumstances, conduct or conditions to meet the needs of the child, and the failure to maintain regular visitation, contact, or communication.

How Do Paternity Issues Affect Children's Cases?

Findings/Rationale for Recommendations: The Board finds that paternity had not been established for 604 (14.7%) of 4,116 reviewed children's cases. Paternity was undocumented, and therefore likely not determined, in another 676 (16.4%) children's cases. Most of these 1,280 children (1,194 or 93.3%) had been in care for more than 6 months at the time of review; and most (891 or 70.0%) had been in care for more than 12 months, yet paternity was not established.

Without paternity identification, children cannot be freed for adoption and the father's suitability, as a caregiver cannot be fully assessed. If the child has had a positive relationship with a purported paternal relative, timely paternity identification can help assure these relations remain intact. If paternity identification is delayed or does not occur, however, case stability will not be achieved.

Once paternity is established, children can experience a significant delay in permanency as the non-custodial parent's rights and ability to parent are examined. The Board has reviewed cases in which children's mothers had relinquished their rights or had their rights terminated prior to identification of the children's father. The children then needed to wait more months for permanency as the father's rights were addressed, because children cannot be placed for adoption or guardianship until both parent's rights have been settled.

The following case illustrates this point.

> *"Julie" entered care at birth when the hospital reported that she was born with two different illegal drugs in her system. Julie is now 11 months old. Since paternity has not been established, the father has not been included in the court actions. The alleged father is in prison out of state, and paperwork on paternity has just begun. As with all cases, at twelve months in foster care the court is to have a permanency hearing where the case direction will be determined; however, with paternity uncertain Julie's case is in limbo.*

The paternity identification problem has been especially acute in Douglas County, where about 35 percent of the children in out-of-home care in the state reside. In 2002, the Board worked with the Douglas County Court Administrator's office to increase paternity identification in the county. As a result, affidavits of paternity in Douglas County will be given during the initial intake process.

Recommendations:

1. HHS should work with county attorneys from all 93 counties to assure that paternity has been addressed for every child who has been in care for six months or more.

Could Drug Courts Help Children and Families?

Findings/Rationale for Recommendations: Many of the parents of children who have been abused or neglected have substance abuse issues. For these parents, drug courts may result in more permanent lifestyle changes.

Recommendations:

1. Establish more drug courts where parents could receive court ordered services and be held accountable to the degree of mandatory training on how to properly care for the physical and emotional care of their children.

Each day an average of 13 Nebraska children and youth are removed from their home of origin, primarily due to abuse or neglect (4,773 children were removed in 2003).

Preventing Detours on Life's Journey – Child Abuse Prevention Issues

How Many Children Could Be Benefit From Prevention Efforts? What Additional Prevention Efforts Are Needed?

Findings/Rationale for Recommendations: All responsible Nebraskans should be concerned that **each day an average of 13 Nebraska children and youth are removed from their home of origin, primarily due to abuse or neglect** (4,773 children were removed in 2003). In 2003, the daily population of Nebraska children in out-of-home care fluctuated between 5,300 and 5,700 children. Clearly, too many Nebraska children have suffered child abuse, child neglect and/or child sexual abuse

Unfortunately, these grim statistics represent only a small fraction of the true population of children in Nebraska who suffer abuse or neglect each year. How widespread is such abuse? No one knows for sure. However, it is known that children who suffer abuse or neglect can be divided into the following categories:

1. Children whose abuse or neglect is never reported to authorities;
2. Children whose abuse is reported, but is not investigated so no action to prevent further abuse takes place;
    - 14,595 of the 22,446 calls received between July 2002-July 2003 were not accepted and, therefore, no further action was taken to protect the children.[42]
3. Children whose abuse is reported and investigated, and who are able to remain in the family home with appropriate services; and,
4. Children whose abuse is reported and investigated, and who must be removed from the home in order to assure their safety.
    - 10,140 children were in out-of-home care for some or all of 2003.
        - 4,773 children were removed from the home during 2003.
        - 5,367 who had been removed from the home in prior years were in out-of-home placements on Jan. 1, 2003.

Research shows that child abuse and neglect occurs in families from every geographic, socioeconomic, religious, and ethnic group. Abused children are our children's and grandchildren's classmates and friends. Many such children have behavioral issues and carry the scars of abuse for their entire lives.

There is a need for proven home visitation programs and other proven prevention and intervention programs to lessen the ever-growing number of children suffering abuse, and to reduce the numbers of children entering the system.

[42] Foster Care Review Board study of response to child abuse or neglect allegations.

Home visitation programs need to include:

- Early intervention,
- Intensive services over a sustained period,
- Development of a therapeutic relationship between the visitor and parent,
- Careful observation of the home situation,
- Focus on parenting skills,
- Child-centered services focusing on the needs of the child,
- Provision of concrete services such as health care or housing,
- Inclusion of fathers in services, and
- Ongoing review of family needs to determine frequency and intensity of services.[43]

Nebraska needs to build on the positive experiences of other regions. For example, the William Penn Foundation funded 14 child abuse prevention demonstration programs in Philadelphia in the 1990's and sponsored one of the most comprehensive evaluations of parent education services. The National Committee for the Prevention of Child Abuse evaluated the outcomes. They found that parents' potential for physical child abuse decreased significantly, with those at highest risk on the pre-test showing the greatest improvements. Similar gains were found in providing adequate supervision of children, and responding to children's emotional needs.[44]

In Hawaii, the rate of substantiated cases of child maltreatment for families receiving program services was found to be less than half that of the control group (3.3% vs. 6.8%). Healthy Families Maryland had only two indicated reports of child maltreatment among 254 families served in 4 years of program operation (a rate of 0.8%).[45] Vermont's Success by Six Initiative, which also involves school readiness, reports good results as well.

The Centers for Disease Control studied prevention efforts, and concluded in Feb. 2002:

> *"On the basis of strong evidence of effectiveness, the [CDC] Task Force recommends early childhood home visitation for the prevention of child abuse and neglect in families at risk for maltreatment, including disadvantaged populations and families with low-birth weight infants. Compared with controls, the median effect size of home visitation programs was reduction of approximately 40% in child abuse or neglect...Programs delivered by nurses demonstrated a median reduction in child abuse of 48.7%...programs delivered by mental health workers demonstrated a median reduction in child abuse of 44.5%"*[46]

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[43] Leventhal, as quoted by National Clearinghouse on Child Abuse and Neglect, www.calib.com/nccanch/, August 2003.
[44] National Committee for Prevention of Child Abuse, 1992, www.childabuse.com, August 2003.
[45] Children's Bureau Express, http://cbexpress.acf.hhs.gov, April 2003.
[46] Centers for Disease Control, www.cdc.gov, October 2003.

Based on the research of the CDC and the experience of other states, it is reasonable to conclude that if Nebraska consistently used proven prevention services, the incidence of child maltreatment should decrease – saving the children involved from harm and freeing resources for families more resistant to change. The CDC study looked at cost savings and found "*In the study subsample of low-income mothers, the analysis showed a net benefit of $350 per family.*"[47]

Recommendations:

1. Legislate a mandatory in-hospital risk assessment at birth by hospital social worker staff, offering parents information on bonding and attachment, and at least three follow up visits to the home, longer if risk is identified or parents request services. Utilize public service agencies and volunteer organizations to provide in home safety checks and to provide printed materials for handouts at doctor's offices, Social Service offices, WIC offices, and other child related offices.
2. Conduct intensive home visitation for high-risk populations (birth-2) and universal visitation with focus on school readiness (birth-5).[48]
3. Expand prevention programs that have been shown to be effective and maximize child abuse prevention resources. Select one or more proven prevention models and implement them statewide to expand child abuse prevention efforts.
4. Provide a systematic match of parental needs with appropriate, accessible, affordable services.
5. Create parent support centers that would focus on children of all ages, and could serve as an advocacy and training center, be a source of respite care, and be a host site for parent and adolescent support groups.
6. Encourage employers to have their training specialists give seminars to all employees on the criteria for reporting child abuse and neglect, becoming involved in the community as a mentor, or how to serve in some type of prevention program such as manning a 24- hour hot-line for services that treat both parents and children.
7. Assist business owners in the development of quality low cost child-care.
8. Provide incentives to improve the supply of, and support for, mental health professionals in rural areas.
9. Continue training for Protection and Safety staff on early intervention services that are available in different areas across the state.
10. Increase Kids Connection[49] coverage to 200% of the level of poverty and subsidize respite and after school care for children qualifying for Kids Connection.
11. Involve younger children in a poster making contest for prevention and reporting of child abuse, using the Governor or other prominent Nebraskans to promote this project.

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[47] Ibid.

[48] Hawaii has had continued success with a similar program.

[49] Kids Connection is a program of the Department of Health and Human Services that during 2004 provides assistance with health care coverage for children living in families whose income is at or below 185% of the federal poverty level. Kids Connection includes both the Children's Health Insurance Program (CHIP) and the Nebraska Medical Assistance Program (Medicaid).

12. Provide materials for home economics, health, and related classes for teens so they learn the basics about child safety prior to parenthood and can use this information if providing babysitting services

Removing Detours on the Journey – Other Persistent Child Welfare Issues

What Does the System Do to Find Runaway Children and Youth?

Findings/Rationale for Recommendations: The Board notes that in recent years some runaway state wards have been injured or killed while on the run. It is imperative for children's safety that efforts are made to locate runaways and give them the services they need to grow into productive adults.

If a child is missing from some facilities, the reported procedure is that facility workers will assist in a ground search if the runaway is known to be in the vicinity and if the child is not found then his/her name is forwarded to the State Patrol to be included in a list of missing persons. This minimum effort is not enough to help bring stability to this vulnerable population.

Recommendations:

1. An assessment needs to be done of each runaway incident to determine the cause(s).
2. HHS, the State Patrol and local law enforcement need to increase efforts to locate runaways.
3. HHS needs to implement clearer guidelines for placement decisions, treatment decisions, and service decisions, and to put into practice effective means to monitor and review these decisions.

Are Some Children Charged as Status Offenders When They Are Actually Abuse or Neglect Victims?

Findings/Rationale for Recommendations: The Board has reviewed a number of status offenders[50] whose behavior was a result of abuse or neglect, yet due to the adjudication status the abuse or neglect is not addressed. A system should be developed and put in place to provide services for the families of children who are adjudicated as status offenders, who often come into care due to family situations. When child abuse or neglect is the root cause of the behavior, the court petition should address these issues.

Recommendations:

1. Develop programs to allow HHS to work with the families of children adjudicated as status offenders.
2. Decrease the number of children and youth charged by county attorneys as status offenders whose actions are a result of being abused or neglected and file charges instead on the parents for the abuse or neglect.

[50] Status offenders are children charged with offenses that cannot be charged against adults (e.g. truancy, failure to obey parents). This is not the same as delinquency, in which there is other criminal activity.

3. File petitions that address each of the family member's issues when children are adjudicated as status offenders.
4. File supplemental petitions if new evidence on abuse surfaces.
5. Clarify the court's jurisdiction over families of status offenders and delinquents with appropriate legislation.

How Could Guardians Ad Litem Play A Larger Role in Assuring Safety?

Findings/Rationale for Recommendations: Many guardians ad litem could play a more substantial role in assuring their clients safety. Courts should hold guardians ad litem accountable.

Recommendations:

1. Guardians ad litem should be mandated to see their children on a monthly basis or to make telephone contact with children out of state. This would require a change of statute.
2. Case managers and guardians ad litem should confer with the county attorney at the onset of each case to go over the Safety Plan that has been devised by the worker to see if it is appropriate for the risk involved.

Does the Child Death Review Team Play An Essential Role in Determining Deaths from Child Abuse?

Concern/Rationale for Recommendations: The current Child Death Review Team is not playing an essential role regarding child abuse and could be revamped to aid in the investigation process.

Recommendations:

1. Examine and define the role of the Death Review Team.
2. Determine whether the team should be moved out of HHS as the team will on occasion be reviewing the actions of CPS (another division of HHS) and thus there appears to be a conflict of interest.
3. Revamp the Death Review Team to do timely assessments of child deaths.
4. Establish effective means of communication with prosecutors/Attorney General's office if evidence points to child abuse.
5. Child suicides need to be reviewed thoroughly as well, since other states have found a high correlation between abuse (especially physical and sexual) and suicide.

Are Foster Care and Group Home Payments Equitable?

Findings/Rationale for Recommendations: For several years the Board has noted the apparent inequity in foster care payments made to foster homes and to group homes. The basic rate for foster care starts at $222 per month, which essentially covers room and board. Medical, mental health, and other services are extra. Group home care starts at $1,935 per month. Often there seems to be little difference between children placed in group homes and children placed in foster homes.

The Board has reviewed some children and youth placed in HHS foster homes at one rate and other similar children and youth placed in agency-based foster homes or therapeutic foster homes at a much higher rate. This apparent inconsistency in payment amounts has frustrated a number of providers. In addition, there is an economic disincentive for private contractors to recruit foster homes when group homes receive higher payments for essentially the same children.

Recommendations:

1. HHS should continue its work on equity of payments to foster parents and group home providers.

How Can HHS Get Better Results From Its N-FOCUS Computer System?

Findings/Rationale for Recommendations: Due to the impact of inadequate reports from this system on the children in care and on the Board's efforts to track and review children's cases, this issue is covered in greater depth in the special section on N-FOCUS found later in this document.

Recommendations:

1. A better use of valuable HHS staff time would be to have data entry specialists do routine entry on N-FOCUS, freeing the time of trained case managers to be used in other areas of children's cases.
2. Develop an easier way to monitor and correct errors on the system.

Conclusion

Nebraska can choose to follow the common sense steps recommended by its citizen reviewers and prioritize the safety and well-being of children who have suffered abuse and/or neglect.

Nebraska can choose to help children and families break the cycle of abuse by providing the services children and families need for the children to become productive adult members of society.

Nebraska cannot afford to neglect one of our most valuable resources, namely our children.

OVERVIEW TABLES 1 AND 2

(The remaining tables begin on page 119)

TABLE 1

SOME CHARACTERISTICS OF CHILDREN IN FOSTER CARE - 2003

(A Ten-Year and One-Year Comparison)

Who are the Children?

Children in Out of Home Care on Dec. 31st – A Comparison

1993	2002	2003
6,240	5,367	5,522

Children in Out-of-Home Care on Dec. 31st By Age on Dec. 31st

1993		2003		2003		
1,396	22.4%	1,235	23.0%	1,308	23.7%	Infants & Preschoolers (0-5)
1,486	23.8%	1,263	23.5%	1,267	22.9%	Elementary School (6-12)
1,132	18.1%	1,285	23.9%	1,304	23.6%	Young Teens (13-15)
1,791	28.7%	1,579	29.4%	1,640	29.7%	Older Teens (16+)
435	7.0%	5	>0.1%	3	>0.1%	Age not reported
6,240	100.0%	5,367	100.0%	5,522	100.0%	Total in care Dec. 31st

Children in Out-of-Home Care on Dec. 31st By Race

1993		2002		2003		
3,432	55.0%	3,259	66.7%	3,534	64.0%	White
793	12.7%	898	16.7%	891	16.1%	Black
208	3.3%	405	7.5%	387	7.0%	Native American
238	3.8%	265	4.9%	See below	See below	Hispanic as race[1]
87	1.4%	64	1.2%	73	1.3%	Asian
1,482	23.7%	476	8.9%	637	11.5%	Other or Race Not Reported
6,240	100.0%	5,367	100.0%	5,522	100.0%	Total in care Dec. 31st
--	--	--	--	474	8.6%	Hispanic as ethnicity[1]

[1] In 2003, Hispanic was counted as an ethnicity, not as a separate race. Of the 474 children with Hispanic ethnicity: 167 are White, 41 are Native American, 5 are Black, 1 is Asian, and 240 children did not have a race reported.

continued...

Explanation of Table 1—This table compares some characteristics of children in foster care from 1993, 2002, and 2003. Most categories are taken from the 5,522 children who were in out-of-home care on 12-31-2003, unless otherwise marked.

Some percentages in this table may not equal 100% due to rounding.

