# Hope is On the Horizon
## by Carolyn K. Stitt, M.S.W.

"*All our children ought to be allowed a stake in the enormous richness of America…they are all quite wonderful and innocent when they are small. We soil them needlessly*."
Jonathan Kozal, *Savage Inequalities*

During the last few years, Nebraska has become aware of the challenges and failures in the child protection and foster care systems. Through the commendable leadership of Governor Dave Heineman and Former Chief Justice John Hendry, major collaborative efforts are underway to sharpen the focus upon the goal of improving Nebraska's child welfare system. As a result, the people of Nebraska have reason to anticipate improvements in their foster care system.

The Foster Care Review Board (the Board) knows that the child welfare system can and does work well for approximately half of the children in the system. It assists children and their families in resolving problems. When that is not possible, it provides children the security and permanency to which they are entitled. "Andrew's"[1] case is a good example:

> *"Andrew," entered care at age one because he was physically abused. He was placed with a relative whom he knew and who was able to meet his needs. His mother was given family support services and participated in a parenting class. As the mother progressed, visits were increased and a transition plan put in place. The visits were scheduled with consideration of the mother's employment schedule, and the mother attended all visits. Andrew was reunited with his mother in less than eight months. It is reported that he continues to do well in his mother's care.*

The other half of the children struggle within the system.[2] According to the U.S. Department of Health and Human Services, Nebraska ranks first in the nation for the number of children, per capita, in the child welfare system. This FCRB 2005 Annual Report documents that more Nebraska children are in foster care, they remain longer in foster care, and they endure an increased number of different placements.

The causes underlying these startling statistics are complex. They include parental, social, and systemic failures, including: increased parental addiction to methamphetamine, crack cocaine, marijuana and alcohol; the State's slow response to reports of abuse and neglect; inadequate prevention or early intervention to improve the child's home environment; and high caseworker turnover in the Department of Health

[1] In all case examples in this Report, names have been changed to maintain confidentiality. The examples are from cases reviewed by the Foster Care Review Board.
[2] This figure is based on the number of children with multiple placements, the number of children who have been in foster care for extended periods of time, and the number of children with other negative statistical indicators. Each of these indicators are described in greater detail later in this Report.

and Human Services (HHS) which**,** in some cases, contributes to poorly-coordinated services and inadequate case documentation.

The Board acknowledges that, due to the complexity of these problems, no single agency, organization, or branch of government, can address all of the issues and implement meaningful solutions to fully resolve each problem. With that in mind, the Board has produced three summary versions of the 2005 Annual Report, targeting the Executive, Legislative, and Judicial branches of government, where each branch is provided specific information and recommendations for its specific crucial roles in child welfare.

The Board here reports the following statistics, which signify positive trends in the care of foster children.

1. There has been a decrease in the number of children who, after familial reunification, return to the foster care system. (34% of those in care on Dec. 31, 2005, compared to 46% of those in care on Dec. 31, 2000),
2. More cases have written plans designed **to** correct problems which led to removal of children from their homes. (72% of those reviewed in 2005, compared to 52% of those reviewed in 1995)
3. More HHS case managers are regularly seeing the children (87% of children's cases reviewed in 2005, compared to 39% of children's cases reviewed in 1999).

These improvements have occurred because of the dedication and hard work of Judges, prosecutors, guardians ad litem, defense lawyers, caseworkers, supervisors, and administrators. These accomplishments should be celebrated.

But the following sobering statistics also clearly demonstrate that there is an urgent need for more improvement:

1. 6,204 children were in foster care in Nebraska on Dec. 31, 2005.
2. 1,915 (30.9%) of the children have been moved to six or more foster placements.
3. 2,339 (37.7%) of the children have had four or more different caseworkers on their cases.
4. 2,021 (31.0%) of the 3,309 reviewed children had been in foster care for two years or more.
5. 906 (13.9%) of the reviewed children had been in foster care for five years of more.
6. 76.8% of the children age birth through two years reviewed during 2005 were placed in foster care due to parental substance abuse.

