Dave Heineman
Governor

Carolyn K. Stitt
Executive Director

"THE JOURNEY CONTINUES – PROTECTING AND SERVING NEBRASKA'S FOSTER CHILDREN"

22ND ANNUAL REPORT OF

THE STATE FOSTER CARE REVIEW BOARD

2004

Submitted Pursuant to

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

State Foster Care Review Board

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"THE JOURNEY CONTINUES – PROTECTING AND SERVING NEBRASKA'S FOSTER CHILDREN"

22nd ANNUAL REPORT OF THE NEBRASKA STATE FOSTER CARE REVIEW BOARD

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

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Dr. Ann Coyne, Bonding & Attachment Advisor
Karen Kilgarin, Communication Advisor
Nancy Thompson, LMHP, Bonding & Attachment Advisor

The State Foster Care Review Board gratefully acknowledges the perseverance and dedication of each local board member citizen reviewer

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(bold indicates Board Chairpersons)

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(bold indicates Board Chairpersons)

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2004 LOCAL FOSTER CARE REVIEW BOARD MEMBERS

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Judy Meter		
Dixie Ramirez		
Andrea York		

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The State Board and Staff would like to thank Jim Gordon, Michele Harp, Kay Lynn Goldner, and Joellen McGinn for assisting with the proofreading of this report.

THE JOURNEY CONTINUES – PROTECTING AND SERVING NEBRASKA'S FOSTER CHILDREN

A COMMENTARY

The Journey Continues –
Protecting and Serving Nebraska's Foster Children
by Carolyn K. Stitt, M.S.W.

"The solution of adult problems tomorrow depends in large measure upon the way our children grow up today. There is no greater insight into the future than recognizing that, when we save children, we save ourselves."
Margaret Mead

In the last few years, Nebraska has become aware of many challenges in its child welfare system, both in child protection and in foster care. The challenges have been pointed out by a number of groups, including the 2002 Federal Child and Family Services audit, the Omaha World Herald, in its series of articles that began September 6, 2003, which included the "Our Dead Children" series, the Governor's Children's Task Force, Voices for Children, Kids Count, the Child Death Review Team, the Foster Care Review Board's annual statistics and analyses, and the research the Board conducted in 2003/2004 on child abuse deaths.

These groups have made many similar recommendations, including:

1. Develop statewide child abuse prevention and home visitation programs.

2. Improve Child Protective Services' (CPS) response to reports of child abuse, improve training for first responders, and strengthen child advocacy centers.

3. Strengthen accountability in all systems affecting children.

4. Ensure that children have plans which address the reasons they entered care and the services they need, that they are safe, that their care is stable, and that they reach permanency (safe, permanent homes) in a timely manner.

5. Increase the number of appropriate placements available for children of all ages and decrease placement disruptions.

Based on over 5,700 case reviews conducted annually, the Foster Care Review Board also recommends:

6. Strengthen the intake process by creating a single point of entry which ties the person receiving child abuse reports to the first responder. The Board is especially concerned with how the system responds to allegations against foster or group homes, where in many cases there has been very little done to assure children's safety.

7. Criminally prosecute severe abuse in the 25% of the cases which involve sexual assault or other severe abuse as outlined in the Adoption and Safe Families Act. Currently these cases are often dealt with only in juvenile court which by statute is a non-punitive court, and must make attempts to reunify the children with the parents unless there has been a felony abuse conviction.

8. Assure that courts more closely scrutinize the case plans which HHS (the Nebraska Health and Human Services System) offers to ensure that the plans are specific, with timeframes and goals clearly delineated, and with sufficient means to monitor progress.

9. Create special units within HHS to expedite permanency for children in severe abuse cases.

10. Utilize money spent on contracts more wisely, while simultaneously improving children's outcomes.

    a. Evaluate all contracts in terms of the children's experiences and outcomes. Assure that children are safe, and receive needed treatments and placements.

    b. Eliminate contracts for transporting children and monitoring children's visitations with the parents. Instead, hire permanent case aides who would better understand the cases and more effectively and efficiently communicate observations with the case managers.

    c. Cancel the managed care contract and return responsibility for determining children's placements to HHS.

    d. Monitor placements obtained through contractors to ensure safety, appropriateness, and receipt of treatment services.

11. Implement supports for caseworkers in order to stabilize the work force, with improved salaries, educational incentives, attention to caseload sizes, and support and mentoring from supervisors. Case manager turnover is extremely detrimental as the new case managers must take time to familiarize themselves with the cases, some of which have very complicated issues, and to establish the trust of the child and family. Oftentimes when the case manager changes, the case in effect "starts over," causing children to spend more time in care.

12. Increase the number of workers completing adoptions. At the end of 2004 there was only one worker completing all adoptions for the Omaha metro area. Improve or strengthen the number of adoption subsidies. Allow for children's future treatment needs, as many adopted foster children will periodically or throughout their childhood have mental health and other needs. This would decrease adoption disruptions.

Because of the commitment and dedication of many people in the child welfare system, approximately half of the children in out-of-home care are experiencing good outcomes. This means that there are appropriate plans, stable and appropriate placements, timely adjudication and other court hearings, timely reviews, and a timely progression towards permanency. Mary's case is but one example:

> *"Mary,"*[1] *age 6, has been in a stable foster care placement for 12 months. During this time, her mother completed a drug treatment program. Her mother now regularly attends aftercare and has random urinalysis, all of which have shown her to be 'clean' of drugs. Mary will soon be transitioned back to her mother's care.*

Children's outcomes have improved because of some recent efforts spearheaded by HHS Director Nancy Montanez and Administrator for Protection and Safety, Todd Reckling, and carried out by HHS caseworkers, supervisors, and managers, and the child welfare system.

1. **More children have written case plans outlining what must be done to achieve permanency.**
   a. 72.1% of children reviewed in 2004 had written plans, compared to 50.4% in 1999.[2]
2. **Fewer children experience multiple removals from the home.**
   a. 33.7% of children who entered care in 2004 had prior removals, compared to 41.4% of those entering care in 1999.
3. **More HHS case managers are regularly seeing the children.**
   a. 89.5% of the children reviewed in 2004 had been seen within 60 days of the most recent review, compared to 39.0% of the children in 1999.

These are important achievements for a number of reasons.

1. Case plans are road maps laying out strategies which allow children to be in safe placements, have their needs met, and ultimately achieve permanency.
2. Lessening the number of children removed from the home multiple times means that fewer children are going home prematurely, only to suffer abuse again.
3. Having case managers see the children on a regular basis is important to ensure the children's safety, assess their needs, and ensure that the placement is able to meet these needs.

In addition to these achievements, HHS has implemented a procedure which enables the Board to routinely bring the cases of highest concern to the regional administrators' and supervisors' attention. HHS Director Montanez attended the first of these meetings to vividly demonstrate to her staff the importance of these sessions. From the relationships built in these sessions, the Board now can bring cases of immediate concern directly to the supervisors/administrators, and issues are being addressed.

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[1] All names are changed to preserve confidentiality.
[2] All statistics from the Foster Care Review Board's independent tracking system unless otherwise noted.

The staffings not only are helping to resolve individual case issues, they have also improved the flow of communication between HHS and the Board, and have enabled the two agencies to consider strategies for cooperation on issues that are outside the control of either agency.

The Foster Care Review Board thanks HHS for these successful collaborations.

Building on these noteworthy efforts, the Board seeks to include in its focus those children in out-of-home care who do not have such positive outcomes. Recent statistics demonstrate the needs of these children:

1. **1,780 (46.6%) of the 3,819 children reviewed in 2004 had been in care for two or more years.**
2. **2,855 (46.9%) of the children in care on December 31, 2004, had experienced four or more placement disruptions, a level of instability that will negatively affect nearly all children.**
3. **1,006 (26.3%) of the children reviewed in 2004 had plans that were inappropriate, and another 701 (18.1%) had no written plan at all.**
4. **259 (6.8%) of the children reviewed in 2004 were in unsafe or inappropriate foster placements.**

To clarify, the Board is required to make a finding of whether it agrees with the child's plan. If it does not, it is required to recommend an alternate permanency objective and provide the rationale for such finding. In making this determination, the individual child's health, safety, and well-being are considered. For example, the Board might disagree with a plan of guardianship for a five-year old child, as adoption is a more permanent arrangement. Or, the Board would disagree with a plan of reunification for an infant whose parents have left the area and not made contact with HHS for some time.

The Board is also required to make a finding of whether the placement is safe and appropriate. In doing so it considers the individual needs of the child being reviewed, the mix of children in the placement, and whether or not an appropriate safety plan is in place. For example, if a child with serious aggression issues is placed in a foster or group home, the Board would determine if provisions have been made for extra monitoring so that the aggressive child, the other children in the placement, and the caregivers remain safe.

What are the Goals of This Report?

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

1. Serve as an independent voice to inform policy makers and the public on issues related to Nebraska's response to child abuse and neglect.
2. Identify the successes of programs and individuals.
3. Identify deficiencies in individual cases reviewed.
4. Offer its experience-based knowledge and expertise 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 the trauma each has experienced.

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. It includes concise descriptions of obstacles to safety and well-being, and offers the Board's recommendations for reducing or eliminating those obstacles. The Board's vision includes these elements:

1. Every 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.
3. Every child under the State's jurisdiction has a unique and tailored permanency plan for the future, one which is the best for that particular child and for 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.

What is the Basis for the Board's 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 community-based volunteer local boards. After careful review and research, a local board itemizes its concerns and provides recommendations for the ongoing care and safety of the child. Findings are then forwarded to the judge and to other parties 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.[3]

The Board bases the analysis and recommendations in this Report on the collected results of the **5,728 reviews** which were conducted on the cases of **3,819 children** during 2004. The other basis for the recommendations is the Board's 22-year history of analyzing the Nebraska child welfare system.

[3] See pages 143 and following for a more complete description of the structure of the Board and the case review process.

The following data from those reviews illustrates the obstacles faced:

1. 1,780 children (46.6%) had been in out-of-home care for at least two years of their lives, an increase from the 41.7% in 1994.
2. 1,064 children (27.9%) either did not have current written plans for reaching permanency as required by state or federal laws, or had incomplete plans which could not be used to fully measure parental compliance. This is a decrease from the 40.8% in 1994.
3. 1,006 children (26.3%) had plan objectives which the Board found did not meet the children's best interests, up substantially from the 11.4% in 1994.
4. 259 children (6.7%) were in unsafe or inappropriate foster placements, and 619 children (16.2%) had insufficient documentation to assure safety.

Other indicators, identification of causal factors, and recommendations for system improvements are found throughout this Report.

Individuals involved in Nebraska's child welfare system worked diligently to meet the needs of the 10,361 children who entered out-of-home care during 2004. However, as this Report 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.

We must recognize the societal changes which have greatly affected the foster care system. Negatively impacting the child welfare system over the past two decades, and children's lives today, are the proliferation of substance abuse (particularly methamphetamine abuse) among parents and teens, increased violence in homes and communities, families lacking stability, economic pressures, other societal ills, and changing cultural norms.

What are the Potential Benefits To Following the Board's Recommendations?

The Foster Care Review Board estimates that the number of children in out-of-home care could be reduced by one-third (2,000 children) or more, if Nebraska would:

1. Increase prevention efforts.
2. Create units which would focus on the special developmental needs of young children in foster care with the goal of making permanency decisions within 18 months of the children coming into care.
3. Improve support for caseworkers and reduce turnover.
4. Eliminate contracts for children's transportation and visitation monitoring.
5. Improve oversight for all contracted services and placements.
6. Put more children whose parents cannot or will not safely parent on the fast track to permanency. Criminally prosecute the parents in cases of severe abuse so that permanency can be expedited and the abuse stopped.

These steps would also improve outcomes and free up resources for the children in care.

With the goal of improving the outcomes for children, the Foster Care Review Board offers its recommendations on how the system must be restructured if more children are to have appropriate outcomes.

The Foster Care Review Board's main recommendations for restructuring the child welfare system follows.

Next Steps on the Journey – Priority Recommendations

I. Create a children's agency, or separate children's services, designed to have primary responsibilities of prevention of child abuse and neglect, appropriate response to reports of child abuse, neglect, or sexual abuse, assurance that children's mental health treatment needs are met, and ultimately achievement of permanency for children in out-of-home care.

Build accountability for decision-making into every level, whether front-line, middle management, or top management, to ensure that children's health, safety, and well-being are the priorities for all agency decision making.

A. Rationale

1. The majority of the children in out-of-home care have serious mental health or behaviors issues and/or special needs as a result of the abuse and neglect they suffered prior to their removal from the parental home. The agency spends millions of dollars on the children's care, stabilizing their conditions, and trying to help them overcome the effects of abuse. In order to better address these children's vulnerability, they must be the primary focus.

2. The volume of the child welfare workload is immense. HHS must:
   a. Be responsible for administering any statewide child abuse prevention programs.
   b. Respond to the more than 24,000 child abuse and neglect calls received annually, and place many children in foster care.
   c. Provide care, custody, and control of the more than 10,000 children who are in out-of-home care annually, and supervise other children who are with the parents, but still under HHS supervision.
   d. Monitor all the children's placements, develop plans for each child's future, and monitor contracts for children's transportation, visitation monitoring, placements, and services.
   e. Assist parents in accessing services needed to address the issues which brought each child into care.
   f. Work closely with the legal system to ensure that parents' due process rights are protected and court standards are adhered to.

3. In the current structure, child welfare is only one of many areas for which HHS is responsible. In addition, HHS must be responsible for Medicaid and income assistance programs, public health, responses to terrorism, (which has grown significantly post-911), care for the elderly and veterans, credentialing/licensing of numerous professions, mental health care access, and other programs all of which require serious attention.

4. Understandably, with so many programs competing for attention, important child welfare issues can be overlooked, leading to poor outcomes for children in care.

5. Nebraska must be a better steward of the state and federal funds dedicated to child welfare, and a better guardian of the children entrusted to its care. **Whether or not a separate children's agency is created, lines of accountability must be strengthened, and a division of contract administration and oversight created.**

II. Examine the methods other states have used to improve outcomes for children and utilize the best of these ideas to reduce the number of children in out-of-home care, and to shorten the time it takes for children to achieve permanency.

A. Other State's Actions Which Improved Outcomes

1. Delaware and Illinois professionalized and supported caseworkers by analyzing caseload sizes, supervision, and mentoring. This has resulted in reduced turnover of caseworkers, more support for foster parents, and higher numbers of children achieving permanency in a timely manner.

2. Delaware has placed the emphasis on the child and child safety first, building partnerships to ensure community-based services are available, and focusing on prevention, early intervention, and strengthening the foster care system.

3. Delaware also has instituted an annual State of the State's Children address and summit to recognize achievements and to develop consensus on next steps.

4. Illinois reduced caseloads for on-going workers, increased adoption subsidies, and developed better exit strategies. As a result that state has significantly reduced the number of children in out-of-home care. Illinois' percentage of foster children being adopted each year is more than double Nebraska's.

5. Washington organized special units to focus on permanency for children who had experienced extreme or chronic abuse.

6. Oregon passed legislation requiring the department to respond to the concerns outlined by their foster care review board after the review of each child's case.

7. Iowa has changed the term "neglect" to "denial of critical care" to better reflect the serious consequences for the children.

8. In 36 other states, the law specifies that parental failure to maintain regular visitation, contact or communication with the child constitute grounds for termination of parental rights.

9. Kansas law[4] 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*" in its grounds for termination.

III. Designate a lead agency responsible for a consistent response to child abuse and neglect reports across the state.[5] 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.
Investigations will provide the county attorney with all of the information necessary to file a proper petition with the court.
HHS and law enforcement will share information so that whoever goes out to investigate a report has all of the information necessary to make appropriate decisions regarding children's safety.

A. Rationale

1. According to HHS, in 2004 the CPS hotline received 24,111 reports, of which 20,568 alleged child abuse or neglect. In addition, there are approximately 300 law enforcement agencies statewide all of which also receive reports of abuse and neglect. Calls are often not documented nor shared with CPS.

2. 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 Lincoln and Omaha, where special juvenile units exist, it is usually a street officer with little training who responds to many of the calls received.

3. Law enforcement agencies have indicated that they lack the necessary manpower to solve crimes, much less to monitor HHS contracts, problematic foster homes and facilities.

4. The current response "system" encompasses two unrelated entities, local law enforcement agencies and CPS. These entities do not consistently collaborate and coordinate efforts nor do they internally manage their aspects of investigations.

5. The monitoring designed to improve the CPS response has failed to address the serious issues in the system. There remains a lack of consistent response

[4] Kansas statute §38-1583.
[5] See page 37 and following for more information on CPS concerns.

by CPS and by law enforcement agencies. Most allegations of abuse involving foster placements are "screened out" (not acted upon).

6. The Board continues to be contacted by persons frustrated by how calls are screened, how reports are labeled for investigation, and how reports are referred to law enforcement. This frustration mirrors the Board's experience regarding safety concerns in many foster placements.

7. Under federal regulations and state law the Board is required to make findings on the safety and appropriateness of each child's placement. The Board's reviewers must therefore research whether any allegations have been made regarding the placement of the children being reviewed and the system's response.

8. There are a number of placements, especially those provided by some of the HHS contractors, about which the department has received numerous calls of concern regarding abuse or neglect. Often there is little, if any, documentation about the follow up on these issues. Intakes received by the department regarding abuse/neglect allegations made against foster homes are oftentimes not acted on by an initial assessment worker, but are instead deemed a "licensing" issue and referred to resource development, where little is done to ensure the child's safety.

IV. **Create specialized units within HHS which focus on the special needs of children age birth through five[6] who, due to their developmental needs, require consistency and stability.[7] Assure that persons in these units, and other parties to the cases, receive specialized training on bonding and attachment and child development, and that they understand the impact that placement disruptions can have on young children.**

Act to assure that stability is maintained for young children by minimizing placement disruptions, identifying relatives early and determining their suitability as placements, and providing intensive services to parents to assess their long-term willingness and ability to safely care for their children.

Build on the success of the Douglas County Family Drug Treatment Court, expand this pilot program, and consider creating other family drug treatment courts across the state.

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[6] See page 47 and following for more information on young children in foster care.

[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.

A. Rationale

1. Stabilizing the placements of young children would minimize the trauma of removal from the parental home, increase the number of children experiencing timely permanency, and decrease the number of children in out-of-home care.

2. 1,534 children in out-of-home care on December 31, 2004, were under age six, the group most vulnerable to permanent damage from abuse and unstable living situations. 35.0% of these children have been moved to three or more different placements – a level of instability which experts find can cause damage. 13.8% of these children have had multiple removals from the parental home.

3. Many children are abruptly moved from stable foster homes, in which the children have thrived, only to be placed with relatives who are strangers to them, adding to children's trauma.

V. **Expedite permanency[8] by identifying cases of extreme abuse where reunification is not a possibility, and create a special fast track to permanency for such cases.**

For families who may be able to change, expedite permanency by assuring that caseworkers are better able to: 1) assure that parents and children receive needed services, 2) monitor parental compliance, and 3) continually assess children's safety and other needs.

A. Rationale

1. Too many children remain in care too long, with 458 of the reviewed children languishing in care for more than five years.

2. While there has been improvement in the number of children who have written plans, many times the plans do not reflect the abuse these children have suffered, nor how best to achieve permanency for them.

3. Families are typically not involved in the planning at removal or when case plans are developed and updated. A window of opportunity to work with the families when they are most likely to be responsive is being lost, and potential relative placements are not being determined early enough on in the cases.

NOTE: In the latter half of 2005, HHS is training staff on family group conferencing and family centered practices. If implemented as intended, these important changes of practice could help correct this situation. The Board is hopeful that this focus shift may improve other outcomes as well. The Board thanks HHS Director Nancy Montanez

[8] See page 105 for more information on case planning.

for arranging a special training session on this program for the Board's staff.

4. Caseworkers report a general lack of support. Delaware has a model to stabilize case management and enable caseworkers to achieve better outcomes.

5. Case workers often find that the training they receive does not fully prepare them for dealing with the families, brokering services obtained through contractors, and interfacing with the legal system.

6. Permanency can be delayed if potential adoptive parents are reluctant to adopt due to the fear of not being able to provide for foster children's future mental health and other needs without a subsidy. Nebraska needs to make sure that children who cannot go home safely have adoptions or guardianships established which have subsidies to cover the future mental health needs of the children. These measures will promote adoption and will prevent disruption of the arrangements made.

VI. **Use funds currently spent on the contract system to hire permanent staff to provide children's transportation and to monitor children's visitations with the parents. These staff would be assigned particular cases with which to become familiar, and thus they will more effectively communicate observations with the case managers. Provide each staff person the expertise needed so that courts and caseworkers can use and rely on their observations, and their information can be provided in a timelier fashion.** [9]

A. Rationale

1. Those who observe parent/child interactions on a daily basis are best able to determine whether the parent is able to provide appropriate care and supervision to the child.

2. Case managers who are unable to observe first-hand the interactions between parent and child must have regular communication with those who do.

3. Contractors transport approximately 1,825 children each week.[10]

4. The Board finds that there are major problems with the contract system:
   a. In some cases there is no consistency in the staff assigned to transport and/or monitor the visitation. Some contractors simply post the names of children needing the service on a board and drivers can "bid" for the job.

[9] See page 65 for more information about transportation contracts.

[10] 30% of children reviewed in October 2004 had contractors providing their transportation. 30% of the 6,083 children in out-of-home care on 12/31/2004 would be 1,825 children.

This means children often must deal with a new driver each time they are transported, adding to their stress.

b. Because of this revolving door of drivers, drivers are often uninformed about the case and what to communicate to the caseworker and to the children's caregivers.

c. Due to the lack of oversight, there is no assurance that drivers will have car seats for infants and will not smoke while transporting children with asthma.

5. Using the same dollar amounts now spent on contractors, the State could hire enough case aides to provide consistency and safety in transportation, and to quickly report their observations to the case managers. This would improve communication, improve safety, and likely provide cost savings.

6. The current system does not have clear lines of accountability. This makes it difficult for persons in the system to take action on behalf of children. The following example shows the Catch-22 this structure can create.

   a. During a review, the Board finds allegations of abuse or neglect regarding a child's placement. The Board attempts to report this, and:
      - The Board's staff is told by the HHS CPS hotline to report it to the caseworker.
      - The Board reports the abuse to the HHS caseworker, who says to report it to Resource Development.
      - The Board reports the abuse to HHS Resource Development, who says to report it to the CPS hotline.
      - Often no one investigates the abuse. Or the Board may be told that a safety plan would be put in place, only to later determine that the child's abuse has continued.

   b. It is especially difficult to determine who is responsible when issues arise with contracted services. There is no system to monitor contracts, nor to change or terminate contracts, withhold payments, nor levy fines for poor performance.

VII. End the managed care contract. Fund each HHS region based on the population served to allow the regions to determine how best to obtain needed treatments and/or therapeutic placements. Until the managed care contract can be ended, ensure that children receive needed treatment placements from other funding sources if managed care denies payment from its funds.

A. Rationale

1. The current managed care contract provides a bonus for decreasing treatment placements, but does not take into account the growing foster care population of children with serious behavioral needs. Thus, many children are denied

needed placements, or are moved before treatment is completed to the point at which children's behaviors truly stabilize.

VIII. Re-establish control and supervision of foster care placements provided by private contractors.

Better screen and monitor children's placements. Work to make sure children are safe in their placements.[11] Assure that training prepares foster parents for the tough issues they are likely to encounter. Evaluate the foster parents abilities and expectations during the screening and training processes, and do not license those who cannot cope.

Provide foster parents the support needed to address issues before they affect a child's safety. Make certain there is adequate communication of any issues regarding a foster home or day care used by foster children.

A. Rationale

1. Caring for a foster child is substantially different than caring for one's own child. Many foster parents simply have not been adequately prepared or have unrealistic expectations. Supervision needs to be in place to ensure all foster parents receive adequate training and screening so that foster parents are not set up to fail. This same supervision will also prevent safety issues that can arise when foster parents are unable to cope.

2. PRIDE training[12] for foster parents varies significantly depending on the presenter and contractor.

3. The Board is concerned about HHS' recently announced significant reductions in the number of training sessions to be held for currently unlicensed foster parents and prospective foster parents. This decision will:

   a. Impact children's safety if foster parents are unprepared,
   b. Reduce the desire of persons to become foster parents if they must wait for months for training, and
   c. Decrease the federal funds which Nebraska can receive for foster placements and reviews, as federal IV-E funds are contingent on licensure.

4. Due to the lack of placements, children are often placed with little consideration of the mixture of children in a foster home or facility, and how <u>each</u> child's needs will impact the ability to give safe and adequate care to <u>all</u> of the children.

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[11] See page 85 for general information about placements, and page 69 for issues related to contracted placements.

[12] See page 73 for more information on PRIDE training.

IX. Increase the number of placements (foster homes, group homes, other facilities)[13] available and develop specialized placements 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.

A. Rationale

1. Many children are placed where an available bed is the primary consideration, rather than in a placement best equipped to meet their needs, creating disruptions.

2. Children experiencing 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.

    a. 46.9% (2,855 of 6,083) of the children in out-of-home care on December 31, 2004, had experienced four or more placement disruptions in their lifetime.
    b. Some children experience even more disruptions, with 31.0% having six or more disruptions, 15.8% having 10 or more, and 3.0% experiencing over 20 placement disruptions throughout their lifetime.

3. Necessary transitions between placements are often not well-planned or are not done in a way to minimize the trauma for the children. Children are often abruptly moved without consideration for their bonding and attachment needs.

4. Delaware has recognized that the quality of children's lives is related to the recruitment, retention, and support of foster parents. That state instituted comprehensive assessments of the strengths and needs of all foster children and foster parents with the goal of providing "*each child safety, stability, self-esteem, and the sense of hope that comes with a single and best foster care placement.*"

[13] See page 85 for general information about placements, and page 69 for issues related to contracted placements.

X. Minimize Restraints.[14] Restraints include physical restraints, also called takedowns, chemical restraints, confined isolation or seclusions, and prolonged deprivation 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 caregivers.

Ensure group home staff and foster parents are adequately trained in proven de-escalation techniques. Require that placements not rely on restraints as their primary means of controlling children's behaviors, and rely instead on de-escalation child development models and soft rooms, using restraints only as a last resort. Monitor restraint incidents to assure children's safety.

NOTE: The Board notes that in 2005 UtaHalee/Cooper Village has lead efforts to adopt de-escalation training for all group facilities. The Board commends this action.

A. Rationale

1. Files on 285 of the children reviewed contained information indicating restraints were used within the six months prior to the review.

2. 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.

3. Some placements do not have programs to effectively deal with children's behaviors before an incident occurs, or if programs exist staff members are not adequately trained.

XI. Hold perpetrators of serious abuse accountable in criminal court.

Strengthen the petitions which are filed in Juvenile Court, as this forms the basis for the children's case.

Add a Unit in the Attorney General's office to Assist in Prosecutions.[15]

A. Rationale

1. Cases involving child abuse or neglect can and should go through two separate tracks – juvenile court and criminal court. Juvenile courts focus on entering orders on behalf of the child. Criminal courts focus on holding the parents accountable for their actions. Both types of cases are important but there are flaws in both systems.

[14] See page 101 for more information on restraints.
[15] See page 43 for more information on investigations, see page 115 for prosecutions.

2. Some prosecutors do not have the resources to simultaneously deal with the rise in methamphetamine related crimes and crimes against children.

3. Some prosecutors lack training and experience in these specialized areas.

4. Prosecutions can be hampered by poor investigations which provide insufficient or incomplete evidence. Prosecutors need evidence in order to prove in court the most serious allegations that led to children being removed from the home.