TABLE 1 (continued)

Who are the Children? *(continued...)*

Children in Out-of-Home Care on Dec. 31st By Gender

1993		2002		2003		
3,347	53.6%	2,885	53.8%	2,983	54.0%	Male
2,556	41.0%	2,375	44.3%	2,457	44.5%	Female
337	5.4%	107	2.0%	82	1.5%	Gender not reported
6,240	100.0%	5,367	100.0%	5,522	100.0%	Total in care Dec. 31st

Children in Out-of-Home Care on Dec. 31st By Number of Placements Experienced

1993		2002		2003		
6,240	100.0%	5,367	100.0%	5,522	100.0%	Total in care Dec. 31st
1,785	28.6%	2,754 [1]	51.3%	2,747 [1]	49.7%	# in 4 or more foster homes
1,073	17.2%	1,902 [1]	35.4%	1,867 [1]	33.6%	# in 6 or more foster homes

Number of Local Foster Care Review Boards on Dec. 31st

1993	2002	2003
28 local boards	62 local boards	62 local boards

Children Reviewed by the Foster Care Review Board and Total Reviews

1993	2002	2003
1,823 children reviewed [2,3]	4,242 children reviewed [3]	4,116 children reviewed [3]
3,097 reviews conducted [3]	6,378 reviews conducted [3]	6,503 reviews conducted [3]

Reviewed Children by Length of Time in Foster Care

1993		2002		2003		
1,823 [3]	100.0%	4,242 [3]	100.0%	4,116 [3]	100.0%	Children reviewed
866	47.5%	2,064	48.7%	2,054	49.9%	# In care at least 2 years
315	17.3%	541	12.8%	547	13.3%	# In care at least 5 years

[1] The number of children experiencing multiple placements is understated due to a lack of reports by the Department of Health and Human Services on children's placement changes following the 1997 implementation of the N-FOCUS computer system.

[2] This was prior to LB642 (1996) that increased the scope and funding for the FCRB.

[3] Children are normally reviewed every 6 months while in out-of-home care, thus many children may have more than one review during a calendar year. In 2003, the number of children reviewed went down slightly, but the total reviews conducted were up due to the number of re-reviews.

continued...

TABLE 1 (continued)

Where are the Children?

Children in Out-of-Home Care on Dec. 31st By Type of Placement

1993		2002		2003		
2,225	35.7%	2,400	44.7%	2,443	44.2%	Foster home & fos/adopt homes
446	7.1%	1,025	19.1%	1,041	18.9%	Group homes & residential treatment facilities
465	7.5%	802	14.9%	868	15.7%	Relatives
639	10.2%	548	10.2%	518	9.4%	Jail/Youth Development Center
328	5.3%	165	3.1%	215	3.9%	Emergency Shelter
not available		104	1.9%	105	1.9%	Adoptive home, not final (private)
47	0.8%	112	2.1%	133	2.4%	Runaway, whereabouts unknown
172	2.8%	43	0.8%	32	0.6%	Psychiatric Treatment or substance abuse facility
11	0.1%	14	0.3%	10	0.2%	Center for Develop. Disabled
68	1.1%	66	1.2%	61	1.1%	Independent living
54	0.9%	64	1.2%	84	1.5%	Medical facility, nursing home
157	2.5%	0	0.0%	0	0.0%	Child Care Agency
1,628	26.1%	24	0.4%	12	0.2%	Other or type not reported
6,240	100.0%	5,367	100.0%[1]	5,522	100.0%	Total in care Dec. 31st

[1]Percent column total appears to be 99.9% due to rounding on subtotals.

Children in Out-of-Home Care on Dec. 31st By Closeness to Home (Proximity to Parent)

1993		2002		2003		
3,270	52.4%	2,724	50.8%	2,894	52.4%	In same county
967	15.5%	883	16.5%	925	16.8%	In neighboring county
1,136	18.2%	1,162	21.7%	1,171	21.2%	In non-neighboring county
See below		138	2.6%	109	2.0%	Child in other state
See below		99	1.8%	93	1.7%	Parent in other state
206	3.3%	See above		See above		Either parent or child in another state
661	10.6%	361	6.5%	330	6.0%	Proximity not reported
6,240	100.0%	5,559	100.0%	5,522	100.0%	Total in care Dec. 31st

continued...

TABLE 1 (continued)

What Happened to the Children?

Children Who Left Care During the Year By Reason For Leaving Care

1993		2002		2003		
1,777	57.0%	2,608	53.3%	2,358	57.4%	Returned to parents
Included in 'other' category below		743	15.7%	269	6.5%	Released from corrections (no further information given)
414	13.3%	322	6.6%	363	8.8%	Reached Age of Majority (19th birthday)
221	7.1%	277	5.7%	356	8.7%	Adopted[1]
43	1.4%	140	2.9%	156	3.8%	Court terminated (no specific reason given)
99	3.2%	277	5.7%	280	6.8%	Guardianship
152	4.9%	4	>0.1%	5	>0.1%	Custody transferred
20	0.6%	3	>0.1%	3	>0.1%	Marriage or Military
390	12.5%	522	10.7%	317	7.7%	Other/reason not reported
3,116	100.0%	4,762	100.0%	4,107	100.0%	Total left care during year

[1] The number of adoptions completed is likely somewhat understated due to the number of reports from HHS indicating children left care, but not indicating the reason for leaving care. .

Children in Out-of-Home Care on Dec. 31st By Number of Times Removed From Home

2001		2002		2003		
3,292	59.2%	3,168	59.0%	3,349	60.6%	In care - initial removal
2,267	40.8%	2,199	41.0%	2,173	39.4%	In care - had prior removal
5,559	100.0%	5,367	100.0%	5,522	100.0%	Total in care Dec. 31st

(1993 figures not available)

Children Who Entered Care During the Calendar Year By Number of Times Removed From Home

1993		2002		2003		
2,821	80.2%	3,110	58.4%	2,898	60.7%	Entered care - initial removal
695	19.8%	2,211	41.6%	1,875	39.3%	Had prior removal
3,516	100.0%	5,321	100.0%	4,773	100.0%	Total entered care during year

TABLE 2

COST OF OUT-OF-HOME CARE ROOM AND BOARD BY PLACEMENT TYPE 2003

Placement Type	No. of Children	Cost or Range	Minimum Monthly
Foster Home	2,392	$222 - $1,200 or $1,875 [1]	$688,914 [2]
Group Home or Residential T. C.	1,041	$1,935, $2,670, or $5,794 [3]	$3,608,453 [4]
Relative Placement	868	$222 - $1,200 or $1,875 [5]	$241,636 [6]
Jail/Youth Development Center	518	$3,300-7,500 [7]	$2,076,097 [8]
Emergency Shelter	215	$839, 1,785, 3,225 [9]	$417,867 [10]
Runaway/Whereabouts Unknown	133	n/a	n/a
Adoptive Home Not Final - Private	105	n/a	n/a
Independent & Semi-Ind. Living	61	$352	$21,472
Adoptive Foster Home – Not Private	51	$222 - $1,200 or $1,875 [11]	$14,502 [12]
Assisted Living Nursing Facility	57	$14,858 [13]	$846,906
Psychiatric Treatment Facility	32	$4,920 [14]	$157,440
Medical Facility	27	$26,697 [15]	$720,819
Center for Developmentally Disabled	10	$2,400	$240,000
Special School - boarding	6	$1,935 (est.)	$11,610
Other	6	$222 (est.)	$1,332
Children in Care on Dec. 31, 2003	**5,522**	**Minimum monthly total**	**$9,047,048**

Minimum Annual Cost for Room and Board only $108,564,576

The costs reflect only the basic board rate for the children - medical expenses, counseling fees, special needs amounts, school tuition, case worker/supervisor salaries, judicial system costs, and other non-room and board costs are not included in the above minimum monthly costs, with the exception of children in assisted living nursing facilities where nursing care is part of the daily rates.

Explanation of Table—This table shows the number of children on 12-31-2003, and would be representative of the number of children and mix of placements on any given day. In cases where there is a range of costs, the lowest amount has been used unless otherwise noted.

[1] HHS determines the maintenance payment for a child in foster family home or in relative care by the age of the child and the child's needs as scored on the FCPAY Checklist. According to an HHS official who confirmed the rates 11/3/2003 and again on 6/14/2004, the following rates have been the same since Feb. 1998:

- Foster home payments for care of children from age 0-5 ranged from $222-$1,070 per month.
- Foster home payments for care of children age 6-11 ranged from $292-1,140 per month.
- Foster home payments for care of children age 12-18 ranged from $352-1,200 per month.
- Agency based foster care began reimbursement at $62.50 per day (about $1,875 per month).

[2] Minimum monthly costs for care in foster homes were calculated as follows:

- 817 children age 0-5 @ minimum $222 per month = $181,374
- 781 children age 6-11 @ minimum $292 per month = $228,052
- 794 children age 12 -18 @ minimum $352 per month = $279,488

TABLE 2 (Continued)

[3] HHS group home rates are determined by the group home level. According to an HHS official who confirmed the rates 11/3/2003 and again on 6/14/2004, the following rates have been the same since Feb. 1998:

- Basic group homes are paid $64.50 per day ($1,935 per month),
- Group Home A's are paid $89.00 per day ($2,670 per month),
- Treatment Group Homes (formerly Group Home II's) are paid $193.12 per day ($5,794 per month).

[4] Costs were calculated at 347 @ $1935 per mo (basic) + 347 @ $2,670 per mo (A's) + 347@ $5,794 (treatment).

[5] Relatives are paid at foster parent rates. See footnote 1.

[6] Costs for relative care was calculated as follows:

- 354 children age 0-5 @ minimum $222 per month = $78,588
- 298 children age 6-11 @ minimum $292 per month = $87,016
- 216 children age 12 -18 @ minimum $352 per month = $76,032

[7] The following per diem rates were in effect as of 2003:

- Kearney Youth Rehabilitation and Treatment Center - $123.63 ($3,709 per month).
- Geneva Youth Rehabilitation and Treatment Center - $141.51 ($4,245 per month).
- Douglas County Youth Center - $123.60 for Douglas County wards, $170.00 for state wards.
- Lancaster County Youth Service Center ranges from $170 to $200 depending on the contract. The contract for state wards is $170.00 ($5,100 per month).
- Northeast Nebraska Juvenile Services in Madison ranges from $110 to $250 depending on the contract and the level. The contract for state wards is $170.00 per day.

[8] Cost for care of youth was calculated as follows:

- 157 youth at Kearney @ $3,709 per month = $582,313.
- 92 youth at Geneva @ $4,245 per month = $390,540.
- 193 youth at Douglas County @ $3,708 per month = $715,644.
- 19 youth at Lancaster @ $5,100 per month = $96,900.
- 57 youth at other facilities @ $5,100 per month = $290,700.

[9] HHS emergency shelter rates are determined by the level. According to an HHS official who confirmed the rates 11/3/2003, the following rates have been the same since Feb. 1998:

- Individual Emergency Shelter homes are paid $27.95 per day.
- Agency Based Emergency Shelter homes are paid $59.50 per day.
- Emergency Shelter Centers are paid $107.50 per day.

[10] Costs for care in emergency shelters was calculated at:

- 72 children at $27.30 x 30 days ($838.50) = $60,372.
- 72 children at $59.50 x 30 days ($1,785.00) = $128,520.
- 71 children at $107.50 x 30 days ($3,225.00) = $228,975.

[11] State wards whose adoption has not been finalized by the courts would be at foster parent rates. See footnote 1.

[12] Costs for care by potential adoptive parents was calculated at the minimum rates as follows:

- 15 children age 0-5 @ minimum $222 per month = $3,330.
- 25 children age 6-11 @ minimum $292 per month = $7,300.
- 11 children age 12 -18 @ minimum $352 per month = $3,872.

[13] Based on a $495.27 per diem rate ($14,858.10 per month), which includes provision of skilled nursing care.

[14] The cost for psychiatric/substance abuse is based on the residential services rate, which as of early 2002, was $164.00 per day ($4,920 per month).

[15] Based on 2002 daily costs for newborns with significant health issues as provided by the Nebraska Hospital Association ($2,428 per stay for an avg. 2.6 day stay --calculated at an average of $809 per day)

SPECIAL SECTION

FOSTER CARE REVIEW BOARD FORCED BY FEDERAL HHS OFFICIALS TO PLACE ITS STATE MANDATED INDEPENDENT TRACKING SYSTEM ON PROBLEMATIC NEBRASKA HHS N-FOCUS COMPUTER SYSTEM

Foster Care Review Board Forced by Federal HHS Officials to Place State Mandated Independent Tracking System on Problematic Nebraska HHS N-FOCUS Computer System

When the Nebraska Department of Health and Humans Services accepted millions of federal dollars for the development of a new state automated child welfare computer system, N-FOCUS,[1] in 1995, it knew that the Foster Care Review Board's independent tracking system would be forced by federal regulations to move onto N-FOCUS. However, HHS did not inform the Board, the Governor, or the Legislature of this regulation until early 2003.

Nebraska HHS is required to report to the Board when children enter foster care, when they change placement or case managers, and when children leave care. It does so via its N-FOCUS computer system. This information is used to track children and to know when/where to schedule their cases for review. Since HHS converted to N-FOCUS there have been serious problems with the accuracy of data on these reports. This situation is described in more detail later in this section.

The accuracy problems were significant, and in early 2003, the Board arranged a meeting with the Legislature's Appropriations Committee to explain the issues and the costs involved in verifying whether the data on the reports was accurate or not, and in trying to locate children whose records had not been entered on the N-FOCUS system. At the meeting, HHS middle management presented a letter they had received from federal officials in 2002 stating that, since the Board's system was independent, N-FOCUS was out of compliance with federal regulations, and there could be severe penalties.

The Board immediately contacted federal officials upon learning of the regulation and pending fines. The Board noted in numerous contacts thereafter that state statute requires an independent tracking system and that the Board's system is funded solely by state funds. The Board also noted that shared use of inaccurate data could result in the Board not being able to function, negatively impacting children. Federal officials were not swayed, and stated that the Board must integrate its tracking system into N-FOCUS or the State of Nebraska would be penalized and forced to refund $12.7 million in development fees plus about $4 million on-going federal monies.

Paying this penalty was not a fiscal or political option, so the Board entered into intensive discussions with HHS on how the Board's data can be housed on the N-FOCUS system without sacrificing quality, availability, and independence. These discussions continue.

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[1] N-FOCUS is the Nebraska Online Client User System, the Nebraska SACWIS (state automated child welfare information system) approved by the federal government.

The tentative date for the data merger is July 2005; however, a number of issues remain.

Issue: Accurate Information

1. When the Legislature put the Foster Care Review Board in place in 1982, it mandated in statute that the Board is to maintain an independent tracking system due to the historical problems with HHS lacking accurate data on children in out-of-home care.
    a. At that time, HHS did not know how many children were in care or where they were placed, and estimated that 1,800 Nebraska children were in foster care.
    b. At the end of the Board's first year of tracking, there were actually 4,071 children documented to be in foster care in Nebraska.
2. Without independent oversight, Nebraska may again be in a situation similar to 1982, not knowing who is in care or where they are placed. This has led to tragic consequences in other states such as Florida and Texas.
3. From N-FOCUS' inception to the present, the Board has found a continued high rate or error or omissions in key data elements. After numerous discussions and offers to work with HHS on its internal quality assurance over the years since N-FOCUS went online, the Board finds it must continue to verify at least 50% of the 60,000+ reports received from HHS each year due to inaccurate, conflicting, or missing data (this is described in greater detail later in this section).
4. While the Board controls the quality of its data entry on its current system, in the combined system some key data elements (i.e., date of birth), will be able to be changed by both Board staff and HHS staff from a variety of different programs. The Board will not be able to control for most errors on these key elements made by workers outside its agency. This may affect data quality and the ability of the Board to schedule cases for review.
5. Based on the experience since 1997, the Board's ability to continue to provide high-quality data may be at risk in a combined system, and there is no assurance that N-FOCUS data quality will improve.

Issue: Access to Information

1. As the state's IV-E review agency, the Board receives some federal funds for reviews. Key data elements on the Board's tracking system are used to assure these reviews are scheduled appropriately. Access to accurate information on these elements is critical to continuing to receive federal funds and to affording children the protections of citizen review.
2. The current and immediate past HHS director have been very responsive to the Board's concerns with N-FOCUS data quality issues and the effect on the children; however, this has not always been the case. Future directors, like many in the past, may view the Board's ability to review cases and provide independently verified outcome indicators as politically threatening and react against the Board accordingly.
3. Throughout the Board's 21-year history, there have been several attempts by different HHS administrators to eliminate the Board and/or to remove the Board's

ability to provide independently verified information on outcomes for children in foster care to policy makers and the public.

4. When N-FOCUS was implemented in 1997 without the ability to provide the reports to the Board required in statute, the Board tried in good faith to work with that administration, but regardless of these efforts, it did not take corrective actions. It took a change of Governor before preliminary efforts were started to provide the reports, and considerably more time before the reports were actually programmed and issued on a daily basis.

Issue: Costs will be Beyond the Board's Control

1. The Board's current system, which works very well, is extremely cost-efficient. In contrast, N-FOCUS is an enormously costly system.
2. An administration determined to silence the Board could create a cost structure that would be beyond the Board's budget limitations.
3. Since the merged system is still under development it is unclear exactly how much more expensive it will be to operate.
    a. Queries needed to extract key data needed for daily operations will be much more complicated, and thus likely to be far more expensive.
    b. Entry will take longer due to its cumbersome N-FOCUS design structure. This will result in increased expenditures for staff.

Nothing in the Board's historical or current experiences with N-FOCUS would indicate that the impending data merger will be positive for the Board or children in out-of-home care.

