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"LOOKING OUT FOR THE CHILDREN"

SEVENTEENTH ANNUAL REPORT OF

THE NEBRASKA STATE FOSTER CARE REVIEW BOARD

1999

Submitted Pursuant to

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

State Foster Care Review Board

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ACKNOWLEDGEMENTS - 1999

The 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, and on-going training:

All Saint's Parish, Omaha
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American National Bank, Nebraska City
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Bess Johnson Library, Elkhorn
Blue Valley Mental Health, Falls City
Blue Valley Mental Health, Nebr. City
Brun Library, Humboldt
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Educational Service Unit #16, Ogallala
Family Resource Center, Lincoln
First Christian Church, Lincoln
First Christian Church, Omaha
First Congregational United Church of Christ, Hastings
First Lutheran Church, South Sioux City
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Granton Township Library, O'Neill
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Lincoln Benefit Life, Lincoln
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Nemaha County Hospital, Auburn
New Life Baptist Church, Bellevue
New World Inn, Columbus
Odyssey III Counseling, Norfolk
Pierce County Courthouse, Pierce
Police Union, Omaha
Project Harmony, Omaha
Rainbow House, Omaha
Regional West Medical Center, Scottsbluff
Seward Civic Center, Seward
Sheridan Lutheran Church, Lincoln
Sidney Memorial Health Center, Sidney
St. Francis Medical Center, Grand Island
St. Joseph's Catholic School, Beatrice
St. Timothy's Lutheran Church, Omaha
St. Wenceslaus Catholic Church, Omaha
State Office Building, Omaha
Swanson Library, Omaha
Tecumseh Hospital, Tecumseh
Tri-County Hospital, Lexington
University of Nebraska Medical Center, Omaha
York General Hospital, York

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 accomplishes this by:

- Reviewing 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, by trained citizen volunteers;
- Making findings based on the review and 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, evaluating judicial and administrative data collected on foster care;
- Disseminating data and findings through means such as an Annual Report, community meetings, and legislative hearings;
- Visiting facilities for children in out-of-home care;
- When deemed appropriate by the state board, 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;
- Advocating for children and their families through individual case review, legislation, and pressing for policy reform;
- Organizing, sponsoring, and participating in educational programs.

AGENCY VISION

The vision of the 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, productive adult.

The Board works to ensure this by reviewing cases, visiting facilities, tracking children, and taking legal standing on cases where the Board believes the children and youth's best interests are not being met. The Board collects data, disseminates data and finding through the annual report, community meetings, and legislative hearings.

The Board accomplishes this vision by:

1. Reviewing the plan, 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 placements, by trained citizen volunteers,

2. Making findings based on the review and the specific rationale for these findings,

3. Sharing the findings with all the legal parties to the case,

4. Collecting data on children in out of home care, updating data on these children, evaluating judicial and administrative data collected on foster care,

5. Disseminating data and findings through means such as an Annual Report, community meetings, and legislative hearings,

6. Visiting facilities for children in out of home care,

7. When deemed appropriate by the State Board, 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,

8. Advocating for children and their families through individual case review, legislation, and pressing or policy reform,

9. Organizing, sponsoring, and participating in educational programs.

The State Foster Care Review Board
would like to express its appreciation
to Barbara Heckman and James Ganz. Jr.
for editing this annual report.

"LOOKING OUT FOR THE CHILDREN"

SEVENTEENTH ANNUAL REPORT OF THE NEBRASKA STATE FOSTER CARE REVIEW BOARD

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A PREVIEW AND COMMENTARY

A Preview and Commentary
by Carolyn K. Stitt, M.S.W.
with assistance by Linda Cox and Heidi Ore

"It was the best of times, it was the worst of times."
Charles Dickens, A Tale of Two Cities

In many ways the words of Charles Dickens quoted above hold true for the conditions for children in out-of-home care[1] in Nebraska today.

As "the best of times", Nebraska has never had an Executive Branch, Legislature, and Judiciary more unified in a commitment to make improvements in the child welfare/foster care system. **The Foster Care Review Board would like to take this opportunity to publicly acknowledge the efforts of the following public officials, agencies, legislature, judiciary and others on behalf of children in out-of-home care**:

- **Governor Mike Johanns**, for making child welfare a priority; for asking members of the child welfare system to build consensus on ways in which Nebraska could improve its approach to child abuse and neglect, and for his participation in adoptive and foster home recruitment advertisements;

- **HHS,**[2] for conducting tours of facilities with the FCRB to ensure children are safe, for implementing a procedure whereby top HHS officials could be notified of cases with particularly acute concerns; for prioritizing the creation of reports to the FCRB Tracking System from the HHS N-FOCUS system; and, for facilitating discussions on a wide range of child welfare issues;

- **HHS Case Managers,** for their continued commitment to finding appropriate placements and working to find permanent homes for children.

- **Foster Parents,** for showing their concern and dedication by providing children with the nurturing attention needed to help overcome the children's past traumas;

- The **Nebraska Legislature,** for passage of the Adoption and Safe Families Act in 1998, and for concerns expressed in regard to child welfare system inadequacies;

- The **Judiciary,** for putting the intent of the Adoption and Safe Families Act into practice; for notifying parents that they have a limited time to correct the conditions that led to the children's removal from the home; and for reporting to the Board

[1]Out-of-home care is placement of the child or youth outside the home or origin, such as a foster family home, a kinship/relative's home, group home, emergency shelter, youth detention center, psychiatric treatment facility, etc. Additional definitions are available in the glossary.
[2]Nebraska Department of Health and Human Services, referred to as "HHS" throughout this section.

earlier in the children's cases than previous practice to enable verification of children's status.

There have been some positive results from these efforts. It appears that for approximately one-half of the children in out-of-home care, the system seems to be working. This analysis is based on the results of the 5,816 citizen reviews conducted by Local Boards during 1999 on 3,834 children's plans[3], along with other information recorded on Nebraska's model independent tracking system. For example, at the end of 1999:

- 50.4 percent of children reviewed in 1999 (1,934 of 3,834) had a complete permanency plan as required by Nebraska statutes;
- 51.1 percent of children in out-of-home care at the end of 1999 (2,840 of 5,557) had experienced less than four placements;[4]
- 58.5 percent of those entering care during 1999 (2,862 of 4,884) had been placed in out-of-home care only one time; and,
- 46.7 percent of children reviewed in 1999 (1,789 of 3,834) had been in care for less than two years at the time of their last review.

Yet, in many ways, it is "the worst of times" for the child welfare system. The same figures also concurrently indicate that for about two thousand Nebraska children there is significant work to be done. Nebraska has never had a child welfare system in such disarray or so in need of improvements. There are serious concerns as Nebraska's over-burdened child welfare system strains to meet the needs of children and families.

Local Boards have identified a number of areas where **the child welfare system does not meet the needs of many of the children in out-of-home care**. It should be noted that the problems described in this report do not occur in isolation. Each problem affects many other parts of the child welfare system. Therefore, many changes need to occur to move the system from a crisis mode to one that can offer the best possible future for abused and neglected children.

The following combination of circumstances have worsened conditions for children in out-of-home care:

- The number of children in out-of-home care has significantly increased each year since 1996;
- Children entering care have suffered more serious or chronic abuse than was true in the past, thus entering care with a higher level of need; and,

---

[3]Children's cases are reviewed by Local Boards of the FCRB system 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. See the separate section on the Foster Care Review Board for more information about the FCRB's structure.
[4]Placements are moves between individual foster homes, group homes, or specialized placements.

- The numbers and types of placements and services available have not kept pace with the needs of the children.