5. In juvenile court cases, courts can only order services to address the allegations of the petition which were proven at the adjudication hearing. With insufficient or inadequate evidence, the petition and the resulting orders cannot fully address all conditions which brought the child into care.

6. In the absence of felony criminal conviction, under federal law juvenile courts must offer children's parents a chance to rehabilitate– even if it is clear that these parents cannot or will not safely parent their children. This leads to children languishing in care, unable to return home and unable to achieve permanency.

7. Plea bargaining reduces or drops serious case concerns (e.g. sexual abuse). This practice places children at risk for future harm since courts cannot address issues not contained in the petition. However, in some cases prosecutors feel they have little choice. Either they were given insufficient evidence or the child was too fragile to provide testimony under cross-examination.

8. The U. S. Supreme Court's decision in the case of Crawford v. Washington[16] affects the admissibility of children's testimony given to law enforcement, medical personnel, and others outside of a court hearing. Judges and prosecutors alike have noted that this can make prosecution substantially more difficult, particularly in cases involving children who are very vulnerable due to their abuse and their tender age, and who cannot withstand the rigors of cross-examination.

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

XII. Create coordinated prevention efforts in every part of the state.[17] Include home visitation programs, such as those in Vermont and Hawaii, which demonstrated success in substantially reducing abuse and neglect, and those that the Centers for Disease Control (CDC) found reduced abuse by 40 percent or more.[18]

A. Rationale

1. Nebraska has one of the highest national per capita ratios of children in foster care,[19] primarily due to a lack of prevention programs capable of identifying and addressing many family issues before they became so critical that removal is necessary.

2. In 2004, 10,361 children were in foster care for periods of up to 365 days.

3. Home visitation programs have been found to reduce the number of children being abused and needing removal from the parental home.

4. While there are costs to such a system, the benefits can outweigh the expenditures. For example, the CDC study found that in a sub-sample of low-income mothers, the prevention system generated a net benefit of $350 per family.

[17] See page 121 for more information on prevention.
[18] Centers for Disease Control, www.cdc.gov, October 2003.
[19] U.S. Department of Health and Human Services, Child Welfare Outcomes, 2001.

Commendations for Leaders of the Journey

Governor Mike Johanns and the Legislature, particularly Senators Aguilar, Brashear, Bromm, Landis, Stuthman, and Wehrbein, are commended 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 more than $3.5 million for additional CPS workers.[20]
- Providing funding for child advocacy center coordinators.
- Increasing funding for skills development for child abuse investigators.
- Funding to provide CPS and law enforcement better access to each other's computer systems to obtain needed information on the families.

Continuing these efforts into 2005, **Governor Dave Heineman** is commended for increasing the funding for child advocacy centers by $375,000 for FY06 and $562,500 for FY07, and for meeting with the Foster Care Review Board several times to discuss the most serious child welfare issues.

Members of the Legislature, particularly Senators Aguilar, Bourne, and Howard, are commended for continuing to put forth study resolutions on important subjects as diverse as Child Abuse Prevention, Behavioral Medications for State Wards, Methamphetamine Abuse, and Compliance with the Adoption and Safe Families Act.

Senators Cudaback, Engel, Heidemann, Kruse, and Price, are commended for their actions to restore a portion of the Board's funding that was lost during the recent budget cutting years.

The Legislature is also commended for its 2005 approval of $50,000 for a pilot home visitation child abuse prevention project.

Chief Justice John Hendry is commended for forming a commission to address the time it takes to appeal terminations of parental rights, and for strengthening the education and functioning of the guardians ad litem.[21] Chief Justice Hendry also called for a summit for children so those involved could discuss ways to improve outcomes for children.

Juvenile and County Court Judges are commended for their responsiveness to the issues identified by the Board and for their actions to ensure the courts appropriately address children's needs for bonding and attachment, safety, and permanency.

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

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

[21] Guardians ad litem are attorneys who represent the children's best interests.

Scottsbluff Deputy County Attorney Doug Warner is commended for his many efforts to assure that Nebraska's children are safe. Examples of his efforts include serving on the Governor's Task Force for Children and providing information to members of the Legislature.

The District, Juvenile, and County Court Judges are commended for holding a joint educational program in 2003 to study what was learned from the child abuse deaths, and for continuing to examine ways to improve court processes. Many judges have assisted the Board with educational programs, such as those on the effects of methamphetamine abuse, and the Project Permanency programs on children's needs for stability and bonding with caregivers.

The Juvenile Court Judges of Douglas and Lancaster Counties are commended for providing additional information that helped assure children who had not been reported by HHS were not lost in the system. Due to these efforts, these children were tracked and received timely reviews.

Douglas County is commended for piloting the Family Drug Treatment Court for children ages birth through three and their families.

Professor Ann Coyne is commended for freely giving many hours of consultation advice on how best to ensure that the structure of the research in the child deaths to lead to credible results.

Guardians ad litem who do an outstanding job of advocating for their clients are commended. In particular we note the work of John Braaten, Lynnette Boyle, Leslie Christensen, Chris Costantakos, Kelly Coughlin-Beatty, Susan Dempsey, Leta Fornoff, Jim Gallant, Bob Goodwin, Tom Incontro, Rebecca McClung, Forrest Peetz, Carol Pinard-Cronin, Nancy Rath, Kathleen Rockey, Jim Ruby, Pat Samuels, Liliana Shannon, and Roberta Stick.

CASA workers are commended for their dedication to the individual families and children they serve.

Child Advocacy Centers are commended for their dedication to easing the trauma experienced by children during the investigation and interview of child abuse, neglect, and sexual abuse.

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.

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.

Voices for Children is commended for issuing the Kids Count Report and for its many efforts to improve the economic, health care, and well-being status of all Nebraska children.

The Nebraska Health and Human Services System (HHS) is commended for interfacing more with the child advocacy centers, developing an internal accountability plan, adding the additional staff approved by the Legislature, starting a program to give caseworkers more flexibility in planning children's cases through family based practice, reinstating a supervision mechanism, and instituting more case worker support.

HHS is commended for the following significant trend improvements:

1. A 22% increase in children with complete written plans, up from 50% in 1999 to 72% in 2004.
2. A 7% decrease in the number of children who re-enter care after failed reunifications, down from 41% in 1999 to 34% in 2004.
3. A 51% increase in the number of case managers who are regularly having contact with the children on their caseloads, up from 39.0% in 1999 to 89.5% in 2004.

In addition, HHS is collaborating with the Foster Care Review Board by:

1. Establishing a protocol to forward cases with the most serious concerns to the HHS Director and/or the HHS Administrator for Protection and Safety,
2. Holding joint staffing of cases of concern with the Board and providing more access to workers, supervisors, and administrators,
3. Inviting Board representatives to meetings with HHS area administrators,
4. Naming Board staff to be part of the HHS program improvement project, and
5. Facilitating contact between the HHS Director and the Board's Executive Director.

The Omaha World Herald is commended for its comprehensive series of articles about child abuse deaths and the issues affecting child protection in Nebraska, which began on September 6, 2003, and continued into 2004.

Project Permanency is a project that has touching the hearts of many individuals and groups across the state. The Board sincerely commends all who have contributed to bringing educational materials to foster parents, providing foster parents a small "thank-you" for their service, and/or providing toys, blankets, and backpacks for the children.

The Board especially notes and commends the following major contributions:

1. **Project Linus** is commended for providing many of the blankets that are given to the children on each Project Permanency visit. These blankets are all hand-made by Project Linus volunteers.
2. **KMTV-3** is commended for providing publicity for the project.
3. **Wal-Mart** is commended for providing places for individuals to make donations.
4. **The Omaha Foundation** is commended for providing a $10,000 grant.

Project Permanency Contributors 2003-2005

20 Grand Theatre
Alpha Delta Kappa Nu Chapter
Altrusa
Anderson Ford
Arby's
Betty Keithen
Big Mac Kiwanis Club – Ogallala
Bison Dental
Borsheim's
Burger King
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Champions Fun Park
Cheryl Svoboda
Cindy McCumbers
Cinema 3 – McCook
City of Carter Lake
Columbus MPS group
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Foster Care Review Board Local Board Members
Gallup
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Golden Corral
Good Samaritan Hospital – Project Snowflake
Gordman's
Harlan and Sharon Johnson
Havelock United Methodist Church
Heartland United Way Grand Island
Hobby Lobby
Horizon Designs
Hy-Vee
Ideal Grocery
Jennifer Sissen
Jim Friend
Joan Morrison and Al Thomas
Karen Earl and her scout troop
Keystone Community Club
Kim Riley-Keystone
Kiwanis of North Platte
KMTV-3
LaDonna Pankoke
Lewis and Moore
Lincoln Federal Bank – McCook
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State Farm Insurance – McCook
Strong's County Store of Scottsbluff
Subway – McCook
Susan Gilmore

Project Permanency Contributors 2003-2005 continued...

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TCBY
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the McKenzie Foundation's
Children to Children foundation
the National Guard
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Union Pacific Employees
United Methodist Church – Gibbon
United Way – Omaha
USA Steak Buffet
Valentino's
Valentinos
Walgreens
Wal-Mart
Wells Fargo Bank
Wendy's
Women's Auxiliary
YMCA – McCook

On behalf of the children, the Foster Care Review Board sincerely thanks each and every one of these contributors for their assistance in making Project Permanency a success.

The following section outlines some of the major efforts of the Foster Care Review Board.

Foster Care Review Board
Major Activities of 2004

I. Tracking Children

Pursuant to Neb. Rev. Stat. §43-1303 (1), §43-1303 (2) (d), §43-1303 (2) (e), and §43-1314.01, the Board:

A. Tracked 10,361 children who were in out-of-home care during 2004 as reported to the Board by HHS, the Courts, and private agencies.
B. Researched and verified the out-of-home care status, and then closed the cases of approximately 138 children whose cases had been closed without HHS issuing a report.
C. The Federal Department of Health and Human Services has directed that the Board's tracking system be put on the HHS N-FOCUS platform. The Board and HHS have begun this conversion. For the Board's tracking system staff, this involved a time intensive process of describing individual data fields and communicating how the Board's tracking system will need to function on the new platform.
D. Assigned 5,728 cases for review by citizen review board across the state.
E. Worked to overcome omitted or inaccurate reports from HHS to the Board's Tracking System.
F. Provided statistical and other information to researchers, grant seekers, governmental officials, and child advocates.

II. Case Reviews

Pursuant to Neb. Rev. Stat. §43-1308, and §43-1314.01, the Board:

A. Completed 5,728 reviews on 3,819 children during 2004. (This is less than the 6,503 reviews completed in 2003 due to budget cuts of $208,772, which led to the loss of five review and support staff positions.)
B. Issued 40,096 case specific reports with recommendations to the courts, agencies, attorneys, guardians ad litem, county attorneys, and other legal parties.
C. Facilitated local board members volunteering over 32,077 hours of service.

III. Tours of Foster Care Facilities

Pursuant to Neb. Rev. Stat. §43-1303 (3), §43-1308 (b), and §43-1302 (2), the Board:

A. Toured group home and detention facilities to assure that the individual physical, psychological, and sociological needs of the children are being met.
B. Continued visits under Project Permanency, where trained local board members visit the foster homes of young children, ages birth through five

years, to assure safety and to provide additional information to the foster parents on behaviors common to young foster children.

C. Completed over 200 visits to foster homes of young children, many to homes caring for more than one child.

D. Secured funding for Project Permanency from a number of corporate and public donations. Used this funding for educational programs on bonding and attachment, for the informational books given to foster parents, for a gesture of appreciation for the foster parents, and for the backpacks, blankets, and toys given to the children.

IV. Appearing in Court, Legal Standing

Pursuant to Neb. Rev. Stat. §43-1313, §43-1308(2), and §43-1308(b), the Board:

A. Appeared in court over 1,083 times during 2004, with the courts taking the recommendations in approximately 75 percent of the cases.

B. Issued 40,096 case specific reports with recommendations to the courts, agencies, attorneys, guardians ad litem, county attorneys, and other legal parties.

V. Reporting Abuse of Children in Foster Placements

Pursuant to Neb. Rev. Stat. §43-1308 (b), and §28-711, the Board:

A. Researched problems in the CPS system after the failure of the system to respond to safety concerns regarding foster children. Under the Governor's and then Director Ross' direction, did further research to determine the systemic problems in the system and to develop solutions.
   1. Pulled the more than 22,000 intake reports.
   2. Computed the number of workers needed to handle this volume.
   3. Testified before the Legislature on the need for additional workers.

B. Brought those concerns to the attention of then Governor Johanns, the HHS Director, and the Legislature. The Governor subsequently named the Board's Executive Director as Research Chair for the Children's Task Force. With the leadership of the Governor and key Senators, the following was enacted in the 2004 Legislative Session:
   1. $3.5 million was appropriated for additional caseworkers.
   2. Additional training for law enforcement was funded.
   3. Funding was secured to improve computer access for law enforcement and CPS.
   4. Seven child advocacy coordinators were to be hired.

C. Provided Governor Johanns with a report on reported abuse in certain group homes.

D. Researched, at Governor Johanns request, cases involving sexual abuse of children in foster homes to determine who knew about the allegations and how they responded.

E. Discussed the lack of accountability in the child protection system and the serious communication gaps between CPS and law enforcement.
F. Met with Governor Heineman shortly after he assumed office to inform him of concerns in the child welfare system.

VI. Promoting Children's Best Interests

Pursuant to Neb. Rev. Stat. §43-1308 (d), §43-1314.01, and §43-1303:

A. FCRB Work In Cooperation with HHS

1. Participated in regular meetings between the Board's Executive Director, the HHS Director, and the HHS Administrator for Protection and Safety.
2. Participated in monthly staffings on cases of concern.
3. Provided the new HHS Director background information on the child welfare issues identified by the Board as she assumed her new position in spring 2004.
4. Discussed ways to improve CPS response.
5. Discussed the disconnect between licensing for daycare providers and licensing for foster parents, and caseworkers who utilize these services, following an incident of abuse in an Omaha day care that was run by a foster parent, and that cared for many foster children.
6. Discussed problems identified with private contracts for transportation of children and supervision of visitation between parents and children.
7. Revised the process of staffing cases of concern with HHS caseworkers and supervisors, and flagging cases of significant concern for the HHS Director's attention.
8. Worked to address systemic issues that affect permanency and safety for children.
9. Completed a memorandum of agreement regarding HIPAA.
10. Participated in the HHS Performance Improvement Plan team.
11. Encouraged increased HHS participation in reviews.

B. FCRB Work In Cooperation with Members of the Legislature

1. Organized a joint release of the Annual Report with Senators Wehrbein, Jensen, and Stuthman.
2. Continued to respond immediately to case concerns brought forward by State Senators on behalf of constituents.

C. FCRB Work In Cooperation with the Chief Justice

1. Met with Chief Justice Hendry to discuss ways to improve judicial responses to children suffering abuse. The Chief Justice appointed a special commission to address the issue with special focus on expediting reviews, improving guardian ad litem representation, and creating a summit on child welfare cases.

D. FCRB Work In Cooperation with the Attorney General

1. Met with the Attorney General to discuss child protection issues.
2. Partnered with the Attorney General on bringing attention and awareness to child abuse deaths.
3. Referred cases of concern to the special unit of the Attorney General's office.

E. FCRB Other Efforts to Promote Best Interests

1. Advocated for children through team meetings, meetings with legal parties, special correspondence, and the like.
2. Several review specialists and supervisors met regularly with their area's "1184 teams" (child abuse investigation teams).
3. Sponsored educational events on Bonding and Attachment for local board members and members of the child welfare system, and held educational programs on precision in report language.
4. Gave an April 2004 educational program in Lincoln to child welfare professionals in conjunction with Project Permanency, which was opened by the Governor.
5. Gave an educational program in Omaha in conjunction with Project Permanency which was opened by Judge Elizabeth Crnkovich, Senator Lowen Kruse, and Representative Lee Terry. There were over 70 participants.
6. Worked in conjunction with the University of Nebraska – Omaha School of Social Work.
   a. Dr. Theresa Baron-McKeagney invited the Board to participate in meetings with a representative of the Child Welfare League of America.
   b. Dr. Ann Coyne provided consultation on the CPS research.
   c. Board staff spoke at various social work classes.
7. Maintained a booth at the May 21, 2004, Law Enforcement Coordinating Committee conference in Kearney. U. S. Attorney Mike Heavican offer the booth as this conference was sponsored in part by his office. This facilitated the Board being able to describe concerns and recommendations to a number of county attorneys and law enforcement personnel.
8. Made numerous presentations on the Board and on the status of children in out-of-home care to focus groups, community organizations, service clubs college classes, and foster parent training classes.

VII. Other Issues That Affected the Board

A. Began work on the state's new accounting system, and modified internal practice to conform to the new standards required of state agencies.
B. Developed means of coping with major budget cuts made in light of an economic downturn.

General Questions About the Foster Care Journey

How Many Children are in Foster Care?

Nebraska has one of the highest per capita ratios of children in foster care[22] with 10,361 children in out-of-home care for one or more days during 2004.[23] On December 31, 2004, there were 6,083 children in out-of-home care, 526 more children than the same date in 1999.

Why Are So Many Children in Foster Care?

There are numerous intertwining issues that affect how many children are in foster care, including:

1. Nebraska lacks prevention programs that could address problems before they are so severe that a child must be removed for the home.
2. Nebraska does not have a single entry point for children entering care.
3. About 20-25% of the cases involve extreme or chronic abuse. County Attorneys often do not criminally prosecute extreme abuse. Without a criminal conviction, there is no expedited permanency in the juvenile court system. Further, HHS often does not differentiate these cases, and attempts reunification even where clear the parents cannot or will not safely parent their children.
4. Caseworkers are often not supported, their caseloads are often too high, and there is a high turnover rate leading to instability and inconsistency in case management. Contracting for services such as visitation monitoring and placements has added a layer of bureaucracy between caseworkers and the children, without allowing for oversight or monitoring. Poor communication between contractors and caseworkers about parental attendance/response to visitation, a key indicator of whether reunification would be safe and successful, delays permanency.
5. Children are often not placed in placements that are therapeutic or meet their needs, so they are moved. As a result about half the children experience too much instability while in foster care, affecting their behavioral and mental health needs, which in turn lengthens their time in care.
6. If parents are non-compliant, there is often little action to change case direction.

Why is the System Slow to Self-Correct?

Nebraska's child welfare system, like most across the county, does not easily self-correct when issues are identified due to: 1) a lack of resources, 2) an overwhelming number of inter-connected issues and structural barriers within the system, 3) confidentiality restrictions that prevent information on individual case and systems failures from being

[22] U.S. Department of Health and Human Services, Child Welfare Outcomes, 2001.
[23] Statistics are from the Board's tracking system unless otherwise noted.

available to those outside the system, and, 4) a lack of voluntarily accepted or compulsory accountability measures for some parts of the system.

Under these challenging circumstances the Foster Care Review Board continues to push to ensure children's best interests are met.

Why Are Children Removed From Their Homes?

The summary table that follows shows why children reviewed during 2004 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. For example a child could enter care due physical abuse, neglect, and parental substance abuse.

% Children Reviewed	Condition	Important Facts
59.5%	Neglect	Neglect has serious consequences. Nationally, almost as many children die each year from neglect as from physical abuse.[24] [If a child has not been provided for physically, medically, and/or emotionally, it is considered neglect. Neglect can include the denial of critical care, 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.]
32.9%	Inability to cope with children's behaviors	Many child and youth behaviors stem from unrecognized abuse or neglect.
24.4% (or 30.9%, if including disclosures made after removal) See note regarding how this affects very young children.	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. **Note: 57% of the children reviewed in 2004 who were age birth through three years had parental substance abuse as a factor in their case.**
21.0%	Physical Abuse	This can include bruises, lacerations, broken bones, concussions, and brain damage.
19.1%	Unsafe or substandard housing	Parental substance abuse and mental health issues often contributes to housing issues.

[24] National Clearinghouse on Child Abuse and Neglect, www.calib.com/nccanch/, July 2003.

% Children Reviewed	Condition	Important Facts
12.5%	Abandonment	
8.5% (or 17.4%, 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.

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.

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?

The Foster Care Review Board conducted 5,728 comprehensive reviews on 3,819 children's cases in 2004. Most of these children had been in care for at least six months prior to their first review. The following data from those reviews illustrates the obstacles faced:

1. 1,780 children (46.6%) had been in out-of-home care for at least two years of their lives, an increase from the 41.7% in 1994.
2. 1,064 children (27.9%) either did not have current written plans for reaching permanency as required by state or federal laws or had incomplete plans that could not be used to fully measure parental compliance. This is a decrease from the 40.8% in 1994.
3. 1,006 children (26.3%) had plan objectives the Board found did not meet the children's best interests, up substantially from the 11.4% in 1994.
4. 259 children (6.7%) were in unsafe or inappropriate foster placements and 619 children (16.2%) had insufficient documentation to assure safety.

Other indicators, identification of causal factors, and recommendations for system improvements are found throughout this document.

Individuals involved in Nebraska's child welfare system worked hard trying to meet the needs of the 10,361 children who entered out-of-home care during 2004. 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

Complete, Written Plans

72.1% (2,755 of 3,819) of children reviewed in 2004 had a complete permanency plan as required by Nebraska statutes.

Less Than Two Years in Care

53.4% (2,039 of 3,819) of children reviewed in 2004 had been in care for less than two years at the time of their last review.

No Prior Removals from the Home

66.3% (3,208 of 4,839) of those entering care during 2004 had been placed in out-of-home care only one time and had not suffered a premature reunification.

Stable Placements

53.1% (3,228 of 6,083) of children in out-of-home care at the end of 2004 had experienced 1-3 placements.

Work to Be Done to Improve System

Incomplete or No Current Written Plans

27.9% (1,064 of 3.819) of children reviewed in 2004 did not have a complete plan as required by Nebraska statutes.

More than Two Years in Care

46.6% (1,780 of 3,819) of children reviewed in 2004 had been in care for more than 2 years at the time of their last review.

Previous Removals from the Home

33.7% (1,631 of 4,839) 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 in 1992 (when it became standard practice in HHS to pursue reunification in all cases, regardless of severity) can be seen in the following comparison statistics.

Year	Percent with Previous Removals
1989	2.1%
1992	13.9%
1994	27.8%
1999	41.4%

Multiple Placements

46.9% (2,855 of 6,083) of children in out-of-home care at the end of 2004 had experienced four or more placement moves.

What do the Statistics Mean for An Individual Child?

These numbers in the previous chart represent significant trauma added to the lives of children already traumatized by abuse and neglect. The following is a case example that illustrates some of the previously mentioned statistics.

> *"Blake[25]," who is almost 3 years of age, and "Tom", who just became 2 years of age, entered care just over a year ago due to their mother's substance abuse and instability. Several months before this involuntary removal there was a voluntary case open on the children, during which the mother asked for the children to be removed on three different occasions. Blake and Tom are not developmentally on track, and are being tested for fetal alcohol effects. Tom is on special formula and unable to eat all table foods due to a physical problem. Tom also has a skin condition that requires a medical ointment be applied three times per day.*
>
> *Blake and Tom were placed in a problematic foster home. Concerns include:*
>
> 1. *There have been multiple reports of abuse in this home.*
> 2. *The foster father is enrolled in anger management classes.*
> 3. *The foster mother has a physical disability and is battling depression.*
> 4. *Already in the home are:*
>   a. *a son who has been accused of a major arson incident,*
>   b. *a son with sexual perpetration issues,*
>   c. *a child with the effects of shaken baby syndrome,*
>   d. *a child with explosive temper tantrums, and*
>   e. *a child with learning disabilities.*
> 5. *In addition, soon to return to the home are two youth with serious needs – a child with aggressive tendencies and psychological issues, and another child with mental health issues.*
> 6. *It is reported that the child with serious learning disabilities is responsible for caring for Blake and Tom.*
> 7. *Blake and Tom have been displaying behavioral problems.*
> 8. *Blake" and Tom are not seen by schools or others outside the home and are at an age to be vulnerable to abuse.*
>
> *The Foster Care Review Board reviewed the case and brought these issues to the legal parties attention through the formal recommendation submitted to all parties and through telephone contacts. The Board also brought the case to the attention of HHS administrators. The Board has since learned that the foster father has been accused of physically abusing Tom.*

Nebraska should design and support a system that responds to children's needs, and responds more immediately to issues that affect children's health and safety.

[25] Names and other identifying characteristics are changed to maintain confidentiality; however, the case conditions are actual findings from a review.

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, that 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.[26] The chart below summarizes major barriers.

Most Frequently Identified Parental Barriers to Permanency

1. Parental unwillingness or inability to safely parent their children
   36.0% (1,375 of 3,819 children reviewed in 2004)
2. Past histories of abuse, neglect and violence
   25.7% (980 of 3,819 children reviewed in 2004)
3. Parental substance abuse
   23.3% (891 of 3,819 children reviewed in 2004)

Most Frequently Identified System Barriers to Permanency

1. Length of time in care, with reduced likelihood of successful permanency
   22.7% (868 of 3,819 children reviewed in 2004)
2. Lack of case progress
   12.2% (466 of 3,819 children reviewed in 2004)
3. Lack of current, written plans for the child's future
   12.1% (464 of 3,819 children reviewed in 2004)

[26] See Table 4 on page 166 for more information on identified barriers to permanency.

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

How Many Child Abuse Reports Are Received Per Year?

Since the summer of 2003 there has been increased media attention on child abuse. HHS reports it received 24,111 reports in calendar year 2004, of which 20,568 involved allegations of child abuse or neglect.

In a 12-month period (July 2002-June 2003) studied by the Foster Care Review Board, (as described later) there were over 22,000 reports received by CPS, and approximately 17,000 of those reports were on children allegedly being in dangerous situations.

What Can Go Wrong When a Child Abuse Report is Received?

Background information: Most calls to report child abuse go to CPS, either through calls to the toll-free hotline 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, which is 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:

1. The Board's research on child deaths due to abuse.
2. The Board's attempts to access the CPS system regarding children who are placed in out-of-home care.

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:

1. **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.
2. **Even if a call is "accepted" that does not mean that any further action will be taken to ensure the safety of the child.**

Other issues found during the research of the child deaths included:

1. There appeared to be no supervisory review of hotline decisions to accept or not accept a report, and no supervisory review of whether any further action was taken on calls that were accepted. Supervision levels varied across the state, so even within CPS there were significant differences in response.

2. CPS attempted 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 was unclear how a thorough safety evaluation could be completed without seeing the child.
3. CPS did not effectively compile all the information they have about a family while screening the calls, or assure this was readily available on the computer.
4. Cross reporting from CPS to law enforcement, and from law enforcement to CPS, did 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:

1. Law enforcement dispatchers are not always trained in making safety assessments to prioritize the calls that they receive, or on confidentiality issues.
2. There have been problems in assuring consistent communication with CPS.
3. Cross reporting from law enforcement to CPS does not always occur.
4. Communication across law enforcement jurisdictional lines, which has historically been problematic, is uncertain, such as communication between the State Patrol, Sheriff's office, and local law enforcement agencies, all of whom may have had interactions with the family.
   a. For example, the law enforcement computer system, JUSTICE, does not include safety checks nor 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 more than 300 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 intake 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 the skill levels of 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. All screeners should be M.S.W.'s[27]. [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.

[27] Masters of Social Work.

What Were the Research Findings on Nebraska's Child Deaths Due to Abuse?

With all the efforts made to improve the lives of Nebraska children, it was with heavy hearts that the Board became aware of the number of Nebraska children who have died due to abuse, neglect, or violence.