The Review Board's Historical Experience with N-FOCUS

During the planning stages of N-FOCUS, 1995-1996, the Board was told that N-FOCUS would continue to report to the Board. Discussions were held on how N-FOCUS would interface with the Board's tracking system to facilitate a data dump or other means of reporting. As N-FOCUS was gradually implemented from 9-1997 to 1-1998, reports from the previous HHS computer system dwindled and the Board learned that no current or future provisions had been made to report to the Board. In spite of holding many meetings with the HHS administration, they chose not to prioritize complying with statute.

To compensate for this reporting deficit, the Board contacted the larger Court and County Attorney's offices, representing about 75 percent of the children, to verify that the Board knew of all children in out-of-home care and to request additional information. The Board attempted to utilize a limited internal HHS report to support the Board's federal and state requirement to review children as well as the state's requirement to track children in out-of-home care, but this report was incomplete. HHS eventually provided a temporary employee to assist the Board with the labor-intensive process of verifying all the fields of information on the internal HHS report.

After receiving little data for a year and a half, a new administration prioritized the FCRB report and mid-year 1999 the reports went on-line. Upon reviewing the data it was found to contain a 60 percent level of errors or omissions in the following basic fields:

- Child's out-of-home care status either the date entered or the date leaving care;
- Identifying information such as date of birth and/or SSN,
- Child's placement and placement date;
- Identification of the case manager and local office that has the child's file, and/or child's IV-E status

Even though the Board had previously purchased software to facilitate a data dump, based on the N-FOCUS report error rate, the State Board determined it would not be feasible to accept data dumps and a verification and correction process was implemented.

Verification has been necessary from 1999 to present. The verification efforts applied to over 60,000 reports each year include:

- Calling HHS to verify conflicting or omitted pieces of information;
- When Courts, who continue to report at point of removal, report children in care that HHS has not reported, contacts are made with HHS to verify the child's status (in 2001 there were 600 of these children and youth);
- Information is collected and verified during the Case Assignment Process;
- The Board gathers and verifies children's information during the review of the child's file; and
- Courts have been asked to supply additional information on children from the point of removal from the home.

The Board has found through its verification process that the errors, discrepancies and omissions on the N-FOCUS reports vary tremendously across the state and over time. Staff find new and varied issues on a daily basis. These issues continue to be communicated to HHS and the FCRB continues to do everything possible to obtain, correct, and verify data on children in out-of-home care.

It was not until January 2003, after the Board had again briefed the Governor, the Legislative Appropriations Committee, and key HHS administrators on the continual problems the Board found with N-FOCUS data on critical parts of children's records, that HHS disclosed that the Board's computer system must integrate into N-FOCUS.

At these briefings, the Board shared its experiences as an end user of N-FOCUS data. Several years after N-FOCUS went online, the Board continued to find significant levels of incorrect or missing data in the basic fields previously described. These problems were so pervasive that over half of the 60,000+ reports received from HHS each year hade to be independently verified to determine accuracy.

Notably, there was no disputing of the error rate on the N-FOCUS system from the HHS administrators at these briefings.

The Review Board's Current Experience with N-FOCUS

Over 32,657 (53.1%) of the 61,542 reports HHS issued to the Board in 2003 could not be used without further research or verification by the Board staff because:

1. Reports had an incorrect entry in one or more of the following critical items:
    - The child's name, date of birth, and/or other identifier.
    - The date the child entered out-of-home care.
    - The date, name, and location of the child's current placement.
    - The name of the case manager.
    - The location of the HHS office assigned to the child's case.
    - The date and reason that the child's case closed.

2. Reports were incomplete, with one or more critical items left blank.

3. Reports had ambiguous messages that could have dual meanings, such as "no active placement" – which in some instances means the child is in the process of moving to a new foster placement and other times means the child was returned home.

4. Reports were of a type that has historically had such a high error rate that all such reports must be verified. Case closures, which should only indicate children no longer subject to review, are one such example since these reports are often issued in error.

Because the Board's ability to meet federal compliance standards for reviews depends on its ability to know whether children remain in care, when a closure report is received, staff look to see if the closure has been reported by the Courts, or discovered during the review process (since closures often are not reported in a timely manner). If there is no record from the court or other sources, then the Board must verify whether the report is accurate. The Board finds that a significant number of these reports are not accurate.

The following figures give some idea of the staff time needed to assure accuracy. Verification was needed on reports of children entering care (281 of the 2,815 reports received), changing status while in care (32,376 of the 58,727 reports received), and all reports of children leaving care. This is only part of the story. Additional verification was needed in the many instances when:

- Information was received from the courts that had not yet been reported by HHS,
- Information was received from courts that showed that N-FOCUS was in error,
- Corrections were made during the case review process, or
- Legal parties, such as guardians ad litem or others provided information that either had not been input on N-FOCUS or was input in error.

In addition to errors or omissions on the reports, there were also many instances where N-FOCUS failed to generate the required report when children entered care, changed status (such as placement changes or changes in case managers), or when children left care. Many of these instances were caught because the courts had reported the child was in care.

HHS data problems not only impact the Board, but also impact HHS' ability to know the following critical information:

- which children are in HHS custody,
- who is each child's case manager,
- what is the child's case status,
- whether HHS can receive certain types of federal funding for each child, and
- where the child is placed.

The Board's Continuing Response to HHS N-FOCUS Report Problems

Chronic HHS N-FOCUS report deficits have forced the Board to take a number of proactive steps to assure that up-to-date, accurate information is obtained about children in out-of-home care. Without these steps, the Board's state and federally mandated missions could not be met and children could get "lost" in the system.

The following Board efforts to compensate for inaccurate or incomplete HHS N-FOCUS reports will continue as long as necessary.

- Including research and verification steps in the internal processes used by all staff members who use the Board Tracking System or gather information from the reviews.
- Providing an additional point of verification during the Board case assignment process to check children's out-of-home status, their HHS case manager, and the HHS office where their file information is located.
- Incorporating into the Board review process gathering and verifying information on children's case histories, such as which placements the children have been in and how long the children have been in care.
- Communicating specific case examples with the N-FOCUS liaison to help HHS determine if the problems are related to the data on the N-FOCUS system, the way that N-FOCUS reports the data, or both.
- Contacting HHS to verify children's information when courts reported children in care that HHS had not reported.
- Contacting HHS case workers to verify conflicting or omitted pieces of information from HHS reports.
- Comparing unclear N-FOCUS reports with case manager narratives on N-FOCUS to see if there is clarifying information that was input in sections that are not data fields and thus do not transmit on N-FOCUS reports.

- Continuing to meet and update top HHS officials on the reporting problems.
- Continuing to obtain additional information from courts to use to assure the Board knows of all children in care, so children can be tracked and reviews can be scheduled appropriately.
- Generating lists of children in out-of-home care that courts were asked to verify.

By scrutinizing the N-FOCUS reports, the Board was able to provide the N-FOCUS liaison with much of the information necessary to determine why the reports had certain problems. Some report problems were related to data entry, others were caused by the way that N-FOCUS reports are generated. While programming changes made by HHS in late 2001 and again in early 2002 were helpful, they did not fully correct the situation, nor did they address the data entry component.

Recommendations to Improve HHS Data Accuracy

The Board finds that the recommended actions listed below would help the front-line HHS N-FOCUS user, and would also increase accuracy of children's information.

1. Require less information to be input on the computer.
2. Achieve consistency by using trained data entry operators and conducting rigorous quality control.
3. Build features into the system that encourages accuracy, such as alerts and edits.
4. Revamp the screens to increase efficiency and to provide only one location to put each critical piece of information.
5. Change programming to eliminate problems caused by cases having more than one caseworker, cases in the process of transferring, and case closure reports that do not indicate the reason for closure.
6. Clearly define the data elements required of each case, and where/how this data must be input on the system.
7. Increase the ability of help desk staff and programmers to support the work being done on the system.
8. Decrease the time that caseworkers must spend on the system to free them for managing the cases.
9. Utilize the Board's findings as part of an over-all quality control effort.

The next section describes the Foster Care Review Board's mission and organization.

INFORMATION ABOUT THE

FOSTER CARE REVIEW BOARD

AND ABOUT CASE REVIEWS

THE FOSTER CARE REVIEW BOARD

MISSION STATEMENT

The State Foster Care Review Board's mission is to ensure the best interests of children in out-of-home care are being met through external citizen review, monitoring facilities that house children and youth, maintaining up-to-date data on a statewide tracking system, and disseminating data and recommendations through an Annual Report.

The Board attempts to accomplish this by and through:

- Utilizing trained citizen volunteers to review the plans, services, and placements of children in out-of-home care whether in out-of-home care through the Department of Health and Human Services, or through private placement;
- Making findings based on the review and setting forth the specific rationale for these findings;
- Sharing the findings with all the legal parties to the case;
- Collecting data on children in out-of-home care, updating data on these children, and evaluating judicial and administrative data collected on foster care;
- Disseminating data and findings through an Annual Report, community meetings, and legislative hearings;
- Visiting facilities for children in out-of-home care;
- Requesting appearance in further court proceedings through limited legal standing by petitioning the Court at disposition to present evidence on behalf of specific children in out-of-home care and their families when deemed appropriate by the state board;
- Advocating for children and their families through individual case review, legislation, and by pressing for policy reform;
- Organizing, sponsoring, and participating in educational programs.

AGENCY VISION

The vision of the State Foster Care Review Board is that every child and youth in out-of-home care live in a safe, permanent home, experience an enduring relationship with one or more caring adults, and have every opportunity to grow up to become a responsible and productive adult.

Unique and Beneficial Aspects of Citizen Review in Nebraska

- **The Board's structure gives the agency the independence needed to point out the flaws at every stage of a child's case, and to provide input to policy-makers on what is needed to promote best practices.** The Nebraska Legislature designed the Foster Care Review Board to be an independent state agency that is not directly affiliated with either the judicial branch or the Department of Health and Human Services. In other states the review agency is a part of a larger social services or judicial system, and thus must answer to them when reporting on conditions for children.

- **In Nebraska, a State Board that is appointed by the Governor and approved by the Legislature governs the agency. The terms of office are staggered so that a change in Governor does not automatically result in an entirely new State Board.** The State Board by law must include representatives from each of the state's congressional districts. The State Board oversees the agency, whose staff facilitates local Foster Care Review Boards in communities across the State and manages the Board's tracking system (an extensive database of all children in out-of-home care).

- **Board staff members go into the HHS offices across the state to actively research all file information on the children and discuss cases with the case managers**, rather than accepting whatever the HHS office chooses to impart as happens in some other states. The section on case reviews gives more details on the entire case review process.

- **The Board invites all interested parties, including the legal parties, foster parents or other placement providers, educators and service providers to give information through questionnaires. Whenever time permits interested parties are also invited to attend a portion of the local board meeting** where they could speak directly with the local board members. Parents who retain their parental rights are always invited to attend the reviews of their children's case. It should be noted that the availability of questionnaires as a means for interested parties to provide input has helped to mitigate some of the distance challenges inherit in the state.

- **Additional contacts are made with the foster parents/placements, the guardians ad litem, and the case managers** to clarify conflicting or omitted file information and to get information on the latest developments in the case.

- **After careful review and research by Board staff, materials are presented to multi-disciplinary trained community-based boards that study the information then itemize their concerns and recommendations** for the ongoing care and safety of the child. This is written into a formal document that is distributed to the judge and all legal parties. Local board structure and makeup is discussed in more detail later in this section.

- **The Board is required under Nebraska statute to maintain an independent tracking system.** The Nebraska system is a national model, both for the information compiled and for its ease of use. The independent tracking system enables the Board

to both track and report on indicators of how the system is responding to children's needs. Information from this system was given in testimony to Congress on several occasions. For instance, Nebraska's Foster Care Review Board was invited to give testimony before Congress on what became the 1997 Adoption and Safe Families Act. Information from this system is used to compile the statistics for the agency's annual report.

- **The Board is statutorily required to create a yearly comprehensive assessment of conditions for children in foster care** and report those conditions to the Governor, members of the Legislature, the Judiciary, HHS, the press and the public. This is done through the annual report. The Board also provides special reports and fact sheets.

- **As a result of its dialogue with policy makers the Board has been instrumental in the passage of local Nebraska legislation** to require an assessment of whether a termination should be filed after the child has been in care for 18 months, providing for mandatory training of prosecutors, creating the Child Protection Unit in the State Attorney General's office, and under certain circumstances allowing an open adoption contract between parents of state wards and the adoptive parents in order to facilitate permanency.

- **The Board has limited legal standing available to appear in court on behalf of foster children** to challenge inappropriate plans. This is discussed in more detail later in this section.

- **The Board works cooperatively with HHS, the Bar Association, and the Judiciary, and others to provide continuing educational programs for legal parties, child welfare professionals, and local board members** on issues such as children's bonding and attachment needs, how to conduct investigations of alleged abuse, neglect, or sexual abuse; provisions of the Adoption and Safe Families Act (ASFA), reasonable efforts and reunification plans, developmental disabilities and abuse, alternatives to restraints. The Board has also facilitated Legislative caucus meetings on the child welfare system and worked with the Governor's office to plan an adoption summit.

The Structure of the State Foster Care Review Board

The State Foster Care Review Board is responsible for governing the agency and setting agency policy. The State Board consists of nine members selected by the Governor and approved by the Legislature. Two members are chosen from each of the three Congressional Districts. These members serve three-year terms and are selected on a staggered basis. Three additional Board members are appointed from the Local Review Board chairpersons, one from each Congressional District. These members serve two-year terms. Terms are staggered so that a change in Governor does not automatically mean a change in the makeup of the State Board.

The responsibilities of the State Board include:

- Creation and revision of Rules and Regulations, and Policies and Procedures;
- Oversight of the budget, expenses, and agency requests;
- Selection, training, and supervision of Local Foster Care Review Boards;
- Development and maintenance of a tracking system of all children in out-of-home care;
- Approval of Annual Report recommendations; and,
- Policy decisions and general oversight of the agency.

The State Board holds several meetings each year, usually in Lincoln. State Board meetings are open to the public.

Local Foster Care Review Boards

At the end of 2003 there were 62 Local Boards composed of 333 unpaid volunteer citizens from the community who have completed required training and meet monthly to review the cases of children in out-of-home care. In order to provide maximum input on a child's case, an attempt is made to select board members from a variety of different occupations and viewpoints. A typical board might include an educator, a medical professional, an attorney, a mental health practitioner, and a foster parent.

Each board meets monthly for approximately 3-4 hours. Informational packets are mailed to board members prior to the meeting, and board members spend 3-4 hours in preparation for the meeting.

Three training sessions are required before a person can be placed on a local board. The training includes:

a. The history and role of the Foster Care Review Board;
b. Information on the need for permanency planning;
c. The importance of bonding and attachment;
d. The effect of separation and loss on children at various ages;
e. How a child enters the legal system;
f. The roles of the judge, county attorney, guardian ad litem, child-caring agency, and foster parent;
g. Reviewing a case and comparing the review conducted by the new board with the recommendation of an existing board;
h. The importance of confidentiality; and,
i. Observation of a local board meeting.

The following is a list of the cities as of the end of 2003 that have one or more local foster care review boards (number of local boards in parentheses):

Alliance (1), Auburn (1), Beatrice (1), Bellevue (2), Columbus (1), Elkhorn (1), Fremont (1), Grand Island (3), Hastings (2), Kearney (2), LaVista (1), Lexington (1), Lincoln (10), Norfolk (1), North Platte (2) O'Neill (1), Ogallala (1), Omaha (20), Papillion (1), Pierce (1), Scottsbluff/Gering (3), Seward (1), South Sioux City (1), and York (1).

Thousands of Unpaid Hours are Donated Annually

The Foster Care Review Board in Nebraska exists due to the time and efforts of its volunteers. **State and Local Board members are unpaid volunteers.** State Board members, who may drive up to 400 miles each way to attend State Board meetings, may receive reimbursement for mileage and any needed overnight accommodations. Many local board members drive up to 60 miles or more (one way) to attend regular board meetings; however, they do not receive any compensation due to budgetary considerations.

In addition to attending their regular meetings, State and Local Foster Care Review Board members attend initial and ongoing training sessions, tour foster care facilities (including group homes and institutions), increase their knowledge at seminars and conferences, visit with Legislators, and volunteer in the Review Board's office.

Local and state board members donated over 36,417 hours of service during 2003.

State and local board members represent a variety of professions and occupations, such as law, education, medicine, business, and social services.

The value of the time that state and local board members donated in 2003 to assist the abused and neglected children of Nebraska, taken at a very conservative estimate of $15 per hour, was $546,255, at $20 per hour it would be $728,340.