In particular, Local Boards have expressed concerns regarding the following issues in the child welfare system:

- Additional prevention efforts are needed to reduce the incidence of child abuse;
- Young children's care and placements need stability;
- There is insufficient recruitment of quality foster homes;
- There is no program or system in place to effectively retain quality foster homes;
- There is an over-reliance on restraints in some facilities[5];
- There are insufficient appropriate placements of every type;
- Many children and youth experience too many placements;
- There is not consistent oversight of agency-based placements[6];
- The HHS N-FOCUS system remains unreliable;
- There is insufficient training and oversight for contracted personnel providing children's transportation and visitation monitoring;
- If managed care denies payments, children most likely will not receive needed services;
- Case management is fragmented due to key duties being contracted out; and,
- Ongoing child welfare system breakdowns continue to be problematic, such as inadequate response to child abuse reports, investigation and prosecution issues, and inappropriate plans for children's cases.

Barriers to Permanency Reported By Local Boards

In each case reviewed, Local Board members identify barriers to children achieving safe, permanent homes. The following shows the top barriers cited by local board members as they competed 5,816 reviews on 3,834 children in 1999 (A full list of possible identified barriers is reported in Table 6):

Parental Barriers

- The ability/willingness of parents to parent their children (1,247 of 3,834 children reviewed);
- Past histories of abuse, neglect, and violence (906 of 3,834 children reviewed);
- Drug/Alcohol abuse by the parent (811 of 3,834 children reviewed);

System Barriers

- The lack of current plans (800 of 3,834 children reviewed);

---

[5]Restraints used to maintain order in many facilities include physical restraints (also referred to as "takedowns" or "holds"), chemical restraints (medications), and prolonged isolation.

[6]Agency-based placements are foster homes and facilities that are recruited, monitored, and retained by private organizations that have contracts with HHS for these types of services.

- The lack of documentation of case progress (692 of 3,834 children reviewed); and,
- The length of time in care (658 of 3,834 children reviewed).

The problems and concerns outlined above illustrate the complexity of the problems that face children in out-of-home care. This preview and commentary will focus on the Local Board's recommendations and rationale for reducing these problems. The recommendations in this report are made with the goal of developing a child welfare system that will:

- Reduce the number of children coming into the system;
- Allow for an increase in appropriate services being available for children and their families;
- Reduce the number of placements which each child experiences;
- Increase the number of children who are in appropriate placements; and,
- Better meet the individual needs of children in out-of-home care.

The Foster Care Review Board (FCRB) recognizes and commends the many committed and caring individuals in the child welfare system who are doing their best to provide children with what they need. This report does not discount their efforts, rather the intent of this report is to take a closer look at the child welfare system as a whole, focusing on what works, what does not work, and what should be changed.

By addressing the identified concerns and taking the recommended steps, the state would begin the process of building a stronger statewide, consistent and comprehensive child welfare system.

Additional Child Abuse Prevention Efforts are Needed

During 1999, 10,286 individual Nebraska children were in out-of-home care for some or all of the year. Clearly, too many Nebraska children have suffered child abuse, child neglect, and/or child sexual abuse; efforts must be made to prevent as many instances of abuse as possible. Therefore, there is a need for proven home visitation programs and other proven prevention programs to lessen the ever-growing number of children suffering abuse, and reduce the numbers of children entering the system.

FCRB Recommendations to reduce child abuse:

- The state should chose from proven prevention models and implement them statewide, and expand child abuse prevention efforts;
- The state should conduct intensive home visitation for high risk populations (birth-2) and universal visitation with focus on school readiness (birth-5);

- The state should create parent support centers which would focus on children of all ages, serve as an advocacy and training center, be a source of respite care and a host site for parent and adolescent support groups;
- The state should subsidize respite and after school care for children qualifying for Kids Connection;
- The state should assist business owners in the development of quality low cost child care;
- The state should increase Kids Connection coverage to 200% of the level of poverty;
- The state should provide incentives to improve the supply of and supports for mental health professionals in rural areas; and
- The state should explore funding the prevention initiative through the Tobacco Trust Fund.

There Must be a Focus on Stabilizing the Care for the Youngest of Children in Out-of-Home Care

The State Foster Care Review Board recommends additional efforts be made to assure children, newborn to age 5 have stability and continuity of care. The following are the numbers of infants, toddlers and pre-school aged children in out-of-home care as of 12-31-99.

- 1,125 (20.2%) of the 5,557 children in care on 12-31-99 were preschoolers (age birth through 5 years)
- 890 of the 4,884 children (18.2%) who entered care during 1999 were aged birth through 5 years
- **112 of the 890 children (12.6%) this age who entered care during 1999 had experienced prior removals from the home**
- Of the 1,125 children in care aged 0-5, the following is the number of placements they have experienced:
    - 1-3 placements – 924 of 1,125 children - 82.1%
    - 4-5 placements - 147 of 1,125 children - 13.1%
    - 6-9 placements – 48 of 1,125 children - 4.3%
    - 10 or more placements – 6 of 1,125 children - 0.5%

The State Foster Care Review Board is especially concerned for the 201 infants, toddlers and pre-school aged children who have experienced 4 or more placements while in out-of-home care.

"Moves from foster home to foster home should be limited to all but the most unavoidable situations. Every loss adds psychological trauma and interrupts the tasks of child development."[7]

As Drs. T. Berry Brazelton & Stanly Greenspan recently stated in a Newsweek article regarding the needs of children in early childhood:

"Parents [or caregivers and in the case of children in out-of-home care, HHS] cannot underestimate the importance of their role in these early years. Each child is born with a unique biology but that doesn't mean his or her future is preordained. The way a parent nurtures a baby has a profound effect on how the child develops.

The seven needs we [Dr. Brazelton & Greenspan] have identified provide the fundamental building blocks for our higher-level emotional social and actual abilities:

1. **Ongoing nurturing relationships:** Every baby needs a warm, intimate relationship with a primary caregiver over a period of years, not months or weeks. This is far more important to emotional and intellectual development than early cognitive training or educational games. If this relationship is absent or interrupted, a child can develop disorders of reasoning, motivation and attachment. Infants, toddlers and preschoolers need these nurturing interactions most of their waking hours.
2. **Physical protection, safety and regulation:** Both in the womb and infancy, children need an environment that provides protection from physical and psychological harm, chemical toxins and exposure to violence.
3. **Experiences tailored to individual differences:** Every child has a unique temperament. Tailoring early experience to nurture a child's individual nature prevents learning and behavioral problems and enables a child to develop his or her full potential.
4. **Developmentally appropriate experiences:** Children of different ages need care tailored to their state of development. Unrealistic expectations can hinder a child's development.
5. **Limit setting, structure and expectations**: Children need structure and discipline. They need discipline that leads to internal limit setting, channeling of aggression and peaceful problem solving. To reach this goal they need adults who empathize as well as set limits. They need expectations rather than labels, and adults who believe in their potential but understand their weaknesses. They need incentive systems, not failure models.

[7] Vera I. Fahlberg, M.D., A Child's Journey Through Placement, Page 176. Perspectives Press, c. 1991

6. **Stable Supportive communities and culture:** To feel whole and integrated children need to grow up in a stable community. This means a continuity of values in family, peer groups, religion and culture, as well as exposure to diversity.
7. **Protecting the future:** Meeting all these needs should be our highest priority. If we fail, we will jeopardize our children's future.

We can feel empathy only if someone has been empathetic and caring with us. We can't experience the consistency and intimacy of ongoing love unless we've had that experience with someone in our lives. From some it may be a grandmother or an aunt, or it may even be a neighbor, but it must be there. There are no shortcuts."[8]

FCRB Recommendations to stabilize the care for the youngest of children in out-of-home care:

- Provide intensive services to parents with the intent to assess their long term willingness and ability to parent;
- Minimize placement disruptions by recruiting and working with foster care families for infants, toddlers and pre-school aged children and identifying appropriate relative placements early in the child's case;
- Provide specialized training on the importance of bonding and attachment to foster parents, case managers and supervisors;
- Reduce the case loads for specialized case managers of young children in out-of-home care; and
- Develop specialized units where highly trained professionals focus on providing permanency for children who have been identified as not being able to return home due to parental inability or unwillingness to provide long term care.