The following describes the Board's 2003/2004 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. This research was done at the direction of Governor Johanns.

Recognizing the increase in child deaths due to abuse or neglect over the past few years, the Board researched the cases to determine if the children who died 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:**

1. **26 of the 32 children killed (81%) were newborn through five years old.**
   a. The Board continues to recommend that reports of abuse involving young children be prioritized.

2. **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.
   a. 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.

3. **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.
   a. The Board recommends that the child protection system be revamped so that children's safety is the highest priority.

4. **3 of the 32 children killed (9%) were state wards at the time of their death.**
   a. 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.
   b. 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.**

The Board was directed by Governor Johanns to examine past child abuse reports in order to determine if the above cases were representative of problems with the entire system.

Research Findings on 5,947 Calls of Child Abuse or Neglect

Methodology

A sample of 5,947 calls (25.9%) of the 22,921 calls made from July 1, 2002 to June 30, 2003 was selected according to the proportion of calls made in each of the 12 Districts of the Nebraska Department of Health and Human Service by specially trained staff and local board members. Staff and members of the Nebraska Foster Care Review Board recorded the data contained in those 5,947 calls and assessed the safety of the child(ren) involved.. Staff with at least eight years CPS experience evaluated about 70 percent of this sample.

Calls That Were Not Abuse Reports

It was apparent that not all calls were reports of abuse and neglect but were about children already in foster care. Physicians needing permission to treat, grandparents wanting to visit grandchildren, foster parents trying to determine their child's new caseworker were mixed in with the calls reporting abuse and neglect. There appeared to be differences in how Districts handle these calls. Caseworkers in some districts fill out an intake form when they take an informational call on the hotline, while caseworkers in other districts do not consider these calls a CPS report and do not fill out an intake form. This makes it difficult to get an accurate count of how many reports of child maltreatment actually came into the department during a year.

To try to remove information calls from the data, only those calls that had an incident identified in one of the 12 HHS Districts and also had the age of at least one child were included in the data set. While this resulted in a 28% reduction of the data set, it provides a conservative view. The final data set consisted of 4,262 calls, of which 49.3% came from urban areas and 50.7% came from rural areas of Nebraska.

Calls That Reported Abuse or Neglect

From these 4,262 calls, 30.9% were accepted for initial assessment; 36.5% were screened out; and 32.6% were coded as something else or left blank. The percentage of calls accepted for initial assessment varied by District with a high of 56.8 % in District 10 (Sandhills) and a low of 18.9 % in District 8 (Kearney). Five of the Districts accepted over 35% for initial assessment, District 2 (Sarpy); District 6 (Norfolk and northeast); District 7 (Grand Island); District 10 (Sandhills); and District 11 (North Platte and southwest). Four of the districts accepted fewer than 25% for initial assessment, District 3 (Lincoln); District 5 (Fremont); District 8 (Kearney and central); and District 9 (Holdrege and south-central).

Intake was quite centralized. Four workers located in Omaha at the Hot Line took over 44.1 % of the calls. And, only18 workers statewide received 74.6 % of the total calls. There were considerable individual differences among the caseworkers taking the calls in the percent of calls he/she accepted for initial assessment, ranging from 13.7 % to 53.6%. There also appeared to be a particular code called 'other' used only by the four Omaha based hot line workers. Over 83.5 % of the 334 cases coded as "other" were coded by the four hot line workers. Workers outside of Omaha rarely used that code

The assessment of child safety differed between workers of HHS and readers, even though the readers for approximately 70% of the cases were Board staff members with significant prior CPS experience. On a scale from 1-4, where "1" means no risk and "4" means high risk, foster care review board members consistently rated the risks higher compared to the caseworkers. For risk of maltreatment the average score was 2.47 by the FCRB readers and 1.63 by the HHS caseworkers. For nature of the circumstances accompanying the maltreatment it was 2.47 to 1.70. For vulnerability of the child it was 3.27 to 2.85. For identity, which is how parents view or label the child, it was 2.02 to 1.44. For child functioning it was 1.91 to 1.39. For adult functioning it was 2.44 to 1.69. For parenting it was 2.38 to 1.53. All of these differences were statistically significant ($p < .0001$).

In evaluating risk of physical abuse, physical neglect, emotional abuse, and/or sexual abuse, after the case had been assessed, the same pattern was seen.

1. Of the 332 cases evaluated by the FCRB reader to be 'not safe' of physical abuse, 57.1 % were closed by the caseworker as 'not applicable,' 'screened out,' 'unfounded,' or 'inconclusive.'
2. Of the 518 cases evaluated by the FCRB reader as being not safe from physical neglect, 63.9 % were closed by the caseworker for the above reasons.
3. Of the 208 cases evaluated by the FCRB reader to be not safe from emotional neglect, 44.7 % were closed for the above reasons.
4. And, of the 144 cases evaluated by the FCRB reader to be not safe from sexual abuse, 45.9 % were closed for the above reasons.

By age:

1. Children age birth through five accounted for 33.8% of the 7,655 children identified in the 4,262 calls.
2. Children age 6-11 accounted for 33.1% of the children reported.

3. Children age 12-15 accounted for 20.4 %, and
4. Children ages 16-19 accounted for 12.8% of the children reported.

Of the 4,262 cases 30.9% were accepted for initial assessment. There appeared to be a slight preference based on age, with 36.6% of the children age birth through five accepted for initial assessment, 34.0% of the children 6-11, 27.3% of the children 12-15, and 19.2% of the children age 16-19.

There were considerable differences by District, however. In District 8 (Kearney) only 16.0 % of the children birth through five were accepted for initial assessment, while in District 10 (Sandhills), 66.7% of the children 0-5 were accepted. In five of the 12 districts, children age 6-11 were more likely to be accepted for initial assessment compared to children birth through five. In three districts children age 12-15 were more likely to be accepted for assessment compared to children age birth through five.

When a child was accepted for initial assessment, most of the time the investigation was done. Out of the 1318 cases accepted, 959 assessments were found (72.8 %) and 915 of them had dates of completion (69.4 %). There were 762 safety plans found (57.8 %). The vast majority of the plans were 'remain at home' (71.6 %) with or without the perpetrator removed. Only 19.6 % were a form of out-of-home care.

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 Child Protective Services, a division of the Nebraska Department of Health and Human Services System. 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 more than 300 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. Many officers are not well equipped to handle investigations involving preverbal or handicapped children, or the subtler forms of child neglect. Officers in juvenile units, such as in Lincoln or Omaha, have more training; yet due to the volume of reports, the first responder usually is a street officer who has had only four hours of specialized training on child abuse investigations rather than an officer from the special units.

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. Some law enforcement officers do not document a well-being check done on a child.

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.

Although progress is being made, many investigations do not involve both law enforcement and CPS. However, 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 creating 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" or eliminate many calls alleging serious abuse or neglect.

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. The 1184-team meetings are a good forum to discuss some of the cases, but are not a good forum to address supervision, screening, and investigation issues. **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 high number of cases makes staffing all cases impossible.
2. The teams were not funded or designed to have a leader with authority to compel immediate corrective actions on behalf of a child or to handle crisis situations.
3. The teams were not built to handle the volume of abuse reports received.
4. The teams cannot impact law enforcement jurisdictional issues, nor law enforcement or CPS staffing issues.

5. 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.
6. Investigation protocols are in place, but there is no mechanism to assure these protocols are followed.

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. There must be someone who is in charge of the investigation and who is accountable for the outcomes.

At the very least, "intakes," the receipt of child abuse calls, must be tied to investigations and coordinated with access to previous calls made to either law enforcement agencies or CPS.

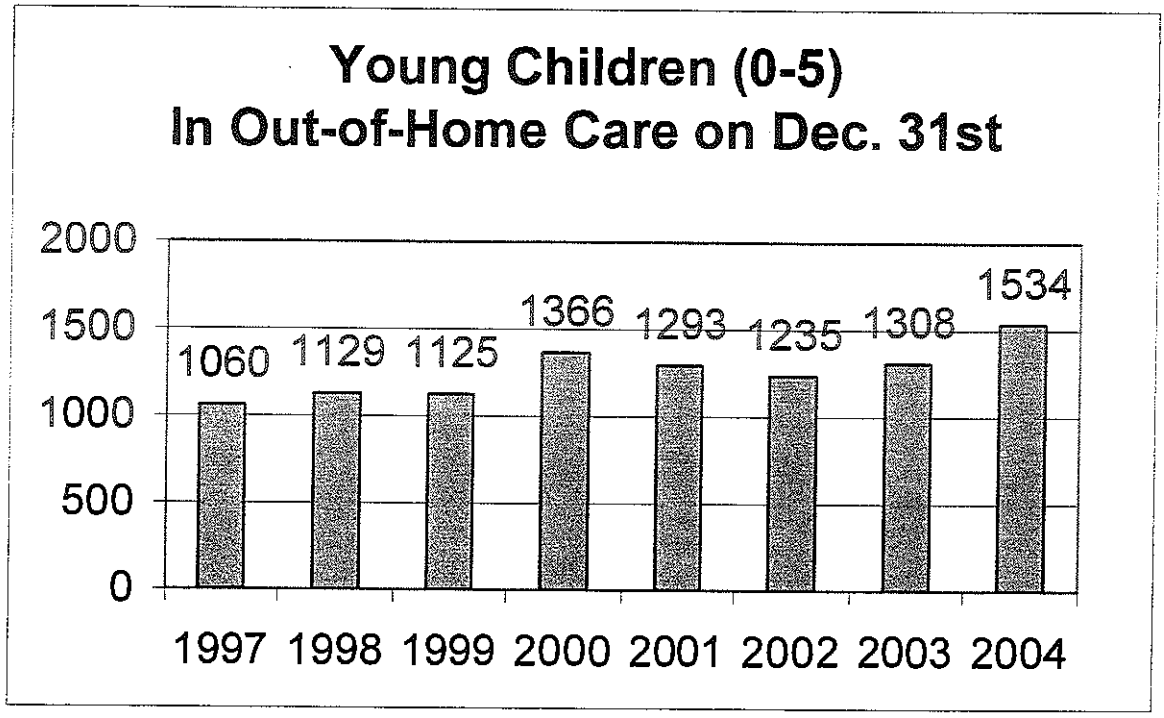
The lead agency would act much like prosecutors do when leading drug investigations. The state is broken into regional drug task forces to coordinate response to drug problems based on regional strengths, expertise, and demand. Similarly, the lead agency the Board proposes: 1) would review every intake, 2) would assign cases for investigation to trained investigators, with the more serious being assigned to one or more investigation specialists, and 3) 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:

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

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.


Young Children (0-5)
In Out-of-Home Care on Dec. 31st
2000
1500
1000
500
0
1060
1129
1125
1366
1293
1235
1308
1534
1997 1998 1999 2000 2001 2002 2003 2004

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: *"The importance of positive early environments and stable relationships for a child's healthy development is incontrovertible. At the same time, a lack of attention to infants in or at risk of foster care placement has long-term implications for those children and our society. Children who spend their early years in foster care are more likely than other children to leave school, become parents as teenagers, enter the juvenile justice system and become adults who are homeless, incarcerated and addicted to drugs. Answering the cry of infants in foster care is an investment in their lives and the future of all children."*[28]

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[29]

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.[30]

Separation from parents, sometimes sudden and usually traumatic, coupled with the difficult experiences that have precipitated out-of-home placement can leave infants and

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[28] Ensuring the Healthy Develop of Infants in Foster Care: A Guide for Judges, Advocates, and Child Welfare Professionals, Permanent Judicial Commission on Justice for Children, Zero to Three Policy Center, January 2004.

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

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

toddlers dramatically impaired in their emotional, social, physical, and cognitive development.[31] Children who have been abused and neglected often lack empathy and truly do not understand what others feel like when they do something hurtful.[32]

Further, children of substance abusers become victims of their parents' drug-focused lifestyles, which are often characterized by neglect, physical or sexual abuse, domestic violence, and other criminal activities.[33]

As much as possible, the child welfare system must reform practice to provide consistency, repetition, nurturance, predictability, and control to diminish the fearful nature of interventions.[34]

The American Academy of Pediatrics has found that paramount in the lives of foster children is the children's need for continuity with their primary attachment figures and the sense of permanence that is enhanced when placement is stable.[35]

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.

Attachments

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

1. The attainment of full intellectual potential,
2. The ability to think logically,
3. The development of a conscience,
4. The ability to cope with stress and frustration,
5. The ability to become self-reliant,
6. The development of positive relationships,
7. The ability to handle fear and worry, and
8. The ability to correctly interpret and handle any perceived threat to self.

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[31] Permanent Judicial Commission on Justice for Children, Zero to Three Policy Center, July 2004.
[32] Understanding the Effects of Maltreatment on Early Brain Development, National Clearinghouse on Child Abuse and Neglect Information, October 2001.
[33] Understanding Substance Abuse and Facilitating Recover: A Guide for Child Welfare Workers, U.S. Department of Health and Human Services, 2005, page 7.
[34] Understanding the Effects of Maltreatment on Early Brain Development, National Clearinghouse on Child Abuse and Neglect Information, October 2001.
[35] Rosenfeld, Pilowsky, Fine, et al as quoted in the American Academy of Pediatrics Policy Statement on Developmental Issues for Young Children in Foster Care, November 2000.

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."*[36]

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 and attachments needed to grow and thrive.

1. On an average day in 2004 about 1,500 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.
2. 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.
3. The Board commends efforts by child welfare professionals to ensure that the majority of preschool children do not experience excess moves. The Board is concerned, however, that the percentage of children experiencing multiple moves is still too high.
   a. 537 (35.0%) of the 1,534 preschool children in out-of-home care on December 31, 2004, had been in more than two foster homes.
      - This compares to 38.0% in 2003, and 36.5% in 2002.
   b. 299 (19.5%) of the 1,534 preschool children in out-of-home care on December 31, 2004, had been in more than three foster homes.
      - This compares to 21.4% in 2003, and 19.5% in 2002.
4. 185 (13.8%) of the 1,534 preschool children who entered foster care during 2004 had been removed from the home at least once before. This compares to 13.0% in 2003, and 13.7% in 2002.

Parental Substance Abuse

An additional concern is the number of young children who come into care due to parental substance abuse. Substance abuse is always difficult to overcome, and it appears that methamphetamine abuse may be more difficult to overcome than many other mood-altering drugs.

1. 57% (362 of 635) of the children ages birth through three reviewed by the Board during 2004 had parents with a documented substance abuse problem.
2. By the midpoint of 2005, the percent was up to 62%.

The Board strongly supports the Douglas County pilot of a Family Drug Treatment Court (FDTC) that serves children age birth through three and their parents. The Court is very clear; it serves children first with a clear focus on permanency, and then the families. From the beginning parents are made aware that the focus of the FDTC is on child well-being and permanency, not simply parental sobriety. The abuse/neglect case

[36] Quoted in the first annual report of the Nebraska Foster Care Review Board, 1983.

is not separate from the drug case. The following quote from Judge Douglas Johnson of the Separate Juvenile Court of Douglas County explains the program:

> *"Recognizing that babies are the most vulnerable children to enter foster care, why not help the youngest of the young. Why not focus on their right to a timely, permanent, safe home? It made all the sense in the world to start a 0 to 3 family drug treatment court...The juvenile and family court focus is the baby's timely right to a decent life and a permanent parent...At the very beginning, parents are warned of a concurrent permanency plan of reunification and adoption. Parents are made aware that the focus of our FDTC is the child's well-being and permanency, not simply parental sobriety...*
>
> *Parental skill sets are taught: how to nurture and care for a baby in order to promote bonding and attachment; conflict resolution for couples; budgeting; housing; education; domestic violence; and employment, to name a few. Babies are screened for early childhood developmental delays, and any necessary medical and mental health care is provided. The parents, primarily mothers, must learn to juggle and manage all of their parental responsibilities within 12 to 18 months, or the child may be freed for adoption. The program has five progressive phases leading to commencement.*
>
> *A key feature promoting bonding and attachment and the regular opportunity to hone parent skill sets is that most parents live safely with their babies. The Court uses licensed relative foster placements, licensed foster parents and residential treatment living centers—all trained specifically for this duty.*
>
> *Other features common to most FDTC's include regular court appearances; frequent, observed urinalysis; Alcoholics Anonymous/Narcotics Anonymous participation, including the use of sponsors; dual diagnosis treatment; mental health therapy; medications; and relapse prevention programs. Sustained sobriety is part of the larger balancing act to be a responsible parent."*[37]

In 2005, the pilot was dealing with 10 families and 13 children. The Board supports the concept and recommends that it be expanded.

Vulnerability of Young Children

Like many in the system, 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. For young children, especially, it is important that their situations are stabilized, that they obtain permanent homes, and that a long-term plan is made that will optimize the their development. 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*

[37] Judge Douglas F. Johnson, Separate Juvenile Court of Douglas County, as quoted in Judges, Pages, National CASA, October 2005.

> *were more than three times as likely to experience recurrence compared with children without a prior history."*[38]
>
> 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."*[39]

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.

Multiple Daily Caregivers

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 as long as 10-12 hours per day. Some of the daycares used are not high quality and have high staff turnover.

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.

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. 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.
2. Develop specialized units where highly trained professionals focus on providing permanency[40] 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.
3. 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.

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[38] National Clearinghouse on Child Abuse and Neglect, www.calib.com/nccanch/, July 2003.
[39] A Scientific Approach to Child Custody, National Public Radio broadcast, March 3, 2003.
[40] 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.

4. Provide specialized training on the importance of bonding and attachment to parents, foster parents, case managers and supervisors.
5. 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.
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 circumstances, conduct or conditions to meet the needs of the child, and the failure to maintain regular visitation, contact, or communication.
8. Increase the scope of the pilot Family Drug Treatment Court in Douglas County, and use what is learned from this pilot to help other children of parents with substance abuse issues.

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

As previously discussed in this section, there are a lot of reasons to be concerned about young children in foster care. The Board found that in a number of cases the home study information about the foster home was outdated, and that the Board's findings would not be accurate without more current information.

At the same time, foster parents were approaching the Board wanting more information. Courts, under their heavier caseloads, were entrusting the Board more than ever to provide clear, accurate, information on how the child was doing. And, the Board had reviewed a number of cases in which the foster parents were providing exemplary care, and the Board wanted a way to thank these foster parents for their service.

These came together in Project Permanency, 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.

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, with a focus on permanency.
   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.

There is a clear procedure to follow with each of these visits, as well as with visits to group homes. The questionnaires used can be found in the appendix.

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 to obtain permanency in a timely manner.

The following section describes how Children can be effected by the separation from parents and/or trusted caregivers, and the grief over these losses.

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: Children who are separated from parents or trusted caregivers will experience grief. Typical grief reactions can be the unidentified cause for many behaviors that foster children exhibit. Often these children are labeled as behavioral problems, or they are punished for what is actually a predictable behavior.

As noted by the American Academy of Pediatrics:

> *"Adults cope with impermanency by building on an accrued sense of self-reliance and by anticipating and planning for a time of greater constancy. Children, however, especially when young, have limited life experience on which to establish their sense of self. In addition, their sense of time focuses exclusively on the present and precludes meaningful understand of 'temporary' versus 'permanent' or anticipation of the future. For young children, periods of weeks or months are not comprehensible. Disruption in either place or with a caregiver for even 1 day may be stressful. The younger the child and the more extended the period of uncertainty or separation, the more detrimental it will be to the child's well being."*[41]

Being in foster care is a defining experience in children's lives, yet 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.

Robin Karr-Morse reminds us that, ***"If a baby is separated from the mother, he or she experiences the loss not only of the emotional but also of the physiological balance of basic systems that are maintained by the mother's proximity. This is similar if not***

[41] American Academy of Pediatrics Policy Statement on Developmental Issues for Young Children in Foster Care, November 2000.

identical to the kind of loss adults experience at the death of a life companion or great love. One's entire physiological system may go into shock."[42]

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. She found **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 six to eight 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 one to two 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.

As numerous sources, including the American Academy of Pediatrics; the American Academy of Child and Adolescent Psychology; Zero to Three; nationally known expert on children's attachments needs, Nancy Thompson, M.S.W., L.M.H.P.; and other respected organizations and experts too numerous to cite have noted, children may display grief as:

1. Regressive behaviors (e.g., return to baby talk, lapse of toilet training, bed-wetting)
2. Distracted easily, thinking disorganized, memory lapses, learning difficulties
3. Problems with judgment and cause/effect, increased mischievous behavior
4. General anxiety, separation anxiety, alarm, panic, fears
5. Food issues, including hoarding food or refusing to eat
6. Abnormal displays of anger to normal situations
7. Sadness, depression, despair, self-esteem problems, feeling they've been "thrown away," yearning and pining for the lost caregiver
8. Sudden flairs of anger

[42] Ghosts from the Nursery, Robin Karr-Morse and Meredith S. Wiley, c. 1997.

9. Physical symptoms such as sleep disturbances, rapid or irregular heart rates, and lower resistance to infection
10. Blaming others or themselves for the situation
11. Denial of events
12. Avoidance of future relationships.

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 to case managers, foster parents, guardians ad litem, county attorneys, law enforcement, and the judiciary 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.

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.

> "*In the context of permanency decision making, changes in placement and visitation can produce great stress for infants of all ages and should raise a red flag for decision makers.*"[43]

> "*The emotional consequences of multiple placements or disruptions are likely to be harmful at any age, and the premature return of a child to the biologic parents often results in return to foster care or ongoing emotional traumas to the child.*"[44]

[43] Permanent Judicial Commission on Justice for Children, Zero to Three Policy Center, Ensuring the Healthy Develop of Infants in Foster Care: A Guide for Judges, Advocates, and Child Welfare Professionals, January 2004.

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 thanks 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.

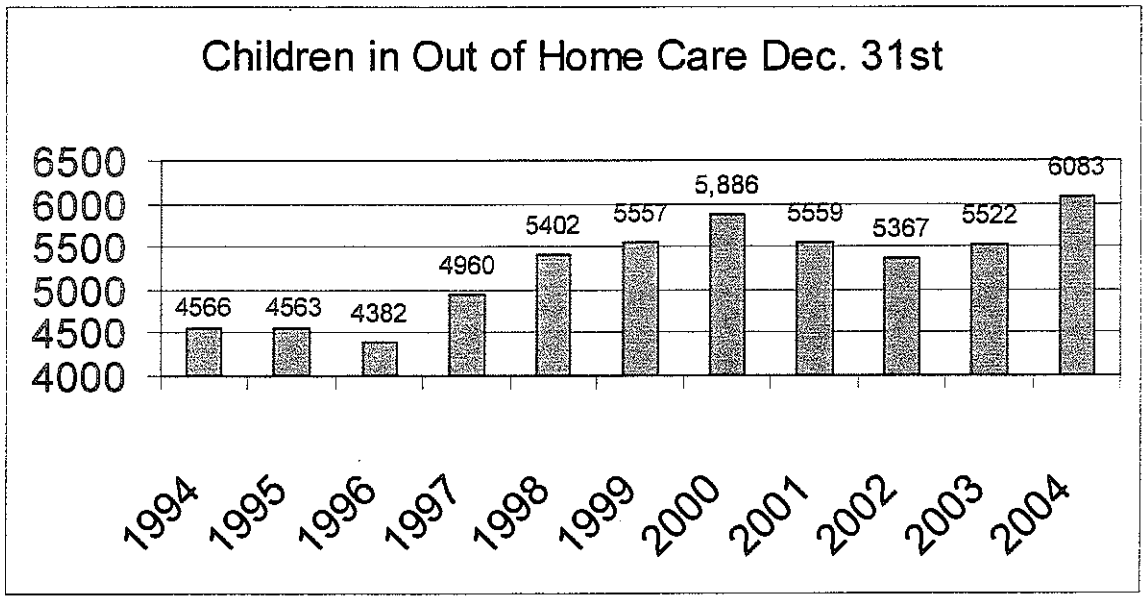
- Early in the transition process obtain a special object such as a blanket, teddy bear, etc. For older children this may be a clothing item, toy, or pillow. If it is impossible to secure the original item, replicate the item as closely as possible and as early as possible in the transition process.
- 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.

[44] Simms, quoted in the American Academy of Pediatrics Policy Statement on Developmental Issues for Young Children in Foster Care, November 2000.

- 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.


Children in Out of Home Care Dec. 31st
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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 2004, 2,240 (58.7%) of the 3,819 children reviewed had four 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.

> *"Child welfare personnel are repeatedly asked to make major life decisions on behalf of children who they do not know well. They must achieve a delicate balance. On the one hand, they must never minimize the life-long impact of the decisions they make. On the other, they must not allow themselves to become paralyzed by fear of making a wrong decision. Some conclusions are made as a result of well defined assessments of current conditions. Unfortunately, many decisions are made by default [e.g., agency policy, lack of resources]."*[45]

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

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

[45] A Child's Journey Through Placement, Vera Fahlberg, MD., c. 1991

When Delaware and Illinois faced a similar situation, each professionalized and supported caseworkers, resulting in lower turnover of caseworkers, more support for foster parents, and higher number of children achieving permanency in a timely manner. Methods of doing so included offering rewards for obtaining certificates of proficiency, lowering caseloads, and raising salaries.

Recommendations:

1. Make caseloads manageable.
2. Build in rewards for good performance and enhanced skills.
3. Increase levels of support and supervision for case managers.
4. Reduce computer time for case managers by utilizing data-entry personnel.
5. 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.
6. Examine how communication now takes place between case managers and contractors and examine communication breakdowns and frustrations.
7. 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 should be adopted, along with a recommended caseload for each level of worker.
8. Analyze the training required for new case managers. The analysis should cover course duration, location and content.
9. Reduce supervisor caseloads so they have time to train and guide caseworkers.
10. Consider how Delaware, Illinois, and other states have been able to reduce turnover and improve outcomes.

Do Case Managers Maintain Contact With the Children?

Findings/Rationale for Recommendations: This is an area of great improvement. **In a five-year span, the percent of reviewed children that had documentation of recent caseworker contact increased by 50.5% -- from 39.0% in 1999 up to 89.5% in 2004. The Board commends HHS caseworkers, supervisors, and administration on this improvement.**

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."[46]

Recommendations:

1. Reduce caseloads and encourage case managers to maintain and document their contacts with the children. Keep working to ensure that most children are routinely seen by their caseworkers.
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.

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

The following section describes how children are affected by issues related to contracting for transportation and visitation monitoring.

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

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

Background information: HHS has entered into contracts with private organizations for the transportation of some children to and from visitation with the parents, and into contracts for the monitoring of some children's visitation. Contractors also transport some children to and from school and/or therapy appointments. Several different agencies hold these HHS contracts.

In some instances the same contractor provides both transportation and visitation monitoring, in others there are separate contractors involved. 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 the ones who take the children to and from the arranged contact with the parents.

The Board is concerned that some contracted transportation providers change drivers on every visit; therefore, the caseworker does not get accurate information on which to base case decisions.

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. If that percent remained constant over all children in care, contractors would have transported approximately 1,825 of the 6,083 children in care on December31, 2004.

Findings/Rationale for Recommendations: 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. The person who monitors parental reactions and keeps children safe during visitation must understand the case dynamics and have a close connection with the caseworker so that concerns can be accurately described in a timely manner. Therefore, the Board is recommending that drivers be assigned to particular workers and particular cases.

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.

In the current system, not only are the children responding to the visits and the post-visit separation from the parents, many are also adjusting to having new, unfamiliar adults transporting them during what can be a highly emotional time for them.

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, as shown by the following example.