Use of Limited Legal Standing

The Foster Care Review Board was granted limited legal standing by the Legislature in 1990 and the State Board developed Rules and Regulations governing how and when legal actions should be considered. A public hearing was held and the revised Rules and Regulations were submitted for approval. Consequently, the Board may request legal standing under any of the following conditions:

- Reasonable efforts were not made to prevent a child from entering care,
- There is no permanency plan,
- The permanency plan is inappropriate,

- The placement is inappropriate,
- Regular court hearings are not being held,
- Appropriate services are not being offered,
- The best interest of the child is not being met, or,
- The child is in imminent danger.

Neb. Rev. Stat. §43-1313 allows the Board to request and participate in review hearings at the dispositional level[1], when the Board deems it necessary to assure one or more of the following:

- the child's safety,
- the child's basic needs are being met, and
- the child's case is moving toward the goal of a safe, permanent placement.

Since the Board was granted legal standing in 1990 through the end of 2003:

- 529 cases involving 875 children have been acted upon or utilized legal standing.
- Most (701 of 875) children's cases were handled through meetings with the county attorney and/or other parties to the case.
- An attorney was hired to represent the Board for 163 children.
- During 2003, the Board attended 980 hearings involving cases of concern, with the Board's concerns being addressed in over 75 percent of the cases.

During 2003, the Board made a concerted effort to dramatically increase its presence in court hearings. Staff attended over 980 hearings on cases of concern. This increased presence has resulted in many legal parties being more receptive to the Board's concerns and has better enabled the court to address the issues the Board identified.

In addition, due to the authority derived by the Board from §43-1313, many potentially problematic cases have been resolved without involving the costly and time-consuming process of the courts. A local board review may be held instead, followed by a case status meeting with representatives from the responsible agency and other legal parties.

The Board retains attorneys when other avenues are unsuccessful in addressing the local board members' concerns or if there is little time to respond. The process for hiring an attorney starts when local boards/staff identify problem cases for which hiring an attorney might be appropriate. In these cases, the local board's review specialist compiles the case information and submits this to his/her supervisor. The identified cases and the objectives of what would be accomplished by taking legal standing are then submitted to the Executive Committee of the State Board for review.

This process has proven very successful in addressing the concerns the local boards have expressed regarding the children.

[1] For explanation of the steps in a child case, see Appendix A.

The Board's Tracking System Database

Per statute, the Board maintains an independent computerized tracking system, which is housed in its main office in Lincoln. Since this system began in 1983 through the end of 2003, 68,377 individual Nebraska children in out-of-home care have been tracked.

Up to 82 articles of information are kept on children once they enter out-of-home care. After a local board has reviewed the child's case an additional ninety-three pieces of data are added. Information on the Board's tracking system includes why and when the child entered care, court dates and results, sibling information, adoption data, and barriers to the permanency plan. Information on the children is continually updated as changes occur.

Nebraska's tracking system is one of few in the country that follows all children placed in out-of-home care in the state. The Nebraska Foster Care Review Board receives reports and updates from the Juvenile and County Courts, the Department of Health and Human Services, and private agencies throughout the state.

HHS is a primary source for information about the children, and there have been on-going problems with the reports available since HHS converted to the N-FOCUS computer system for child welfare cases in 1997. There is a separate section of this report dealing specifically with HHS N-FOCUS report issues and how those issues have forced the Board to institute a number of pro-active steps to ensure that data on the Board's tracking system is the most reliable possible. As a result of these steps, Board data on key foster care indicators is considered much more reliable than available through HHS.

Data from the Board's tracking system is used throughout this report. Nebraska data has been used repeatedly to challenge the concept of mandatory plans of reunification on both a state and a national level. The Board views compliance with the Adoption and Safe Families Act as meaning that the child's best interests are being served, and the Board is a firm advocate for best interests on both a case-by-case and a systems level.

Why Citizen Review Was Enacted in Nebraska

The legislation creating the Foster Care Review Act was inspired by child advocates with faith in the concept of permanency planning reviews and the vision to see how citizen review boards would help the foster children of Nebraska move from the foster care system towards permanent homes in a timely manner.

The Nebraska State Legislature enacted citizen review in Nebraska in 1982 when it passed the Nebraska Foster Care Review Act. The Act was created in response to PL 96-272, federal legislation that mandated the development of permanency planning and periodic review of children in foster care, and in response to other problems in the Nebraska foster care system. The Act established the State Foster Care Review Board and also mandated periodic court reviews of children in foster care. The Act is found in Neb. Rev. Stat. §43-1301 to §43-1318.

At the time that citizen review in Nebraska was initially proposed, many children had languished in the child welfare system for years, and many children had been "lost" in system; that is, due to poor tracking methods no one knew where some of the children in foster care were placed. Some of these children were never found.

In 1982 the Department of Social Services estimated that there were about 1,800 children in foster care in Nebraska. By the end of 1983 (the Review Board's first year of tracking foster children), it was clear that there were over 4,000 children in foster care in Nebraska. At the end of 2002, the daily average number of children in foster care in Nebraska is about 5,300.

Important Milestones in the History of the Board

A. Studies on the Effectiveness of Citizen Review

In the 1980's Dr. Ann Coyne with the School of Social Work at the University of Nebraska at Omaha conducted three separate studies of the efficacy of reviews. The studies revealed that children whose parents were unable or unwilling to provide care and whose case had the benefit of citizen review were two to four times more likely to have adoption as a plan when compared to other cases similar in every way except not reviewed.

B. Additional Mandatory Findings on Placement Appropriateness

In 1990, the Legislature increased the Board's responsibilities to include determining if the child's placement is appropriate and if there is a continued need for out-of-home placement.

C. Legislative Study of 1994

In a Legislative Study issued in February 1994, the Legislative Research Division recommended that "*...the Legislature should decide the type and number of review systems Nebraska needs. Making such decisions will require weighing the benefits of each existing system against the larger policy issues, including how to make the overall system as effective as possible within resource constraints.*"

D. Full Implementation of the Foster Care Review Act - 1996

In response to the Legislative Study of 1994, LB 642 was sponsored in February 1995 by Senator Michael Avery (and named his priority bill) and co-sponsored by Senators Brashear, Brown, Crosby, Dierks, Engel, Hartnett, Hudkins, Jensen, Kristensen, Lynch, McKenzie, Schellpeper, Vrtiska, Warner, and Wehrbein.

This bill facilitated the original intent of the Legislature when the Foster Care Review Act was passed in 1982. [From the time the Board was created in 1982 until mid-1996, the Board received less funding than was necessary to review all

of the state wards in out-of-home care. Therefore, during this period it was only possible to review about 60 percent of the wards.]

LB 642 established the Foster Care Review Board as the agency responsible for the periodic reviews of children in out of home care pursuant to the federal Adoption Assistance and Child Welfare Act of 1980, Public Law 96-272. LB 642 provided personnel and funding installments starting July 1, 1996, to achieve this goal. Seven staff members were added in July 1996 and three more in September 1996.

Citing the quality of the reviews, the fact that reviews are shared with all legal parties, that reviews are a community-based, multi-disciplinary approach, and that the data collected from these reviews would be valuable to policy makers, the Legislature passed LB 642 on April 10, 1996, with approval by the Governor following on April 12, 1996.

In response to this new opportunity to provide more children with the benefit of citizen review, the Board immediately began to implement reviews for all children.

During the summer and fall of 1996, the Board recruited and trained 225 community volunteers to serve on new and existing local boards in response to the mandate to review all children who have been in out-of-home care for six months or longer. Additional review and support staff were also hired and trained. The increase in the number of children reviewed since 1996 is a direct result of LB 642.

E. Additional Mandatory Findings Added - 1998

In 1998, as part of the Nebraska Adoption and Safe Families Act, the Legislature again increased the Board's responsibilities to include findings on whether the placement and the plan is safe, whether grounds for termination of parental rights appear to exist, and to name a preferred alternate permanency if reunification does not appear to be in the children's best interests.

The National Association of Foster Care Reviewers

Nebraska is a member of the National Association of Foster Care Reviewers (NAFCR). The NAFCR was established in 1985 to promote permanent families for children by assuring that every child in foster care receives an independent, timely, and complete external citizen review. Nebraska hosted the 1995 NAFCR Conference that was held in Omaha. Carolyn Stitt, Executive Director of the Review Board, is a past president of the NAFCR. Burrell Williams, past State Board chair and current member of an Omaha Local Board and the State Board, previously served on the National Board of Directors.

Local and state board members donated over 36,417 hours of service during 2003.

CASE REVIEW PROCESS

The Foster Care Review Board completed 6,503 reviews on 4,116 children in 2003, and issued approximately 45,521 reports with recommendations regarding reviewed children's cases to courts, agencies, guardians ad litem, attorneys, and county attorneys.

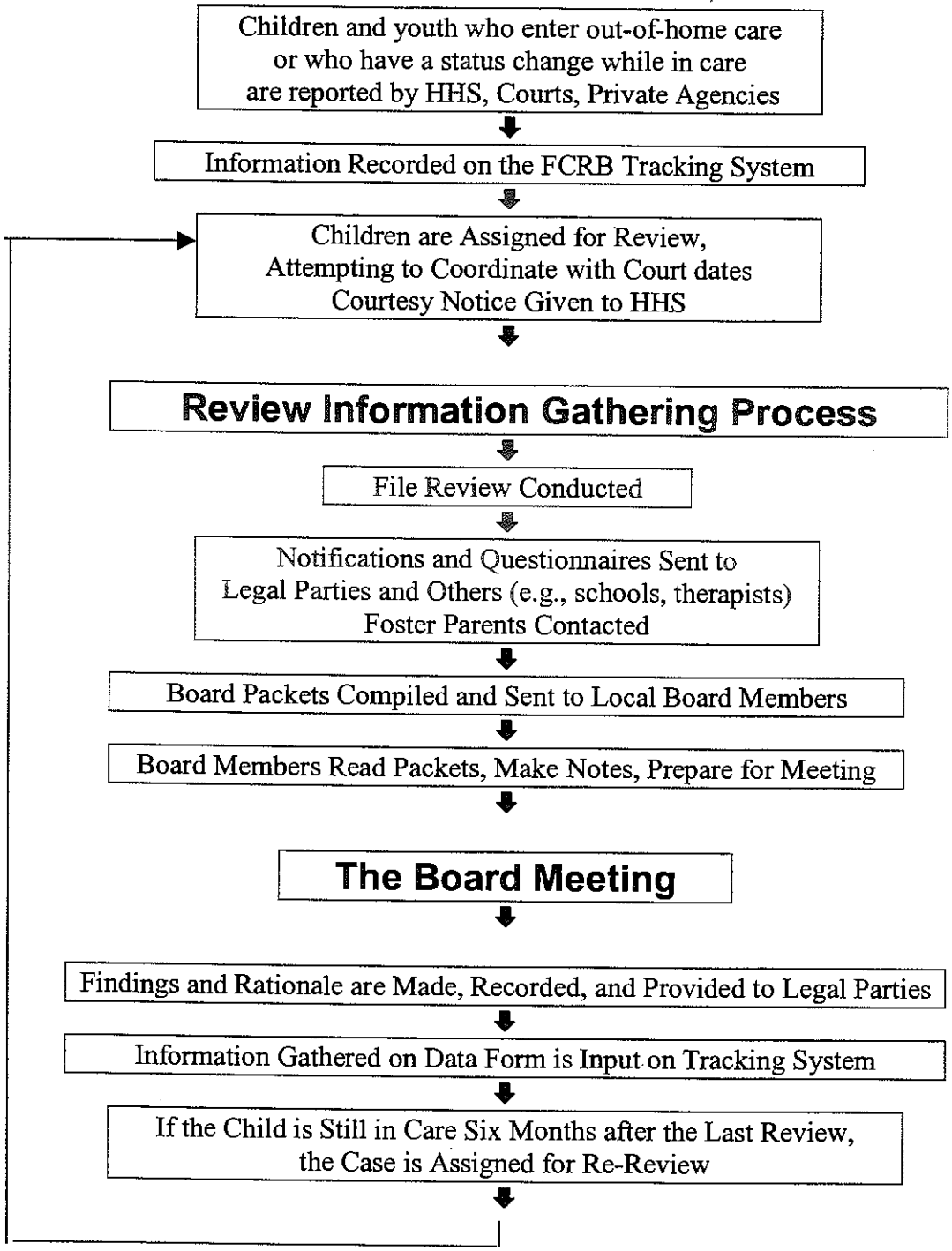
Each report included a case history of the child with the reasons why the child was placed in foster care; court dates; information on services, education, and visitation; recommendations and findings on the placement, services, and plan; and remaining barriers to permanency.

The following is a brief description of the Nebraska Foster Care Review Board case review process.

A. The FCRB goes into the HHS offices to pull the case plan and other relevant file information, and to verify previously received information
B. Contacts are made with foster parents/placements, guardians ad litem, and case managers
C. Legal parties are given several opportunities to provide additional information
   - All legal parties are invited to give information at the review meetings
   - All legal parties are given questionnaires designed specifically for their profession that they can return if unable to attend the meeting
   - All legal parties are given the opportunity to provide information via telephone that is taped for consideration by the local board reviewing the case
D. Other interested parties, such as teachers, counselors, and the like are also provided questionnaires and the opportunity to respond via telephone. When time allows they may also be invited to give information at the review meeting.
E. After careful review and research by review specialists, multi-disciplinary boards itemize their concerns and recommendation for the ongoing care and safety of the child
F. The recommendations are then forwarded to the judge and all legal parties.

The following chart shows this process in graphic format.

The Foster Care Review Board – Review Process



CHILD WELFARE SYSTEM PERFORMANCE MEASURES
TABLES 3 –14

(Tables 1 and 2 are at the end of the Commentary, beginning on page 93)

TABLE 3

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT
LOCAL BOARD FINDINGS FOR CHILDREN REVIEWED DURING 2003

Is there a written permanency plan	# Children	Percent
•There is no plan or the plan is incomplete.....	1,247	30.3%
•There is a written plan with services, timeframes, and tasks.....	2,869	69.7%
Total	4,116	100.0%

Included in Above	# Children	Percent
No plan.	686	16.7%
Incomplete plan.	561	13.6%

Board agreement with child's permanency plan	# Children	Percent
•The Board disagrees with the plan, or there is no plan.....	1,911	46.4%
•The Board agrees with the child's permanency plan.....	2,205	53.6%
Total	4,116	100.0%

Included in Above	# Children	Percent
Board disagrees with the plan.	1,040	25.2%
No current written plan.	525	12.7%
Cannot agree or disagree due to....	346	8.4%

Services in the plan	# Children	Percent
•Needed services not provided, or not utilized.....	2,203	43.6%
•All services in the plan are presently in motion.....	1,910	46.4%
Total	4,116	100.0%

Included in Above	# Children	Percent
Some services are in motion.	518	14.1%
Services offered, not utilized.	839	20.3%
Unclear what is being provided.	243	7.7%
No plan, no services provided.	606	1.5%

continued...

Explanation of Table—This table shows compliance with the Foster Care Review Act as determined through the findings of the local Foster Care Review Boards that reviewed the children's cases during 2003.

TABLE 3 (continued)

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT

Progress being made toward permanency plan objective			**# Children**	**Percent**
•No progress or progress unclear.....			2,274	55.2%
Included in Above	# Children	Percent		
No progress towards permanency.	1,116	27.1%		
Unclear	1,027	25.0%		
Not applicable due to court sentence/OJS	131	3.2%		
•Progress is being made towards the permanency objective.....			1,842	44.8%
		Total	4,116	100.0%

Is current placement appropriate and safe			**# Children**	**Percent**
•Placement inappropriate, unsafe, or it is unclear.....			1,037	25.2%
Included in Above	# Children	Percent		
Unsafe, thus inappropriate.	117	2.8%		
No documentation/homestudy on which to base finding	749	18.2%		
Safe, but not appropriate.	171	4.2%		
•Current placement appears appropriate and safe.....			3,077	74.8%
		Total	4,116	100.0%

Safety evaluation by department or custodial agency			**# Children**	**Percent**
•Custodial agency has not fully evaluated safety or it is unclear...			793	19.3%
Included in Above	# Children	Percent		
Custodial agency has not evaluated the safety/taken action.	157	3.8%		
Unclear if custodial agency has evaluated safety.	636	15.5%		
•Custodial agency evaluated the safety of the child and taken the necessary measures in the plan to protect the child.....			3,323	80.7%
		Total	4,116	100.0%

continued...

Explanation of Table—This table shows compliance with the Foster Care Review Act as determined through the findings of the local Foster Care Review Boards that reviewed the children's cases during 2003.