There Must be a Continued Emphasis on Recruitment and Retention of Quality Foster Homes

Many quality foster parents have reported that they quit being foster parents because they were not being given background information on the children placed with them, adequate respite care[9] was unavailable, and support from case managers was unavailable when problems arose. Foster parents need to be given background information on the children placed with them in order to ensure the safety of themselves, their families, the children being placed with them, and other children entrusted to their care. Some foster homes have also not been provided adequate training or programs to deal with some of the behaviors of children and youth placed with them.

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

[9] 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.

FCRB Recommendations to increase recruitment/retention of foster family homes:

- HHS should put in place well-supervised procedures to ensure that foster parents are given essential background information on the children being placed with them;
- Foster parents need access to immediate and effective support when issues arise to assist in the reduction of placement disruptions. Since foster parents may need assistance 24 hours a day, seven days per week, HHS needs to build a system where there is a toll-free assistance line or a caseworker from the area assigned on-call to meet the needs of foster parents;
- HHS staff must recognize that foster parents are a vital component of the system;
- HHS and its contractors must provide foster parents with training to address the more complex problems being presented by children today, and to give them the support and respite they need; and
- HHS and its contractors should explore the creation of "professional foster parents" that is, foster parents who are provided enough in wages to be in the home providing daily care for a limited number of children in a home setting.

Physical and Chemical Restraints Are a Common Practice in Some Nebraska Facilities, Thereby Placing Children and Youth at Risk

Local boards have expressed numerous concerns about the rising use of restraints as well as the inappropriate use of physical restraints (also referred to as "takedowns"), chemical restraints, and prolonged isolation, to maintain order in many different facilities across the state.

It appears that physical restraints are more likely to occur in situations (1) where children and youth with multiple serious problems are in the same living situations and (2) where staffing and supervision are inadequate and (3) where there is not a program to address behaviors. 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, including, in many cases, 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.

The FCRB is concerned that many of the physical restraint incidents happening in Nebraska today are the result of staff who lack the sophistication to de-escalate a troubled youth without resorting to physical measures. Indeed, staff that has not developed the skills to relate to youth verbally is virtually forced to use physical means. It is unclear whether group home providers have adequately trained staff on how to de-escalate children's negative behaviors, if group home providers have established de-escalation as

the preferred practice over the use of restraints, and how group homes monitor restraints in their facilities.

In addition to the very real risk of physical injury to youth as well as to staff, the FCRB is concerned that the use of physical restraints are an affront to the child's dignity, a detriment to the child's self-esteem, and is not helpful in teaching the child to control his or her own behaviors. It also conveys 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. Even with the most violent youth, de-escalation techniques may prevent many instances of physical restraint. While discussion among providers used to center around *whether* to use physical restraints, it is now *assumed* that they will be using them.

A number of factors are affecting this apparent rise in physical restraint, including:

- Placements do not have programs to effectively deal with children's behaviors before an incident occurs, or staff trained in the programs;
- 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;
- HHS has no policy limiting or monitoring the use of restraints;
- The "no eject, no reject" clause in HHS contracts has resulted in some inappropriate placements. This clause states that facilities cannot turn down a youth being placed at the facility and cannot have the child removed if the facility is not appropriate. Because this negatively affects the need levels and mixtures of youth at facilities, the use of restraints to respond to incidents has increased;
- In some instances, lack of appropriate staffing levels and lack of staff training have led to the inappropriate use of restraints; and
- Throughout the system, there are problems with the decision-making process used when placing children at facilities.

The following is a case illustrating the reliance on restraints, and the negative effects on the child.

> *"Charlie," who is profoundly deaf in one ear, has been removed from his home three times. He was living in a border state when first removed from his home at age five because of physical abuse by his mother's boyfriend (his father is unknown). "Charlie" remained out of the home for two months. Subsequently, his mother moved to Nebraska. At age eight, "Charlie" and his sisters were removed from the home due to the mother's drug addiction. This time he was in care for almost two years before returning to the mother's home. After six months at home, "Charlie", who was then age 10, was removed from the home for the third time. Since then, his mother has been sentenced to twelve years in a federal penitentiary for drug charges.*

During these three times in care, "Charlie" has been in over 20 different shelters, foster homes, and group facilities. "Charlie" is now 12 years old and slight in build. His lack of physical stature, and his reliance on a large and noticeable hearing aid have made him the target of children's taunts. "Charlie" wants to be with his mother and this is impossible because she will be in prison without chance of parole until "Charlie" has reached adulthood. Understandably, "Charlie" is very angry, and has been aggressive.

"Charlie" needs proven de-escalation techniques and consistent care to help him work through his anger. However, what "Charlie" received in his months at his last group home were numerous physical restraints being put on him (takedowns), numerous shots of chemical restraints (Thorazine, etc.), and extended periods in seclusion. It should be noted that due to his mother's drug abuse, "Charlie" is very frightened of needles/shots. The staff of his facility knew of this profound fear, yet they repeatedly forced "Charlie" to undergo shots of a chemical restraint, which has only broadened this fear.

As could be predicted, "Charlie's" behaviors worsened at this group home. Thus, "Charlie" recently moved to his twenty-second placement, where he is now one of the youngest and smallest residents among many troubled youth.

FCRB Recommendations to reduce the numbers of restraints:

- Programs need to be put in place to assist in addressing youth's behaviors;
- Training should be provided to group home staff emphasizing alternatives to restraints, including comprehensive de-escalation techniques;
- A policy should be developed, implemented, and closely monitored by HHS to ensure appropriate use of restraints;
- Contracts for service and placement providers should include clear expectations regarding the use of de-escalation techniques and a requirement for proof of training in prevention and de-escalation techniques;
- Uniform documentation of physical restraints should be developed and reviewed both internally and externally by trained professionals for safety and appropriateness;
- Competitive salary guidelines and qualifications for staff dealing directly with children in group settings should be set to attract quality staff; and
- HHS standard contracts should be reviewed to address concerns regarding physical restraints;
- Every restraint incident should be subject to mandatory outside review;
- The "No Eject – No Reject" clause in HHS contracts needs to be re-examined, as does the ability of placements to cope with the needs and behaviors of certain mixes of children and youth. If the facility is unable to provide for the safety or other needs of a proposed new resident due to mixture of children or youth in the placement or other factors, the facility must be able to decline; and,

- HHS needs to implement clearer guidelines for placement decisions, treatment decisions, and service decisions and put into practice effective means to monitor and review these decisions.

In addition, at the time of writing this report in late 2000, the State Foster Care Review Board has adopted a policy and has made recommendations regarding physical restraints. The following are the highlights of the State Board's recommendations:

- Restraint-free therapeutic care environments and programs should be developed with the intent to eliminate the use of physical restraints; and
- De-escalation of violent and aggressive behavior must be the primary consideration of every provider and treatment program and special training in de-escalation techniques should be provided to caretakers.

The State Board is concerned that while there are protections against restraints for the elderly populations, there are no such protections for Nebraska's foster children

Appropriate Placements of all types are Lacking, Especially for Children with Severe Emotional or Behavioral Problems, or who are Sexually Acting Out

There is a general lack of placements available for children and youth in out-of-home care, including foster homes, therapeutic foster homes, group homes, and residential care facilities. This need is especially acute west of Grand Island.

Available placements frequently do not meet the needs of individual children, causing difficulties, conflict, and eventual removal from the placement. There has been a failure to develop sufficient therapeutic placements for violent youth, sexual perpetrators, emotionally disturbed children, children with a dual-diagnosis (example: substance abuse and mental health issues), pregnant girls, and children with severe behavior problems.