> *"Chrissie," age 15 months, is transported by a contractor to her supervised visits with her mother. During the review of her case, the Board found that in the past few months she has had at least 9 different visitation workers who have supervised the visits. It is unclear how familiar they have become with her case. Chrissie screams when she sees the visitation workers come and realizes that she has to leave for a visit. When she returns she is often hungry. The foster parents report that they get no information about the visit, for example, whether Chrissie had a nap, if/what she ate, if the parents attended the visits, or anything else of relevance to their care pre- and post-visit.*
>
> *The Board forwarded this information to all of the legal parties in the case, the caseworker's supervisor, and the head of the Protection and Safety division.*

Contracts for visitation need to be evaluated to ensure that case managers are being promptly and appropriately informed of whether the parent attends scheduled visitation, whether the parent is appropriate at the visitation, and how the child reacted before, during, and after the visitation.

The following summarizes other major problems the Board has identified with contracted transportation for children.

1. **There is little oversight of the contract system.**

2. **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. Children often experience trauma at having to leave the parents again at the end of the visit, and may be afraid of the parent.

a. 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.

3. **The Board has been contacted by day care center and foster parents who report that some contractors have engaged in unsafe practices.**

4. **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.**
   a. Drivers usually are not trained on what information to give to foster parents or caseworkers and how to relay that information.
   b. 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.
   c. Some contract reports are difficult to read. When the Board's staff persons have questioned this, they were told that writing legibly was not in the contract.

5. **There is no incentive for drivers to report when parents do not show for visitation.**

6. **Contractor scheduling difficulties have resulted in no transportation being available.** Many drivers are college students. When college classes stopped some parental visitations were cancelled due to a lack of drivers.

7. **Contractors are being paid 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.** According to the HHS contract for July 1, 2004-June 30, 2006, the amount paid is $19.00 per hour plus mileage. Case aides are salary grade 336. A case aide with five years experience would cost about $18.44 per hour. This figure is computed at the $9.622 per hour starting salary, with cost of living increases of 2% per year, which would be $10.41 per hour. Benefits would include $0.80 for Social Security (7.65%), $0.50 for retirement (4.8%), and $6.73 for health insurance (the maximum $14,000 per year for the family health plan.)

8. **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.

Costs

The most significant benefits from eliminating the contracts would be decreasing children's stress and increasing communication on the vital indicator of visitation. However, as the following example shows, the State could also potentially save by eliminating contracts and hiring permanent case aides.

Scenario: 1,800 children are having weekly visits of two hours each.

Contract	State Employee Case Aides
At the contract rate, the State would pay $3,556,800 annually, plus mileage.[47]	For case aides, the State would pay about $3,451,968 annually, plus mileage.[48]

Recommendations:

1. Hire permanent case aides to complete visitation, and assign them to work with individual workers and cases.
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. All the oversight recommendations from the all contracts section also applies.

[47] According to the HHS contract for July 1, 2004-June 30, 2006, the amount paid is $19.00 per hour plus mileage. According to the HHS budget analyst, HHS coded payments of $4,078,398 as being for visitation monitoring or mileage in FY 04.

[48] Case aides are salary grade 336. A case aide with five years experience would cost about $18.44 per hour. This figure is computed at the $9.622 per hour starting salary, with cost of living increases of 2% per year, which would be $10.41 per hour. Benefits would include $0.80 per hour for Social Security (7.65%), $0.50 for retirement (4.8%), and $6.73 for health insurance (the maximum $14,000 per year for the family health plan.)

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 have a contract with HHS to provide the recruiting, assessing, screening, training, supervising, and 24-hour support for agency-based foster homes, which are the next step up from standard foster homes, therapeutic foster homes, which are the next step up from agency-based foster homes, and higher level group homes. The placements they provide are to be well equipped to meet the needs of children with more difficult behavioral or physical challenges.

Under statute, HHS retains the responsibility for proper care, custody, and control of state wards, regardless of whether a contractor provides the children's placements or the child is in a "standard" placement.

Costs

Contractors are paid significantly more for the higher levels of care they are to provide, as the following chart shows. HHS staff has confirmed that the rates below are accurate.

Foster homes

1. Standard foster care is paid between $222-$1,200 per month per child, depending on the child's needs.
2. Agency based foster care is paid $1,875 per month per child.
3. Treatment foster care is paid between $3,127-$3,257 per month per child, depending on the child's age.

Group homes

1. Standard group homes are paid $1,935 per month per child.
2. Group home level "A's" are paid $2,670 per month per child.
3. Treatment group homes are paid $5,794 per month per child.

Findings/Rationale for Recommendations: Through reviews the Board has identified the following:

1. Different contractors have different standards for their agency-based homes. Some contractors generally provide good to excellent care of the children in their facilities or foster homes while others do not. Even within a particular agency and license type there can be significant variance in the quality of the care children receive. For example, one agency-based foster home from company "X" may provide exemplary care, while another is borderline.
2. There is often little or no difference in the needs of children placed in standard foster care homes as compared to children placed at the agency-based or

treatment foster care levels. The same is true for children at the various levels of group homes.

3. Case managers for some reviewed children could not identify where the children were placed—only that the children were placed with 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.
4. Serious abuse, such as severe burns, broken bones, concussions, has occurred in some contractor's placements as a result of a lack of supervision and misuse of restraints[49] while other contractors rarely, if ever, have injuries to the children. Serious abuse incidents in some placements, coupled with the lack of thorough investigations, are a major concern of the Board.
5. Even after a clear pattern of abuse or neglect has been detected in certain contractor's placements, the contractor has continued to place the child and/or other children in the questionable placement without resolving the placement problems.
6. Many contractors fail to develop child-specific placements geared to meeting the physical, emotional, or behavioral needs of an individual child.
7. Some children in out-of-home care placements provided by a particular contractor 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.
8. 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 contractor's home studies have been seriously outdated (e.g., over 20 years old). This compares with other contractors where the home studies are routinely timely and thorough and updated as changes occur. Often, case managers have not reviewed the home studies.
9. In some cases, case managers have never met the agency-based foster family.
10. Procedures for licensing have been problematic. HHS has granted some licenses for agency-based foster homes without a review of the home study.
11. Some foster parents hold multiple licenses, such as agency-based foster care, therapeutic foster care, standard foster care, daycare, and/or care for dependent adults. There is little coordination and communication between the different licensure types to ensure that the foster parents can adequately care for the children entrusted to them.
12. 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.
13. 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.

[49] See page 101 for more information on restraints.

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. Assure effective methods of supervision.
3. Provide a method of evaluating the effectiveness of agency-based placements, and assure contracts are performance based.
4. 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.
5. Provide better oversight of all contracts (see separate section on all contracts.)
6. Liaison with the Foster Care Review Board on a quarterly basis to address the Board's placement concerns.

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

1. 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. Consider the needs and behaviors of other children placed in the home prior to making placement. For example, do not place both sexual abuse victims and children with sexual perpetration behaviors in the same facility nor place physically vulnerable children with children with aggression issues.
2. Check all providers against prior allegations of abuse, including allegations involving providers who are/were also day care providers or staff. Do this on initial application and on renewal.
3. Assure that there is adequate communication between those involved with the different licensure types that an individual may hold. For example, assure that if a person has both a daycare and a foster care license, that any problems are effectively communicated to all involved.
4. 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.
5. Assure any home studies completed by another entity are provided to HHS in a timely manner and included in the child's permanent file.
6. 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.

7. Assure that adequate background checks are being completed, and that the home studies are complete and up to date.
8. Eliminate the use of any foster home previously found to be unsuitable.
9. 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.
10. Provide a method of evaluating the effectiveness of agency-based placements.
11. 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
    a. children needing extraordinary amounts of assistance with behavioral management and modification,
    b. children who are physically aggressive,
    c. children with sexualized behaviors,
    d. children requiring intense supervision,
    e. children with attachment disorders, depression, anxiety, or suicide ideation,
    f. children with sleeplessness,
    g. children requiring medication for physical and/or mental health issues.

Recommendations Specific to Group Homes

1. Assure that problems with a particular facility or contractor are addressed. Some problems, including the overuse of restraints and injuries, are much more prominent in some organizations than others. Patterns of issues with individual contractors or facilities should be recognized, as these issues are not resolved by the firing of staff, but are indicative of problems with the management that need to be addressed if children are to be safe.
2. 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.
3. Review staffing ratios in conjunction with the number, sex, age, and behaviors of the youth placed in each particular group home.
4. Ensure that supervision is adequate and that effective emergency procedures are in place in case of injury.
5. Discourage the use of restraints as the primary behavioral control strategy.
6. Assess the skill levels and training of the staff.
7. Review all background checks of staff hired by the group homes.
8. Review the standard of care being provided to the residents.
9. Assist the agencies in establishing and providing the services necessary for the youth placed in the group home.
10. Regularly review all allegations and reports of abuse or neglect involving a group home or its employees.
11. Liaison with the Foster Care Review Board on a quarterly basis to address the Board's placement concerns.
12. Provide a method of evaluating the effectiveness of agency-based placements.

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. Some of the category names are confusing, as the following chart shows:

Term	Meaning
"Court substantiated"	A District, County, or Juvenile Court ruled the abuse or neglect occurred.
"Court pending"	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 was filed). **This does not mean that it is unlikely that the abuse occurred as would be implied by the common use of the word "inconclusive."**
"Unable to locate"	After trying at least once, the alleged perpetrator was unable to be located.
"Unfounded"	Anything not in the other categories. **This 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," the current term for likely that the abuse happened, 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. Consider patterns of injury involving a particular person, or a particular contractor, when determining the proper response to an abuse allegation.
7. Assure that if an issue is raised regarding abuse in any license type, that those responsible for all other license types, and case managers, are informed promptly.
8. "Unfounded" encompasses too many conditions, and implies that the incident(s) did not happen, even though there could be suspicions. "Unfounded" should not be used in cases where a group home staff person was involved and either quit or was fired. "Unfounded" should be broken into the following categories:
    a. "Suspected" when it appears something did occur, but there isn't enough proof to be "Inconclusive."
    b. "Unlikely" where there is a plausible explanation other than abuse or neglect and the situation is unlikely to occur again.
    c. "False" where the reporter apparently knowingly made a false claim.
9. Carefully review all requests for expungements, the removal of a person's name from the abuse registry. Assure that persons are not removed from the list improperly.

Roadblocks in the Journey – Issues with Managed Care Contracts

What is the Managed Care Contract?

HHS has a contract with a managed care company, Magellan, to approve any specialized treatment placement or services. The contract was let as a means to control the costs of inpatient treatment and psychiatric placements. The contract includes incentives to minimize the number of inpatient beds available to state wards.

How Does Managed Care Impact Children?

Findings/Rationale for Recommendations: The managed care provider does not fund services to address and/or control behavioral problems – only "medically necessary" services. Yet the reason that many children need the higher-level treatment services is due to behavioral issues.

Consequently, many children 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 consequences for children can be great, as shown in the following case examples.

Case 1 – *"Craig," age 11, has a history of behaviors escalating to the point that hospitalizations were required. He had been placed in a therapeutic level foster home where he had continued to run away. He threatened the foster mother with a knife four days prior to being placed with his grandparents. At his grandparents he continued to run away, became aggressive, and threatened to kill his grandfather. He was then moved to a shelter, where he was aggressive and out-of-control. From there he was placed in a hospital for six days to get his behaviors under control. Since Magellan has denied inpatient treatment for him, he has been returned to the shelter, where he is reported to still be aggressive and quickly out-of-control. Because of these behaviors a family support worker is assigned to assist the shelter with his care and to assure that other children in the shelter remain safe. It is unclear if Craig will receive the higher levels of care and treatment that he needs.*

Case 2 – *"Ned," age 14, was repeatedly denied placement is a residential treatment program for sex offenders, which was recommended when he had a sex offender evaluation by a mental health professional. He finally received the needed treatment when the*

> *Court ordered HHS to place him at that level of treatment. Due to the Court Order, HHS had to obtain the placement and paid for it from a different funding stream.*

In addition, many children are prematurely moved from treatment placements based on whether the managed care contractor will continue to approve payments, rather than based on the children's needs.

> *"Erin," age 12, was repeatedly self-mutilating. After one episode, she was admitted to a hospital for an evaluation. The hospital requested that she be moved to a higher level of care to deal with her suicidal tendencies, however, the managed care contractor denied the placement. She was placed back in the foster home. The foster home reports that Erin seems depressed and anxious.*

Other children have to go through a process of unnecessarily experiencing repeated failings at lower levels of care before Magellan will approve the higher-level placement that was originally recommended based on the child's needs.

Recommendations:

1. Cancel the managed care contract and return responsibility to HHS.
2. If it is not possible to cancel the contract, rewrite contracts with managed care to include payment for services for children and youth with a wide array of behavioral problems.

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

What is Contracted That Affects Children?

As previously described, the majority of the children in care are affected by contracts for transportation, visitation, placements, and/or managed care approvals for treatment level services.

What Happens if Something Goes Wrong with a Contracted Service?

Findings/Rationale for Recommendations: The Board finds that core case management duties have been contracted out to the private sector without putting adequate safeguards in place. HHS has care, custody, and control of all wards, yet many times it relegates this responsibility with little oversight.

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 some cases the foster parents receive excellent support and oversight, the children receive quality care, and the quality of the services received is good. However, this is not due to HHS oversight but rather to the commitment of the individual contracting agencies.

In other 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 due to breakdowns in communication.

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:

1. 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.
2. When the Board has reported concerns to these HHS staff members, a common response is "did you call the [other party]."
3. Even when Board staff members have contacted all three parties, there is often no investigation to correct the situation.
4. While this is happening, the contractor may not take corrective action as it could be viewed as admitting fault.
5. 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 with clear expectations and communicated outcomes.
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. Determine the cause for breakdowns in communication 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.
9. Since the majority of children in care are affected by one or more contract, assure that all contracts lead to better outcomes for children.

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. Confirming that HHS tracks allegations regarding contractor staff both by the individual and by the contractor agency.
    f. 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.
    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.
    j. Conducting outcome evaluations.

Clarify Contract Provisions

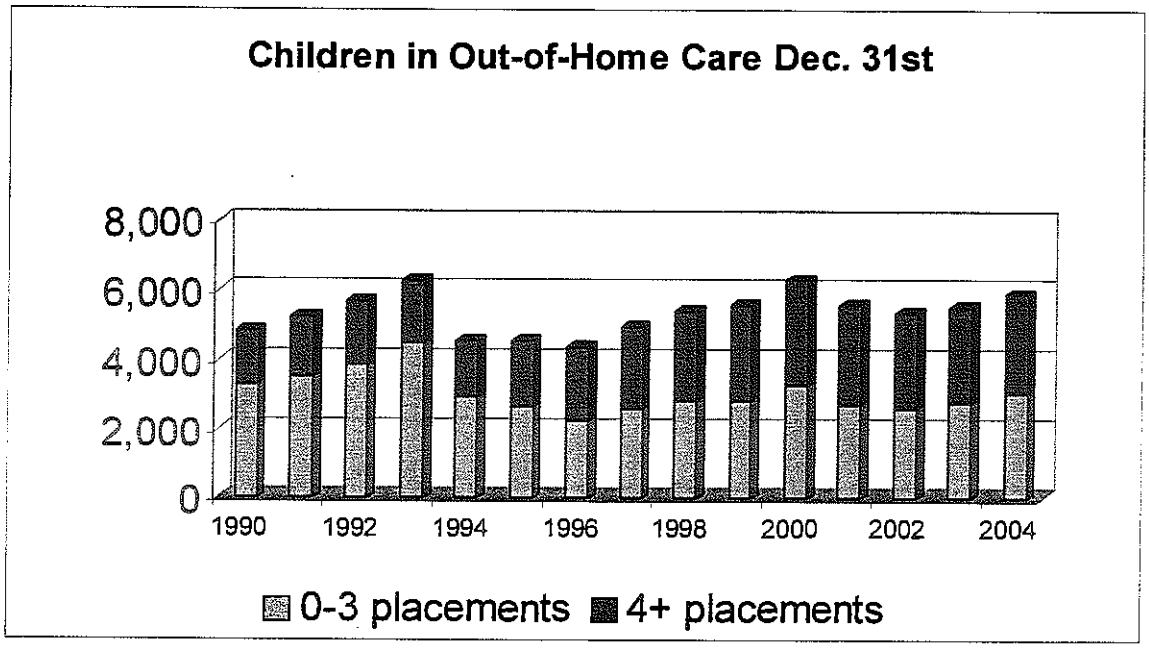
1. Present and future contracts must include provisions that:
    a. Describe how children's safety will be maintained.
    b. Specify minimal performance standards.
    c. Clarify who has authority to act if problems arise.
    d. List results-oriented penalties, including monetary penalties or immediate 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 and set protocols for other communication that is not about immediate safety issues.
    g. Provide standards for documentation.
    h. Clarify that the FCRB has statutory authority to visit facilities, review facility files, and review home studies.
    i. Specify training requirements for the employees that have child contact and how this is to be monitored.
    j. Allow for on-site review and inspection of services at any time during the contract.
    k. Specify that there will not be automatic renewal of contracts.
    l. 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. Determine the causes of communication breakdowns 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.
4. Assure that the mixture of children already in a facility or foster home is considered prior to making children's placements. For example, if a child is developmentally or physically unable to defend him or her self, do not place the child with children with aggression issues. Do not place sexual abuse victims with children who are displaying sexual perpetration.


Children in Out-of-Home Care Dec. 31st
8,000
6,000
4,000
2,000
0
1990
1992
1994
1996
1998
2000
2002
2004
0-3 placements
4+ placements

Stops Along the Journey – Placement Issues

Contract issues affecting placements are discussed in the sections immediately prior, and issues related to abuse in foster placements are discussed on page 99.

What Types of Additional Placements Need to Be Developed?

Findings/Rationale for Recommendations: Nearly half of the children in care of December 31, 2004, had experienced four or more placement disruptions/moves (2,855 of 6,083 children, or 46.6%).

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:

1. 127 children reviewed in 2004 were found to be in unsafe placements.
2. 132 children reviewed in 2004 were found to be in placements that were inappropriate for the children's needs, even though the child was temporarily safe there.
3. 619 children reviewed in 2004 had insufficient documentation available to determine if the placement was appropriate.
4. 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 the managed care contractor, and/or due to placement and service deficits.
5. 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.

6. 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.
7. There have been many cases where the Board has disagreed with the placement decisions of the new managed care provider, Magellan.
8. 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.

In addition to obtaining more placements, there must be a concerted effort to assure that the placements are stable, so that the child is not unnecessarily moved and thus further traumatized. 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.*"

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.
    i. Placements that do not inappropriately mix children (e.g., placing low functioning children with children who are sexually acting out, placing physically vulnerable children with physically aggressive children).

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.
9. Make efforts to stabilize children's placements and avoid placement disruptions.

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:

1. Support from case managers was unavailable when problems arose.
2. Adequate background information was not given on children placed with them.
3. Sufficient respite care[50] was unavailable.
4. Foster parents who care for relative children often need more help.

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 Report, 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.

Relative foster parents often find that when they try to address concerns with HHS, the response is to term the issue "a custody battle." This has even occurred in cases where the relatives report that children were placed at risk during unsupervised visits, such as children coming back from visits with unexplained bruises. Some of these children are

[50]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.

inappropriately removed from the relatives and/or inappropriately placed with the parents.

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.

Fostering abused and neglected children is significantly different than caring for one's own children, and thus support is necessary.
As discussed in the section on grief, abused and neglected 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. Abused children are often in a heightened state of vigilance, a survival skill left over from their abusive past. This may lead to heightened anxiety about each new experience or change of routine and to perceiving threats where no threats exist. Abused children may lack empathy and understanding of what others feel. The abuse they have experienced could have left their emotional, behavioral, cognitive, and social potential diminished. All of these conditions affect the interactions between caregivers and foster children.

The following quote shows how these children can be different:

> *"The Bayley Infant Neurodevelopmental Screens (BINS) was used to assess the risk of developmental delay or neurological impairment in [foster] children ages 3 to 24 months. The serious risk of developmental delay or neurological impairment was pervasive....Children in out-of-home care have extraordinarily high rates of behavioral problems...the fraction of young children (2- to 3- year olds) who are already showing signs of problem behavior is twice the norm..."*[51]

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 must 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.

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[51] Beyond Common Sense, Child Welfare, Child Well-Being, and the Evidence for Policy Reform, Fred Wulczyn, Richard P. Barth, Ying-Ting T. Yan, Brenda Jones Harden, and John Landsverk. Chapin Hall, c. 2005. Page 105-107, 172.

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.

Effects of Communication Gaps

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:

1. **398 (10.4%) of the 3,819 children reviewed in 2004 had foster parents or placements that reported they had not been given medical records about the child.** The Board is concerned about these children, as often this information can be critical.
2. In an additional 547 children's cases it was not possible to determine whether the foster parents/placement had received medical records.
3. 2,749 (72.0%) of the 3,819 children reviewed had foster parents or placements that reported they had received the medical records for the child. This is a significant improvement from the 50% figure in 2002.
4. 129 of the 1,061 children age birth through five 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 126 young children.

In regard to educational records:

1. In 2004 1,807 children were reviewed who were between ages 6 – 15 and, therefore, were school age.
2. For this population it would be expected that educational records should be provided, yet **195 (10.8%) of the 1,807 children's foster parents or placement reported they had not been given educational records.**
3. For another 297 (16.4%) of the 1,807 children it was unable to be determined if the placement had been given educational information.

Communication gaps could lead to serious consequences. In the general population many children have allergies to common medications, asthma, or serious medical conditions. For foster children it could be expected the percent with medical issues would be even higher since some suffered serious neglect of health concerns or may have had pre-natal exposures to drugs or alcohol.

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.*"

Our system is not geared to preserving children's relationships with trusted caregivers or seeing how detrimental these moves can be.[52]

Transition Planning

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.

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.

[52] See pages 47 for young children's need for stability, and page 55 for general information on stability.

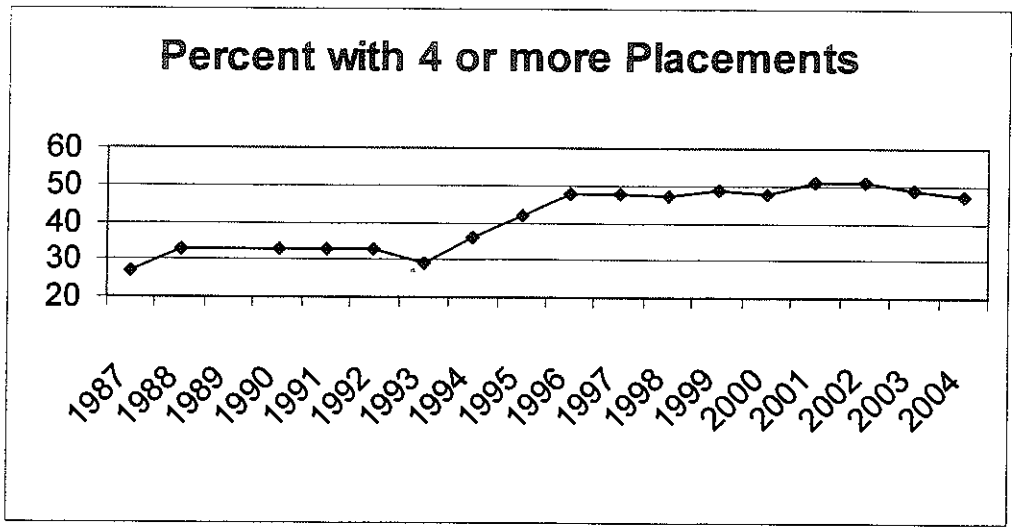
The Board finds that 46.9% (2,855of 6,083) of the children in care on December 31, 2004, had experienced four or more placement disruptions and 31.0% (1,890 of 6,083) had experienced six or more placements during their short lifetimes. Many experts believe that children who experience four or more placement disruptions can be irreparably harmed by the multiple broken attachments.[53]

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."*[54]

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 remain high, although there has recently been a slight decrease. This means that the system has many children who have experienced an often-painful separation from their foster parents, and who may be growing more resistant to forming attachments that facilitate their ability to relate to those around them.



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.

[53] See page 55 for more information on grief and broken attachments.
[54] March 29, 2004, editorial by a member of Pew Commission as it appeared on www.tallahassee.com.

> ***"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."***[55]

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.

> "***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."*[56]

> *"Each new loss triggers memories of previous losses and stirs up the strong feelings yet to be released.... It is not at all unusual for a child who has changed families several times before at a particular time of year to begin to deteriorate into old patterns of interaction or emotional upset when that time of year rolls around again...* ***Many of them [children with multiple moves] appear bound and determined to force change of caregiver at 'dangerous' times of year in order to avoid having another terrible, out-of-control move take them by devastating surprise again."***[57]

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[58].

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 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. Relative placements are not identified early or were disrupted when relatives brought case concerns to the case manager's attention.
3. 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.

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[55] J. Freud Goldstein and A. J. Solnit, Beyond the Best Interests of the Child, c. 1973.
[56] Vera I. Fahlberg, M.D., A Child's Journey Through Placement, page 176. Perspectives Press, c. 1991.
[57] Claudia Jewett Jarratt, Helping Children Cope with Separation and Loss. c. 1994.
[58] Susan Downs et al, Child Welfare and Family Services Policies and Practice, c. 1991, page 280.

4. 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.
5. 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.
6. There is a misconception that anytime a relative is identified the child must be moved.[59]

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

Recommendations:

1. Identify relatives and non-custodial parents within the first 60 days of a child's placement so that delayed identification does not result in unnecessary moves. Require relative caregivers to pass the same standards as other foster care providers to ensure that children are safe and well cared for.
2. Recruit, develop, and retain child-specific placements for young children, especially those with special physical, emotional, or behavioral needs. Build the capacity of out-of-home placements to match the population of children, their location, and their needs.
3. 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. 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.
4. Implement foster parent retention steps such as:
   a. Recognizing that foster parents are a vital component of the system.
   b. Providing access to round-the-clock immediate and effective support when issues arise.
   c. Providing health and educational records to foster parents upon placement or within a few hours of placement, as well as other background information.
   d. Offer additional training on child development, bonding and attachment, and effective methods of behavior modification, with specialized training provided as needed.
5. 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.
6. Monitor placement providers closely and consistently.

[59] See page 94 for more information on kinship care.

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 if the relative 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 in the past was abusive to the child's parents, or allowed the children's abuse.

Findings/Rationale for Recommendations: Relatives should be identified early, and their appropriateness as a placement should also be identified early, before a child has bonded to a non-relative caregiver.

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.

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 attachment needs. Many case managers have the misperception that it is HHS policy 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 or if there are issues with the relative placement. The following case examples show the consequences for the children.

> *"Tim," age 2, and "Tony," age 1, came into care due to the youngest testing positive for alcohol and methamphetamine at birth. The mother did not attend treatment as ordered by the Court. The mother's current address is unknown and there is an outstanding warrant related to her possession of methamphetamine.*
>
> *Tim lives with one relative, Tony with another. During the review, the Board learned that during a supervised visit in Tim's foster home, a cat that had not received any of its shots bit Tony. This is not the first time that an issue has been raised about the cats in this home. Previously, a different cat had scratched Tim and a caseworker. Since Tony is allergic to pet dander to the extent that an emergency room visit was required after an exposure last Thanksgiving, it is unclear why visitation is taking place where he will be at risk for potentially serious medical consequences.*
>
> *In addition to the concern about the cats, there have been reports that the mother has sporadically been living in the home of the relative who cares for Tim.*
>
> *The Board contacted the guardian ad litem and caseworker. A safety plan was proposed. If this is violated, the guardian ad litem will file a motion for a change of placement. The Board also met with the contractor who monitors Tony's visitation to discuss safety expectations.*

Conversely, the Board has reviewed cases where relative placements have been quite positive.