TABLE 3 (continued)

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT

Reasonable efforts toward reunification	# Children	Percent
•Reasonable Efforts are not being made.	298	7.2%
•Reasonable Efforts are being made.	1,889	45.9%
•Reasonable Efforts are no longer being made because the plan is no longer reunification or reasonable efforts are otherwise not required.	1,745	42.4%
Total	4,116	100.0%

Parent-child visitation arrangements	# Children	Percent
•Parental visitation are not occurring as ordered	743	18.1%
•Parental visitation is not clear	357	8.7%
◦Parental visitation was not ordered	248	6.0%
◦Parental visitation is not applicable due to…	1,048	24.5%
◦Parental visitation is not applicable due to the youth's placement type	123	3.0%
◦Parental visitation are occurring as ordered	1,597	38.8%
Total	4,116	100.0%

Sibling visitation	# Children	Percent
Sibling visitation is not occurring	559	13.6%
Sibling visitation information was not available	624	15.2%
Sibling visitation is not applicable (no siblings or placed together)	1,426	34.6%
Sibling visitation is not applicable due to the youth's placement type (e.g., rehabilitation center)	124	3.0%
Sibling visitation is occurring	1,383	33.6%
Total	4,116	100.0%

continued...

Explanation of Table—This table shows compliance with the Foster Care Review Act as determined through the findings of the local Foster Care Review Boards that reviewed the children's cases during 2003.

TABLE 3 (continued)

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT

Reasonable efforts to prevent the removal	# Children	Percent
•Reasonable efforts were not made to prevent the child's removal from the home	56	1.7%
•It was unclear what efforts were made to prevent removal	115	2.8%
•Reasonable efforts to prevent removal were not necessary due to an emergency or judicial determination	2,653	64.4%
•Reasonable efforts were made to prevent the child's removal from the home	1,292	31.4%
Total	4,116	100.0%

Grounds for Termination of Parental Rights	# Children	Percent
Per §43-1308(1)(b)		
◦ The Board finds that grounds for termination of parental rights appear to exist	940	22.8%
◦The Board finds that grounds for termination of parental rights do not appear to exist	1,453	35.3%
◦The Board finds that grounds for termination of parental rights appears to exist, but it would not be in the child's best interests	844	20.5%
•A finding on grounds for termination is not applicable because the parents are deceased or the rights have already been relinquished or terminated	879	21.4%
Total	4,116	100.0%

continued...

Explanation of Table—This table shows compliance with the Foster Care Review Act as determined through the findings of the local Foster Care Review Boards that reviewed the children's cases during 2003.

TABLE 3 (continued)

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT

The Board's recommended plan if return of the children to the parents is unlikely	**# Children**	**Percent**
The Board find that return is not likely and recommends referral for termination of parental rights and/or adoption.	1,353	32.9%
The Board find that return is not likely and recommends referral for guardianship.	635	15.4%
The Board find that return is not likely and recommends placement with a relative.	167	4.1%
The Board find that return is not likely and recommends a planned, permanent living arrangement other than adoption, guardianship, or placement with a relative.	950	23.1%
The Board finds return of the children to the parents is likely.	1,011	24.6%
Total	4,116	100.0%

Explanation of Table—This table shows compliance with the Foster Care Review Act as determined through the findings of the local Foster Care Review Boards that reviewed the children's cases during 2003.

TABLE 4

BARRIERS TO PERMANENCY FOR CHILDREN REVIEWED DURING 2003

During each review, local boards identify barriers to children's case plans being implemented and children achieving safe, permanent homes. The barriers are reported to all the legal parties of the children's cases in the final recommendation reports issued after completion of each review.

The following is a compilation of the barriers identified during 2003. Categories appear in order of the number of barriers identified. The most frequently identified barriers are parental barriers.

Category	Number of Children[1]
Parental Barriers	
Ability/willingness to parent child	1,385
Past history of abuse/violence/neglect	950
Substance abuse problems of parents	876
Resistant/uncooperative to services	613
Lack of visitation	433
Relationship among family members	392
Inadequate/inappropriate housing	329
Incarceration	222
Parent(s) whereabouts unknown	210
Mental illness	189
Economic stress	160
Possible sexual abuse if returned	159
Inability to cope with child's disability	154
Noncompliance with Court Order	163
Lack of job training/skills	135
Low functioning parent	100
Chronic health problems of parent	50
Bonding problems	45
Number of times child placed in foster care	11
Distance between family members	9
Failure to pay child support	6
Lack of transportation	4
Illiteracy	0
Other parenting barriers	166

continued...

[1]This table compiles the barriers to permanency identified by the local boards for each of the 4,116 individual children reviewed during 2003. There can be up to 10 barriers identified for each child. Barriers may be in any of the categories, and more than one barrier can be in the same category.

TABLE 4 (continued)

BARRIERS TO PERMANENCY FOR CHILDREN REVIEWED DURING 2003

Category	Number of Children[1]
Implementation Barriers	
Length of time in care	721
Lack of progress	434
Number of disruptions/placements/moves	229
Delay in home study	82
Inadequate casework services	77
Inadequate preparation for independence	42
Inadequate contact with parent(s)	6
Inadequate contact with child	2
Worker not facilitating visitation with siblings	2
Inadequate contact with foster parents	0
Worker not facilitating visitation with parents	0
Other implementation barriers	39

Category	Number of Children[1]
Planning Barriers	
No plan	525
Plan inappropriate	147
Inappropriate timeframe (too long or too short)	87
No objectives	79
No timeframe	29
Inappropriate objectives	5
Plan unclear	3
Multiple plans	0
No parent/agency contract/agreement with father	0
No parent/agency contract/agreement with mother	0
Other planning barriers	43

continued...

[1]This table compiles the barriers to permanency identified by the local boards for each of the 4,116 individual children reviewed during 2003. There can be up to 10 barriers identified for each child. Barriers may be in any of the categories, and more than one barrier can be in the same category.

TABLE 4 (continued)

BARRIERS TO PERMANENCY FOR CHILDREN REVIEWED DURING 2003

Category	Number of Children[1]
Management Barriers	
Lack of documentation	352
Case transfer interrupts service	51
Caseload too large	20
Poor monitoring of contracting agencies (purchased services)	8
Uncovered case	6
Inadequate supervision of caseworker	0
Inadequate knowledge of case by case manager	0
Lack of awareness of policy by worker	0
Policy inappropriate to case	0
Other management barriers	41

Case Manager Contact with Children

During the review process Board staff members document whether or not the child's case manager has visited the child within the 60 days prior to the most recent review. Of the 4,116 children's files reviewed during 2003:

- 3,579 (87.0%) *had documentation of case manager contact* with the children within the 60 days prior to review. This is a significant, positive, increase from the 68.5% in 2001.

- 179 (4.3%) *had documentation that there was no contact* between the case manager and the children within the 60 days prior to review.

- 358 (8.7%) *had no file documentation* to indicate whether or not the case manager had visited the children within the 60 days prior to review.

Local Boards have expressed concern that many case managers are not visiting the children and witnessing the interaction of the children with their caregivers. It is concerning that about nine percent of the files have no documentation on this vital safety indicator.

continued...

[1]This table compiles the barriers to permanency identified by the local boards for each of the 4,116 individual children reviewed during 2003. There can be up to 10 barriers identified for each child. Barriers may be in any of the categories, and more than one barrier can be in the same category.

TABLE 4 (continued)

BARRIERS TO PERMANENCY FOR CHILDREN REVIEWED DURING 2001

Category	Number of Children[1]
Legal Barriers	
Parent's rights override children's rights	202
Guardian ad litem not taking active role	122
Lack of legal action to pursue permanency	106
Court delays	58
Clarification of child's legal status	20
No guardian ad litem	5
No court involvement	3
Court does not enforce orders	0
No court reviews	1
Court orders conflict with agency plan	1
Conflict with Indian Child Welfare Act	0
Other legal barriers	117

Category	Number of Children[1]
Resource Barriers	
Lack of independent living skill training	79
Lack of specialized foster homes in community	40
Support services not available	38
Lack of adoptive homes for special needs children	26
Lack of adoptive resources/recruitment	7
Residential treatment facility not available	2
Inadequate health care services	1
Lack of foster homes in community	0
Counseling services not available	0
Group homes not available	0
Lack of home-based services	0
Parenting classes not available	0
Other resource barriers	64

continued...

[1]This table compiles the barriers to permanency identified by the local boards for each of the 4,116 individual children reviewed during 2003. There can be up to 10 barriers identified for each child. Barriers may be in any of the categories, and more than one barrier can be in the same category.

TABLE 4 (continued)

BARRIERS TO PERMANENCY FOR CHILDREN REVIEWED DURING 2001

Category	Number of Children[1]
Placement Barriers	
Placement does not meet special needs (physical, mental, emotional)	107
Problems in foster home	76
Group home/institutional placement	3
Placement does not meet educational needs	2
Other placement barriers	151

Category	Number of Children[1]
Coordination Barriers	
Inadequate coordination/communication within agency	20
Interstate compact delays	4
Inadequate coordination/communication between agency & court	1
Inadequate coordination/communication between agencies	0
Inadequate coordination/communication w/tribe	0
Other coordination barriers	24

Other Barriers in Categories Not Listed Above	889 identified barriers [1,2]

No Barriers Identified	537 children [3]

[1]This table compiles the barriers to permanency identified by the local boards for each of the 4,116 individual children reviewed during 2003. There can be up to 10 barriers identified for each child. Barriers may be in any of the categories, and more than one barrier can be in the same category.

[2]The "Other" category includes older youth who refuse to return home, and unusual situations that do not fall into any of the categories listed.

[3]If the Review Board is unable to identify a barrier to the child achieving permanency, the "No Barriers" category is used. Children in this category should be in the process of being transitioned home or their adoption should be nearing finalization.

TABLE 4B

PROVISION OF HEALTH AND EDUCATION RECORDS TO THE CAREGIVERS FOR CHILDREN REVIEWED DURING 2002

Health Records Given to Foster Parent or Caregiver	Total Children Reviewed		Ages 0-5	Ages 6-12	Ages 13-15	Age 16+
Yes	2,910	70.7%	767	895	535	713
No	398	9.7%	135	133	55	75
Unknown	643	15.6%	140	178	133	192
Not applicable	165	4.0%	11	11	18	125
Total	4,116	100.0%	1,053	1,217	741	1,105

Education Records Given to Foster Parent or Caregiver	Total Children Reviewed		Ages 0-5	Ages 6-12	Ages 13-15	Age 16+
Yes	2,697	65.5%	584	876	527	710
No	349	8.5%	86	128	58	77
Unknown	628	15.3%	119	180	137	192
Not applicable	442	10.7%	264	33	19	126
Total	4,116	100.0%	1,053	1,217	741	1,105

Explanation of Table– The Foster Care Review Board is required under federal regulations to determine if health and educational records had been provided to the foster parents or other care providers at the time of the placement. This table shows that many times this information is not documented.

TABLE 5

SUMMARY OF REASONS CHILDREN ENTERED OUT-OF-HOME CARE FOR CHILDREN REVIEWED DURING 2003

This table includes two charts. The first shows the reasons why the 4,116 children and youth reviewed by the Foster Care Review Board during 2003 were placed in out-of-home care. Each could have multiple reasons identified. The chart on the next page shows conditions identified after the removal and the total number of children significantly affected by the condition.

Reasons for Entering Out-of-Home Care

Category	All Children Reviewed [1]		Children By Number of Removals			
			Reviewed children who were in foster care for the first time [1]		Reviewed children who had been in foster care at least once previously [1]	
Neglect [2]	2,327	56.5%	1,397	57.1%	930	55.7%
Child's Behaviors [3]	1,025	24.9%	361	14.8%	664	39.8%
Physical Abuse	943	22.9%	523	21.4%	420	25.1%
Housing substandard/unsafe	727	17.7%	447	18.3%	280	16.8%
Parental Drug Abuse	676	16.4%	496	20.3%	180	10.8%
Abandonment	532	12.9%	343	14.0%	189	11.3%
Caretaker Inability to Cope due to Parental Illness/Disability	425	10.3%	239	9.8%	186	11.1%
Parental Alcohol Abuse	406	9.9%	290	11.9%	116	6.9%
Parental Incarceration	382	9.3%	227	9.3%	155	9.3%
Child's Mental Health [3]	329	8.0%	110	4.5%	219	13.1%
Sexual Abuse [4]	322	7.8%	178	7.3%	144	8.6%
Relinquishment	115	2.8%	32	1.3%	83	5.0%
Child's Drug Abuse	84	2.0%	26	1.1%	58	3.5%
Child's Alcohol Abuse	68	1.7%	28	1.1%	40	2.4%
Child's Illness	44	1.1%	31	1.3%	13	0.8%
Child's Disabilities	33	0.8%	17	0.7%	16	1.0%
Death of Parent(s)	21	0.5%	7	0.3%	14	0.8%
Child's Suicide Attempt	18	0.4%	3	0.1%	15	0.9%

[1] Up to ten reasons for entering out-of-home care could be identified for each child reviewed. 2,446 of the 4,116 children reviewed were in their first removal from the home, 1,670 of the 4,116 reviewed children had been removed from the home at least once before.

[2] Neglect is the failure to provide for a child's basic physical, medical, educational, and/or emotional needs.

[3] Many of the behaviors identified as a reason for children and youth to enter out-of-home care are predictable responses to prior abuse or neglect. **Note the difference in removals due to behaviors for children on a first removal (14.8%) versus children with multiple removals (39.8%). Similarly, mental health needs increase for children with multiple removals (4.5% versus 13.1%).**

[4] Children and youth often do not disclose sexual abuse until after removal from the home. This figure includes only sexual abuse identified as an initial reason for removal and does not reflect later disclosures. See next page for later identified conditions.

Continued...

TABLE 5 continued...

Each of the 4,116 children reviewed during 2003 could have multiple reasons identified for entering out-of-home care and multiple conditions identified after removal.

Conditions Affecting Children Out-of-Home Care

Category	Children Significantly Affected by the Condition [1]		Conditions Identified at Removal [1]	Conditions Identified After Removal [1]
Neglect [2]	2,675	65.0%	2,327	348
Child's Behaviors	1,324	32.2%	1,025	299
Physical Abuse	1,185	28.8%	943	242
Housing substandard/unsafe	904	22.0%	727	177
Parental Drug Abuse	850	20.7%	676	174
Abandonment	744	18.1%	532	212
Sexual Abuse	657	16.0%	322	335
Caretaker Inability to Cope due to Parental Illness/Disability	615	14.9%	425	190
Child's Mental Health	585	14.2%	329	256
Parental Alcohol Abuse	582	14.1%	406	176
Parental Incarceration	543	13.2%	382	161
Relinquishment	163	4.0%	115	48
Child's Drug Abuse	141	3.4%	84	57
Child's Alcohol Abuse	115	2.8%	68	47
Child's Disabilities	107	2.6%	33	74
Child's Illness	73	1.8%	44	29
Death of Parent(s)	41	1.0%	21	20
Child's Suicide Attempt	31	0.8%	18	13

[1] Up to ten reasons for entering out-of-home care could be identified for each of the 4,116 children reviewed. Similarly, up to ten later identified conditions could be recorded for each of the 4,116 children reviewed.

[2] Neglect is the failure to provide for a child's basic physical, medical, educational, and/or emotional needs.

TABLE 6A

PERCENTAGE OF LIFE SPENT IN OUT-OF-HOME CARE FOR CHILDREN REVIEWED DURING 2003

Percent of Life In Care	Total Children Reviewed		Ages 0-5	Ages 6-12	Ages 13-15	Age 16+
1-10%	935	22.7%	43	257	277	358
11-20%	902	21.9%	119	266	188	329
21-30%	615	14.9%	121	227	113	154
31-40%	448	10.9%	90	171	71	116
41-50%	339	8.2%	106	127	41	65
51-60%	246	6.0%	98	78	22	48
61-70%	157	3.8%	86	35	13	23
71-80%	125	3.0%	86	28	8	3
81-90%	114	2.8%	87	15	6	6
91-99%	65	2.3%	52	8	2	3
100%	170	4.1%	165	5	0	0
Total	4,116	100%	1,053	1,217	741	1,105

- **877 (21.3%) of the reviewed children have spent more than half of their lives in out-of-home care.** This includes
  - 574 preschool children (ages 0-5),
  - 169 elementary school aged children (ages 6-12),
  - 51 middle school/junior high aged children (ages 13-15), and
  - 83 youth over age 16 who will soon be aging out of the system and creating families of their own.

- **235 (5.7%) children and youth have spent nearly every day (over 90%) of their lives in out-of-home care.**

- **170 (4.1%) of the reviewed children have spent every day of their lives (100%) in out-of-home care.** This includes 165 preschool children and 5 elementary school aged children.

Explanation of Table—This table shows the percentage of the child's life that has been spent in out-of-home care. The percentage of life in care is determined by dividing the number of months the child has been in out-of-home care at the time of the Board's review by the child's age, in months, at the time of the review. For example, a 24 month old child who has been in care 6 months would have been in care 25% of his life (6 divided by 24).

While 6 months, 12 months, 18 months, or more in out-of-home care may not seem long from an adult perspective, from the child's perspective it is a long and significant period of time.