The situation today is particularly acute due to increasing numbers of children entering the system, at the same time many children already in the system are increasingly being denied services at the level of care needed due to financial reasons and/or due to placement/service deficits.

Because placements for children and youth in out-of-home care have not been developed, there is an increased reliance on:

- Emergency shelters (where children and youth remain for months instead of the recommended two weeks without education or services); and
- Group Home II's (developed to house and treat violent and aggressive youth, sexual abuse victims, children who are sexually acting out, emotionally disturbed

children, and behaviorally disordered youth together rather than developing specialized care).

One undesirable aspect of shelter and group care is that it tends to result in the placement of very vulnerable children in the same environment (and sometimes even in the same room) with other children who, because of their own issues, are likely to physically or sexually abuse them.

FCRB Recommendation to ensure appropriate placements are developed and retained:

- HHS should increase its focus on placement development to meet the following special needs:
  - Therapeutic placements for violent or aggressive children;
  - Treatment placements for sexual abuse victims or children sexually acting out;
  - Placements equipped to handle disabled children;
  - Therapeutic placements for emotionally disturbed or traumatized children;
  - Placements that specialize in the needs of children who have committed law violations;
  - Treatment placements for children with a dual-diagnosis (ex. substance abuse and mental health issues);
  - Placements able to handle the medical and emotional needs of pregnant girls and adolescents; and
  - Placements for children with severe behavioral problems.
- HHS should work to recruit and retain therapeutic foster homes, group homes, and residential care facilities, especially in the western part of the state;
- The possibility of using state resources, such as using the Nebraska Center on Children and Youth (NCCY) campus as a child-caring facility should be explored; and,
- A clear plan for oversight of agency-based foster care should be implemented to ensure that children are not at risk in an agency-based placement and that the placement is appropriate for the children's needs.

Many Children Experience Too Many Placements

It is reasonable to expect children to have two placements, such as an emergency shelter where an assessment of can be made to determine the most appropriate placement, and then the appropriate placement can be secured. **Unfortunately, most children do not experience this type of continuity while in care.**

In fact, 2,840 of the 5,557 children in care on Dec. 31, 1999 (51.1 percent) experienced four or more placements, and 974 of the 5,557 children (17.5 percent) experienced six or

more placements. Of this group, 172 (3.1 percent) of the children and youth experienced 21 or more placements.

The following chart shows how the number of children experiencing multiple placements has increased over the last five years. It is interesting to note that just ten years ago, in 1989, only 31.5 percent (1,411 of 4,479 children) had experienced this many placements.

Children with Four or More Placements as a Percent of Total Population in Care:

Dec. 31, 1995	41.8%	(2,112 of 4,563 had 4 or more placements)
Dec. 31, 1996	48.2%	(2,112 of 4,382 had 4 or more placements)
Dec. 31, 1997	47.5%	(2,355 of 4,960 had 4 or more placements)*
Dec. 31, 1998	47.3%	(2,554 of 5,402 had 4 or more placements)*
Dec. 31, 1999	51.1%	(2,840 of 5,557 had 4 or more placements)*

*Due to problems with data on reports received from HHS, this is an understatement of the number of placements. See concerns with N-FOCUS in the special section.

The initial disruption of moving children away from their parents is very difficult for them regardless of the poor quality of care that they were receiving. When children are placed in foster care, they must face new surroundings, a new authority figure, a new set of rules, and, often, a new school.

If placements are unable to handle the children's behaviors, children are often moved rather than providing services or support to prevent the removal of children from the placement. This is termed a placement disruption.

The following is a common scenario, illustrating how children and youth may experience multiple placement disruptions because of the general lack of placements and the lack of efforts to recruit placements to meet the needs of individual children:

1. A child may be placed where there is an available bed as opposed to being placed at a specific foster home or group home that is best equipped to meet his individual needs.
2. Such a placement is unable to manage the child's behaviors or meet this child's needs.
3. If the placement is unable to cope with the child's needs or behaviors, it also may not be able to meet the child's safety needs.
4. If the placement fails because it was a bad match to begin with or if the placement did not receive necessary support, the child is moved to another placement.
5. If the initial placement was a shelter and an appropriate placement cannot be found, the child may be moved to a different shelter every 30 days.

6. If an appropriate placement is not available when the child needs to be moved, the child may again be placed based on bed availability and continue to have his or her needs unmet.
7. A child may experience multiple placements in search of an appropriate placement that can finally provide needed services.

Children who experience a number of placement disruptions have an increased probability of depression, confusion, suffering short-term memory loss, learning problems, and/or being behaviorally impaired. Each placement disruption is likely to increase the children's trauma, distrust of adults, and negative behaviors, making future successful placement even more difficult.

The following case illustrates how a shelter was used as long-term placement for a child with multiple and specialized needs:

> *"Sam" was first removed from the home for a few days when age four, and was again removed from the home at age six when it was alleged that 1) he received inadequate supervision from his mother, 2) he had been molested by a family acquaintance, and 3) he had perpetrated on a young half-sibling. From age 6 through age 15, "Sam" was in six different foster homes. "Sam" is now 16 years old, and the following describes his most recent experiences in foster care.*
>
> *At age 15, "Sam" was removed from his sixth foster home due to his behaviors toward a younger foster child in the home who had been a sexual abuse victim prior to entering care.*
>
> *"Sam" was placed in his first emergency shelter for 30 days, and then moved to his second emergency shelter. Shelters are designed for stays of less than 30 days while the child's needs are evaluated and an appropriate home identified. However, "Sam" stayed at his second shelter for over five months. During this time he did not attend school. During this time the case manager did not visit the child in his placement for over 11 months.*
>
> *Due to concerns by the shelter staff that he might injure younger children at the shelter, he was moved to his third shelter after the shelter staff made weekly calls to the case manager, and located his next placement on her behalf. The case manager did not visit the child until just before his move.*
>
> *"Sam" remained at the third shelter for nearly six months before moving to his current placement. He also did not attend school at the third shelter. Therefore, "Sam" lost nearly a year of school. Due to his mental health needs and age, it is doubtful that he will complete his education. "Sam" will most likely remain in foster care until he reaches his 19th birthday.*

Most people working in the field of child welfare probably cannot remember a time when there were ever "enough" foster homes or other resources to meet the needs of children requiring care. However, the situation today is particularly acute because increasing numbers of children are entering the system at a time when many children already in the system are increasingly being denied services at the level of care needed due to financial reasons and/or due to placement/service deficits.

FCRB Recommendations to reduce the number of placements children experience:

- Build the capacity of out-of-home placements to match the population of children, their location, and their needs;
- 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;
- Recruit and retain foster placements by:
  - Providing background information when children are placed in foster homes and facilities;
  - Offering additional training;
  - Offering immediate support for foster parents when problems arise, which would also decrease placement disruptions.
- Monitor placement providers closely and consistently;
- Develop placements for children and youth with multiple or specialized needs;
- Implement guidelines designating who makes 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;
- Identify relatives and non-custodial parents within the first 120 days of a child's placement; and
- Require relative caregivers to pass the same standards as other foster care providers to ensure that children are safe and well cared for.

There is a Lack of Consistent Oversight of Agency-Based Placements

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.

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 has placed children at risk in the past, and the lack of quick and effective response to this situation continues to put children at unnecessary risk in many of these facilities.