> *"Maurice," now age 1 year, 9 months, entered care when not quite 3 months old. At his removal he was found laying face down on the floor, crying, with his mother and a non-relative man passed out from ingesting both drugs and alcohol.*
>
> *It has been over a year since Maurice's mother has attempted to see him. She was to appear in court on the criminal portion of child abuse, but did not appear. A warrant has been issued. She was incarcerated for a time on another charge. His mother states that as soon as paternity is proven and the father's rights terminated, she intends to relinquish her rights to Maurice so that his aunt can adopt him. The County Attorney has filed termination petitions on both parents.*
>
> *Maurice has been placed with his aunt since his removal. She has one biological child, and is employed by a law enforcement agency. His grandmother takes care of him while his aunt is working. Maurice is physically healthy and demonstrates age-appropriate behaviors.*

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.

U-Turn – Abuse in Foster Care

The Board notes that many foster parents provide exemplary care for the children entrusted to them; unfortunately, this is not universally the case. There have been cases of sexual abuse, broken bones, burns, and other maltreatment in some placements. During 2004, the Board reviewed the cases of 127 children who were not in safe placements. Allegations of abuse in any state sponsored facility should be promptly and thoroughly investigated to ensure the safety of the children.

The general expectation for children and youth placed in the care of the state is that they will be well cared for and safe. Conditions in foster homes and group homes are expected to be much better than those the child experienced prior to coming into care. As a result, foster homes and group homes should be held to a higher standard than the homes of origin.

Findings/Rationale for Recommendations: The Board finds that there have been multiple allegations of abuse made against some foster homes, group homes, and agency-based placements. **The Board finds that the system often fails to respond adequately to these types of reports, even if allegations are of serious abuse.**

The Board also finds that even when clear patterns of abuse are identified with certain HHS contractors[60] and facilities that provide placements, HHS has enabled them to continue operation without making needed safety modifications, and with little to no oversight. Often the contractor conducts the sole investigation of the incident, yet contractors have no incentive to report abusive situations or to cease using such placements and are not trained child abuse and neglect investigators.

In some cases HHS has allowed its primary duty, assuring safety for children in its care, to be compromised by its decision to outsource placements and placement supervision without providing oversight to its contractors.

Under federal regulations the Board is required to make findings on the safety and appropriateness of children's placements. Therefore, the Board's reviewers research if any allegations have been made against the placement of the children being reviewed and the protection system's response. In its research, the Board has found some placements that have multiple issues, and have been questionable from the start. The following are some examples:

Case 1 - *"Kay," age 8, has been placed in a foster home where there have been allegations of physical abuse, and documentation of the foster father being hostile and uncooperative. He refused to allow HHS workers unannounced visits. The foster mother refuses to implement the safety plan even though there have been problems with sexualized behaviors*

[60] See pages 65-80 for more information on contract concerns.

between Kay and the foster parent's daughter. The foster father has an extensive criminal history. The Board provided this information to all the legal parties to the case.

Case 2 - *"Doug," age 2 and "Bridget," age 7were placed in a foster home where the foster father has a criminal history of driving under the influence. It would take a high level of supervision to assure that he was not supervising or transporting the children while under the influence. There was no documented approval study on the home, and the "walkthrough" had not been completed. The Board provided this information to all the legal parties to the case.*

The Board is aware that HHS has recently brought in a consultant, who also provides contracted placements, to do safety and risk assessments; however, when serious concerns are brought to light there still appears to be little sense of urgency. Rather than action, the Board finds excuses, especially if the allegation regards foster homes or facilities.

The Board continues to see problems caused by the bifurcated CPS system, as described earlier. On the front lines CPS still regards law enforcement as the first responder. Law enforcement agencies have indicated that they don't have the necessary manpower to solve crimes; much less monitor HHS contracts, and problematic foster homes and facilities. As a result, there is often little or no action by either CPS or law enforcement to protect children. Also, cases involving foster homes are screened out as "unfounded" and referred to Resource Development, but complete information may be lacking.

The monitoring that was supposed to improve the CPS response hasn't addressed the serious issues in the system. There is still a lack of consistent response by CPS and by law enforcement agencies. Most allegations of abuse against foster homes and facilities are "screened out " or not investigated.

Recommendations:

1. 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 cornerstone of effective investigation is the objectivity of the investigator; therefore, contractor administration should not be the sole investigator or contact for any incidents/complaints. State law should be followed and all reports of abuse or neglect investigated.
2. Clearly identify the lines of supervision and means of monitoring that needed investigations take place. Assure timely, thorough investigations of all allegations regarding contracted services or placements.

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. This practice does not recognize what the child has suffered. It also results in many perpetrators not appearing on the central registry, and thus their history is not available should there be future allegations, and future employers would not know of the concerns.
   a. Assure that perpetrators are placed on the central registry, so that the alleged perpetrator is not hired for other positions involving contact with children or dependent adults.
   b. Address staff supervision issues in regard to children's safety and well-being.
   c. Follow the HHS policy of placing persons on the central registry, even if the contractor took disciplinary action.
4. Assure communication of abuse reports regarding contractors occurs with everyone involved.
   a. Assure 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.
   b. Since some agency-based foster parents are also day care providers or workers, ensure communication with to all involved, i.e., foster care caseworkers, HHS resource development, the contractor agency, and day care licensing and oversight.
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. Utilize the history of allegations when investigating new allegations and determining whether to continue or renew contracts.

What are the Communication Gaps that Occur When Persons Hold Multiple Licenses?

Findings/Rationale for Recommendations: It can be beneficial to have foster homes with multiple licenses. For example, a child who needed the "agency-based" level of care can move to the "standard" level of care without having to change the caregiver, if the caregiver is licensed for both types. While the caregiver's reimbursement rate would change, the child would not experience a change in his or her daily caregivers.

The issue is that there is a communication gap between Resource Development, a branch of HHS that recruits many foster homes, contractors, who recruit many foster homes, and the caseworkers who place the children. 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. There must be oversight of the system, with identified issues examined promptly. Currently there is a fragmentation of response.

The same communication gap can result in foster homes caring for too many children, and thus placing children at risk. For example, some homes are licensed as agency-based foster homes, standard foster homes, and as emergency shelters. A person placing a child

in an emergency shelter may be unaware of the number of other children in the home, their needs, and the foster parent's ability to provide care for all the children every day.

As previously described, the Board researches any allegations made against the foster parents of children being reviewed. The Board has found that there can be serious communication gaps when issues arise with persons who hold multiple licenses, such as for foster care, emergency-shelter care, agency-based foster care,[61] therapeutic foster care, day care, etc.

Currently a "hold" or a serious concern involving one license type does not trigger communication to the other license types or their users. The following are a few examples of how important this communication can be, and the consequences of not communicating:

1. A person placing a child in an emergency shelter bed may be unaware that the agency-based foster care license for the same place is on hold because of serious allegations, and thus children can be at risk because there was no alert or communication.
2. A serious allegation of abuse can result in a hold on a daycare license, but does not necessarily trigger an alert to the caseworkers who have foster children in the same home.
3. Foster parents whose foster care license was revoked have applied to provide agency-based care and gotten their licenses through the contracting agency. It is unclear why this did not come up in a background check.

Recommendations:

1. Clearly identify how and when communication takes place between the different license types, and put in place supervision to ensure it happens.
2. Develop a cross-reference system so that the maximum occupancy of all licenses held by a foster home is known prior to workers placing children in that placement.

[61] See page 69 and following for more information on agency-based care.

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 agrees with Coercion Free Nebraska, a voluntary group of some placement providers that began meeting in 2005, that restraints and seclusion:

1. present significant risks,
2. are not therapeutic interventions,
3. should not be utilized for discipline, coercion, staff convenience, or treatment, and
4. we must transform our current culture of placement providers.

Nebraska's goal should be to develop systems that do not use restraints and isolation as a routine part of treatment programs, and to train staff so well in alternatives that using a restraint hold or a seclusion room becomes a thing of the past, while at the same time assuring children's safety and well-being.

According to the group home contract, incidents are to be reported to HHS within 45 days. The Board found that 285 children of the 3,819 children reviewed (7.5%) had file information indicating restraints were used on them during the six months prior to the review.

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 children with documented restraints are very young, with 31 of the 285 being under age 10.

Some of the 285 children restrained experienced more than one type of restraint, and/or restraints in more than one facility.

1. 188 of the 285 children were physically restrained,
2. 76 children were placed in confined isolation,
3. 16 children were chemically restrained,
4. 2 children had food withheld, and
5. 5 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:

1. 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.
2. 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.
3. 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.
4. In some instances, lack of appropriate staffing levels and lack of staff training have led to the inappropriate use of restraints.
5. 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

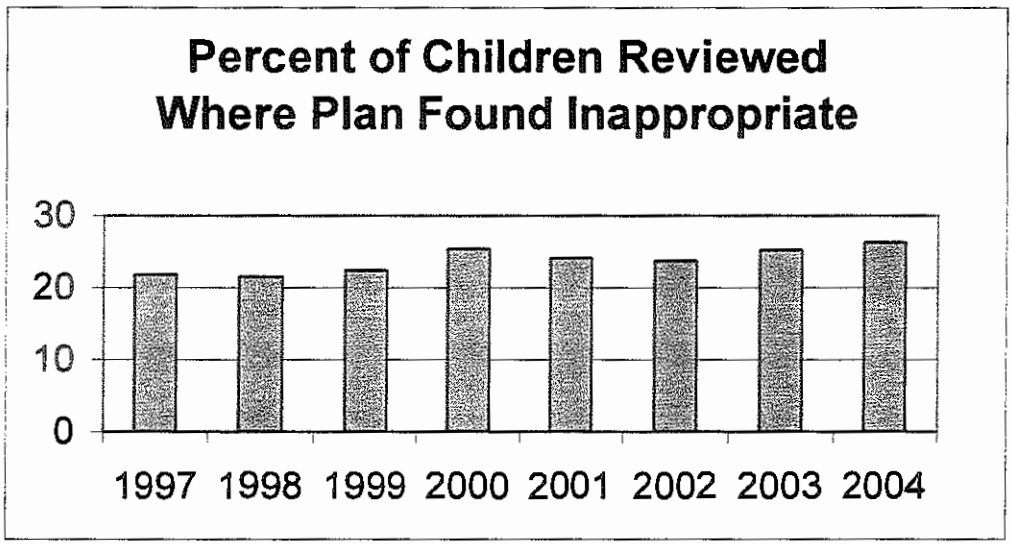
much older than the youth for whom they are providing care. Group homes also experience a high rate of turnover with staff leaving for higher paying positions before they are able to develop any expertise in dealing with troubled young people. Thus, some group home staff are unable to de-escalate a troubled 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. 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. As recommended by the National Technical Assistance Center, develop data that can identify facility usage of restraints and seclusion by facility, unit, shift, day, individual staff member, victim characteristics, and other variables.
2. Review HHS contracts to address concerns regarding restraints. Include clear expectations regarding the use of de-escalation techniques and require proof of training in prevention and de-escalation techniques in all contracts for service and placement providers. Hold facilities accountable for children's safety.
3. Develop restraint-free therapeutic care environments and programs with the intent to eliminate the use of physical restraints and extended seclusion, while providing adequate care for children who have suffered abuse/neglect and/or have serious mental health issues. Provide adequate assessments to identify and implement individualized plans of care. Implement programs that address youth's behaviors.
4. Develop, implement, and monitor a policy to ensure appropriate use of restraints.
5. Analyze the root causes of restraints and then pro-actively act on these causal factors. Determine the adequacy of staffing levels, staff development, and expectations. While it is important for individual agencies to self-assess, there should also be HHS oversight.
6. Provide training to group home staff emphasizing alternatives to restraints, including comprehensive de-escalation techniques.
7. Set competitive salary guidelines and qualifications for staff dealing directly with children in group settings to attract quality staff.
8. Implement clearer guidelines for placement decisions, treatment decisions, and service decisions and put into practice effective means to monitor and review these decisions.
9. Develop better HHS monitoring of which children are placed together.


Percent of Children Reviewed
Where Plan Found Inappropriate
30
20
10
0
1997 1998 1999 2000 2001 2002 2003 2004

Road Map for the Journey – Case 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:

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

Findings/Rationale for Recommendations:
In the last five years, HHS has made significant progress in assuring that children have current, written plans. The percent of cases with plans jumped from 50% of the cases reviewed in 1999 to 72% of the cases reviewed in 2004. The Board congratulates HHS on this important achievement. While there is work to be done, this improvement is very important.

As the U.S. Department of Health and Human Services says, *"In order to achieve the desired programmatic outcomes of CPS (i.e. child safety, child permanency, child and family well-being), interventions must be well planned and purposeful."*[62]

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, such as if the services needed are not available in a geographic area or if the parents are too low

[62] Child Protective Services: A Guide for Caseworkers. U. S. Department of Health and Human Services, Administration for Children and Families, 2003.

functioning to ever comply, then the plan is not realistic and not truly "reunification" even if that is the stated goal. 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:

1. 27.9% did not have complete written permanency plans (1,064 of 3,819 reviewed children).
   a. 569 children had no current plan.
   b. 465 children had incomplete written plans, which are 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 the absence of criminal felony conviction, under federal law juvenile courts must offer children's parents a chance to habilitate. Since this does not happen in every case, and since even when it does happen it can be months after a child comes into care, the Board does not see many children with the "ASFA" hearing, where the court can rule that reasonable efforts are not required.

Therefore, 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). Some of the consequences of this situation are:

1. In 26.3% of the cases reviewed, the Board disagreed with the child's plan (1,006 of 3,819 children reviewed)
2. In 18.4% of the cases reviewed, the Board could not agree with the child's plan because there was no plan or some other factor (701 of 3,819 children reviewed).
3. The Board agreed with the plan in 55.3% of the cases (2,112 of 3,819 children reviewed).
4. 7.4% of the children who left care in 2004 had an adoption finalized, compared to most other states where the figure was 18% or more.
   a. South Carolina was 24% in 2004.
   b. Oregon was 19% in 2003.
   c. Maryland was 18% in 2003.

The following case example illustrates the effects of inappropriate plans on the children involved:

> *"Ruth," age 7, and "Patty," age 6 have been in out-of-home care since birth. Patty is autistic, an illness where stability and predictability of the environment are necessary for children to thrive. A mental health professional has recommended for the last four years that visitation is not in the children's best interests. There is a no contact order with the father. The case plan remains reunification in spite of the fact that both parents have serious mental health issues and have been unable to make any progress toward parenting for over*

seven years. The Board shared these facts and its recommendation that permanency be immediately pursued with each of the legal parties in this case.

In order to write a successful case plan, the caseworker must be well informed of the children's needs and the family's interactions with the children. However, due to contracting out the children's placements, transportation, and visitation monitoring[63], caseload sizes and worker turnover, **there are often communication gaps that affect the ability to create a plan in the children's best interests.**

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."*[64] The Board agrees and has yet to see significant improvement in this area.

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 33.7% (1,631 of 4,839) of children removed from their home during 2004 had already 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.

[63] See pages 65-84 for more information on contract issues.
[64] Final Report, Nebraska Child and Family Services Review, U.S. Dept. of Health and Human Services.

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
↓
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. Case managers assume the standard is to attempt reunification with *all* parents, even when it can be predicted to be unsuccessful.
2. 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.
3. Children may not disclose everything that happened to them, such as sexual abuse, until after being in care for months or years. By that time the allegations can be very hard to prove.
4. Investigations may miss some issues.
5. Child witnesses are very difficult to use. Children may be too traumatized to withstand the rigors of cross-examination. Therefore, they may not be legal grounds to prevent reunification.
6. 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).
7. Children are removed from the home and reunification occurs prematurely, before the parent(s) is ready to reassume the responsibilities of parenthood.
8. Children are removed from the home and then reunified because appropriate placements cannot be found.
9. Young children who were in care act out later as adolescents, and subsequently are returned to care.

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 about 25% of 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.

In order to be included in the court petition, evidence must be effectively gathered to address the issues. This starts when CPS responds to the more than 24,000 reports of child abuse and neglect made annually. The investigation needs to be conducted by specialized investigators who work effectively with the prosecutors.[65]

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.
2. Encourage workers to select the plan's goals based on the children's needs and parental ability to meet those needs.
3. 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.
4. Conduct better assessments of the families and focus reunification efforts on families who have expressed a desire to change.
5. 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.
6. Provide appropriate remedial services to families who are identified as willing to work on new behaviors.
7. 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.
8. Follow the guidelines outlined in the Adoption and Safe Families Act where reunification need not be pursued in:
    a. Cases of murder or voluntary manslaughter of another child by the parent,
    b. Felony assault that results in serious bodily injury to a child,
    c. Abandonment,
    d. Torture,
    e. Chronic abuse,
    f. Sexual abuse, or
    g. Previous involuntary termination of parental rights of a sibling.
9. 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[66] and moving the case to alternate permanency. This time should be

[65] See page 43 for more information on the investigation process.

[66] 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)*

reduced to six months and the system should move to ensure services are in place to accelerate this timeframe.

10. 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 (46.6% or 1,780 of 3,819) of the children reviewed in 2004 had been in care for at least two years without achieving permanency and 12.0% (458 of 3,819) had been in care for five 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.

Lack of documentation of parental compliance can be an issue that affects the length of time in care, as the following case example illustrates:

> *The three "Harris" siblings, ages, 4, 6, and 9, had been in out-of-home care for 15 months at the time of the last review. The file documentation contained nothing that occurred in the last six months. There was no indication of follow-up to the recently disclosed sexual abuse of one of the children.*
>
> *The children's psychological evaluations, the mother's chemical dependency evaluation, the mother's psychiatric evaluation, the mother's therapy reports, and the children's therapy reports for the last six months could not be located. Additionally, the file contained no documentation that the children were receiving medical, education, or mental health services. There was no documentation that the case manager had seen the children in over a year. The file contained no visitation reports from the contractor that was authorized to provide visitation monitoring.*
>
> *The case plan, which should be updated at least every 6 months, was 11 months old. The children have been in out-of-home care for over a year, yet no concurrent planning for permanency was occurring. No basis for termination of parental rights was being documented. The Board provided this information to each of the legal parties in the case.*

Another issue is the lack of staffing toward the completion of adoptions. The following case illustrates this point:

> *The "Davis" children, ages 3 and 5, have been in out-of-home care for over three years. The mother relinquished her rights a year and half ago. One of the children's father indicated he would sign relinquishment papers; the other is address unknown and must be published. Neither action on paternal rights has*

occurred. The caseworker said that adoptions are behind because there is only one staff person in Omaha who deals with relinquishments and publication for paternity.

The children's placement has completed all necessary tasks for adoption, including FBI fingerprinting. The only barrier to these girls being adopted is preventable paperwork delays. The Board provided this information to each of the legal parties in the case.

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. Assure adequate documentation of parental response to services provided and visitation so that there can be better decisions regarding the children.
3. 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.
4. Provide intensive case management for all young children (ages birth through five plus siblings) through additional case managers who would provide focused stability, services, 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.
5. 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.
6. Increase the number of workers that can complete adoption, so children do not linger in care while waiting the finalization of the paperwork.
7. 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.
8. Continue to 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. .
9. 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.

Why Are Services Often Not 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 1,909 of 3,819 (50.0%) of the children reviewed in 2004.

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 provision.

Case 1 - *"Betsy", age 11, has been in out-of-home care for over four years. Betsy is reportedly unable to read simple picture books for young children. She has been tested for learning disabilities, and none have been diagnosed.*

She has lived with the same foster parents in a metropolitan area; however, the foster parents frequently buy homes, fix them, and then sell them. As a result, Betsy has been in five different elementary schools, and her foster parents are about to move again – her sixth school. Betsy has educational difficulties made worse by the school changes. The Court ordered that HHS provide Betsy a tutor, but a year later that service had not been provided. The Board continues to work with the legal parties to address these issues.

Case 2 - *"Devon," age 3, entered care when age 1 as he was left with a person his mother had just met in order for the mother to go smoke crack. The mother could not identify the last name of the person she left Devon with when the police contacted her. A hearing was held to terminate her parental rights, but the court found that HHS had not made reasonable efforts to offer the mother services. HHS has now begun the process of documenting offers of services in order to produce the evidence*

needed for a termination of parental rights. In the meantime, Devon remains in foster care awaiting permanency.

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. These youth, in particular, have been negatively impacted by the lack of placements, lack of services, and managed care denials.[67]

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.

Some of the youth have been placed on psychotropic medications and/or have had professional recommendations for certain types of therapy. The Board finds that there can be communication gaps about these needs that affect the youth, as shown in the following case example.

"Lisa," age 16, was sentenced to the Geneva Youth Rehabilitation Center. At the time of her review, the center did not have any background information about her mental health needs or the psychotropic medication she had been taking prior to

[67] See page 77 for the impact of the managed care contract.

admission. The plan for Lisa did not outline any services, and the Board recommended that mental health and developmental disability services be included in future plans.

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.
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?

Background Information:

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
   a. can either be a county court acting as a juvenile court, or in the larger metropolitan areas, a separate juvenile court.
   b. 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.
   c. actions start with a concept that rehabilitating the parents, if possible, is best for the majority of children.
   d. are required, in the absence of a felony conviction in criminal court, to attempt to rehabilitate the family. Therefore, most cases start with a plan of reunification.
2. Criminal courts focus is on holding the parents accountable for their actions.

Findings/Rationale for Recommendations: 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.[68] 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.**

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.[69]

In addition, the Board finds that:

1. The volume of cases often exceeds the capacity for effective response.

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

[69] 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.

2. Child abuse and neglect cases can be very challenging. Child witnesses often have been terrorized as part of the abuse, yet in court we expect them to tell strangers some of the most dreaded stories of what has happened to them or their siblings. Many children cannot cope with this, leaving it hard to prove the cases.
3. Child Advocacy Centers have a critical role in reducing the trauma children, especially sexual abuse victims, feel during the investigation.
4. Prosecution can be hampered by poor investigations that provide insufficient or incomplete evidence.
5. 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.
6. Newly elected county attorneys are often inexperienced with juvenile court issues. They need for training in this area.
7. Financially, counties are stretched to the limit. Thus, 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.
8. In many instances, parents' cases are handled only in Juvenile Court where there remains a mandate to rehabilitate no matter the circumstances.
9. 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.
10. Courts can only act on what is in the petition and provable in court.

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, and for some children impossible.

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.

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 and to clearly delineate who does what, and when. 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. Encourage appropriate planning. HHS writes the plan and it is legally assumed to be in the child's best interests unless proven otherwise.
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 677 (177%) of 3,819 reviewed children's cases. Paternity was undocumented, and therefore likely not determined, in another 526 (13.8%) children's cases. Most of these 1,203 children (988 or 82.1%) had been in care for more than six months at the time of review; and most (762 or 63.3%) had been in care for more than 12 months, yet paternity was not documented or established.

Without paternity identification, the father's suitability as a caregiver or a relative's suitability cannot be fully assessed, and children cannot be freed for adoption. 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.

> *"Johnny," age 2, has been in out-of-home care since birth. The mother's parental rights were recently terminated. There is no documentation that there have ever been attempts to contact the purported father. If the father decides to purse parenting Johnny, then the process of evaluating his ability to parent begins. This means that Johnny, now age 2, could be forced to have visitation with a man he has never known. If the father is able to parent, Johnny would still need to spend months in foster care as a relationship is built between him and his father. Until the father's rights are established and terminated, Johnny cannot be adopted. In either case, permanency is delayed.*

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.[70]

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.
2. Build on the successes of the pilot drug court in Douglas County, and create similar successes in other areas.

[70] See page 49 for additional information about the Douglas County Family Treatment Drug Court pilot that is targeted to children ages 0-3 and their parents.

The following section describes Nebraska's need for child abuse prevention programs.

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: Each day an average of 13 Nebraska children and youth are removed from their home of origin, primarily due to abuse or neglect (4,839 children were removed in 2004). In 2004, the daily population of Nebraska children in out-of-home care fluctuated between 5,500 and 6,083 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;
   a. The percentage of calls accepted for initial assessment in the Board's study varied by District – with a high of 56.8 % in District 10 (Sandhills) and a low of 18.9 % in District 8 (Kearney).[71]
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.
   a. 10,361 children were in out-of-home care for some or all of 2004.
      - 4,8393 children were removed from the home during 2004.
      - 5,522 who had been removed from the home in prior years were in out-of-home placements on Jan. 1, 2004.

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.

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

Home visitation programs need to include:

1. Early intervention,
2. Intensive services over a sustained period,
3. Development of a therapeutic relationship between the visitor and parent,
4. Careful observation of the home situation,
5. Focus on parenting skills,
6. Child-centered services focusing on the needs of the child,
7. Provision of concrete services such as health care or housing,
8. Inclusion of fathers in services, and
9. Ongoing review of family needs in order to determine frequency and intensity of services.[72]

Nebraska must 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.[73]

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 four years of program operation (a rate of 0.8%).[74] 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%"*[75]

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[72] Leventhal, as quoted by National Clearinghouse on Child Abuse and Neglect, www.calib.com/nccanch/, August 2003.
[73] National Committee for Prevention of Child Abuse, 1992, www.childabuse.com, August 2003.
[74] Children's Bureau Express, http://cbexpress.acf.hhs.gov, April 2003.
[75] 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 studied cost savings and found "*In the study subsample of low-income mothers, the analysis showed a net benefit of $350 per family.*"[76]

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).[77]
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[78] 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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[76] Ibid.

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

[78] 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 the past ten 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.

The following are two examples of runaways that we found as a result of contacts made by the Board's review specialist.

Case 1 - *"Jim" was being reviewed. He had been on runaway status for quite some time. The review specialist suspected that he was living on the reservation. A questionnaire was sent to the tribe. That same month Jim came to the Board's Omaha office to "turn himself in."*

Case 2 - *"Jon" was being reviewed. He had come into care for sexually assaulting young children. He was on runaway status. The review specialist called Jon's home, but no one answered. Later that day Jon called to say he was no longer a state ward. The review specialist contacted the case manager, the deputy county attorney, and the case manager's supervisor. The case manager's only action was to call him to say he should turn himself into court. His father has reported that Jon has since moved out of state.*

Recommendations:

1. An assessment must 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 must implement clearer guidelines for placement decisions, treatment decisions, and service decisions, and to put into practice effective means to monitor and review these decisions.
4. Facilitate relationships between foster youth and schools, foster families, and appropriate biological family members to provide youth with a sense of consistency, stability, and safety.

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[79] 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.
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 the children they represent or to make telephone contact with children out of state. This would require a change of statute. It is hard to imagine an attorney/client relationship where the attorney doesn't see the client child.
2. Guardians ad litem should see the children in their placements because of the special vulnerability of these children. For instance, they need to know who else is placed in the same home or facility.
3. 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.

[79] 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.

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 is to cover room and board. Medical, mental health, and other services are to be paid to service providers after a service is rendered and not included in the base rate. Group home care starts at $1,935 per month.

Often there seems to be little difference between children placed at the different levels.

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:

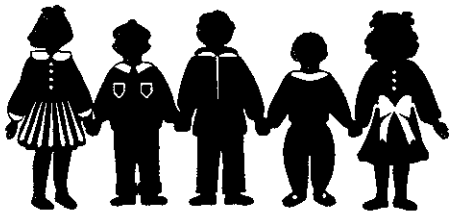
1. A better use of valuable HHS staff time would be to have data entry specialists do routine entry on N-FOCUS, freeing the time of trained case managers to be used in other areas of children's cases.
2. Develop an easier way to monitor and correct errors on the system.