TABLE 6B

MONTHS IN OUT-OF-HOME CARE FOR CHILDREN REVIEWED DURING 2002

Months In Care	Children Reviewed	Ages 0-5	Ages 6-12	Ages 13-15	Age 16+
0-6 months	422	196	123	56	47
7-12 months	692	254	187	127	124
13-18 months	558	178	155	105	120
19-24 months	476	139	125	79	133
25-30 months	400	112	125	52	111
31-36 months	346	73	120	66	87
37-40 months	190	38	73	33	46
41-48 months	253	35	99	45	74
49+ months	779	28	210	178	363
Totals	4,116	1,053	1,217	741	1,105

- **2444 (59.4%) of the 4116 reviewed children have spent more than 18 months in out-of-home care.** This includes:
  - 425 preschool children (ages 0-5),
  - 752 elementary school aged children (ages 6-12),
  - 453 middle school/junior high aged children (ages 13-15), and
  - 814 youth over age 16 who will soon be aging out of the system and creating families of their own.
- **1,222 (29.7%) children and youth have spent over 3 years of their lives in out-of-home care.**
- **779 (18.9%) children and youth have spent over 4 years of their lives in out-of-home care.**

Explanation of Table—This table shows the number of months of the child's life that has been spent in out-of-home care.

TABLE 6C

PATERNITY ESTABLISHMENT FOR CHILDREN REVIEWED DURING 2003

WAS PATERNITY ESTABLISHED

Paternity Established	Children	Age 0-5	Age 6-12	Age 13-15	Age 16+
Yes	2,833	679	871	505	778
No	604	221	184	92	107
Undocumented	679	153	162	144	220
Total	4,116	1,053	1,217	741	1,105

It is likely that paternity has not been established for nearly a third of the children reviewed (1,283 of 4,116)– the 604 (14.7%) where it was documented as yet to be determined and the 679 (16.5%) children who had no documentation of paternity.

- 1,194 of the 1,283 children (93.1%) had been in care for more than 6months at the time of review.
- 891 (69.4%) had been in care for more than 12 months, yet paternity was not established.

Of the 221 young children (birth-five) with no paternity established:

- 65 have been in care between 12-23 months
- 34 have been in care between 24-36 months
- 14 have been in care for over 36 months.

Of the 221 young children (birth-five) with no paternity established:

- 113 (51%) have been in care for over 1 year with no establishment of paternity.
- 48 (22%) have been in care for over 2 years without paternity establishment.

Explanation of Table– Lack of paternity identification has been linked to excessive lengths of time in care for children. Often paternity is not addressed until after the mother's rights are relinquished or terminated instead of addressing the suitability of the father as placement concurrently with the assessment of the mother's ability to parent. This can cause serious delays in children achieving permanency.

TABLE 7

REPORT FROM THE TRACKING SYSTEM REGISTRY- 2003

Number of Children reported to the State Foster Care Review Board from 1983 through 2003	68,377
Children in out-of-home care on December 31, 2002	5,367 [1]
Children who entered care during 2003	+ 4,773
Children whose case was active anytime during 2003	10,140
Children reported to have left care during 2003	-4,107
Children reported/verified in 2003 to have previously left care	- 511 [1]
Children in out-of-home care on December 31, 2003	5,522
Number of Children reviewed by the Foster Care Review Board during 2003	4,116
Number of Reviews conducted by the Foster Care Review Board during 2003	6,503 [2]

Agency with custody of children in out-of-home care Dec. 31, 2003:

Health and Human Services	5,074 [3]
Correction, Detention, Probation, Parole or Courts	144 [4]
Private Agencies (including pre-adoptive)	304
Total	5,522

[1] Prior to and during 2003, HHS frequently did not report when children left out-of-home care or reported the case closure weeks/months after the fact. Therefore, the FCRB made concerted efforts to research the status of children who have been reported to be in care and for whom there were no case closure reports. As a result, it was found that during 2003 over 500 children's case closures had not been reported to the FCRB in a timely manner. The FCRB continues to periodically verify each child's out-of-home care status.

[2] Children's cases are typically reviewed by the FCRB when the child has been in out-of-home care for six months and every six months thereafter until the child returns home, is adopted, or otherwise leaves care. Therefore, some children are reviewed more than once in a given calendar year.

[3] This figure includes children under Child Protective Services, the Office of Juvenile Services (including Geneva and Kearney Youth Rehabilitation and Treatment Centers and Juvenile Parole), and the Lincoln Regional Center.

[4] This figure does not include youth at either the Geneva or Kearney Rehabilitation and Treatment Centers, or Juvenile Parole.

TABLE 8

CHILDREN IN OUT-OF-HOME CARE ON DECEMBER 31, 2003 BY AGE

Children's Age	Number of Children	Subtotals	Subtotal Percents	
under 1 year	197			
1 year	285			
2 years	230			
3 years	212			
4 years	196			
5 years	188			
		1,308	23.7%	Ages birth - 5
6 years	194			
7 years	169			
8 years	163			
9 years	176			
10 years	162			
11 years	200			
12 years	203			
		1,267	22.9%	Ages 6-12
13 years	297			
14 years	431			
15 years	576			
		1,304	23.6%	Ages 13-15
16 years	635			
17 years	690			
18 years	315			
		1,640	29.7%	Ages 16-18
Unreported Age	3	3	>0.1%	Unreported Age
Total	5,522		100.0%	

Explanation of Table—This table shows the number of active children on Dec. 31, 2003, by age. The majority of children in the 0-1 year age category are infants in adoptive homes awaiting finalization. Generally children up to approximately age 11 enter care due to their parent's inability to parent, abusive situations, neglect, or medical problems. After age 12, youth usually enter care because of the youth's actions in addition to the previously stated reasons. The actions of youth during the teenage years account for the increase in the number of youth entering care from age 13 to age 18.

TABLE 9-A

TOTAL LIFETIME PLACEMENTS
(individual foster homes, group homes, specialized facilities)

FOR CHILDREN IN OUT-OF-HOME CARE ON DECEMBER 31, 2003 WHO ARE WARDS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) [1]

[1] Health and Human Services wards include children under Child Protective Services, the Office of Juvenile Services (including Geneva and Kearney Youth Rehabilitation and Treatment Centers and Juvenile Parole), and the Lincoln Regional Center.

Number of Placements	Total	Ages 0 to 5	Ages 6 –12	Ages 13- 15	Age 16+
1	884	371	236	161	116
2	899	370	244	160	125
3	615	198	165	127	125
4	506	115	144	121	126
5	353	46	115	95	97
6	296	39	89	80	88
7	233	27	52	66	88
8	191	12	42	60	77
9	165	12	27	48	78
10	113	0	26	34	53
11-20	657	4	73	206	374
21-30	119	0	7	29	83
31-40	37	0	2	5	30
over 40	6	0	0	1	5
Total	5,074	1,194	1,222	1,193	1,465

Children of any age can be damaged by multiple caregiver changes, yet:

- 2,683 (52.9%) of HHS children had experienced 4 or more placements.
- 819 (16.1%) of HHS children had experienced more than 10 placements.

The Board is especially concerned for the number of preschool children who have had multiple placements. Brain development experts have indicated that young children are permanently damaged by multiple broken attachments to care givers, yet an alarming number of young children have this experience.

- **453 (37.9 %) of the 1,194 HHS preschoolers have lived in 3 or more different homes**
- **140 (11.7%) of the 1,194 HHS preschoolers have lived in 5 or more homes.**

Explanation of Table—Both parts of this table shows the number of lifetime placements the children and youth who were in out-of-home care as of December 31, 2003 have experienced, the difference between the tables is who is the agency with custody.

TABLE 9-B

TOTAL LIFETIME PLACEMENTS
(individual foster homes, group homes, specialized facilities)

FOR CHILDREN IN OUT-OF-HOME CARE ON DECEMBER 31, 2003 AND ARE *NOT* WARDS OF HHS [1]

[1] These children include infants in pre-adoptive placements, children/youth placed with private agencies, children/youth in private mental health facilities, and youth sentenced to local detention/correctional facilities.

Number of Placements	Total	Ages 0 to 5	Ages 6 –12	Ages 13- 15	Age 16+	Age Not Reported
1	321	105	36	77	100	3
2	26	4	2	10	10	0
3	40	4	4	11	21	0
4	16	1	3	5	7	0
5	8	0	0	3	5	0
6	4	0	0	1	3	0
7	6	0	1	2	4	0
8	4	0	1	0	3	0
9	3	0	0	2	1	0
10	5	0	1	1	3	0
11-20	12	0	0	4	8	0
21-30	2	0	0	1	1	0
31-40	0	0	0	1	1	0
over 40	1	0	0	0	1	0
Total	448	114	45	118	168	3

Explanation of Table—Both parts of this table shows the number of lifetime placements the children and youth who were in out-of-home care as of December 31, 2003 have experienced, the difference is who is the agency with custody.

Children of any age can be damaged by multiple caregiver changes, yet:

- 2,683 (52.9%) of HHS children had experienced 4 or more placements.
- 819 (16.1%) of HHS children had experienced more than 10 placements.

TABLE 10
Listing of Children by COUNTY OF COURT COMMITMENT

This table reads across two pages and shows the number of children according to the county of the court that placed the child in care.

County	Total	# Times Removed		Gender			Age					Race						Hispanic Ethnicity
		1st	2+	Male	Female	Un	0–5	6–12	13–15	16+	Un	Blk	Wht	Ind	Asn	Oth	Unr	
Adams	140	71	69	75	65	0	35	24	36	45	0	2	132	2	0	0	4	5
Antelope	16	12	4	9	7	0	4	5	2	5	0	0	15	0	0	0	1	1
Arthur	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Banner	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Blaine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Boone	3	3	0	0	3	0	0	0	1	2	0	0	3	0	0	0	0	0
Box Butte	13	9	4	9	4	0	4	3	3	3	0	0	4	9	0	0	0	1
Boyd	1	0	1	1	0	0	0	0	1	0	0	0	1	0	0	0	0	0
Brown	1	1	0	1	0	0	0	0	0	1	0	0	1	0	0	0	0	0
Buffalo	94	40	54	58	36	0	15	22	26	31	0	3	79	2	0	0	10	10
Burt	25	13	12	13	12	0	6	9	5	5	0	0	18	6	0	0	1	0
Butler	24	15	9	11	13	0	5	9	4	6	0	0	24	0	0	0	0	0
Cass	61	46	15	32	29	0	19	16	7	19	0	0	58	0	1	0	2	0
Cedar	12	11	1	6	6	0	4	3	2	3	0	0	12	0	0	0	0	0
Chase	5	3	2	1	4	0	1	0	1	3	0	0	5	0	0	0	0	0
Cherry	8	6	2	5	3	0	1	2	2	3	0	0	3	3	0	0	2	0
Cheyenne	27	16	11	15	12	0	8	6	8	5	0	1	15	5	0	0	6	4
Clay	14	4	10	5	9	0	3	4	2	5	0	1	13	0	0	0	0	0
Colfax	19	6	13	14	5	0	3	3	6	7	0	0	8	2	0	0	9	9
Cuming	3	1	2	1	2	0	0	0	0	3	0	1	0	0	0	0	2	1
Custer	30	19	11	13	17	0	8	9	5	8	0	0	26	2	0	0	2	1
Dakota	58	39	19	31	27	0	13	13	17	15	0	0	32	5	0	0	21	13
Dawes	8	6	2	5	3	0	1	2	3	2	0	0	4	4	0	0	0	0
Dawson	98	64	34	50	48	0	20	25	28	25	0	0	67	4	1	0	26	31
Deuel	3	1	2	3	0	0	1	0	1	1	0	0	3	0	0	0	0	0
Dixon	15	12	3	10	5	0	1	3	8	3	0	0	15	0	0	0	0	0
Dodge	148	83	65	79	69	0	33	33	34	48	0	5	130	1	1	0	11	6
Douglas	1,950	1152	798	1012	890	48	465	466	450	567	2	672	944	108	7	4	215	140
Dundy	2	1	1	1	1	0	0	1	0	1	0	1	1	0	0	0	0	0
Fillmore	30	15	15	14	16	0	2	16	5	7	0	1	28	1	0	0	0	0
Franklin	7	1	6	5	2	0	2	3	2	0	0	0	7	0	0	0	0	0
Frontier	1	1	0	1	0	0	0	0	0	1	0	0	1	0	0	0	0	0
Furnas	9	3	6	6	3	0	0	3	3	3	0	0	8	1	0	0	0	0

 # Removals – 1st is a first removal from the parental home, 2+ indicates the child had experienced one or more failed, premature reunifications and prior removals from the parental home
Gender - male, female, unreported gender
Age group - ages 0-5 (preschool), 6-12 (grade school), 13-15 (junior high), 16+ (high school), or unreported age
Race - Black, White, Indian, Asian, other, unreported race
Hispanic – Number indicating Hispanic ethnicity, regardless of race

TABLE 10
Listing of Children by COUNTY OF COURT COMMITMENT (continued...)

This table reads across two pages and shows the number of children according to the county of the court that placed the child in care.

		Adjudication Status							# of Placements				Closeness to Home				
County	**Total**	**Misd**	**Fel.**	**Ab/n**	**Sta**	**Men**	**2+**	**Unk**	**1-3**	**4-6**	**7-9**	**10+**	**Same**	**Neigh**	**Non**	**0-C**	**Unc**
Adams	140	8	1	74	7	1	26	23	59	30	15	36	56	54	28	1	1
Antelope	16	1	0	11	1	0	1	2	11	0	4	1	4	8	3	0	1
Arthur	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Banner	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Blaine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Boone	3	0	0	1	1	0	1	0	2	0	0	1	0	1	2	0	0
Box Butte	13	1	0	1	0	0	2	9	9	2	0	2	7	1	5	0	0
Boyd	1	1	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0
Brown	1	0	0	0	1	0	0	0	0	1	0	0	0	0	1	0	0
Buffalo	94	7	5	31	5	0	14	32	35	30	9	20	38	16	30	4	6
Burt	25	0	0	8	2	0	0	15	11	5	9	0	5	4	15	0	1
Butler	24	3	0	12	1	0	3	5	16	4	0	4	6	8	9	1	0
Cass	61	2	0	27	2	0	6	24	43	8	4	6	30	17	11	0	3
Cedar	12	0	0	5	1	0	1	5	8	2	1	1	2	6	3	1	0
Chase	5	0	0	2	0	0	0	3	2	0	2	1	1	1	3	0	0
Cherry	8	0	0	1	0	0	0	7	5	1	1	1	3	0	4	0	1
Cheyenne	27	0	0	17	1	0	8	1	13	5	3	6	13	2	9	1	2
Clay	14	0	0	8	2	0	1	3	6	1	4	3	5	7	2	0	0
Colfax	19	3	0	6	0	0	5	5	6	7	4	2	4	2	13	0	0
Cuming	3	2	0	1	0	0	0	0	1	1	0	1	0	2	1	0	0
Custer	30	2	1	15	1	0	1	10	22	1	4	3	13	7	10	0	0
Dakota	58	6	1	24	0	1	0	26	35	12	7	4	36	0	18	3	1
Dawes	8	0	0	1	0	0	3	4	5	1	0	2	1	0	5	0	2
Dawson	98	4	0	46	15	0	18	15	56	13	6	23	46	21	26	3	2
Deuel	3	0	0	0	2	0	0	1	1	2	0	0	1	1	1	0	0
Dixon	15	3	0	7	0	0	3	2	8	4	1	2	5	2	7	1	0
Dodge	148	10	3	67	7	2	20	39	70	43	12	23	47	54	37	4	6
Douglas	1,950	35	19	1223	53	0	221	399	880	484	225	361	1344	218	219	73	96
Dundy	2	0	0	0	0	0	1	1	0	0	2	0	1	0	1	0	0
Fillmore	30	0	0	23	2	0	1	4	14	11	3	2	8	16	6	0	0
Franklin	7	0	0	7	0	0	0	0	1	5	0	1	0	5	2	0	0
Frontier	1	0	0	0	0	0	0	1	0	1	0	0	0	0	1	0	0
Furnas	9	0	0	3	3	0	1	2	3	3	2	1	2	0	6	1	0

Adjudication status – misdemeanor (1), felony (2), abuse and/or neglect (3a), status offender (3b), mental health hold (3c), adjudicated under two or more categories, and unreported or pre-adjudication.

Number of placements - 1-3, 4-6, 7-9, 10 or more.

Closeness to home - reflects the proximity of the child to the parent according to the child's placement. Categories include placed in same county as parent (same), placed in neighboring county to the parent (nei), placed in non-neighboring county to parent (non), child placed out of state (0-C), and unclear proximity (unc) where either the parent address or child's address is unreported or the parents live out of state so proximity is difficult to determine.

TABLE 10
Listing of Children by COUNTY OF COURT COMMITMENT (continued...)

This table reads across two pages and shows the number of children according to the county of the court that placed the child in care.