The FCRB has reviewed cases where children were found to be at risk in some state-approved facilities agency-based foster care homes, and found that:

- When abuse in a agency-based foster home has been alleged, the abuse allegations are investigated by the home's private contract provider without further or separate investigations by HHS or the police;
- Some children lack appropriate supervision;
- Some children in out-of-home care have experienced several placement moves while in the care of a private contract provider without the knowledge or consent of the case manager;
- Some case managers do not know where the children in their care are specifically placed in some cases – only that they are in the custody of a contract provider;
- In some cases, case managers do not have a copy of the agency-based foster home's home study—important background information needed for assessing appropriateness;
- In some cases, case managers do not have knowledge of the other children placed in the agency-based foster home—information needed to assess the children's health and safety in the placement;
- In some cases, case managers have never met the agency-based foster family; and
- Procedures for licensing have been problematic. Some licenses for agency-based foster homes have been granted without a review of the home study.

The general expectation for children placed in the state's care is that they will be well cared for and safe. Conditions in foster homes and group homes are expected, by definition, to be much better than what these children experienced prior to coming into care.

As identified by Local Boards, some children placed in foster and group homes are not receiving the necessary supervision and care. Unfortunately the reports of injuries, abuse, and/or neglect in agency-based homes is increasing, rather than decreasing.

The following shows how a child experienced severe trauma in an agency-based home.

> *"Tony" tested positive for cocaine addiction at birth. His mother never visited him, and the parental rights were severed. Like many cocaine-addicted babies, "Tony" was an agitated, fussy child. He was placed in his first foster home when released from the hospital only a few days old. "Tony" was placed in his second home at age 10 months. This home had 9 other children, and he was moved.*
>
> *"Tony" was then placed in agency-based care, entering his third foster home at age 19 months. He was removed from this home when it was alleged that the foster parent's child had physically abused him. "Tony" entered his fourth home at age 28 months. When these foster parents had another baby, they asked that he be removed. "Tony" entered his fifth home at age 42 months. While there, he alleged abuse at the fourth home.*

After being in his fifth foster home for about 10 months, "Tony" was hospitalized due to severe burns and moved to his sixth foster home after hospital discharge.

It should be noted that his HHS case managers have not visited "Tony" in any of the agency-based foster homes he has lived in and the agency based care contractor investigated the abuse allegations at each foster home themselves. At age 4 ½ "Tony" has been in care his entire life, and has been injured in three of the six foster homes where he has been placed. "Tony" is showing the effects of the trauma that he has suffered.

Agency-based care is paid at a significantly higher rate than standard foster homes, yet the benefits in some cases are not getting to the children.

There has been a consistent fragmenting of the case managers job by contracting the management of children's placement, placement recruiting, visitation monitoring, and other services to other entities. While this may reduce the number of people working directly for the Department of Health and Human Services, it has not increased agency efficiency. In fact, it has added another layer of cumbersome bureaucracy between the case managers and the children and as a result critical information is not shared and responsibility is diminished.

FCRB Recommendations to improve oversight of contract service providers:

- HHS should re-commit to aggressively monitoring the services and placements that are currently contracted to private agencies;
- HHS should not expand the autonomy of private agencies' decisions concerning the placement and services for children;
- HHS should implement immediate, proportional consequences for agencies that fail to meet strict guidelines regarding children's safety; and
- Service provider contracts should be clarified to include clear expectations.

HHS Reports from the N-FOCUS System Remain Unreliable

Children and youth in out-of-home care and the work of the Foster Care Review Board have been adversely impacted by the continued lack of reliable data on reports from the Department of Health and Human Services (HHS) on children's entrance into care, and status changes while in care. These statutorily required reports are needed to: (1) track children in out-of-home care according to state mandates, (2) schedule children's cases for timely review according to state and federal mandates, and (3) to provide accurate case information as required by state and federal mandates. In addition, there are significant concerns with the impact on HHS case managers of this particular information system.

Due to the impact of this system on the children in care and on the Foster Care Review 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.

Lack of Training and Oversight for Contract Personnel Providing Children's Transportation and Visitation Monitoring

As a broker of services, HHS has become responsible for monitoring contracting agencies to ensure the safety and security of youth, to ensure that services agreed upon are provided, and to ensure that contractors are fiscally responsible.

The FCRB is concerned that even though HHS has implemented a system for monitoring contracted service providers, **it remains unclear who is accountable when problems occur, who is responsible for addressing these problems once they are identified, and how carefully providers are monitored.** In many instances, both HHS and its contract providers have been slow to respond to serious concerns.

In some areas HHS contracts with private agencies, such as VISINET, Lutheran Family Services, OMNI, etc., to monitor visitation. In some communities, HHS family support workers monitor visits. The FCRB's primary concern is whether the children are safe during visits and, if they are not, whether appropriate corrective action is taken.

The FCRB is concerned that crucial information concerning a child's safety may not be reaching the case manager or the person who supervises visitation in a timely manner. Visitation contract providers are to send their reports to the case manager. In some cases, they do not prioritize or flag the cases with the most serious concerns.

Visitation can be the most reliable indicator of success of reunification. Parent and child interaction during visitation is a vital benchmark to determine if reunification is in the child's best interests or if the child would be placed in imminent danger if returned home. The FCRB's staff reviews the visitation contract provider's documentation. In some cases they find incidents or information the case manager should know. When the FCRB's staff contacts case managers bringing incidents to their attention, case managers often state that they have not reviewed or even received the visitation documentation.

The FCRB is concerned that HHS does not oversee these visitation contract providers or control the quality or continuity of the service being provided. Also, there is a lack of identification of who takes responsibility for problems identified during visitation and a lack of clarity about what corrective actions are being put in place to assure children's safety.

Another area of concern is transportation of the children. It has been reported that public transportation providers, such as Armadillo Express, Eppley Express, Prince of the Road, and the Greyhound bus lines have been contracted to transport some children to new

placements and/or services instead of case managers. In other cases, temporary case aides provide the transportation. At traumatic points in their lives, some children are now being transported by strangers rather than by someone they know and trust, such as a case manager or foster parent.

FCRB Recommendations to improve oversight of contract service providers:

- HHS should study the cost-effectiveness of all contracts and define a reasonable caseload for its workers;
- HHS could hire permanent case aides to complete visitation and/or transportation services and to improve coordination and supervision of these critical areas. These case aides need to receive extensive instruction on how to correctly interpret parental actions and the children's reactions at visitation and to help children deal with the trauma of moves to new facilities/homes. (Currently contract providers are paid at least $14 per hour for their service, while case aides are paid less.);
- HHS should re-commit to aggressively monitoring the services and placements that are currently contracted to private agencies; and
- Service provider contracts should be clarified to include clear expectations.

The State's Contract with Managed Care (FHC ValuOptions) Causes Children to Not Receive Needed Services and Treatment Placements

Medicaid costs for mental health and substance abuse services for children were to be contained through the HHS contract with ValuOptions, a private managed-care company. These are expensive treatments that should be used wisely. However, ValuOptions has denied necessary treatments, placements, and/or services for children so that children's needs are not being met. The state contract for managing the costs of mental health services gives a financial incentive for ValuOptions to deny children needed services.

The FCRB has two concerns with the contract that HHS has with ValuOptions and one concern with ValuOptions' resulting practice:

- **The contract between HHS and ValuOptions makes it possible for ValuOptions to deny the treatment services** that most children and youth in out-of-home care need, i.e., behavioral services. One of the most predictable consequences of being physically abused, sexually abused, and/or neglected is for children and youth to present behavioral problems. Therefore, the FCRB is concerned that services for children and youth with behavioral problems are being denied.
- **ValuOptions is rewarded financially for denying children and youth the services that they need** to recover from the abuse and trauma they have suffered. This places the children needing services at risk, as well as increasing the risk for other children in the placement and for the community at large.

- In cases where therapists believe that ValuOptions will deny payment for the services a child needs, **some therapists write diagnoses based on what ValuOptions will pay for rather than writing the diagnosis to cover all of the children's needs.** Therapists do this so that at least *some* of the child's needs can be addressed. However, this practice makes it difficult to determine the true extent of the child's needs and the extent of the consequences of ValuOptions' denials for services.