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 157)

TABLE 1

SOME CHARACTERISTICS OF CHILDREN IN FOSTER CARE - 2004

(A Ten-Year and One-Year Comparison)

Who are the Children?

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

1994	2003	2004
4,566	5,522	6,083

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

1994		2003		2004		
1,087	23.8%	1,308	23.7%	1,534	25.2%	Infants & Preschoolers (0-5)
1,151	25.2%	1,267	22.9%	1,415	23.3%	Elementary School (6-12)
1,005	22.0%	1,304	23.6%	1,275	21.0%	Young Teens (13-15)
1,323	29.0%	1,640	29.7%	1,856	30.5%	Older Teens (16+)
0	0.0%	3	>0.1%	3	>0.1%	Age not reported
4,566	100.0%	5,522	100.0%	6083	100.0%	Total in care Dec. 31st

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

1994		2003		2004		
2,557	56.0%	3,534	64.0%	3,984	65.5%	White
758	16.6%	891	16.1%	980	16.1%	Black
247	5.4%	387	7.0%	424	7.0%	Native American
201	4.4%	See below		See below		Hispanic as race[1]
77	1.7%	73	1.3%	76	1.2%	Asian
726	15.9%	637	11.5%	619	10.2%	Other or Race Not Reported
4,566	100.0%	5,522	100.0%	6,083	100.0%	Total in care Dec. 31st
--	--	474[1]	8.6%	633[1]	10.4%	Hispanic as ethnicity[1]

[1] Beginning in 2003, Hispanic was counted as an ethnicity, not as a separate race. Hispanic children's race could be identified as White, Black, Native American, Asian or "other" race, and thus are distributed in the racial categories above. Prior to 2003, it was considered a separate race.

continued...

Explanation of Table 1—This table compares some characteristics of children in foster care from 19934, 2003, and 2004. Most categories are taken from the 5,522 children who were in out-of-home care on 12-31-2004, 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

1994		2003		2004		
2,347	51.4%	2,983	54.0%	3,321	55.0%	Male
1,826	40.0%	2,457	44.5%	2,720	44.7%	Female
393	8.6%	82	1.5%	42	0.3%	Gender not reported
4,566	100.0%	5,522	100.0%	6,083	100.0%	Total in care Dec. 31st

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

1994		2003		2004		
4,566	100.0%	5,522	100.0%	6,083	100.0%	Total in care Dec. 31st
1,653	36.2%	2,747 [1]	49.7%	2,855[1]	46.9%	# in 4 or more foster homes
1,005	22.0%	1,867 [1]	33.6%	1,890[1]	31.0%	# in 6 or more foster homes

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

1994	2003	2004
28 local boards	62 local boards	local boards[2]

Children Reviewed by the Foster Care Review Board and Total Reviews

1994	2003	2004
1,936 children reviewed [3, 4]	4,116 children reviewed [4]	3,819 children reviewed [2,4]
3,165 reviews conducted [4]	6,503 reviews conducted [4]	5,728 reviews conducted [2,4]

Reviewed Children by Length of Time in Foster Care

1994		2003		2004		
1,936 [3]	100.0%	4,116 [4]	100.0%	3,819[2,4]	100.0%	Children reviewed
807	41.7%[3]	2,054	49.9% [5]	1,780	46.6%[5]	# In care at least 2 years
294	15.2%[3]	547	13.3% [5]	458	12.0%[5]	# 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] **During the period of economic downturn in the early 2000's, the Boards budget was cut by over 16%. This necessitated staffing cuts, which reduced the number of reviews.**

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

[4] 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.

[5] Due to staffing reductions, in 2004 all children in care for six months or more could not be reviewed. Therefore, comparisons to 2003 may be misleading.

continued...

TABLE 1 (continued)

Where are the Children?

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

1994		2003		2004		
1,659	36.3%	2,443	44.2%	2,704	44.5%	Foster home & fos/adopt homes
444	9.7%	868	15.7%	1,062	17.5%	Relatives
506	11.1%	1,041	18.9%	1,027	16.9%	Group homes & residential treatment facilities
423	9.3%	518	9.4%	574	9.4%	Jail/Youth Development Center
483	10.6%	215	3.9%	276	4.5%	Emergency Shelter
52	1.1%	133	2.4%	109	1.8%	Runaway, whereabouts unknown
213	4.7%	105	1.9%	105	1.7%	Adoptive home, not final (private)
26	0.6%	84	1.5%	88	1.4%	Medical facility, nursing home
35	0.7%	61	1.1%	82	1.3%	Independent living
175	3.8%	32	0.6%	34	0.6%	Psychiatric Treatment or substance abuse facility
11	0.2%	10	0.2%	6	>0.1%	Center for Develop. Disabled
65	1.4%	0	0.0%	0	0%	Child Care Agency
474	10.4%	12	0.2%	16	0.3%	Other or type not reported
4,566	100.0%	5,522	100.0%	6,083	100.0%	Total in care Dec. 31st

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

1994		2003		2004		
2,616	57.3%	2,894	52.4%	3,291	54.1%	In same county
703	15.4%	925	16.8%	1,013	16.7%	In neighboring county
827	18.1%	1,171	21.2%	1,259	20.7%	In non-neighboring county
109	2.4%	109	2.0%	158	2.6%	Child in other state
311	6.8%	93	1.7%	84	1.4%	Parent in other state
0	0.0%	330	6.0%	278	4.6%	Proximity not reported
4,566	100.0%	5,522	100.0%	6,083	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

1994		2003		2004		
2,309	47.4%	2358	57.4%	2,789	67.44%	Returned to parents
N/A	N/A%	269	6.5%	9	0.2%	Released from corrections (no further information given or found in research)
423	8.7%	363	8.8%	413	10.0%	Reached Age of Majority (19th birthday)
289	5.9%	356	8.7%	305	7.4%	Adopted[1]
22	0.5%	156	3.8%	103	2.5%	Court terminated (no specific reason given)
108	2.2%	280	6.8%	226	5.5%	Guardianship
78	1.6%	5	>0.1%	22	0.5%	Custody transferred
33	0.7%	3	>0.1%	2	>0.1%	Marriage or Military
1,608	33.0%	317	7.7%	271	6.5%	Other/reason not reported
4,870	100.0%	4,107	100.0%	4,140	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

2002[1]		2003		2004		
3,168	59.0%	3,349	60.6%	3,916	64.4%	Initial Removal
2,199	41.0%	2,173	39.4%	2,167	35.6%	Had Prior Removal(s)
5,367	100.0%	5,522	100.0%	6,083	100.0%	Total in care Dec. 31st

[1] 1994 figures not available

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

1994		2003		2004		
2968	72.2%	2,898	60.7%	3,208	66.3%	Entered care - initial removal
1143	27.8%	1,875	39.3%	1,631	33.7%	Had prior removal
4,111	100.0%	4,773	100.0%	4,839	100.0%	Total entered care during year

TABLE 2

COST OF OUT-OF-HOME CARE ROOM AND BOARD BY PLACEMENT TYPE 2004

Placement Type	No. of Children	Cost or Range	Minimum Monthly
Foster Home	2,704	$222 - $1,200 or $1,875 [1]	$2,077,059 [2]
Relative Placement	1,062	$222 - $1,200 or $1,875 [3]	$296,844 [4]
Group Home or Residential T. C.	1,027	$1,935, $2,670, or $5,794 [5]	$3,562,182 [6]
Jail/Youth Development Center	574	$3,300-7,500 [7]	$2,528,850 [8]
Emergency Shelter	276	$839, 1,785, 3,225 [9]	$536,268 [10]
Runaway/Whereabouts Unknown	109	n/a	n/a
Adoptive Home Not Final - Private	105	n/a	n/a
Independent & Semi-Ind. Living	82	$352	$28,864
Assisted Living Nursing Facility	67	$14,858 [11]	$995,486
Psychiatric Treatment Facility	34	$4,920 [12]	$167,280
Medical Facility	21	$33,060 [13]	$694,260
Center for Developmentally Disabled	6	$2,400 (est.)	$14,400
Special School - boarding	9	$1,935 (est.)	$17,415
Other	7	$222 (est.)	$1,554
Children in Care on Dec. 31, 2004	**6,083**	**Minimum monthly total**	**$10,920,462**

Minimum Annual Cost for Room and Board only $131,045,544

The costs above reflect only the minimum 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 12-31-2004, 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 6/23/2005, 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).
- Treatment foster care is paid the minimum foster home payment for the age plus $96.86 per day.

[2] Minimum monthly costs for care in foster homes were calculated based on:

- 803 children age 0-5 @ minimum $222 per month = $178,266
- 498 children age 6-11 @ minimum $292 per month = $145,416
- 576 children age 12 -18 @ minimum $352 per month = $202,752
- 827 children at agency-based @1,875 per month = $1,550,625
  (This includes 156 children ages 0-5, 249 children ages 6-11, and 422 children age 12-18).
- Children in treatment foster care were calculated at the base rate above for their age.

TABLE 2 (Continued)

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

[4] Costs for relative care was based on actual numbers, calculated as follows:
- 444 children age 0-5 @ minimum $222 per month
- 321 children age 6-11 @ minimum $292 per month
- 297 children age 12 -18 @ minimum $352 per month

[5] HHS group home rates are determined by the group home level. According to an HHS official who confirmed the rates 6/23/2005, 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 are paid $193.12 per day ($5,794 per month).

[6] Costs were estimated as follows: 342 @ $1935 per mo + 342 @ $2,670 per mo + 343@ $5,794.

[7] According to an HHS official who confirmed the rates 6/23/2005, the following daily rates for HHS wards have been the same since 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 estimated as follows:
- 150 youth at Kearney @ $3,709 per month
- 100 youth at Geneva @ $4,245 per month
- 75 youth at Douglas County @ $3,708 per month, plus 75 youth at $5,100 per month
- 30 youth at Lancaster County @ $5,100 per month
- 144 youth at other facilities @ $5,100 per month

[9] HHS emergency shelter rates are determined by the level. According to an HHS official who confirmed the rates 6/23/2005, 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 estimated as follows:
- 92 children at $27.30 x 30 days
- 92 children at $59.50 x 30 days
- 92 children at $107.50 x 30 days

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

[12] 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).

[13] Based on 2004 daily costs for newborns with significant health issues as provided by the Nebraska Hospital Association ($2,994 per stay for an avg. 2.72 day stay -- an average of $1,102 per day)

SPECIAL SECTION

ISSUES RELATED
NEBRASKA HHS N-FOCUS COMPUTER SYSTEM

Side Trips to the Journey –

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

Background

The Board's independent tracking system is used to schedule cases for review and to measure outcomes for children.

Nebraska HHS is required to report to the Board when children enter foster care, when placements or case managers change, and when children leave care. It does so via reports from its N-FOCUS computer system. Information from the reports is subsequently entered on the Board's tracking system after verification (described in more detail later). The information HHS provides 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.

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 with verifying whether the data on the reports was accurate or not, and with 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, any state accepting SACWIS federal funding must have only one official record concerning children in out-of-home care. 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 many 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. The Board suggested an electronic link.

Federal officials stated that since Nebraska HHS had developed its N-FOCUS system with federal funds, the Board must fully integrate its tracking system into N-FOCUS, rather than electronically link, or the State of Nebraska would be penalized and forced to refund $12.7 million in development fees utilized in the implementation of N-FOCUS 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.

The process and diligent work of attempting to ensure that the Board's data would remain accurate, independent, and easily available on the N-FOCUS platform began in 2004. It continues in 2005. Since the Board had experienced serious budget cuts just prior to this process, the Board's staff persons involved with the conversion process have been trying to do this while simultaneously accomplishing their other duties.

Conversion is scheduled for March 2006, with some data being mechanically converted from the old system to the new, and most other data requiring later manual conversion.

Remaining Issues

The tentative date for the data merger is March 2006; however, a number of issues remain.

Issue: Structural Impediments

1. Entry will take longer due to a more complicated N-FOCUS design structure.
2. Queries needed to extract key data needed for daily operations will be much more complicated, and thus likely to be far more expensive.
3. Since the Board does not control the central processing hardware and software used for N-FOCUS, the Board will not be able to control system downtime or the requirements for the PC equipment needed to access the system.

Issue: Information Accuracy

1. While the Board controls the quality of its data entry on its current system, in the combined system some key data elements (i.e., child's name, date of birth, race, gender), 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.
2. 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.
3. 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.
4. 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.

5. Based on the experience since 1997, when N-FOCUS was implemented, 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: Conversion will not include all data

1. Data conversion from the current system to the N-FOCUS platform will be problematic. HHS does not intend to electronically convert the Board's existing historical data and much of the data on active children. Data that does not electronically convert will need manual conversion. The Board has no funds that can be diverted to hiring temporary help.

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.

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 for 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.

Through its verification process the Board has found 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. Notably, there was no disputing of the error rate on the N-FOCUS system from the HHS administrators at these briefings.

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.

For the first half of 2004, over 17,087 (58.1%) of the 29,416 state change reports also required further research or verification (statistics were not kept in the last half of 2004 due to conversion activities). Verification was needed 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 gives some idea of the staff time needed to assure accuracy. Verification was needed on reports of children entering care, changing status while in care, and all reports of children leaving care, a total of over 60,000 reports per year. 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 of 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.

Steps the Board Takes to As a Result of HHS N-FOCUS Errors

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.

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.[1] 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 2004 there were 55 Local Boards (some part time) composed of 372 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;

[1] A change to the State Board structure was approved by the Legislature in 2005, and will take effect 1/1/2006. This paragraph refers to the rules effective throughout 2004.

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 2004 that have one or more local foster care review boards (number of local boards in parentheses):

Alliance (1), Auburn (1), Beatrice (1), Bellevue (1), Columbus (1), Fremont (1), Grand Island (3), Hastings (2), Kearney (2), LaVista (1), Lexington (1), Lincoln (10), Norfolk (3), North Platte (2) O'Neill (1), Ogallala (1), Omaha (18), Papillion (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 32,077 hours of service during 2004.

More would have been donated if the Board had not been forced to reduce the number of boards due to budget cuts.

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 2004 to assist the abused and neglected children of Nebraska, taken at a very conservative estimate of $15 per hour, was $481,155, at $20 per hour it would be $641,540.

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[2], 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 2004:

- 529 cases involving 875 children have been acted upon or utilized legal standing
- 1567 cases involving 1913 children have been acted upon or utilized legal standing. (This includes the 1,038 times that staff attended court during 2004).
- Most (701) children's cases were handled through meetings with the county attorney and/or other parties to the case, or through staff appearing in court (1,038 children).
- An attorney was hired to represent the Board for 163 children.

During 2004, the Board made a concerted effort to dramatically increase its presence in court hearings. Staff attended over 1,038 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.

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

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.

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 2004, 71,399 individual Nebraska children in out-of-home care have been tracked.

Up to 130 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 (now called Dept. of Health and Human 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 2004, the daily average number of children in foster care in Nebraska is about 6,050.

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.

FAQ's about the Foster Care Review Board

What is the Foster Care Review Board? The agency is an independent state agency with local boards made up of trained community volunteers from a variety of professional backgrounds (such as nursing, mental health care, foster care, child development, law, and advocacy). The Board is mandated to review cases to meet state and federal laws and regulations.

What does the Board do and why? The Board reviews the cases of child in foster care (foster homes, relative placements, group homes, specialized facilities), visits facilities, and monitors outcomes for children. The Board's goal is to make sure that children's needs are being met and that they do not stay in the foster care system too long.

How does the Board obtain its information? Board staff go to the agency with control of the child (usually HHS) to research the files and talk to the case workers. The Board also invites all legal and interested parties to return information via questionnaire. In addition, the Board contacts the foster parents and guardians ad litem (child's attorney). Parents who have not lost the rights to their children are invited to come in person to briefly discuss the children's case. Caseworkers are also invited to the meetings. Other parties (like attorneys, foster parents, grandparents, therapists, family support workers) may be invited to attend the meeting as time allows.

How does the Board make its findings? After the persons who came to discuss the case have left, the Board deliberates on the file documents and other information presented. Since the Board members come from a variety of disciplines, they bring a broad range of expertise to this process. The Board then makes its formal findings on the plan for the child's future and the safety and appropriateness of the child's current placement, and gives its rationale for these findings.

Who receives the Board's recommendations? Information about the children reviewed is confidential, and only parties with a legitimate interest in a case are asked to participate. By law, the Board only submits its findings to the judge and to the legal parties in the case.

How can I contact the Board? The Board's main office is at 521 S. 14th, Suite 401, Lincoln, NE 68508. The phone number there is 402.471.4420. The Board also has a smaller office in Omaha, at 1313 Farnam, 3rd Floor, Omaha, NE 68102. The Omaha office phone number is 402.595.2764.

The State Foster Care Review Board thanks each and every local board volunteer for his or her unwavering dedication to Nebraska's foster children.

CASE REVIEW PROCESS

The Foster Care Review Board completed 5,728 reviews on 3,819 children in 2004, and issued approximately 40,096 reports with recommendations regarding reviewed children's cases to courts, agencies, guardians ad litem, attorneys, and county attorneys.

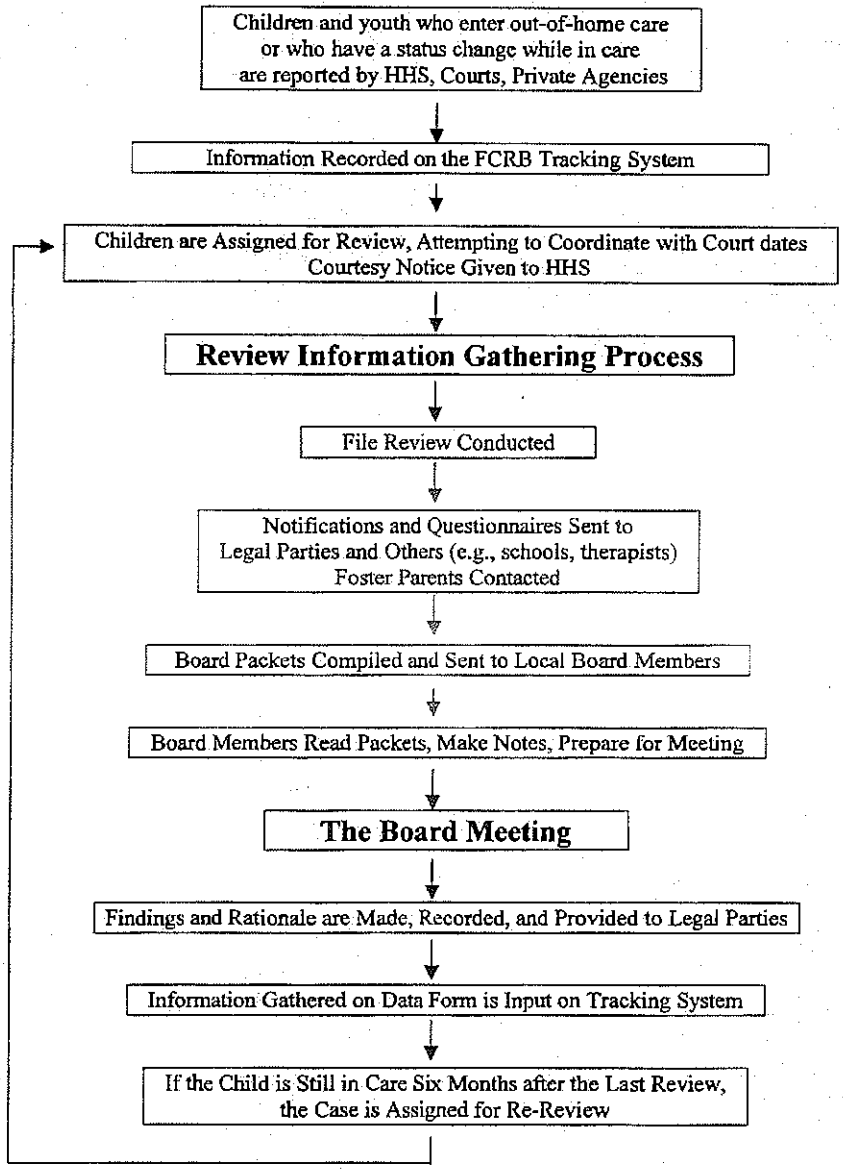
Each report included a case history of the child with the reasons why the child was placed in foster care; court dates; information on services, education, and visitation; recommendations and findings on the placement, services, and plan; and remaining barriers to permanency.

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 Review Process



CHILD WELFARE SYSTEM PERFORMANCE MEASURES TABLES 3 –14

(Tables 1 and 2 are at the end of the Commentary, starting on page 129)

TABLE 3

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT
LOCAL BOARD FINDINGS FOR CHILDREN REVIEWED DURING 2004

Is there a written permanency plan	# Children	Percent
•There is no plan or the plan is incomplete.....	1,064	27.9%
•There is a written plan with services, timeframes, and tasks.....	2,755	72.1%
Total	3,819	100.0%

Included in Above	# Children	Percent
No plan.....	569	14.9%
Incomplete plan.....	495	13.0%

Trend Notes:
In 1994, 51.5% of the reviewed children had complete written plans.
In 2004, 72.1% of the reviewed children had complete written plans. However, as shown below, having a written plan with an inappropriate goal remains a problem.

Partial basis for this finding:

- Each child in foster care shall have a case plan that is written and complete with services, timeframes, and tasks identified within 60 days of placement. [Neb.Rev.Stat.§43-1308, §43-1312, Section 475 (1) of the Social Security Act (SSA) and 390 NAC 5-004.02A, 8-001.11]
- The plan shall contain at least the following:
  - The purpose for which the child has been placed in foster care
  - The estimated length of time necessary to achieve the purposes of the foster care placement
  - The person or persons who are directly responsible for the implementation of such plan, and
  - A complete record of the previous placements of the foster child. [Neb. Rev. Stat. §43-1312]
- The child's case plan objective shall be appropriate to the individual child's circumstances. Circumstances would include such items as the reason(s) that the child entered care, pertinent concerns uncovered after the child's removal, and the child's physical, emotional, and psychological needs.
- If a child is 16 years of age or older, the plan shall include services designed to assist the youth in acquiring independent living skills. [Neb.Rev.Stat.§43-285(2) and 390 NAC 5-004.02A]
- Written case plans can help ensure that parents understand what they must accomplish before children can be reunified. Measurable goals are needed to document parental compliance or non-compliance.

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 2004.

TABLE 3

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT
LOCAL BOARD FINDINGS FOR CHILDREN REVIEWED DURING 2004

Board agreement with child's permanency plan		**# Children**	**Percent**
•The Board disagrees with the plan, or there is no plan.....		1,707	44.7%
Included in Above	# Children	Percent	
Board disagrees with the plan.....	1,006	26.3%	
No current written plan.....	442	11.6%	
Cannot agree or disagree due to....	259	6.5%	
•The Board agrees with the child's permanency plan.....		2,112	55.3%
	Total	3,819	100.0%

Partial basis for this finding:

- The Board shall review what efforts have been made to carry out the plan, including the progress or lack thereof towards meeting the case plan objective, and reasonable efforts to accomplish permanency. [Neb.Rev.Stat.§43-1308]
- In its report to the court and other legal parties the Board must provide its rational for all findings. [Neb.Rev.Stat.§43-1308] Therefore, the reasons for disagreement are communicated to all legal parties for consideration.

Services in the plan		**# Children**	**Percent**
•Needed services not provided, or not utilized.....		1,910	50.0%
Included in Above	# Children	Percent	
Some services are in motion.....	440	11.5%	
Services offered, not utilized.....	764	20.0%	
Unclear what is being provided.....	202	5.3%	
No plan, no services provided.....	504	13.2%	
•All services in the plan are presently in motion.....		1,909	50.0%
	Total	3,819	100.0%

Partial basis for this finding:

- The Board shall review what efforts have been made to carry out the plan, including the progress or lack thereof towards meeting the case plan objective, and reasonable efforts to accomplish permanency. [Neb.Rev.Stat.§43-1308]

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 2004.

TABLE 3 (continued)

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT
LOCAL BOARD FINDINGS FOR CHILDREN REVIEWED DURING 2004

Progress being made toward permanency plan objective	# Children	Percent
•No progress or progress unclear.....	2,278	59.6%

Included in Above	# Children	Percent
No progress towards permanency.....	1,052	27.5%
Unclear	908	23.8%
Not applicable due to court sentence/OJS....	318	8.3%

•Progress is being made towards the permanency objective.....	1,541	40.4%
Total	3,819	100.0%

Partial basis for this finding:

- The Board shall review what efforts have been made to carry out the plan, including the progress or lack thereof towards meeting the case plan objective, and reasonable efforts to accomplish permanency. [Neb.Rev.Stat.§43-1308]

Continued need for out-of-home placement	# Children	Percent
There is a continued need.....	3,736	97.8%
There is no longer a need for out-of-home placement.....	83	2.2%
Total	3,819	100.0%

Partial basis for this finding:

- The Board is to determine whether there is a continued need for out-of-home placement. [Neb. Rev. Stat. §43-1308(1)(b)]

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 2004.

TABLE 3 (continued)

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT
LOCAL BOARD FINDINGS FOR CHILDREN REVIEWED DURING 2004

Is current placement appropriate and safe	# Children	Percent
•Placement inappropriate, unsafe, or unclear.....	878	23.0%

Included in Above	# Children	Percent
Unsafe, thus inappropriate.....	127	3.3%
Safe, but not appropriate.....	132	3.5%
No documentation/homestudy on which to base finding.....	619	16.2%

•Current placement appears appropriate and safe.....	2,941	77.0%
Total	3,819	100.0%

Trend Notes:
In 1994, 4.2% of the reviewed children's placements appeared to be inappropriate.
In 2004, 37.9% of the reviewed children's placements appeared to be inappropriate.

Partial basis for this finding:

- A child's current placement is to be safe and appropriate. [Neb. Rev. Stat. §43-1308]
- When a child cannot remain with his/her parents, relatives shall be given preference as a placement resource. [Neb.Rev.Stat.§43-533 (4)]. The child's health and safety are of paramount concern. [Adoption and Safe Families Act]
- The State shall minimize the number of placement changes for children in out of home care. [Neb.Rev.Stat.§43-533 (4)]
- A written home study must be completed on the child's placement prior to placement. [390 NAC 6-002.04]
- Each child's placement shall receive educational and health information at the time of placement. [Section 475 (5) of the Social Security Act (SSA)]

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 2004.

TABLE 3 (continued)

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT
LOCAL BOARD FINDINGS FOR CHILDREN REVIEWED DURING 2004

Safety evaluation by department or custodial agency	# Children	Percent
•Custodial agency has not fully evaluated safety or it is unclear...	831	21.8%

Included in Above	# Children	Percent
Custodial agency has not evaluated the safety/taken action.....	151	4.0%
Unclear if custodial agency has evaluated safety.....	680	17.8%

•Custodial agency evaluated the safety of the child and taken the necessary measures in the plan to protect the child.....	2,988	78.2%
Total	3,819	100.0%

Partial basis for this finding:

- The custodial agency, normally HHS, is to evaluate the safety of the child and take the necessary measures in the plan to protect the child. [Adoption and Safe Families Act]

Reasonable efforts toward reunification	# Children	Percent
•Reasonable Efforts are not being made.....	172	4.5%
•Reasonable Efforts are being made.....	2,038	53.4%
•Reasonable Efforts are no longer being made because the plan is no longer reunification or reasonable efforts are otherwise not required.....	1,609	42.1%
Total	3,819	100.0%

Partial basis for this finding:

- HHS is required to make reasonable efforts to reunite a child with his or her family unless certain circumstances exist [Neb.Rev.Stat.§43-533 (4), Neb.Rev.Stat.§43-283.01 and Adoption and Safe Families Act].
- In determining whether reasonable efforts have been made to preserve and reunify the family, the child's health and safety are of paramount concern. [Neb.Rev.Stat.§43-283.01]

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 2004.