		# Times Removed		Gender			Age					Race						Hispanic
County	Total	1st	2+	Male	Female	Un	0–5	6–12	13–15	16+	Un	Blk	Wht	Ind	Asn	Oth	Unr	Ethnicity
Gage	35	23	12	22	13	0	7	8	6	14	0	0	31	2	0	0	2	0
Garden	5	5	0	2	3	0	1	2	0	2	0	0	3	2	0	0	0	0
Garfield	4	1	3	2	2	0	0	1	3	0	0	0	4	0	0	0	0	0
Gosper	4	2	2	0	4	0	0	2	1	1	0	0	4	0	0	0	0	0
Grant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Greeley	6	2	4	2	4	0	2	0	1	3	0	0	6	0	0	0	0	0
Hall	176	110	66	101	75	0	49	43	45	39	0	3	148	9	3	0	13	50
Hamilton	8	2	6	7	1	0	3	0	1	4	0	2	6	0	0	0	0	0
Harlan	4	3	1	1	3	0	0	3	1	0	0	0	4	0	0	0	0	0
Hayes	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hitchcock	4	4	0	2	2	0	2	1	1	0	0	0	4	0	0	0	0	0
Holt	37	26	11	22	15	0	7	9	8	13	0	0	33	1	0	0	3	2
Hooker	1	0	1	0	1	0	0	0	1	0	0	0	1	0	0	0	0	0
Howard	18	11	7	8	10	0	6	2	3	7	0	0	18	0	0	0	0	0
Jefferson	22	14	8	13	9	0	4	6	6	6	0	1	20	1	0	0	0	0
Johnson	11	10	1	5	6	0	6	3	1	1	0	0	10	1	0	0	0	1
Kearney	13	6	7	7	6	0	0	7	2	4	0	0	13	0	0	0	0	0
Keith	16	8	8	7	9	0	3	5	4	4	0	0	15	1	0	0	0	1
Keya Paha	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Kimball	24	17	7	14	10	0	11	4	2	7	0	0	21	3	0	0	0	1
Knox	3	2	1	2	1	0	1	1	0	1	0	0	0	3	0	0	0	0
Lancaster	852	526	326	467	385	0	214	209	183	246	0	146	583	61	10	1	51	59
Lincoln	192	100	92	104	88	0	55	39	39	59	0	5	153	8	0	0	26	28
Logan	1	1	0	0	1	0	0	0	0	1	0	0	1	0	0	0	0	0
Loup	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0
Madison	133	72	61	68	65	0	29	21	41	42	0	9	84	12	0	0	28	15
McPherson	2	1	1	0	2	0	0	0	1	1	0	0	2	0	0	0	0	0
Merrick	8	6	2	5	3	0	1	0	3	4	0	0	8	0	0	0	0	2
Morrill	13	9	4	4	9	0	3	3	4	3	0	0	10	0	0	0	3	2
Nance	5	3	2	4	1	0	0	0	1	4	0	0	5	0	0	0	0	0
Nemaha	2	2	0	1	1	0	0	2	0	0	0	0	2	0	0	0	0	0
Nuckolls	8	3	5	5	3	0	0	3	4	1	0	0	8	0	0	0	0	0

 # Times Removed – 1st is a first removal from the parental home, 2+ indicates the child had experienced one or more failed, premature reunifications and prior removals from the parental home

Gender - male, female, unreported gender

Age group - ages 0-5 (preschool), 6-12 (grade school), 13-15 (junior high), 16+ (high school), or unreported age

Race - Black, White, Indian, Asian, other, unreported race

Hispanic – Number indicating Hispanic ethnicity, regardless of race

TABLE 10
Listing of Children by COUNTY OF COURT COMMITMENT (continued...)

This table reads across two pages and shows the number of children according to the county of the court that placed the child in care.

		Adjudication Status							# of Placements				Closeness to Home				
County	**Total**	**Misd.**	**Fel.**	**Ab/n**	**Stat.**	**M.**	**2+**	**Un**	**1-3**	**4-6**	**7-9**	**10+**	**Same**	**Neigh**	**Non**	**0-C**	**Unc**
Gage	35	4	1	16	2	0	5	7	16	8	6	5	6	10	14	1	4
Garden	5	0	0	5	0	0	0	0	3	1	1	0	2	0	2	0	1
Garfield	4	0	0	2	1	0	0	1	0	3	0	1	1	2	0	0	1
Gosper	4	0	0	0	1	0	1	2	2	1	1	0	0	0	4	0	0
Grant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Greeley	6	0	0	6	0	0	0	0	0	3	2	1	0	3	3	0	0
Hall	176	9	2	106	8	0	10	41	92	39	12	33	90	47	35	1	3
Hamilton	8	2	0	3	1	0	0	2	2	1	2	3	1	5	2	0	0
Harlan	4	0	0	1	0	0	0	3	3	0	0	1	3	0	1	0	0
Hayes	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hitchcock	4	0	0	3	1	0	0	0	4	0	0	0	0	3	1	0	0
Holt	37	1	0	20	6	0	7	3	17	4	8	8	11	5	20	1	0
Hooker	1	0	0	1	0	0	0	0	0	1	0	0	0	1	0	0	0
Howard	18	2	0	9	0	0	3	4	8	6	1	3	4	7	5	2	0
Jefferson	22	2	0	4	0	0	1	15	15	4	2	1	6	7	7	0	2
Johnson	11	0	0	5	1	0	1	4	5	5	1	0	2	5	3	1	0
Kearney	13	1	0	7	0	0	2	3	5	3	1	4	7	2	4	0	0
Keith	16	1	0	11	0	0	2	2	8	4	1	3	5	10	1	0	0
Keya Paha	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Kimball	24	1	0	14	1	0	3	5	18	1	4	1	9	11	4	0	0
Knox	3	0	1	2	0	0	0	0	0	1	1	1	2	0	1	0	0
Lancaster	852	46	4	478	26	0	110	188	427	181	97	147	540	58	212	28	14
Lincoln	192	12	2	81	29	0	26	42	92	31	24	45	110	19	49	9	5
Logan	1	0	0	0	1	0	0	0	0	1	0	0	0	0	1	0	0
Loup	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Madison	133	8	3	50	9	0	8	55	63	28	17	25	64	14	51	1	3
McPherson	2	0	0	0	0	0	0	2	2	0	0	0	2	0	0	0	0
Merrick	8	1	0	3	0	0	0	4	6	1	0	1	4	2	2	0	0
Morrill	13	0	0	12	0	0	0	1	6	4	1	2	4	4	1	4	0
Nance	5	0	1	2	1	0	1	0	1	1	1	2	1	0	3	1	0
Nemaha	2	0	0	2	0	0	0	0	2	0	0	0	2	0	0	0	0
Nuckolls	8	0	0	4	3	0	0	1	4	1	0	3	5	2	1	0	0

Adjudication status – misdemeanor (1), felony (2), abuse and/or neglect (3a), status offender (3b), mental health hold (3c), adjudicated under two or more categories, and unreported or pre-adjudication.

Number of placements - 1-3, 4-6, 7-9, 10 or more.

Closeness to home - reflects the proximity of the child to the parent according to the child's placement. Categories include placed in same county as parent (same), placed in neighboring county to the parent (nei), placed in non-neighboring county to parent (non), child placed out of state (0-C), and unclear proximity (unc) where either the parent address or child's address is unreported or the parents live out of state so proximity is difficult to determine.

TABLE 10
Listing of Children by COUNTY OF COURT COMMITMENT (continued...)

This table reads across two pages and shows the number of children according to the county of the court that placed the child in care.

		# Times Removed		Gender			Age					Race						Hispanic
County	Total	1st	2+	Male	Female	Un	0–5	6–12	13–15	16+	Un	Blk	Wht	Ind	Asn	Oth	Unr	Ethnicity
Otoe	28	16	12	14	14	0	3	8	9	8	0	0	26	0	0	0	2	1
Pawnee	3	2	1	2	1	0	0	0	2	1	0	0	3	0	0	0	0	0
Perkins	2	1	1	2	0	0	0	0	0	2	0	0	2	0	0	0	0	0
Phelps	21	9	12	13	8	0	5	5	3	8	0	0	21	0	0	0	0	0
Pierce	4	1	3	2	2	0	0	0	2	2	0	0	4	0	0	0	0	0
Platte	43	19	24	23	20	0	5	7	11	20	0	1	37	4	0	0	1	1
Polk	6	4	2	6	0	0	0	3	1	2	0	1	5	0	0	0	0	00
Red Willow	21	17	4	12	9	0	8	5	7	1	0	0	21	0	0	0	0	1
Richardson	10	4	6	9	1	0	1	4	4	1	0	0	9	1	0	0	0	0
Rock	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Saline	30	17	13	19	11	0	9	9	4	8	0	0	30	0	0	0	0	1
Sarpy	264	142	122	129	131	4	47	45	65	107	0	27	204	5	3	0	25	21
Saunders	28	18	10	14	14	0	5	1	10	12	0	0	25	1	0	0	2	0
Scotts Bluff	156	87	69	100	56	0	34	45	44	33	0	0	97	45	0	0	14	55
Seward	32	14	18	19	13	0	5	6	7	14	0	0	31	0	0	0	1	0
Sheridan	17	16	1	12	5	0	4	2	4	7	0	0	5	12	0	0	0	0
Sherman	2	0	2	2	0	0	0	1	1	0	0	0	2	0	0	0	0	0
Sioux	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Stanton	3	2	1	3	0	0	2	0	1	0	0	0	2	0	0	0	1	0
Thayer	5	1	4	4	1	0	0	0	2	3	0	0	5	0	0	0	0	0
Thomas	1	1	0	0	1	0	0	0	1	0	0	0	1	0	0	0	0	0
Thurston	10	2	8	6	4	0	1	2	4	3	0	1	1	8	0	0	0	1
Valley	12	5	7	9	3	0	1	4	1	6	0	0	9	2	0	0	1	0
Washington	21	11	10	12	9	0	2	8	4	7	0	0	17	2	0	0	2	0
Wayne	8	5	3	5	3	0	0	1	3	4	0	2	5	0	0	0	1	0
Webster	6	4	2	4	2	0	2	2	1	1	0	0	6	0	0	0	0	0
Wheeler	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
York	36	24	12	18	18	0	6	6	12	12	0	0	36	0	0	0	0	1
Tribal	51	34	17	28	23	0	13	16	14	8	0	1	2	35	0	0	4	0
Unreported	156	156	0	93	33	30	5	22	62	66	1	1	23	15	0	0	140	0
Voluntary	114	114	0	62	52	0	92	11	1	10	0	4	51	0	47	0	0	7

 # Times Removed – 1st is a first removal from the parental home, 2+ indicates the child had experienced one or more failed, premature reunifications and prior removals from the parental home

Gender - male, female, unreported gender

Age group - ages 0-5 (preschool), 6-12 (grade school), 13-15 (junior high), 16+ (high school), or unreported age

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Hispanic – Number indicating Hispanic ethnicity, regardless of race

TABLE 10
Listing of Children by COUNTY OF COURT COMMITMENT (continued...)

This table reads across two pages and shows the number of children according to the county of the court that placed the child in care.

		Adjudication Status							# of Placements				Closeness to Home				
County	**Total**	**Mis**	**Fel**	**Ab/N**	**Stat.**	**M.**	**2+**	**Unr**	**1-3**	**4-6**	**7-9**	**10+**	**Same**	**Neigh**	**Non**	**0-C**	**Unr**
Otoe	28	2	0	4	2	0	7	13	16	7	2	3	7	10	9	0	2
Pawnee	3	0	0	1	0	0	1	1	1	1	1	0	1	0	2	0	0
Perkins	2	2	0	0	0	0	0	0	0	0	1	1	0	0	1	1	0
Phelps	21	1	1	8	5	0	2	4	7	9	3	2	4	8	9	0	0
Pierce	4	0	0	0	0	0	0	4	3	0	1	0	0	2	2	0	0
Platte	43	4	0	14	4	0	3	18	18	9	6	10	8	14	19	2	0
Polk	6	0	2	0	0	0	1	3	3	1	1	1	1	1	4	0	0
Red Willow	21	0	0	10	3	0	1	7	8	9	1	3	7	0	14	0	0
Richardson	10	0	0	6	0	0	3	1	6	1	1	2	2	0	8	0	0
Rock	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Saline	30	1	1	20	1	1	5	1	22	2	4	2	9	16	2	0	3
Sarpy	264	5	1	94	18	0	74	72	122	54	29	59	111	111	25	10	7
Saunders	28	2	0	5	0	0	5	16	14	7	3	4	8	13	5	1	1
ScottsBluff	156	6	3	78	7	0	21	41	66	31	20	39	73	11	54	15	3
Seward	32	1	0	14	2	0	3	12	13	9	4	6	11	12	8	1	0
Sheridan	17	2	4	3	0	0	0	8	11	5	1	0	1	4	7	0	5
Sherman	2	0	0	1	0	0	0	1	1	1	0	0	1	1	0	0	0
Sioux	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Stanton	3	0	0	2	0	0	0	1	2	1	0	0	0	3	0	0	0
Thayer	5	0	1	0	1	0	1	2	0	3	0	2	1	1	3	0	0
Thomas	1	0	0	0	0	0	0	1	1	0	0	0	0	0	1	0	0
Thurston	10	2	1	0	0	0	1	6	3	3	2	2	5	1	3	1	0
Valley	12	0	0	9	0	0	1	2	5	5	1	1	4	1	6	1	0
Washington	21	0	0	9	1	0	4	7	9	3	6	3	5	10	4	2	0
Wayne	8	0	0	3	0	0	0	5	3	1	3	1	0	0	4	3	1
Webster	6	0	0	4	0	0	1	1	2	2	1	1	0	3	3	0	0
Wheeler	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
York	36	4	0	11	1	0	8	12	21	3	2	10	13	9	13	1	0
Tribal	51	0	0	6	1	0	1	43	34	5	6	3	25	13	11	1	1
Unreported	156	1	1	0	0	0	0	154	154	0	2	0	34	9	47	19	47
Voluntary	114	Not applicable							114	0	0	0	4	2	1	2	105

Adjudication status – misdemeanor (1), felony (2), abuse and/or neglect (3a), status offender (3b), mental health hold (3c), adjudicated under two or more categories, and unreported or pre-adjudication.

Number of placements - 1-3, 4-6, 7-9, 10 or more.

Closeness to home - reflects the proximity of the child to the parent according to the child's placement. Categories include placed in same county as parent (same), placed in neighboring county to the parent (nei), placed in non-neighboring county to parent (non), child placed out of state (0-C), and unclear proximity (unc) where either the parent address or child's address is unreported or the parents live out of state so proximity is difficult to determine.

TABLE 11

NUMBER OF REVIEWED CHILDREN BY PLAN

Permanency Plan	Children
Return to Parent	2,185
Adoption	618
Guardianship	354
Long Term Foster Care	308
Independent Living	270
Multiple Plans	14
Relative Placement	1
Long Term Group	1
No Plan	345
Other/Unknown	20
Total	4,116

Explanation of Table—This table shows the permanency plans as of December 31, 2003, for children reviewed during 2003.

TABLE 12

CHILDREN ENTERING OUT-OF-HOME CARE DURING THE YEAR BY AGE

	Entering Care in 2003			Prior Years	
Age of child as of December 31st	First Removal from home In 2003	Prior premature, failed reunifications	Total Children Entering Care In 2003	Children Entering Care In 2002	Children Entering Care In 2001
Under 1	243	4	247	297	270
1 year	209	16	225	223	193
2 years	144	39	183	180	170
3 years	124	26	150	148	152
4 years	128	37	165	148	142
5 years	112	23	135	136	120
6 years	106	43	149	156	120
7 years	102	38	140	125	112
8 years	75	28	103	129	139
9 years	87	36	123	109	128
10 years	77	40	117	143	141
11 years	80	54	134	146	145
12 years	94	58	152	157	168
13 years	161	86	247	253	260
14 years	215	152	367	492	370
15 years	279	233	512	562	608
16 years	249	322	571	712	776
17 years	274	395	669	740	767
18 years	122	215	337	390	365
19 + years	14	29	43	71	49
Unknown age	3	1	4	4	37
TOTAL	2,898	1,875	4,773	5,321	5,232
# removed more than once			1,875	2,238	2,211
recidivist rate*			39.3%	42.8%	41.6%

*Recidivism rate here is computed as the percent of children entering care in the year who had been removed from the home at least once before, as in 1,875/4,773 = 39.3%)

Explanation of Table—This table shows the number of children who entered out-of-home care through both public and private agencies, and includes past years for comparison. Most children who enter care when age newborn through pre-adolescence enter care due to the parent's inability to parent, an abusive situation, neglect, or medical problems. Some are infants placed for adoption whose adoption has not been finalized. Older children may also enter care because of their own actions. This chart is based on the child's December 31st age, so children in the 19+ age group would have entered care while age 18 (19 is the age of majority).