A fundamental conflict exists between the role of ValuOptions and the role of HHS. HHS is responsible for providing "medically necessary services" to children in its custody. ValuOptions' role is to determine the necessity of services in evaluations, counseling, and treatment. ValuOptions is the gatekeeper of the mental health system for children in care, yet the ValuOptions staff making decisions on whether to approve treatments for the children do not actually see the children in question. Because of the monetary benefit to ValuOptions when services are denied, the definition of "medically necessary services" becomes an issue.

For many children, part of their "necessary services" is a treatment placement that provides an appropriate level of care. ValuOptions states it is not responsible for placements, only treatment. When a "medically necessary service" for children is an expensive higher treatment level or treatment placement, ValuOptions often recommends less expensive treatment placement levels. These levels are often not available, thus, effectively denying necessary treatment based on financial reasons alone.

Because HHS case managers cannot move children to a higher level of treatment than ValuOptions approves without a lengthy and complicated appeals process, children are placed at a lower level of treatment than needed for the children's health and safety, and many times for the safety of the community as well. HHS case managers are denied appropriate placements for the children they serve based on the lack of approval from ValuOptions for higher levels of care. The FCRB finds that many children are being denied necessary services.

The FCRB has received reports that a number of children have been moved prematurely (before completion of treatment) because ValuOptions has denied payment for further treatment apparently for the sole reason that higher levels of treatment are more expensive. Incomplete treatment normally will not accomplish the children's treatment goals. While acknowledging that treatment for these children is very expensive, the FCRB feels that in many cases money spent on treatment today may prevent the child being institutionalized later at a much greater expense or endangering the community upon discharge from the system.

There is a serious issue of community safety when children and youth do not receive the services they need. For example, if a child is sexually acting out, ValuOptions will deny treatment for the child, calling the issue behavioral and saying that treatment cannot begin until the behavior is under control. However, the sexual acting out behavior cannot be successfully addressed without treatment. The child remains in a "Catch-22 situation,"

unable to receive the treatment needed. In the meantime, any child in contact with the youth exhibiting this behavior is placed at risk.

HHS officials have clearly stated that HHS is responsible for services for children who are their wards. However, the FCRB continues to review cases where children are not receiving services due to a ValuOptions denial. **HHS appears to have delegated their statutory duties to a private company whose compensation base encourages treatment denials.**

Many programs that would have provided necessary treatment for these children and youth are unable to continue without approval of payments by ValuOptions. The FCRB has seen how these denials have reduced the array of necessary treatments, placements, and services for children and youth.

ValuOptions may have saved the state money in the short run by denying services. However, this practice has and will continue to put children and citizens at risk and will result in more expense for the state in the long run because children's true needs are not met.

FCRB Recommendations to ensure children and youth receive necessary treatments, services and placements:

- HHS should not use a managed care provider; rather it should internally manage its services and treatment to children and youth in out-of-home care;
- The contract with ValuOptions (or any other provider) should be written to include payment for services for children and youth with behavioral problems [if HHS continues to use a managed care provider]; and
- If the contract between HHS and ValuOptions cannot be re-negotiated to include payment for services for children and youth with behavioral problems, HHS should cancel the contract and reassume these duties.

Case Management is Fragmented Due to Key Duties Being Contracted Out

Children's Files Often Do Not Contain Essential Home Studies and Service Provider Documentation

The FCRB continues to be concerned about the lack of verification that home studies or approval studies for agency-based placements have been completed per HHS regulations for some children in out-of-home care. What this can mean for the child is that no one has done a thorough study of the home to make sure it is safe and appropriate for that particular child.

Home studies indicate the ages and genders of persons living in the home; family history; medical/social/mental health status of the foster parents; their parenting practices and abilities, including which type of children should *not* be placed with the family; physical condition of the home, including sleeping arrangements; the results of Central Registry and law enforcement checks to determine whether there have been prior allegations of child abuse or criminal behaviors; references, and other background checks. Home studies should be completed in a timely manner, either before children are placed in the home or within 30 days of an emergency placement.

A home study enables an evaluation of the special needs of the child to be placed in the home in relationship to the foster parent's ability to meet the child's needs and meet the needs of other children and youth in the home. Updating home studies prior to the child's placement can be an opportunity to avoid placing children with numerous problems in the same home.

When there are home studies in the file, the boards can better meet their statutory obligation in making findings on the appropriateness of placement. The FCRB is concerned that when this policy is not followed, children may suffer. Home studies are demonstrated to be the most reliable vehicle to evaluate a child's placement. **In 32.1 percent of the cases reviewed in 1999 (1,231 of 3,834 children), the FCRB was unable to determine the appropriateness of placement, primarily due to lack of documentation and/or homestudy.** This is a improvement over the 35.3 percent of cases reviewed in 1998 (1,321 of 3,742 children).

Through the reviews of individual children in out-of-home care, it is also evident to the FCRB that some service providers are not held accountable to even provide basic reports on their assessments, evaluations, or ongoing therapy.

Local Boards must make a number of findings in which it is essential to have current information regarding the children reviewed, including services provided. In many cases, it is impossible to assess parents' progress in therapy or substance abuse programs because either the case manager has not taken the necessary steps to obtain progress reports or the service provider has failed to submit such a report. It is also difficult to determine a child's progress in a placement or service without these reports.

During reviews, FCRB staff members document whether or not the child's file indicates that the case manager has visited the child within the 60 days prior to the review. The following chart shows that only 39 percent of the case managers had documented contacts with the children in their care within the last two months before a review. It would seem difficult to accurately assess the appropriateness and safety of placements and services without some face-to-face contact.

Case manager visited the child within the past 60 days	1,496	39.0%
Case manager did not visit the child within the past 60 days	216	5.6%
It is undocumented whether the case manager visited the child in the past 60 days	2,122	55.4%
Total children reviewed	3,834	100.0%

FCRB Recommendations to increase the availability of home studies and service provider documentation in the permanent files of children and youth:

- HHS should follow its policy to conduct home studies prior to placing children or 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 cases by the FCRB;
- Home studies completed by another entity should be provided to HHS in a timely manner and included in the child's permanent file; and
- Service providers should not be paid until their reports are provided to the case managers.

There is a Lack of Efforts to Find Runaway Children and Youth

There is often a lack of effort to find children who have run away from facilities, foster homes, and group homes. A reported procedure for finding runaway children and youth is facility workers will assist in a ground search if the runaway is known to be in the vicinity and then the child's mane 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. It is imperative for these children's safety that efforts be made to locate them and give them the services they need to grow into productive adults.

FCRB Recommendations in regard to runaways:

- An assessment needs to be done of each runaway incident to assess the cause;
- HHS, the State Patrol and local law enforcement need to increase efforts to locate runaways; and
- 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.

Many Case Managers Are Leaving the Profession, Causing Disruption of Many Children's Cases

The case manager is responsible for a child or youth's case management, which includes obtaining services and appropriate placements, monitoring placements and visitation, and writing the permanency plan. Children in out-of-home care need stability from the persons entrusted with their care. Between the five-agency merger, ValuOptions, N-

FOCUS CWIS, and increased caseloads, the case manager's job is nearly impossible to perform and leaves little time to offer stability to children in out-of-home care. Many workers are leaving HHS for higher paying positions with private agencies with which HHS contracts.

Across the state, the turnover in front-line workers has increased. Consequently, it is up to the remaining employees to cover the vacant caseloads. **Due to employee turnover, cases are prioritized based on level of crisis, and some children experience significant delays in permanency**. Other children may be reunified prematurely with parents that are not equipped to safely parent them. Case managers are so busy "putting out fires" that they don't have time for other matters, such as visiting a new placement in advance to ensure it is safe and appropriate for a particular child or providing encouragement and/or assistance to foster parents in order to prevent a child's placement from disrupting (another move for the child).