TABLE 3 (continued)

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT
LOCAL BOARD FINDINGS FOR CHILDREN REVIEWED DURING 2004

Parent-child visitation arrangements	# Children	Percent
•Parental visitation are not occurring as ordered	646	16.9%
•Parental visitation is not clear	314	8.2%
•Parental visitation was not ordered	139	3.6%
•Parental visitation is not applicable due to	958	25.0%
•Parental visitation is not applicable due to the youth's placement type	327	8.6%
•Parental visitation are occurring as ordered	1,435	37.6%
Total	3,819	100.0%

Partial basis for this finding:

- A visitation plan is to be developed for the child and parents to ensure continued contact when appropriate. [390 NAC 7-001.02A]

Sibling visitation	# Children	Percent
Sibling visitation is not occurring	463	12.1%
Sibling visitation information was not available	484	12.7%
Sibling visitation is not applicable (no siblings or placed together)	1,329	34.8%
Sibling visitation is not applicable due to the youth's placement type (e.g., rehabilitation center)	327	8.6%
Sibling visitation is occurring	1,216	31.8%
Total	3,819	100.0%

Partial basis for this finding:

- Sibling contact is often necessary for child well-being and successful reintegration as a family.

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 2004.

TABLE 3 (continued)

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT
LOCAL BOARD FINDINGS FOR CHILDREN REVIEWED DURING 2004

Reasonable efforts to prevent the removal	# Children	Percent
•Reasonable efforts were not made to prevent the child's removal from the home.....	43	1.1%
•It was unclear what efforts were made to prevent removal.....	103	2.7%
•Reasonable efforts to prevent removal were not necessary due to an emergency or judicial determination.....	2,422	63.4%
•Reasonable efforts were made to prevent the child's removal from the home.....	1,251	32.8%
Total	3,819	100.0%

Partial basis for this finding:

- This is a requirement for federal IV-E reviews.
- HHS is required to make reasonable efforts to prevent a child's removal from his or her family, unless an exception exists. [Neb.Rev.Stat.§43-283.01 and Adoption and Safe Families Act]
- In determining whether reasonable efforts have been made to preserve and reunify the family, the child's health and safety are of paramount concern. [Neb.Rev.Stat.§43-283.01]

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 2004.

TABLE 3 (continued)

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT
LOCAL BOARD FINDINGS FOR CHILDREN REVIEWED DURING 2004

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	891	23.3%
•The Board finds that grounds for termination of parental rights do not appear to exist	1,295	33.9%
•The Board finds that grounds for termination of parental rights appears to exist, but it would not be in the child's best interests	764	20.0%
•A finding on grounds for termination is not applicable because the parents are deceased or the rights have already been relinquished or terminated	869	22.8%
Total	3,819	100.0%

Partial basis for this finding:

- The petition filed by the county attorney affects the adjudication and all court proceedings thereafter, since the courts can only require a parent to rehabilitate on those issues found to be true. [Neb.Rev.Stat.§43-274(1)]
- Whether all potential parents have been identified and included in the action. [HHS Program Memo: Title 390, Protection and Safety #1-2005]
- The Board must determine if grounds for termination of parental rights appear to exist. [Neb.Rev.Stat.§43-1308]
- The State is required to file a petition to terminate parental rights if conditions outlined in Neb. Rev. Stat. §43-292.02 are met.

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 2004.

TABLE 3 (continued)

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT
LOCAL BOARD FINDINGS FOR CHILDREN REVIEWED DURING 2004

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.....	1,334	34.9%
The Board find that return is not likely and recommends referral for guardianship.....	596	15.6%
The Board find that return is not likely and recommends placement with a relative.....	120	3.1%
The Board find that return is not likely and recommends a planned, permanent living arrangement other than adoption, guardianship, or placement with a relative.....	734	19.2%
The Board finds return of the children to the parents is likely.....	1,035	27.1%
Total	3,819	100.0%

Partial basis for this finding:

- The Board is to determine if the child is likely to be returned to their parent's care and if not, recommend an alternative plan. [Neb.Rev.Stat.§43-1308(1)(c)]

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 2004.

TABLE 4

BARRIERS TO PERMANENCY FOR CHILDREN REVIEWED DURING 2004

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 2004. 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 to Permanency	
Ability/willingness to parent	1375
Past history abuse/violence	980
Parental substance abuse	891
Resistant, uncooperative to services	557
Lack of visitation	392
Relationship among family	386
Housing issues	331
Parent incarceration	204
Mental illness	196
Noncompliance Court Order	178
Parent whereabouts unknown	154
Possible sexual abuse	153
Inability to cope w/disability	150
Economic stress	143
Lack of job training/skills	141
Low functioning parent	107
Other parent issues	104
Parental health problems	51
Bonding problems	13
Distance between family	11
Number of removals	8
Lack of transportation	5

continued...

[1]This table compiles the barriers to permanency identified by the local boards for each of the 3,819 individual children reviewed during 2004. 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 to Permanency	
Length of time in care	868
Lack of progress	466
Number of placements	220
Inadequate casework services	98
Delay in home study	64
Not prepared for independence	38
Other implementation barriers	37
Inadequate contact with child	9
Inadequate contact with foster parents	5

Category	Number of Children[1]
Planning Barriers to Permanency	
No plan	464
Plan inappropriate	164
Inappropriate timeframe	85
Other planning barrier	37
No timeframe	17
Inappropriate objectives	2
No objectives	1

Category	Number of Children[1]
Legal Barriers to Permanency	
Parent's rights over children's	234
Guardian ad litem not active	164
Other legal issues	144
Lack of legal action	99
Court delays	64
Child's legal status unclear	12
No guardian ad litem	10
Conflict with ICWA	3
Court orders diff. agency plan	2

continued...

[1]This table compiles the barriers to permanency identified by the local boards for each of the 3,819 individual children reviewed during 2004. 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 2004

Category	Number of Children[1]
Case Management Barriers to Permanency	
Lack of documentation	337
Case transfer interrupts service	52
Other case management barriers	44
Poor contractor monitoring	32
Caseload too large	12
Uncovered case	9
Policy inappropriate to case	6
Caseworker supervision	4
Case manager not know case	1

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 3,819 children's files reviewed during 2004:

- 270 (7.1%) of the 3,819 children reviewed during 2004 had documentation showing that *no case manager contact had taken place within 60 days* of the review. This includes 80 children age birth to five.
- 132 (3.5%) of the 3,819 children reviewed during 2004 had n*o documentation regarding case manager/child contacts* and thus likely did not have any contact. This includes 22 children age birth to five.
- 3,471 (89.5%) of the 3,819 children reviewed in 2004 had documented case manager contact within 60 days prior to the 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 132 children's 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 3,819 individual children reviewed during 2004. 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 2004

Category	Number of Children[1]
Resource Barriers to Permanency	
Lack independent living training	59
Lack special needs adopt homes	40
Lack specialized foster homes	37
Other resource issues	33
Support services not available	31
Inadequate health care services	1

Category	Number of Children[1]
Placement Barriers to Permanency	
Placement not meet special needs	71
Problems in foster home	59
Relative paid less than ADC	3
Issue with group placement	1
Other placement issues	194

Category	Number of Children[1]
Coordination Barriers to Permanency	
Communication within agency	23
Other coordination issues	7
Multi-agency communication	1
Agency-court communication	1

Other Barriers in Categories Not Listed Above	695 children
No Barriers Identified	391 children

continued...

[1]This table compiles the barriers to permanency identified by the local boards for each of the 3,819 individual children reviewed during 2004. 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 4B

PROVISION OF HEALTH AND EDUCATION RECORDS TO THE CAREGIVERS FOR CHILDREN REVIEWED DURING 2004

Health Records Given to Foster Parent or Caregiver	Total Children Reviewed		Ages 0-5	Ages 6-12	Ages 13-15	Age 16+
Yes	2,749	72.0%	806	874	456	613
No	398	10.4%	129	139	67	55
Unknown	547	14.3%	121	131	122	181
Not applicable	125	3.3%	5	9	9	102
Total	3,819	100.0%	1,061	1,153	654	951

For this chart on education records, only reviewed children ages 6-15 are included, as all of these children should be of school age.

Education Records Given to Foster Parent or Caregiver	Total Children Reviewed		Ages 6-12	Ages 13-15
Yes	1,315	72.8%	867	448
No	195	10.8%	126	69
Unknown	258	14.3%	132	126
Not applicable	39	2.2%	28	11
Total	1,807	100.0%	1,153	654

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 2004

This table includes two charts. The first shows the reasons why the 3,819 children and youth reviewed by the Foster Care Review Board during 2004 were placed in out-of-home care throughout their lifetimes. 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]		Children By Number of Removals: Reviewed children who had been in foster care at least once previously [1]	
Neglect [2]	2,274	59.54%	1,374	60.05%	900	58.79%
Child's Behaviors [3]	1,255	32.86%	316	13.81%	939	61.33%
Parental Drug Abuse	933	24.43%	679	29.68%	254	16.59%
Physical Abuse	801	20.97%	442	19.32%	359	23.45%
Housing substandard/unsafe	728	19.06%	450	19.67%	278	18.16%
Parental Alcohol Abuse	480	12.57%	323	14.12%	157	10.25%
Abandonment	479	12.54%	302	13.20%	177	11.56%
Parental Incarceration	407	10.66%	253	11.06%	154	10.06%
Caretaker Inability to Cope	382	10.00%	200	8.74%	182	11.89%
Sexual Abuse [4]	324	8.48%	192	8.39%	132	8.62%
Child's Mental Health [3]	209	5.47%	88	3.85%	121	7.90%
Child's Drug Abuse	116	3.04%	25	1.09%	91	5.94%
Relinquishment	67	1.75%	10	0.44%	57	3.72%
Child's Alcohol Abuse	66	1.73%	23	1.01%	43	2.81%
Child's Disabilities	46	1.20%	21	0.92%	25	1.63%
Child's Suicide Attempt	21	0.55%	10	0.44%	11	0.72%
Death of Parent(s)	20	0.52%	6	0.26%	14	0.91%
Child's Illness	0	0.00%	0	0.00%	0	0.00%
Other	34	0.89%	24	1.05%	10	0.65%
Total Children Reviewed	3,819[1]	100.00%[1]	2,288[1]	100.00%[1]	1,531[1]	100.00%[1]

[1] Up to ten reasons for entering out-of-home care could be identified for each child reviewed. 2,288 of the 3,819 children reviewed were in their first removal from the home, 1,531 of the 3,819 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 (13.8%) versus children with multiple removals (61.3%). Similarly, mental health needs increase for children with multiple removals (3.9% versus 7.9%).

[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.

TABLE 5 continued...

Each of the 3,819 children reviewed during 2004 could have multiple reasons identified for entering out-of-home care throughout their lifetimes, and multiple conditions identified after removal(s).

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]	2,537	66.4%	2,274	263
Child's Behaviors	1,464	38.3%	1,255	209
Parental Drug Abuse	1,181	30.9%	933	248
Physical Abuse	991	25.9%	801	190
Housing substandard/unsafe	875	22.9%	728	147
Abandonment	668	17.5%	479	189
Sexual Abuse	666	17.4%	382	284
Caretaker Inability to Cope due to Parental Illness/Disability	657	17.2%	480	177
Child's Mental Health	625	16.4%	407	218
Parental Incarceration	505	13.2%	324	181
Parental Alcohol Abuse	393	10.3%	209	184
Child's Drug Abuse	176	4.6%	116	60
Relinquishment	125	3.3%	67	58
Child's Disabilities	118	3.1%	46	72
Child's Alcohol Abuse	107	2.8%	66	41
Death of Parent(s)	43	1.1%	20	23
Child's Suicide Attempt	30	0.8%	21	9
Child's Illness	14	0.4%	0	14
Other	35	0.9%	34	1
Total Children Reviewed	3,819 [1]	100.0% [1]	3,819 [1]	3,819 [1]

[1] Up to ten reasons for entering out-of-home care could be identified for each of the 3,819 children reviewed. Similarly, up to ten later identified conditions could be recorded for each of the 3,819 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 2004

Percent of Life In Care	Total Children Reviewed	Ages 0-5	Ages 6-12	Ages 13-15	Ages 16-18	Became 19 after last review
1-24%	1,908	206	586	455	600	61
25-49%	997	273	378	139	180	27
50-74%	503	230	152	49	61	11
75-99%	217	161	34	11	10	1
100%	194	191	3	0	0	0
Total	3,819	1,061	1,153	654	851	100

- **914 (23.9%) of the reviewed children have spent more than half of their lives in out-of-home care.** This includes
  - 582 preschool children (ages 0-5),
  - 189 elementary school aged children (ages 6-12),
  - 60 middle school/junior high aged children (ages 13-15), and
  - 83 youth over age 16 who have aged out or soon will be aging out of the system and creating families of their own.

- **411 children and youth have spent the majority (75%+) of their lives in out-of-home care, including 194 reviewed children who have spent every day of their lives (100%) in out-of-home care.**

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. Many children have experienced even longer periods in out-of-home care (see next page).

TABLE 6B

MONTHS IN OUT-OF-HOME CARE FOR CHILDREN REVIEWED DURING 2004

Months In Care	Children Reviewed	Ages 0-5	Ages 6-12	Ages 13-15	Ages 16-18	Became 19 after review
0-6 months	481	247	122	61	51	0
7-12 months	588	204	165	110	105	4
13-18 months	583	215	165	88	110	5
19-24 months	427	142	124	62	89	10
25-30 months	317	84	95	51	74	13
31-36 months	303	78	102	53	63	7
37-40 months	150	24	65	21	37	3
41-48 months	268	44	105	40	67	12
49+ months	702	23	210	168	255	46
Totals	3,819	1,061	1,153	654	851	100

- **2,167 (56.7%) of the 3,819 reviewed children have spent more than 18 months of their lives in out-of-home care.** This includes:
  - 609 preschool children (ages 0-5),
  - 866 elementary school aged children (ages 6-12),
  - 483 middle school/junior high aged children (ages 13-15), and
  - 791 youth over age 16 who will soon be aging out of the system and creating families of their own.
- **1,120 (29.3%) of the reviewed children and youth have spent over 3 years of their lives in out-of-home care.**
- **702 (18.4%) 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 2004

WAS PATERNITY ESTABLISHED

Paternity Established	Children	Age 0-5	Age 6-12	Age 13-15	Age 16+
Yes	2,616	660	112	107	153
No	677	265	841	434	681
Undocumented	526	136	200	113	117
Total	3,819	1,061	1,153	654	951

It is likely that paternity has not been established for nearly a third of the children reviewed (1,203 of 3,819 – 31.5%)– this includes children where it was documented as yet to be determined and children who had no documentation of paternity.

751 (27.3%) of the 2,750 reviewed children who had been in out-of-home care for more than 12 months still had no documentation of paternity establishment.

Paternity and Young Children

- 401 of the young children reviewed did not have paternity established
  - 227 of the 401 children had been in care for over 11 months (1 year or more)
  - 64 of the 401 children had been in care for over 23 months (2 years or more)
  - 22 of the 401 children had been in care for over 36 months (3 years or more)

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- 2004

Number of Children reported to the State Foster Care Review Board from 1983 through 2004	71,399
Children in out-of-home care on December 31, 2003	5,522 [1]
Children who entered care during 2004	+ 4,839
Children whose case was active anytime during 2004	10,361
Children reported to have left care during 2004	-4,140
Children reported/verified in 2004 to have previously left care	- 138 [1]
Children in out-of-home care on December 31, 2003	6,083
Number of Children reviewed by the Foster Care Review Board during 2004	3,819
Number of Reviews conducted by the Foster Care Review Board during 2004	6,083 [2]

Agency with custody of children in out-of-home care Dec. 31, 2004:

Health and Human Services	5,750 [3]
Correction, Detention, Probation, Parole or Courts	71 [4]
Excludes the Kearney and Geneva Youth Rehabilitation & Training Centers, which are under the Department of Health and Human Services	
Private Agencies (including pre-adoptive)	262
Total	6,083

[1] Prior to, during, and since 2004, HHS sometimes does not report when children leave out-of-home care or reports the case closure weeks/months after the fact. Thus 138 children had left care in 2003, but the closure was not reported until 2004 or else was made known when the FCRB attempted to review the child's case.

[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, 2004 BY AGE

Children's Age	Number of Children	Subtotals	Subtotal Percents	
under 1 year	248			
1 year	258			
2 years	315			
3 years	271			
4 years	237			
5 years	205			
		1,534	25.2%	Ages birth - 5
6 years	230			
7 years	198			
8 years	175			
9 years	184			
10 years	201			
11 years	196			
12 years	231			
		1,415	23.3%	Ages 6-12
13 years	293			
14 years	403			
15 years	579			
		1,275	21.0%	Ages 13-15
16 years	732			
17 years	698			
18 years	426			
		1,856	30.5%	Ages 16-18
Unreported Age	3		>0.1%	Unreported Age
Total	6,083		100.0%	

Explanation of Table—This table shows the number of active children on Dec. 31, 2004, 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, 2004 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	1,203	494	316	185	208
2	1,003	392	241	175	195
3	716	234	201	122	159
4	536	127	145	128	136
5	414	66	141	99	108
6	307	44	83	78	102
7	259	21	79	74	85
8	189	22	43	55	69
9	170	8	29	55	78
10	119	5	20	34	60
11-20	656	4	70	182	399
21-30	135	0	8	32	95
31-40	37	0	1	2	34
over 40	6	0	0	1	5
Total	5,750	1,417	1,377	1,223	1,733

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

- 2,828 (49.2%) of HHS children had experienced 4 or more placements.
- 834 (14.5%) 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.

- **531 (37.5 %) of the 1,417 HHS preschoolers have lived in 3 or more different homes**
- **170 (12.0%) of the 1,417 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, 2004 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, 2004 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	267	110	30	44	80	3
2	17	1	3	1	12	0
3	22	4	1	2	15	0
4	9	2	1	2	4	0
5	6	0	1	1	4	0
6	0	0	0	0	0	0
7	2	0	1	0	1	0
8	1	0	0	0	1	0
9	1	0	0	0	1	0
10	2	0	0	1	1	0
11-20	4	0	1	0	3	0
21-30	1	0	0	0	1	0
31-40	1	0	0	1	0	0
over 40	0	0	0	0	0	0
Total	333	117	38	52	123	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, 2004 have experienced, the difference is who is the agency with custody.

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.

		# Times Removed		Gender			Age					Race						Hispanic
County	Total	1st	2+	Male	Female	Un	0–5	6–12	13–15	16+	Un	Blk	Wht	Ind	As	Oth	Unr	Ethnicity
Adams	131	66	65	70	61	0	32	19	33	47	0	7	119	2	0	0	3	3
Antelope	13	9	4	7	6	0	4	5	1	3	0	0	12	0	0	0	1	1
Arthur	1	0	1	1	0	0	0	1	0	0	0	0	1	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	7	4	3	2	5	0	0	0	3	4	0	0	6	0	0	0	1	0
Box Butte	13	6	7	7	6	0	5	1	3	4	0	4	4	5	0	0	0	1
Boyd	2	0	2	1	1	0	0	0	0	2	0	0	2	0	0	0	0	0
Brown	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Buffalo	75	42	33	48	27	0	10	12	19	34	0	3	69	2	0	0	1	8
Burt	18	10	8	12	6	0	5	4	2	7	0	0	12	5	0	0	1	0
Butler	27	18	9	13	14	0	5	10	6	6	0	0	27	0	0	0	0	0
Cass	67	50	17	33	34	0	19	25	7	16	0	0	66	0	0	1	0	0
Cedar	16	15	1	9	7	0	5	4	3	4	0	0	16	0	0	0	0	0
Chase	6	4	2	1	5	0	1	1	2	2	0	0	6	0	0	0	0	0
Cherry	16	13	3	11	5	0	2	7	4	3	0	0	8	6	0	2	2	0
Cheyenne	37	24	13	20	17	0	9	10	8	10	0	1	29	5	0	0	2	6
Clay	18	8	10	9	9	0	4	4	4	6	0	1	17	0	0	0	0	0
Colfax	25	13	12	14	11	0	6	5	7	7	0	0	13	1	0	0	11	10
Cuming	4	3	1	0	4	0	0	2	0	2	0	0	3	0	0	0	1	1
Custer	31	17	14	16	15	0	9	8	7	7	0	0	29	1	0	0	1	1
Dakota	51	35	16	31	20	0	16	11	11	13	0	0	33	5	0	0	13	19
Dawes	10	6	4	6	4	0	2	0	3	5	0	0	3	7	0	0	0	0
Dawson	112	71	41	60	52	0	26	24	28	34	0	1	78	5	0	0	28	36
Deuel	4	3	1	2	2	0	1	0	2	1	0	0	3	0	0	0	1	0
Dixon	9	6	3	7	2	0	0	1	4	4	0	0	9	0	0	0	0	0
Dodge	185	121	64	93	92	0	47	54	37	47	0	6	157	6	1	0	15	20
Douglas	2218	1463	755	1173	1017	28	609	542	441	624	2	732	1130	123	7	1	223	214
Dundy	1	1	0	1	0	0	0	0	1		0	0	1	0	0	0	0	0
Fillmore	27	15	12	11	16	0	1	17	4	5	0	1	25	1	0	0	0	0
Franklin	6	3	3	4	2	0	0	2	2	2	0	0	6	0	0	0	0	0
Frontier	6	6	0	3	3	0	1	0	2	3	0	0	6	0	0	0	0	0
Furnas	9	4	5	6	3	0	0	3	4	2	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**	**Neig**	**Non**	**0-C**	**P-X**	**Unc**
Adams	131	9	0	65	9	1	21	26	54	36	13	28	54	39	32	2	0	4
Antelope	13	2	0	8	1	0	2	0	8	2	1	2	0	8	4	0	0	1
Arthur	1	0	0	0	0	0	0	1	0	1	0	0	0	0	1	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	7	0	0	3	0	0	1	3	5	2	0	0	0	1	6	0	0	0
Box Butte	13	1	2	5	2	0	1	2	6	2	2	3	5	1	6	1	0	0
Boyd	2	1	0	1	0	0	0	0	0	1	0	1	0	0	0	1	1	0
Brown	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Buffalo	75	9	3	21	3	0	20	19	31	13	9	22	36	13	17	2	1	6
Burt	18	1	0	10	1	0	0	6	8	3	5	2	3	5	9	0	0	1
Butler	27	3	0	13	1	0	2	8	16	7	1	3	9	5	12	1	0	0
Cass	67	2	0	29	2	0	7	27	48	9	6	4	34	24	8	0	1	0
Cedar	16	0	0	11	1	0	1	3	13	0	3	0	3	8	3	1	1	0
Chase	6	0	0	2	1	0	0	3	4	0	1	1	1	3	2	0	0	0
Cherry	16	0	0	9	2	0	0	5	12	4	0	0	10	1	4	0	0	1
Cheyenne	37	0	1	20	4	0	8	4	21	8	1	7	16	1	16	2	0	2
Clay	18	0	0	9	1	0	1	7	7	2	5	4	4	8	5	0	0	1
Colfax	25	3	0	6	1	0	4	11	12	6	4	3	11	5	9	0	0	0
Cuming	4	0	0	2	0	0	0	2	3	1	0	0	1	1	2	0	0	0
Custer	31	2	0	21	0	0	1	7	20	5	1	5	12	11	7	1	0	0
Dakota	51	13	2	18	0	1	1	16	27	15	4	5	24	7	18	0	2	0
Dawes	10	0	0	1	0	0	2	7	6	0	1	3	2	6	0	0	0	2
Dawson	112	4	0	41	18	0	14	35	58	23	14	17	43	32	32	3	1	1
Deuel	4	0	0	0	0	0	1	3	3	1	0	0	1	1	1	0	0	1
Dixon	9	3	0	3	0	0	3	0	3	1	2	3	2	0	7	0	0	0
Dodge	185	11	1	82	13	1	14	63	103	38	24	20	85	50	33	9	1	7
Douglas	2218	31	8	1285	48	0	182	664	1122	524	212	360	1550	272	242	65	24	65
Dundy	1	0	0	0	0	0	1	0	0	0	1	0	0	0	1	0	0	0
Fillmore	27	0	0	24	1	0	0	2	11	11	3	2	7	13	4	2	0	1
Franklin	6	0	0	4	1	0	0	1	4	1	0	1	3	0	3	0	0	0
Frontier	6	0	0	0	0	0	0	6	4	1	1	0	1	4	1	0	0	0
Furnas	9	0	0	3	4	0	0	2	4	4	1	0	1	1	7	0	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 (neig), placed in non neighboring county to parent (non), child placed out of state (0-C), parent moved out of state (px) 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	25	10	0	6	6	4	19	0	0	32	1	0	0	2	2
Garden	6	4	2	2	4	0	0	3	0	3	0	0	4	2	0	0	0	0
Garfield	1	1	0	0	1	0	0	0	1	0	0	0	1	0	0	0	0	0
Gosper	10	2	8	4	6	0	2	3	2	3	0	0	10	0	0	0	0	1
Grant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Greeley	7	3	4	2	5	0	2	1	0	4	0	0	6	0	0	0	1	1
Hall	189	112	77	101	88	0	42	40	46	61	0	5	151	8	3	1	21	49
Hamilton	17	7	10	7	10	0	3	4	6	4	0	1	15	0	0	0	1	2
Harlan	3	2	1	3	0	0	1	1	1	0	0	0	1	0	0	0	2	0
Hayes	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hitchcock	6	5	1	3	3	0	4	1	1	0	0	0	6	0	0	0	0	0
Holt	32	22	10	18	14	0	8	7	7	10	0	0	31	1	0	0	0	1
Hooker	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Howard	14	5	9	8	6	0	3	2	1	8	0	0	14	0	0	0	0	0
Jefferson	15	6	9	11	4	0	3	1	4	7	0	0	11	1	0	0	3	2
Johnson	15	12	3	8	7	0	6	5	3	1	0	0	9	0	2	0	4	6
Kearney	10	4	6	6	4	0	0	6	2	2	0	0	10	0	0	0	0	0
Keith	15	11	4	8	7	0	4	4	4	3	0	0	14	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	25	17	8	12	13	0	9	4	3	9	0	0	25	0	0	0	0	0
Knox	3	1	2	2	1	0	0	1	1	1	0	0	1	2	0	0	0	0
Lancaster	936	622	314	523	413	0	234	237	202	263	0	152	643	75	10	0	56	72
Lincoln	210	110	100	114	96	0	44	45	48	73	0	5	177	9	0	0	19	34
Logan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Loup	1	1	0	0	1	0	0	0	0	1	0	0	1	0	0	0	0	0
Madison	148	100	48	83	65	0	46	26	25	51	0	12	96	15	0	0	25	15
McPherson	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Merrick	16	10	6	9	7	0	1	6	5	4	0	0	16	0	0	0	0	2
Morrill	16	9	7	8	8	0	3	3	6	4	0	0	16	0	0	0	0	1
Nance	7	3	4	4	3	0	1	0	2	4	0	0	7	0	0	0	0	0
Nemaha	6	5	1	5	1	0	0	3	0	3	0	0	5	0	0	0	1	0
Nuckolls	10	6	4	6	4	0	1	4	4	1	0	0	10	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...)