The Board is particularly concerned with the number of young children experiencing premature, failed reunifications, due to brain research indicating that there can be physical changes to brain physiology caused by abuse, neglect, and separations from parents/caregivers.

TABLE 13

CASES REPORTED TERMINATED IN 2003 BY REASON

Reason Left Care	No. of Children	
Reunification or Presumed Reunification		
Custody Returned to Parent	2,838	
Released from Corrections (presumably to parents)	327	
Age of Majority or Other Emancipation		
Reached Age of Majority	363	
Emancipated by Military Service or Marriage	3	
Adoption		
Adoption Finalized	357	(274 HHS wards, 83 private)
Guardianship		
Guardianship Established	290	
Other Reasons		
Court Terminated (with no specifics given)	162	
Custody Transferred to Another Agency/State/Tribe	5	
Death of Child	3	
No reason reported or other	270	
Total cases terminated	4,618	

Explanation of Table—This table shows the number of children whose cases were terminated (closed) for each reason during 2003.

TABLE 14

LIFETIME NUMBER OF TIMES IN FOSTER CARE (REMOVALS) FOR CHILDREN IN OUT-OF-HOME CARE ON DECEMBER 31, 2003

Summary

Lifetime Removals for Children in Care on 12-31-2003	Totals	Ages 0-5	Ages 6 –12	Ages 13- 15	Age 16+	Age Not Reported
In First Removal	3,352	1,120	844	700	685	3
Had Previous Removal(s)	2,170	188	423	604	955	0
Total	5,522	1,308	1,267	1,304	1,640	3

Details

Times in Foster Care (removals)	Totals	Ages 0-5	Ages 6 –12	Ages 13- 15	Age 16+	Age Not Reported
1	3,352	1,120	844	700	685	3
2	1,266	157	294	352	463	0
3	532	25	103	147	257	0
4	209	5	12	70	122	0
5	96	1	6	25	64	0
6	38	0	5	6	27	0
7	18	0	2	2	14	0
8	6	0	0	1	5	0
9	2	0	1	0	1	0
10	2	0	0	0	2	0
11 or more	1	0	0	1	0	0
Total	5,522	1,308	1,267	1,304	1,640	3

Explanation of Table – This table shows the lifetime number of times the child or youth has been removed from the parental home. Any number of times in care that is greater than one indicates that the child has experienced a premature or otherwise failed reunification attempt with the parents. 39.3% of the 5,522 children in care on 12-31-2003 had experienced one or more failed reunification attempts.

While failed reunifications can be detrimental for children at any age, the Foster Care Review Board is greatly concerned for the **188 preschool age children (birth through five years old) who have experienced failed reunification attempts**, especially the **31 with multiple failed reunifications**.

Research shows that repeated early childhood traumas can impede normal growth and development, and can cause permanent changes in the physical makeup of children's brains. These changes can cause lifelong deficits in cognitive functions and response to normal stresses.

39.3% of the 5,522 children in care on 12-31-2003 had experienced one or more failed reunification attempts.

APPENDICES

Appendix A

The Juvenile Court Process For Abuse or Neglect Cases

Note: The Foster Care Review Board has the authority to review children's cases any time after the removal from the home. Typically the Board schedules reviews so that information gathered from the review can be shared with all legal parties just prior to a Court hearing, so that the Court can address the Board's concerns.

Report of abuse or neglect (also called a complaint)– is made by medical personnel, educators, neighbors, foster parents, social workers, policy, and/or others. State law requires anyone with reason to believe abuse or neglect is occurring to report this to authorities. This may be reported to the Department of Health and Human Services (HHS-CPS) or a local law enforcement agency. Each of these agencies is to cross report to the other.

Report accepted or screened out – after CPS receives a report, it assesses the nature of the complaint and assigns a prioritization for investigation. Serious flaws in this system exist. (See the section on CPS response to child abuse reports for additional details.)

Investigation– law enforcement and/or CPS (child protective services division of HHS) investigates the allegations or concerns in the report. The investigation provides the evidence for the County Attorney to file a petition. The child may be removed from the home if an emergency situation exists.

County Attorney files a petition – detailing all of the abuse or neglect allegations. This is done within 48 hours of an emergency removal; if not an emergency removal, the County Attorney files a petition requesting removal from the home or requesting HHS supervision of the home. Nothing is determined, found, or ordered at this point, that is done at the hearings described below. Parents who abuse their children can be tried in adult courts for the criminal part of their actions as well as being involved in a juvenile court action about the child and the child's future.

Petition definitions – petitions must contain specific allegations related to specific statutes in the Nebraska Juvenile Code. These are:

- §43-247 (3a) – children who are neglected, abused, or abandoned.
- §43-247 (3b) – children who have exhibited behaviors problems such as being disobedient, truant, or runaways
- §43-247 (3c) – juveniles who are mentally ill and dangerous as defined in §83-1009.
- §43-247 (1) – juveniles who have committed a misdemeanor other than a traffic offense.
- §43-247 (2) – juveniles who have committed a felony.

Detention hearing is held – legal rights are explained to the parents, a Guardian ad litem (special attorney) is appointed to represent the child's best interests, counsel may be appointed for the parents. This hearing determines if probable cause exists to warrant the continuance of Court action or the child remaining in out-of-home care. The Court can only rule on the allegations in the petition. Affidavits and testimony can also be used.

If an emergency removal did not occur, the child may be removed from the home or may remain in the home under the supervision of HHS. Services may be offered to the child and/or the parents after the detention hearing. Parents are frequently advised by their counsel not to accept services, as this may be an admission of guilt for the adjudication hearing to come.

HHS is given custody at the detention hearing – and is then responsible for the child's placement, plan, and services, if the court finds grounds for adjudication. HHS is responsible for developing the child's case plan, submitting the plan to the court, and updating the plan at least every six months while the child remains in care. The Court must adopt the HHS case plan unless other legal parties present evidence that the plan is not in the child's best interest or the Court amends the case plan based on its own motion.

HHS makes a placement – the child's needs are to be evaluated and the child is to be placed in the most home-like setting possible that meets the child's needs, whether through direct foster parents, relatives, or agency-based care. This may occur either before or after the detention hearing, depending on circumstances.

Plea-bargaining – because allegations can be hard to prove, many serious allegations are sometimes removed from the petition in an agreement between the County Attorney and the parents so that parents or youth will admit to lesser charges.

Adjudication hearing is held – facts are presented to prove the allegations in the petition. The burden of proof is on the state, through the County Attorney. If the parents deny the allegations, then a fact-finding hearing like a trial is held, where the parents have a right to counsel.

At this hearing the finding of fact occurs, the allegations in the petition are found to be true or false, and the child is either made a state ward or not. The Court cannot order the parents to services prior to completion of the adjudication hearing. By law this must occur within 90 days of the child entering out-of-home care. In practice the 90-day rule is not always followed.

Dispositional hearing is held – the Court sets the adjudication status for the case, if the parent admits the allegations or is adjudicated, the Court adopts the HHS rehabilitation plan for the parents (case plan) and orders services based on this plan. There is a statutory presumption that the HHS plan is in the best interests of the child. The onus is put on any other party to the proceedings to prove that a plan is not in the child's best interests.

Dispositional review hearings – these court hearings occur at least once every six month to determine whether any progress is being made towards permanency for the child. The child's plan should be updated to reflect the current situation. The State Foster Care Review Board has legal standing to file as a party to any pleading or motion to be heard by the court at these hearings. The Review Board attempts to schedule its reviews in advance of this court hearing so that the Court can act on the Board's concerns.

Permanency hearing – after the child has spent 12 months in foster care, the Court is to hold a special dispositional hearing to determine the most appropriate permanency plan for the child.

When a child has been in care for 15 of the last 22 months – the County Attorney is required to file a motion for a hearing either for a termination of parental rights, or to explain why termination is not in the best interest of the child.

Permanency – is obtained through any of the following: 1) a safe return to the parent's home, 2) adoption, 3) guardianship, 4) a long-term foster care agreement, or 5) by reaching adulthood. Adoption or guardianship can occur following either a relinquishment of parental rights or by a Court-ordered termination of parental rights.

Termination of parental rights hearings – if the state through a county attorney proceeds to a termination of parental rights action, the parents have the right to counsel. In such a trial the burden of proof is greater than the level of proof needed in juvenile court proceedings. Many county attorneys have equated the time to establish grounds and proceed to trial as being equal to involvement in a murder trial. The role of the defense counsel is adversarial—that is the parental attorney has an obligation to defend the client against the allegations in the petition. There is a right to appeal, and many parental attorneys automatically appeal any decision to terminate parental rights.

Relinquishments – relinquishments are actions of the parents to give HHS the rights to the child. HHS will only accept relinquishments if both parents sign or the other parent's parental rights have been terminated or the other parent is deceased. This is sometimes done to facilitate an open adoption.

Open adoption – a legally enforceable exchange of information contract between biological parents who have relinquished rights and adoptive parents, that is agreed to by both parties. This is only applicable for children who are state wards.

Local Foster Care Review Board members come from a variety of backgrounds. If you would be interested in serving on a local board, please complete the form found in Appendix B.

Appendix B

STATE OF NEBRASKA
FOSTER CARE REVIEW BOARD
521 S. 14th Street, Suite 401
Lincoln, NE 68508-2707
(402) 471-4420

Applications for volunteers to serve on a local Foster Care Review Board as set in Nebraska Statue, Section 43-1301 to 43-1319, R.R.S. Employees of the State Foster Care Review Board or child caring and placing agencies or the Courts are ineligible to serve on local boards.

Name _____

Address _____ City _____ ZIP _____ Phone No. _____

Occupation Address _____ ZIP _____ Phone No. _____

I am available for training on the following (check all that apply)					**I am available to serve on a Board that meets on the following (check all that apply)**			
Day	Morning	Afternoon	Evening		Day	Morning	Afternoon	Evening
Mon.					Mon.			
Tues.					Tues.			
Wed.					Wed.			
Thurs.					Thurs.			
Fri.					Fri.			
Sat.			NA		Sat.			NA

Regular exceptions to the above schedule: _____

Nebraska Statute 43-1304 states: "The members of the Board shall reasonably represent the various social, economic, racial, and ethnic groups of the county or counties from which its members may be appointed." In order to comply with the Act, please answer the following:

Your age: 19-30 _____
31-45 _____
46 & older _____

Family income: $ 4,000-10,000 _____
$11,000-20,000 _____
$21,000-39,000 _____
$40,000 - above _____

Race: Caucasian ____ Black _____ Hispanic _____ Indian _____ Asian ____ Other _____

Marital status: _____ Number of children _____

I am presently a foster parent [this is not a requirement]: yes ____ no _____

continued➔

Please list current and past activities (you can use an additional sheet if more room is needed).

Please list the name, address, and phone number of three references.

1. _____

2. _____

3. _____

Please write a short paragraph of why you would like to serve on a local Foster Care Review Board.

FOR OFFICE USE ONLY:

Date application received _____

Part I Training _____ Part II Training _____

Date appointed to Board _____ Appointed to Board _____

STATE OF NEBRASKA

FOSTER CARE REVIEW BOARD

CONFIDENTIALITY

Foster Care, Chapter 43-1310. Records and information; confidential; unauthorized disclosure; penalty. All records and information regarding foster children and their parents and relatives in possession of the state board or local board shall be deemed confidential. Unauthorized disclosure of such confidential records and information and any violation of the rules and regulations of the Department of Social Services shall be a Class III misdemeanor.

Class III misdemeanor:	Maximum -	three months imprisonment, or five hundred dollars fine, or both
	Minimum -	none

CONSENT FORM

I, _____, agree to the rules and regulations set by the
(*please print*)
State Foster Care Review Board.

In particular, I promise not to disclose any information obtained from my participation in the Foster Care Reviews in accordance with confidentiality provisions.

I further promise not to use any information or data for my own personal, professional, or monetary advantage.

_____ _____
signature *date*

_____
address

_____, NE _____

Signed in the Presence of:

_____ _____
Signature *date*

NEBRASKA STATE FOSTER CARE REVIEW BOARD
521 S. 14th Street, Suite 401
Lincoln, NE 68508-2707
(402) 471-4420

Child Abuse/Neglect Central Register Release of Information

I hereby apply to serve on the Foster Care Review Board. I hereby give my permission and authorize any law enforcement agency, child protective service agency, governmental agency, or court to release to the State Foster Care Review Board, its agents or representatives, any documents, records, or other information pertaining to me.

I understand my name will be checked against the Nebraska Department of Health and Human Services Adult/Child Protective Services Central Registers. The purpose of this check will be to determine if my name is being maintained on either register as a result of previous abuse/neglect allegations that have been investigated and have not been determined to be unfounded. To the best of my knowledge, I do not have a conviction or prior history of adult or child abuse/neglect or maltreatment perpetration, neither have I been convicted of a crime involving moral turpitude.

I understand that my refusal to authorize the release of the above-mentioned information may adversely affect my application to serve as a member of the Foster Care Review Board.

I hereby release, discharge, and exonerate the State Foster Care Review Board, its agents and representatives, and any agency, court, or person furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, and other information, or the investigation made by the Foster Care Review Board.

_____ _____
Signature Date

Current Address _____ City_____State____ How Long? _____

Current Employer _____ How Long? _____

_____ _____ _____
Printed Name Birth Date Social Security Number

Other Names Used in Past Twenty (20) Years →
(Please Print or Type)
Use back of sheet if necessary

1. _____
2. _____
3. _____

1. _____
2. _____
3. _____

← Other Addresses Used in Past Twenty (20) Years
(Please Print or Type)
Use back of sheet if necessary

Names of Children Who Have Lived With You →
in Past Twenty (20) Years(Please Print or Type)
Use back of sheet if necessary

1. _____
2. _____
3. _____

Form revised 5-21-2001

Appendix C
ACKNOWLEDGEMENTS - 2003

The State Foster Care Review Board would like to acknowledge and thank the following churches, schools, hospitals, libraries, businesses, and community centers for allowing the local Foster Care Review Boards to use their facilities for monthly board meetings, prospective board member training programs, and on-going continuing education programs:

Abraham's Library, Omaha
Alliance Library, Alliance
Beatrice Community Hospital, Beatrice
Bennett Martin Library, Lincoln
Bergan Mercy Hospital, Omaha
Bess Johnson Library, Elkhorn
Brooke Valley School, Omaha
Calvary United Methodist Church, Lincoln
Children's Hospital Health Care, Omaha
Christ United Methodist Church, Lincoln
Columbus Police Department, Columbus
Educational Service Unit #16, Ogallala
First Christian Church, Omaha
First Lutheran Church, South Sioux City
Fremont Presbyterian Church, Fremont
Girls Inc., Omaha
Grand Generation Center, Lexington
Granton Township Library, O'Neill
Great Plains Medical Center, North Platte
Hastings Police Department, Hastings
Havelock United Methodist Church, Lincoln
Immanuel Alegent, Omaha
Landmark Center, Hastings
LaVista Community Center, LaVista
Law Enforcement Center, Kearney
Lutheran Church of the Master, Omaha
Madonna Rehabilitation Center, Lincoln
Make-A-Wish Offices, Omaha
MidTown Business Center, Kearney
Morning Star Lutheran Church, Omaha
Nebraska State Bar Association, Lincoln
Nemaha County Hospital, Auburn
New Life Baptist Church, Bellevue
Odyssey III Counseling, Norfolk
Pacific Hills Lutheran Church, Omaha
Parkwood Terrace Apartments, Omaha
Pierce County Courthouse, Pierce
Presbyterian Church of the Cross, Omaha
Rainbow House, Omaha
Regional West Medical Center, Scottsbluff
Seward Civic Center, Seward
St. Francis Medical Center, Grand Island
St. Paul's United Methodist Church, Lincoln
St. Stevens Building, Grand Island
St. Timothy's Lutheran Church, Omaha
St. Wenceslaus Catholic Church, Omaha
State Office Building, Omaha
Sump Memorial Library, Omaha
Swanson Library, Omaha
Thanksgiving Lutheran Church, Bellevue
United Nebraska Bank - Lexington
University of Nebraska Medical Center, Omaha
Vine Congregational Church, Lincoln
York General Hospital, York

APPENDIX D

STATE FOSTER CARE REVIEW BOARD
FINANCIAL STATEMENT
Fiscal Year 2003-2004

Appropriations

General Fund	$1,053,841
Cash Fund	$6,000
Federal Funds	$763,886
TOTAL	$1,823,727

Expenditures

Staff Salaries & Benefits	$1,408,256.38
Postage	$37,404.84
Telephone and Communications	$9,686.79
Data Processing Fees	$37,053.65
Publications and Printing	$37,726.47
Rent	$41,989.40
Legal Fees	$10,969.34
Office Supplies & Miscellaneous	$29,994.20
Travel Expenses	$68,437.80
Data Processing & Office Equipment	$3,922.00
Other Administrative & Contractual	$69,859.16
TOTAL	$1,775,300.03