Local boards found during 1999 that it was not uncommon for children to have had several different HHS case managers during recent months in care. This situation has caused a number of poor outcomes for children, including a lack of continuity of care, and a lack of response to cases not in "high crisis" mode.

Case manager turnover is costly, time consuming, and disruptive. The state currently pays $10,000 to train one new case manager. In order to widen the pool of qualified applicants for case manager vacancies, there needs to be an examination of pre-service training.

Case managers have reported that they believe the training course does not provide sufficient expertise in family assessments, risk assessments, and assessments of domestic violence. Protection and safety workers must have knowledge and expertise on domestic violence, as statistics have shown that between 30-60% of child welfare cases also have the dynamic of domestic violence. This lack of sufficient training makes it more difficult for inexperienced case managers to help the family address the issues that led to the removal of the children from the home.

FCRB Recommendations to address case manager turnover:

- HHS needs to provide continued and additional energy in the identification and removal of barriers to case manager effectiveness and productivity so these professionals can serve children, youth, and families across the state;
- HHS needs to reduce the amount of computer time for case workers;
- HHS needs to increase levels of supervision and support for case workers;
- The HHS Child Welfare budget and worker caseload needs a thorough analysis. 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; and

- There needs to be an analysis of the training required for new case workers. The analysis should cover course duration, location, and content.

Case Aides Assigned to Assist Case Managers with Visitation Monitoring or Transportation Often Do Not Have the Training Needed to Successfully Complete Their Assigned Tasks

The FCRB has become increasingly concerned that, based on information from the review of numerous cases, it appears many case aides have been asked to assume traditional case manager duties such as visitation supervision, transportation, and placement visitation without the training and expertise to: 1) understand and report the complex family dynamics that occur during homes visits and supervised visitation, or 2) reduce the trauma for children being moved from one caregiver to another.

An additional concern is that it is reported that case aides in the Omaha area are defined as temporary positions, and that case aides are required to transfer from one caseload to the next every six months. Therefore, the case aides never become familiar with a specific case load and may not have sufficient background on the individual family dynamics to understand the nuances of the family interactions.

From the children's perspective, the case aides who provide them with transportation or safety during visits are a constantly revolving group of strangers. Understandably, the children's reactions to these situations may be substantially different than it would be if there the case aide were a well-known adult in their lives.

While the Board does not dispute that many case managers could use some form of assistance with their cases, for the children's sake it is imperative that case aides be given the training and tools necessary to complete the tasks assigned.

FCRB Recommendations to the role of case aides:

- Case aides need to carry out duties that match their qualifications and expertise and/or be trained to complete the tasks they have been asked to complete; and
- Case aides should assist case managers with entering information onto N-FOCUS CIWS so case managers can do the work they have been trained to complete.

ONGOING CHILD WELFARE SYSTEM BREAKDOWNS

The following problems have been identified by Local Boards in the past, and continue to be problematic. These issues continue to place children at risk and impede the ability of the system to fully address children's needs.

Child Abuse Investigations and Risk Assessments Continue to Be Problematic

The proper investigation of child abuse and neglect complaints depends on an informed public being aware of normal child development patterns. The public must also be aware and capable of identifying and reporting mistreatment when it occurs.

Good investigation relies on the availability of properly trained and experienced investigators statewide within law enforcement, Child Protective Services (CPS) and the medical community. These professionals must work cooperatively and relate effectively with traumatized youth, including those with limited language ability or limited understanding of English.

At the end of 1999, there was still confusion in many counties about how child abuse investigations were to be handled. With the responsibility for investigation assigned to law enforcement, HHS workers are being trained to assess safety rather than participate in investigations. This is resulting in a serious gap in child abuse investigations as illustrated in the following chart:

Gap in Child Protection

HHS workers no longer trained to investigate child abuse – existing staff being told to pull back from investigations.

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Some serious cases are screened out.

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Some law enforcement officers are not provided training on child abuse investigations prior to assuming the responsibility of conducting these investigations.

↓

Some serious cases are screened out.

↓

Nebraska's response to some child abuse cases is not timely, leaving children at continued risk

Investigations are not always complete. This affects what can be put in the Petition filed in court to protect children, and what grounds can be used for a termination of parental rights, if necessary. Problems with investigations can be grouped into two categories:

(1) Concerns for children left in dangerous situations due to problems with the investigation, or

(2) Problems when the investigation does not provide the evidence necessary to successfully prosecute or include all the reasons the child entered care on the child's petition.

A number of specialized skills are required for successful child abuse/neglect investigations. These include knowledge of normal child development patterns, gathering medical evidence, interview and investigation techniques for children with limited language abilities or with speech/language deficiencies, and assessing safety to make a determination of when children are at risk for future harm.

Following are a summary of the FCRB's concerns about the implementation of Child Abuse Investigation teams:

- The public and some professionals are still confused about when, how, and to whom suspected child abuse should be reported.
- Some professionals in the system remain confused about when, how, and who should investigate child abuse reports, causing refusals of receiving reports of child abuse and/or delays in responding to or investigating reports of child abuse. Delays or refusals can result in children being subjected to continued abuse.
- Child abuse investigation team formation has not solved the statewide problem of determining who has responsibility for what aspect of child abuse investigations, nor has it solved the problem of differences between what is actually done about child abuse in day-to-day practice and what is stated in statutes and/or regulations.
- Teams in some counties have not been formed, or have been formed but do not meet, and teams in some communities are made up of administrators, excluding front-line investigators.
- If county attorneys fail in their duty to create a functioning child abuse investigation team, then the county attorney should be removed from office for malfeasance of duty. The public needs to be made aware of such short-comings.
- Some law enforcement officers responding to child abuse calls have not received training on child abuse investigations, even in metropolitan areas where Juvenile Units exist.
- Some law enforcement officers have revealed the name of the person who made the report while conducting an investigation.
- Some dispatchers have not been trained in how to assess safety, how to prioritize calls, or on confidentiality issues.

FCRB Recommendations to increase statewide expertise, completeness, and consistency in child abuse investigations:

To the Governor and the Legislature:

- The Governor and the Legislature should work to establish funding to create regional Child Advocacy Centers to serve children in multi-county districts. By establishing such centers, the state would lead efforts to build and strengthen

regional expertise for law enforcement and Child Protective Services, provide access to expertise and equipment necessary for medical examinations for child victims, and facilitate expert interviews of child abuse and neglect victims.

- The Governor and the Legislature should allocate funding to provide the necessary training for law enforcement officers responsible for conducting child abuse investigations.
- The Governor and the Legislature should provide for additional mandatory training for new and experienced officers through the Grand Island Law Enforcement Training Center about law enforcement's responsibility to investigate allegations of child abuse and neglect.
- The Governor's office, together with the State Patrol and Attorney General's office, needs to make clear to all local law enforcement agencies in the state that it remains their statutory responsibility to investigate allegations of child abuse and neglect, and to inform them of sources of assistance with difficult cases.
- The treatment team component of the 1184 teams (child abuse investigation teams) needs to be eliminated. The function of these teams was not clear in the originating legislation. It appears that treatment teams should be made up of service oriented professionals, such as health care providers, schools, HHS, and the like, who could staff cases to ensure that everything is being done for the families. Many counties find that treatment teams are difficult to coordinate and that they appear to duplicate the functions of the HHS casemanager.

To the Attorney General:

- The Attorney General needs to create an effective system for regularly monitoring the effective implementation and the ongoing functioning of child abuse investigation teams (also known as LB 1184 teams) and ought to provide technical assistance for the child abuse investigation teams.