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		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	P-X	Unc
Gage	35	2	1	14	2	0	5	11	19	5	7	4	15	5	13	0	0	2
Garden	6	0	0	5	1	0	0	0	2	1	3	0	3	0	2	1	0	0
Garfield	1	0	0	0	0	0	0	1	1	0	0	0	0	1	0	0	0	0
Gosper	10	0	0	3	3	0	2	2	2	1	6	1	2	5	3	0	0	0
Grant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Greeley	7	0	0	6	0	0	0	1	2	2	1	2	0	3	4	0	0	0
Hall	189	12	4	92	6	1	12	62	89	40	20	40	92	47	42	3	0	5
Hamilton	17	0	0	6	2	0	1	8	6	7	3	1	9	6	1	0	1	0
Harlan	3	0	0	0	0	0	0	3	2	1	0	0	1	0	2	0	0	0
Hayes	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hitchcock	6	0	0	3	1	0	0	2	5	1	0	0	0	5	1	0	0	0
Holt	32	0	1	14	7	0	4	6	15	8	3	6	9	8	12	1	2	0
Hooker	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Howard	14	3	1	3	1	0	0	6	6	4	1	3	2	3	8	0	1	0
Jefferson	15	2	0	4	0	0	0	9	5	6	2	2	2	5	6	0	2	0
Johnson	15	0	0	6	1	0	1	7	9	3	2	1	0	6	7	0	0	2
Kearney	10	1	0	8	0	0	1	0	2	6	0	2	3	3	4	0	0	0
Keith	15	1	0	5	1	0	2	6	9	3	1	2	7	6	2	0	0	0
Keya Paha	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Kimball	25	1	0	12	1	0	1	10	17	4	0	4	11	5	2	5	2	0
Knox	3	0	1	2	0	0	0	0	0	0	0	3	0	0	3	0	0	0
Lancaster	936	40	7	472	9	0	103	305	497	185	103	151	601	78	222	16	5	14
Lincoln	210	9	4	86	34	0	27	50	92	52	25	41	96	20	76	6	8	4
Logan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Loup	1	0	0	0	0	0	0	1	1	0	0	0	0	0	1	0	0	0
Madison	148	9	2	51	5	0	10	71	87	22	13	26	68	21	51	3	2	3
McPherson	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Merrick	16	0	0	5	1	1	0	9	10	2	3	1	10	1	5	0	0	0
Morrill	16	0	0	12	1	0	0	3	7	6	1	2	4	5	4	3	0	0
Nance	7	0	1	3	1	0	1	1	4	0	0	3	3	1	3	0	0	0
Nemaha	6	0	0	0	0	0	2	4	5	0	0	1	1	1	3	0	0	1
Nuckolls	10	0	0	8	2	0	0	0	7	1	0	2	7	1	2	0	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.

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

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		# 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	19	10	9	11	8	0	4	1	4	10	0	0	18	0	0	0	1	0
Pawnee	2	1	1	2	0	0	0	0	2	0	0	0	2	0	0	0	0	0
Perkins	3	2	1	2	1	0	0	2	1	0	0	0	2	1	0	0	0	0
Phelps	21	13	8	8	13	0	6	2	4	9	0	0	20	0	0	0	1	1
Pierce	13	9	4	6	7	0	3	0	5	5	0	0	12	0	0	0	1	0
Platte	67	36	31	33	34	0	12	16	16	23	0	3	54	3	0	0	7	9
Polk	9	5	4	7	2	0	3	0	3	3	0	1	7	0	0	0	1	1
Red Willow	35	21	14	23	12	0	5	4	12	14	0	0	30	1	0	0	4	4
Richardson	9	8	1	7	2	0	3	2	1	3	0	0	9	0	0	0	0	0
Rock	1	1	0	1	0	0	1	0	0	0	0	0	1	0	0	0	0	0
Saline	34	17	17	22	12	0	13	10	4	7	0	0	30	0	0	0	4	6
Sarpy	290	153	137	160	129	1	50	59	61	120	0	33	236	4	2	0	15	13
Saunders	44	31	13	26	18	0	11	6	7	20	0	0	38	1	0	0	5	4
Scotts Bluff	187	105	82	119	68	0	31	55	37	64	0	0	104	55	0	0	28	70
Seward	37	17	20	18	19	0	6	5	12	14	0	0	35	0	0	0	2	3
Sheridan	15	13	2	9	6	0	1	3	3	8	0	0	7	8	0	0	0	0
Sherman	5	4	1	3	2	0	4	1	0	0	0	0	5	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	8	4	4	6	2	0	3	0	4	1	0	1	6	0	0	0	1	0
Thayer	6	3	3	6	0	0	0	0	3	3	0	0	6	0	0	0	0	0
Thomas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Thurston	2	0	2	1	1	0	0	0	2	0	0	0	0	2	0	0	0	0
Valley	14	8	6	6	8	0	1	5	2	6	0	0	11	1	0	1	1	1
Washington	23	16	7	13	10	0	4	7	4	8	0	0	22	0	0	0	1	0
Wayne	5	4	1	4	1	0	0	0	3	2	0	3	1	0	0	0	1	0
Webster	2	1	1	1	1	0	0	1	0	1	0	0	2	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	57	41	16	28	29	0	16	13	12	16	0	2	54	0	0	0	1	4
Tribal	56	41	15	28	28	0	20	11	11	14	0	0	2	52	0	0	2	1
Unreported	111	103	8	71	27	13	4	14	36	56	1	2	12	3	0	0	94	0
Voluntary	110	110	0	57	53	0	91	13	0	6	0	4	48	3	47	0	8	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

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	Mis	Fel	Ab/N	Stat.	M.	2+	Unr	1-3	4-6	7-9	10+	Same	Neigh	Non	0-C	P-X	Unr
Otoe	19	1	0	4	0	0	7	7	8	7	0	4	4	7	7	0	0	1
Pawnee	2	0	0	1	0	0	0	1	1	0	1	0	0	0	2	0	0	0
Perkins	3	0	0	2	0	0	0	1	2	1	0	0	2	0	1	0	0	0
Phelps	21	2	1	4	1	0	7	6	10	4	3	4	2	10	9	0	0	0
Pierce	13	1	0	2	0	0	2	8	8	3	1	1	5	3	4	1	0	0
Platte	67	4	1	15	4	0	3	40	37	9	4	17	33	5	24	2	2	1
Polk	9	0	0	1	0	0	1	7	5	1	1	2	0	4	5	0	0	0
Red Willow	35	0	0	6	1	0	4	24	19	9	3	4	11	1	17	0	0	6
Richardson	9	1	0	6	0	0	1	1	7	1	0	1	2	2	5	0	0	0
Rock	1	0	0	0	0	0	0	1	0	1	0	0	1	0	0	0	0	0
Saline	34	0	1	20	0	0	5	8	22	7	3	2	14	11	8	0	0	1
Sarpy	290	3	1	106	14	0	66	100	134	57	43	56	122	117	37	5	3	6
Saunders	44	2	0	9	0	0	1	32	33	4	3	4	19	14	9	2	0	0
ScottsBluff	187	8	3	82	11	0	22	61	77	34	26	50	97	13	58	11	5	3
Seward	37	0	0	16	2	0	2	17	18	7	6	6	12	16	8	1	0	0
Sheridan	15	1	1	4	0	1	0	8	8	5	2	0	0	5	7	1	0	2
Sherman	5	0	0	2	0	0	0	3	4	0	1	0	3	2	0	0	0	0
Sioux	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Stanton	8	0	0	3	1	0	1	3	4	2	1	1	2	3	3	0	0	0
Thayer	6	1	1	1	1	0	0	2	1	3	1	1	1	1	3	0	1	0
Thomas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Thurston	2	1	0	0	0	0	0	1	0	0	0	2	0	0	2	0	0	0
Valley	14	0	0	8	1	0	1	4	8	5	1	0	3	3	7	0	1	0
Washington	23	0	0	8	0	0	3	12	12	4	5	2	4	15	4	0	0	0
Wayne	5	0	0	2	0	0	0	3	2	1	2	0	1	0	2	0	2	0
Webster	2	0	0	1	0	0	1	0	0	1	0	1	0	1	1	0	0	0
Wheeler	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
York	57	1	0	16	2	0	4	34	39	12	1	5	29	12	14	2	0	0
Tribal	56	0	0	2	0	0	0	54	39	10	4	3	35	8	5	4	1	3
Unreported	111	1	0	0	0	0	0	110	106	3	1	1	23	10	39	0	12	27
Voluntary	110	Not applicable							110	0	0	0	2	0	1	2	2	103

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 (neig), placed in non neighboring county to parent (non), child placed out of state (0-C), parent moved out of state (px) 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	2,037
Adoption	660
Guardianship	408
No Plan	318
Independent Living	222
Long Term Foster Care	144
Other/Unknown	29
Multiple Plans	1
Total	3,819

Explanation of Table—This table shows the permanency plans as of December 31, 2004, for children reviewed during 2004.

TABLE 12

CHILDREN ENTERING OUT-OF-HOME CARE DURING THE YEAR BY AGE

	Entering Care in 2004			Prior Years	
Age of child as of December 31st	First Removal from home In 2004	Prior premature, failed reunifications	Total Children Entering Care In 2004	Children Entering Care In 2003	Children Entering Care In 2002
Under 1	309	6	315	243	297
1 year	217	26	243	209	223
2 years	172	28	200	144	180
3 years	179	40	219	124	148
4 years	154	41	195	128	148
5 years	128	44	172	112	136
6 years	141	42	183	106	156
7 years	102	40	142	102	125
8 years	107	42	149	75	129
9 years	95	49	144	87	109
10 years	98	53	151	77	143
11 years	97	48	145	80	146
12 years	109	63	172	94	157
13 years	150	80	230	161	253
14 years	196	126	322	215	492
15 years	247	192	439	279	562
16 years	317	257	574	249	712
17 years	257	266	523	274	740
18 years	123	162	285	122	390
19 + years	10	26	36	14	71
Unknown age	0	0	0	3	4
TOTAL	3,208	1,631	4,839	4,773	5,321
# removed more than once			1,631	1,875	2,211
recidivist rate*			35.2%	39.3%	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 2004 BY REASON

Reason Left Care	No. of Children
Reunification or Presumed Reunification	
Custody Returned to Parent	2,789
Released from Corrections with no other information given (presumably returned to parents)	9
Age of Majority or Other Emancipation	
Reached Age of Majority	413
Emancipated by Military Service or Marriage	2
Adoption	
Adoption Finalized	305
Guardianship	
Guardianship Established	226
Other Reasons	
Court Terminated (with no specifics given)	103
Custody Transferred to Another Agency/State/Tribe	22
Death of Child	1
No reason reported or other	270
Total cases terminated	4,140

Explanation of Table—This table shows the number of children whose cases were terminated (closed) for each reason during 2004.

TABLE 14

LIFETIME NUMBER OF TIMES IN FOSTER CARE (REMOVALS) FOR CHILDREN IN OUT-OF-HOME CARE ON DECEMBER 31, 2004

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	3,916	1,313	973	727	900	3
Had Previous Removal(s)	2,167	221	442	548	956	0
Total	6,083	1,534	1,415	1,275	1,856	3

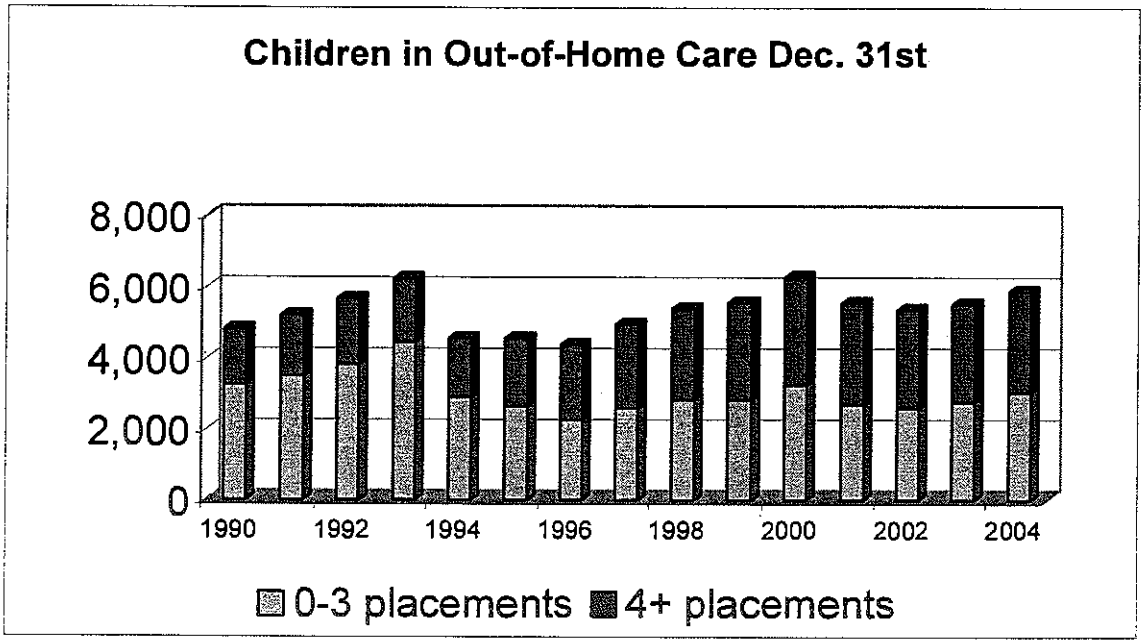
Details

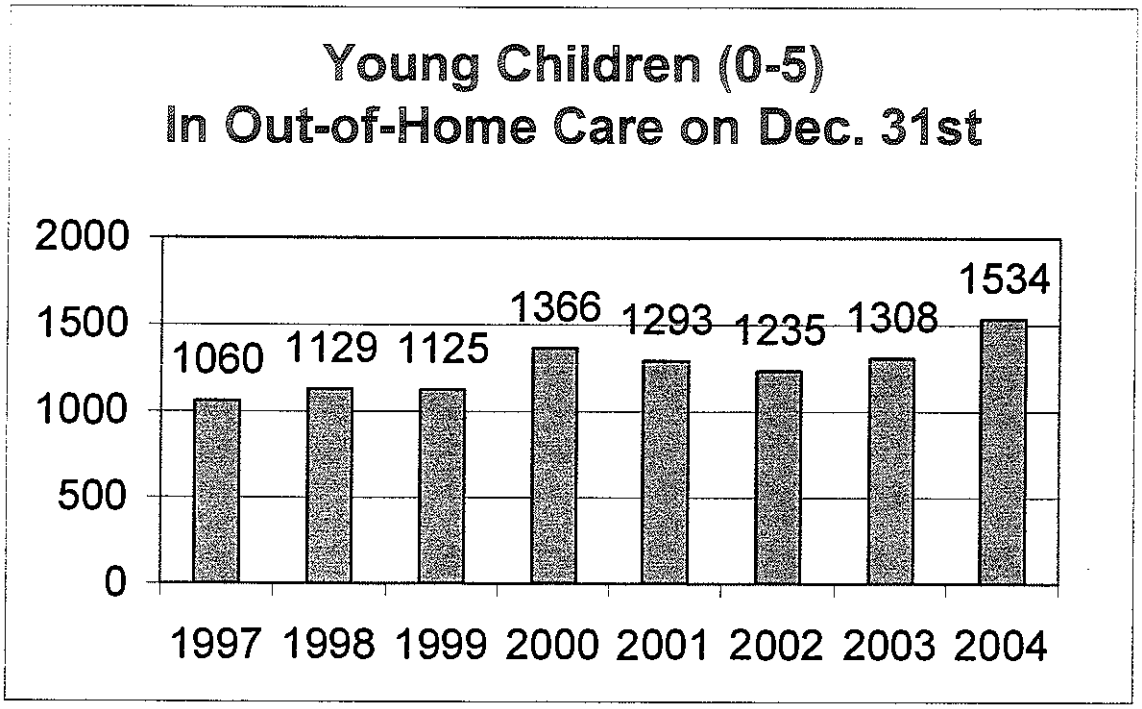
Times in Foster Care (removals)	Totals	Ages 0-5	Ages 6 –12	Ages 13- 15	Age 16+	Age Not Reported
1	3,916	1,313	973	727	900	3
2	1,294	197	306	318	473	0
3	521	23	105	141	252	0
4	203	1	21	56	125	0
5	90	0	7	18	65	0
6	33	0	3	6	24	0
7	17	0	0	6	11	0
8	4	0	0	0	4	0
9	2	0	0	1	1	0
10	1	0	0	0	1	0
11 or more	2	0	0	2	0	0
Total	6,083	1,534	1,415	1,275	1,856	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. 35.6% of the 6,083 children in care on 12-31-2004 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 **221 preschool age children (birth through five years old) who have experienced failed reunification attempts**, especially the **241 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.


Children in Out-of-Home Care Dec. 31st
8,000
6,000
4,000
2,000
0
1990
1992
1994
1996
1998
2000
2002
2004
0-3 placements
4+ placements


Young Children (0-5)
In Out-of-Home Care on Dec. 31st
2000
1500
1000
500
0
1060
1129
1125
1366
1293
1235
1308
1534
1997
1998
1999
2000
2001
2002
2003
2004

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).

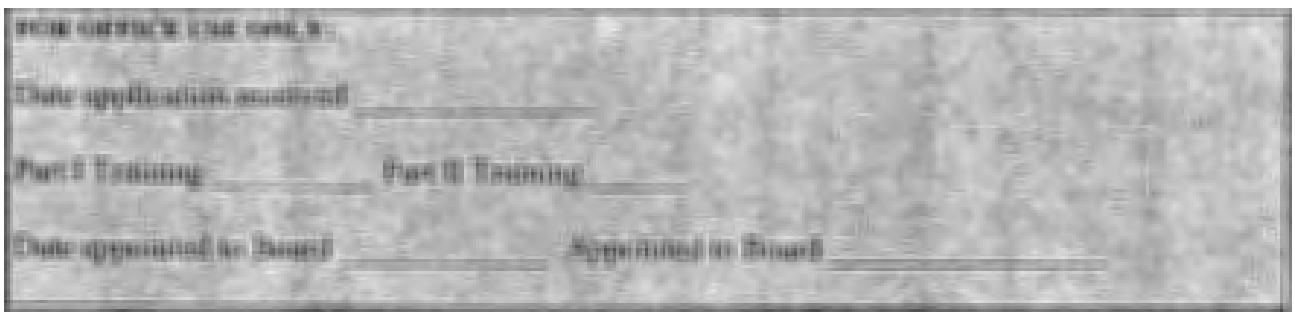
Please list the name, address, and phone number of three references.

1. _____

2. _____

3. _____

Please write a short paragraph of why you would like to serve on a local Foster Care Review Board.



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 - 2004

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
Bergan Mercy Hospital, Omaha
Brooke Valley School, Omaha
Calvary United Methodist Church, Lincoln
Christ United Methodist Church, Lincoln
Columbus Police Department, Columbus
Educational Service Unit #16, Ogallala
First Lutheran Church, South Sioux City
Fremont Presbyterian Church, Fremont
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
Pierce County Courthouse, Pierce
Presbyterian Church of the Cross, Omaha
Rainbow House, Omaha
Regional West Medical Center, Scottsbluff
Seward Civic Center, Seward
St. Andrews Episcopal Church, Omaha
St. Francis Medical Center, Grand Island
St. Paul's United Methodist Church, Lincoln
St. Stevens Building, Grand Island
St. Wenceslaus Catholic Church, Omaha
State Office Building, Omaha
Sump Memorial Library, Omaha
Swanson Library, Omaha
Thanksgiving Lutheran Church, Bellevue
Trinity Lutheran Church, Auburn
United Lutheran Church, Lincoln
United Methodist Church, Norfolk
University of Nebraska Medical Center, Omaha
Vine Congregational Church, Lincoln
York General Hospital, York

Appendix D
Project Permanency Questions

BOARD MEMBER QUESTIONS FOR FOSTER PARENTS

FCRB Home Visit of the _____ **home**

Child's Name _____ **Age** _____

Board members _____ & _____

Date _____ **Time** _____ AM PM

[Be sure that the opening statement has been read]

Key Information About The Child

1. What date was _____ placed in your home? _____

2. When he/she was placed with you, did you receive adequate information regarding:

the child's development	Yes	No
the child's educational needs	Yes	No
the child's medical needs	Yes	No
if the child has allergies	Yes	No
any diet considerations such as which formula	Yes	No

3. What do you understand is the current plan for the child?
(on sheet in the pocket of the binder)

01-Reunification	02-Kinship Care
03-Adoption	04-Long Term Foster Care
11-Guardianship	00-Unreported/unknown
Other: _____	

4. Can you tell me about the child's temperament, personality, and response to stress?

Grief

Research clearly shows that in foster children ages birth through five, most of their behaviors are a result of the grief they experienced because they have been separated from their parents or from a trusted caregiver. Research shows this grief can last for many years.

1. What information, if any, have you been given about childhood grief? What questions do you have about how children respond to separation from parents or from trusted caregivers?
   (Refer to section _____)

2. Next I'll be asking you about some behaviors that are typical of grief. This will help us, on the Board, to better understand what the child's needs are and will help us make better recommendations. Is the child showing...

   Regressive behaviors (soiling self when formerly toilet trained, return to baby talk, use of pacifier when previously weaned, etc.) ..... Yes No

   Not listening or spacey behaviors ..... Yes No

   Sleep Disturbances ..... Yes No

   Food issues (hoarding, refusal to eat) ..... Yes No

   Rhythmic behavior (rocking self excessively.) ..... Yes No

   Rages beyond normal tantrums ..... Yes No

Bothered by nothing – flat emotions..... Yes No

Impulse control weak for their age..... Yes No

Lack of energy ..... Yes No

Over active, without a physical cause..... Yes No

Overly clinging ..... Yes No

Too affectionate with strangers..... Yes No

Intense control battles..... Yes No

Significant learning delays ..... Yes No

Destructive to self ..... Yes No

Destructive to others..... Yes No

Refuses touch or comforting ..... Yes No

3. How do you decide which of the child's behaviors need to be responded to, and how do you to respond to those behaviors?

Services to the Child

1. What is the child's daily routine?

2. Is the child in daycare or an early childhood program?
   Day Care Yes No
   Program Yes No

3. Has the child received a comprehensive health assessment since being placed in your home? Yes No

4. Are the child's immunizations up to date? Yes No Partial

5. When was the child's last visit to the doctor? _____

   1. Who was present at the appointment? _____
   2. What was the reason for the appointment? _____

6. Is the child receiving regular dental exams? Yes No

7. What other services, such as physical therapy, occupational therapy, speech, individual or family counseling, does the child participate in?

8. Are there any services that you feel the child needs that he/she is not receiving?

Visitation Questions

1. Is visitation occurring with the parents? Mother Yes No
   Father Yes No

2. How often are visits occurring?

3. Is visitation supervised? Yes No If yes, by whom? _____

4. Who is transporting the child to visits?

5. Is the child visiting his/her siblings?

6. Do you get reports of how the visits went?

Number In the Home

1. It has been reported to us that the following foster children are currently placed in your home. Can you please confirm if this is accurate?

   1. _____ Age _____
   2. _____ Age _____
   3. _____ Age _____
   4. _____ Age _____
   5. _____ Age _____

2. Are there any other children in the home? Who are they?

   1. _____ Age _____
      Foster child? Yes No If yes, when Placed _____
   2. _____ Age _____
      Foster child? Yes No If yes, when Placed _____
   3. _____ Age _____
      Foster child? Yes No If yes, when Placed _____
   4. _____ Age _____
      Foster child? Yes No If yes, when Placed _____
   5. _____ Age _____
      Foster child? Yes No If yes, when Placed _____

3. Are you a daycare provider? Yes No
   If so, for how many children? _____

4. Are there any disabled adults in the home? Yes No
   If so, how many? _____

5. Do you have respite care available? Is the quality of the respite care acceptable?

Training, Experience

1. How many years have you been a foster placement? _____

2. Has anyone talked to you about basic child development and what is to be expected as "normal" at each stage of growth? Yes No
   (refer to page ___)

Contact with Legal Parties

1. When was the last time the case manager was at your home?
   How much contact does the child have with the case manager?

2. When was the last time the child's guardian ad litem was at your home?
   How much contact do you or the child have with the guardian ad litem?
   (refer to page _____ for GAL definition, to contact page for name)

Other Questions or Comments

Do you have any other concerns that you want the board to be aware of?

Thank you

"Thank you for assisting the Board.

At the end of the binder is an envelope containing some coupons that local sponsors have given us to say "thank you" for your service.

If you think of anything you would like to add or have any other questions, please feel free to contact us. The Board's information is on the contact sheet in the inside pocket of the binder."

Form revised 8-14-2003

Appendix E
Group Home Tour Questions

Youth Detention, Group Home, or other facility questions:

Facility

- What is the Capacity of your facility? How full is it usually?
- What age range of youth are commingled?
- What is the percentage of minority youth?
- How young a child will be admitted here?
  What is the age limit?
- Please describe what will occur when a youth is admitted?
  How long is the youth allowed to stay?
- Describe contact with family, friends, etc.
- Will the youth be given a copy of rules, consequences for certain behaviors, etc.
- What programs and services are available to the youth?
- How is discipline be handled?
  Will there be a time out room and what criteria will there be for placing a youth there.
  Is there a policy limiting the amount of time a youth can be there?
  Is the main focus of the facility on control or on positive guidance?
  Are handcuffs or shackles used for discipline?
  What is the most common method of discipline?
- How are serious incidents (suicide, assaults) handled?
  How often do they occur?
  Is law enforcement contacted?
- Does a citizen advisory board exist to monitor the facility, educate the public, recommended appropriate changes?
- Do you report to the Foster Care Review Board?
- Are children assessed before being accepted to the respite care program?

Staff

- What are the qualifications of the staff?
- What type of training do they receive?
- What is the staff to youth ratio?

- Are social workers, psychologists, certified teachers on staff and available to individual youth at convenient hours?
- Is medical care available at all times? Weekends? Who supervises medications?
- Who supervises the children who are here for respite care?
  How long do they usually stay?
- What opportunity kids have for interaction with staff? Is there any counseling, one on one consultation, etc.

Education

- What is a typical day's schedule?
  Are waking hours filled with productive activities?
- Is the school accredited? By whom?
  How many hours are spent in class work?
  Are School Materials forwarded from children's schools?
- During the education hours when are they in the classroom, and when in recreation?
  How much pure education time do they get per day or week?
  Where will the teachers come from?
- Is there a library? When will they go the the library?
- Exactly where will they be when they're not in classrooms or lunch? Locked in their room? TV room? Any other activities?. Will they go outside? Where?
- What will they do on weekends? Any organized activity? When in rooms?

APPENDIX F

STATE FOSTER CARE REVIEW BOARD
FINANCIAL STATEMENT
Fiscal Year 2004-2005

Appropriations

General Fund	$1,087,946
Cash Fund	$6,000
Federal Funds	$500,000
TOTAL	$1,593,946

Expenditures

Staff Salaries & Benefits	$1,213,462.86
Postage	$32,069.63
Telephone and Communications	$23,765.57
Data Processing Fees	$33,362.89
Publications and Printing	$32,256.70
Rent	$50,653.40
Legal Fees	$6,139.87
Office Supplies & Miscellaneous	$24,997.55
Travel Expenses	$38,066.51
Data Processing & Office Equipment	$8,368.76
Other Administrative & Contractual	$19,761.41
TOTAL	$1,487,905.15