To the State Patrol:

- The State Patrol needs to build on the expertise that is currently being provided to local law enforcement by assuring such expertise is available round-the-clock to enhance law enforcement response to child abuse and neglect cases in each district and create an assistance and referral system to help officers in counties that do not have trained investigators.
- The State Patrol would be an appropriate entity to provide a number of skilled investigators for assistance in child abuse and neglect investigations outside Lincoln or Omaha. These State Patrol officers would need to be available 24 hours per day, seven days per week, and be located so that transportation time to the area requesting assistance is not prohibitive.

To Local Law Enforcement:

- Local law enforcement departments should work together to put in place, across the state, trained investigators who are specialists in child abuse allegations. This could be done by organizing rural counties into multi-county districts where individuals with interest in providing their professional expertise in child abuse

and neglect cases could be identified and trained in each of the above disciplines. Each multi-county district would include a child advocacy center to facilitate the competent interview of child victims.

- Local law enforcement departments need to make provisions to allow officers time to attend training on investigating child abuse, child neglect, and child sexual abuse. In counties where there are few officers, it is difficult to arrange coverage while the officer attends training. It is also a problem when they must use additional time to travel several hundred miles to Omaha, Lincoln, or the Law Enforcement Training Center in Grand Island when training is not available locally. Local law enforcement and the State Patrol should work together to solve these problems.
- Efforts must continue to discuss problems and solutions related to local law enforcement officers and discuss means to build their expertise. As the gatekeepers of the current child welfare system, a lack of expertise on the part of local law enforcement means that initial contacts are often traumatic and that children's harm and/or risk for future harm is not properly assessed. The local law enforcement officers need to be made aware that they are the gatekeepers and that their role is critical, both in the short run and in the long run.

To HHS:

- To ensure that children's safety is evaluated, HHS needs to modify its practice to ensure that mandatory, face-to-face risk assessments are conducted under certain conditions, such as calls from other professionals or when serious risk of maltreatment or neglect is alleged. HHS should provide Child Protective Service workers on a 24-hour on-call basis across the state for immediate face-to-face risk assessments to ensure children's safety.
- HHS should conduct risk assessments within 24 hours of receipt of a report from law enforcement, physicians, medical institutions, nurses, school employees, social workers, home visitation staff, or other involved professionals, and particularly when serious risk of maltreatment or neglect is alleged.
- HHS is encouraged to continue its recent effort to establish more effective supervision and review of caseworker decisions. The roles of front-line CPS caseworkers and supervisors need to be re-examined. It is recommended that all decisions not to accept a report of child abuse and neglect be reviewed because some reports of child abuse are inappropriately excluded from further action (examples: divorce cases, cases involving ex-domestic partners, family members, non-family members, and/or domestic violence). Identification and removal of barriers to effective worker productivity is to be a part of this process as is evaluation of worker performance.
- HHS needs to re-examine its district boundaries in order to determine if persons within each HHS district might be better served by smaller or different districts based on critical masses of population centers and geography.
- The FCRB supports the efforts underway by the Governor's Commission on the Protection of Children's Child Abuse Task Force to change the terminology on the Central Register/Central Registry from "inconclusive" to "agency

substantiated," "agency indicated," or another term, which conveys the same message, in statute, regulations, and policy. As a part of this process, it is recommended that the terms "unfounded" and "petition to be filed" be reassessed to reflect terms that do not empower the batterer in domestic violence situations and that statute, regulations, and policy be changed as necessary.

- There is a need for HHS to better define the difference between the Central Register and the Central Registry[10], and possibly change the names since professionals and the public can be confused by these similar terms.

Prosecution of Child Abuse and/or Neglect Often Fails to Address the Underlying Reasons for the Incidents

In addressing the needs of troubled children, it is essential to establish a sound legal basis for intervening in families where child abuse and neglect occurred and to define the problem in such a way that the issues are clearly identified. This should occur on an ongoing basis.

Moreover, in many instances children across the state are being left in dangerous and sometimes deadly situations because Nebraska does not have an effective child protection system. There is a need for a network of skilled, experienced attorneys with access to adequate resources to legally represent the best interests of children as they move through the legal system.

Prosecution of child abuse and neglect cases continues to be problematic in some areas of the state. County attorneys are responsible for the prosecution of all child abuse and neglect cases. Prosecution of child neglect, child abuse, and child sexual abuse is costly, time-consuming, and, as previously mentioned, dependent on an adequate investigation.

Even when a child is appropriately removed from the home, the quality of the investigation has a direct impact on the petition that the county attorney prepares. With insufficient or inadequate evidence, the petition cannot fully address all conditions that brought the child into care. Consequently, the court can only order services to address the items in the petition. For example, if the petition only alleges a dirty house but doesn't address the parent's alcohol abuse, the court cannot order the parent into alcohol treatment. Therefore, the root cause of abuse is not addressed, and the child may be subjected to continued abuse.

[10] The Central Registry is a database kept by HHS where each report of suspected child abuse and/or neglect is filed. Persons who have committed court substantiated child abuse and/or neglect are listed on the central register. Names on the central register may be revealed to employers or volunteer coordinators if the employment or volunteering would involve working with children.

From children's perspective, it is important that prosecutions occur. Without prosecutions the perpetrator bears 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. Research studies have found both disabled and very young children are capable of testifying in court if the people working with the children know how to proceed.

FCRB Recommendations to increase statewide expertise, completeness, and consistency in child abuse prosecutions:

- Nebraska must focus on building a statewide, consistent, comprehensive child protective services system.
- Communities must develop a coordinated and timely response to child abuse.
- Legislation should be introduced to replace the county attorney system with a publicly elected district attorney system (for counties outside of Lancaster and Douglas Counties).
- The County Attorney's Association should 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.
- The Attorney General's office needs 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 the 1184 Team oversight and technical assistance.
- The State needs to create a publicly elected non-partisan district attorney system, with candidates for office who meet certain professional prosecution standards (such as five years experience prosecuting felony cases).
- Accountability of prosecution of child abuse and neglect needs to be addressed whether the state creates a district attorney system or augments the current county-by-county system.

Delays in Establishing Paternity Can Delay Children's Cases

Paternity is often not identified until children have been in care for several months to well over a year. 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 father. This has resulted in children waiting more months for permanency as the father's rights are addressed. This problem is especially acute in Douglas County, where about 40 percent of the children in care in the state reside.

FCRB Recommendations to identify paternity early in the case:

- County attorneys and HHS need to work together to quickly establish paternity in the case of every child who must be removed from the home.

HHS Continues to Spend Considerable Time, Energy, and Resources on its Internal Organization Rather Than on Substantive Care Needs

It has been the FCRB's experience that rather than focusing on meeting the needs of children in out-of-home care and working to develop necessary services, HHS continues to spend considerable time, energy, and resources on its internal organization rather than on substantive care needs.

The responsibility and accountability for decisions about child protection, child placement, personnel assignment, resource development, etc., have diminished as a result of many factors, including:

- Problems with N-FOCUS
- Size of the agency;
- Chaos that continues because of agency reorganization and personnel shifts;
- Failure to define specific responsibilities for HHS Child Protective Services and Office of Juvenile Services staff, and
- Failure to develop and retain placements for children and youth.

It is the policy of the FCRB to bring serious issues affecting children's lives on an individual case basis to the special attention of the appropriate HHS case manager, supervisor, area supervisors, and/or central office. It has been the FCRB's experience in many of these instances that either HHS staff felt they did not have the authority to address the FCRB's concerns or they felt that it was not their responsibility to address concerns at the case level. Failure to identify roles and responsibilities results in a failure to adequately address children's health and safety needs.

A lack of fiscal responsibility and accountability are additional major concerns. Because the combined HHS budget is so large, it is difficult to determine how resources are distributed and utilized across Nebraska, as well as the true cost of individual programs. Without this specific information, it is difficult to ascertain whether funds are being used effectively and responsibly.