Increased parental substance abuse has added a new element of complexity to case demands. The manufacture and use of the highly addictive stimulant, methamphetamine, has grown exponentially over the last 25 years, gaining a strong and lethal foothold throughout the Midwest and Southwestern United States. The very nature of the drug victimizes not only the addicts, but also the children within their care. The drug is relatively cheap to purchase on the street, or can be inexpensively made following recipes available on the Internet. "Cooking" methamphetamine is almost as easy as baking a

chocolate cake**.** One of the simplest recipes requires the use of anhydrous ammonia, which is abundant in agricultural areas. Laboratories easily fit into car trunks, hotel rooms, garages, and home kitchens.

The use and manufacture of methamphetamine leaves a residue of the drug throughout the home. Blankets, clothing, children's toys, and even teddy bears have tested positive for the presence of methamphetamine, exposing children to the risk of long term physical injury and mental health impairments. The toxins involved cause medical problems, including anemia, respiratory illness, and neurological symptoms in children. Developmental delay and brain damage have also been linked to the toxins.[3]

Parental use of methamphetamine creates a second and perhaps more dangerous threat to children because of the drug's immediate and long term effects on the user. Addicts entrusted with the care of children display post-use behaviors that may include violence, paranoia, hallucinations, agitation, and schizophrenic-like symptoms. Users suffer cognitive impairments such as memory loss, confusion, insomnia, depression and boredom. The cognitive impairments cause users to misinterpret body language and words, which can result in violent paranoiac reactions to perceived threats. Neurological damage and psychotic behavior can persist months and even years after use is discontinued, and often results in children suffering gross abuse and neglect.[4]

When a methamphetamine addict stops using the drug, or when the supply is interrupted, the addict's body often "crashes," from the need for sleep. Addicts may sleep from three to five days leaving their children unfed, unbathed, unsupervised, and often in the "care" or at the whims of fellow drug abusers. Upon awakening the addict may suffer from severe depression, heightened cravings, or suicidal ideations. Throughout all of this the methamphetamine addict is still "parenting" their children.[5]

Children in a methamphetamine home are victimized by the very environment in which they live. They are often victims of, or witnesses to, significant domestic violence and physical abuse. The methamphetamine culture is often sexually explicit. More than one law enforcement officer has marveled that the typical methamphetamine home lacks the basic essentials for the care of children, but contains a large screen television and ample supplies of pornographic videos. The children are exposed to both an alcohol and drug culture as friends of the users come and go. These children tend to isolate themselves from other children, and are characterized by high truancy rates from school.

---

[3] Sources include: Kathryn Wells, MD, Medical Director, Denver Family Crisis Center; the National Jewish Research Center on Methamphetamine Research; Research on Drug Courts: A Critical Review, Steven Belenko, PhD, the National Center on Addiction and Substance Abuse at Columbia University, New York, New York, June 2001; Painting the Current Picture: A National Report Card on Drug Courts, the National Drug Court Institute, Washing, DC, May 2005, Volume I, No. 2; Treatment Methods for Women, National Institute on Drug Abuse, National Institute of Health; Methamphetamine: New Treatment for Women and Children, Kathleen M. West, Drug Endangered Children Research Center, Los Angeles, California, and Dr. Gregg Wright, MD, Med, UNL Center on Children, Families, and the Law.
[4] Ibid.
[5] Ibid.

When identified, "meth" homes are not quickly fixed. Mothers who are required to choose between reunification with their children or continued methamphetamine usage all too often choose their drug rather than their children.[6]

But regardless of the root cause for children coming into foster care, abused and neglected children create additional costs for Nebraska's taxpayers because these children are often in special education,[7] have an increased likelihood of current and future drug and alcohol abuse,[8] are more likely to be homeless, are more likely to enter the prison population,[9,10] and**,** when they have children of their own**,** may perpetuate the cycle of abuse as adults.[11]

While we cannot mitigate all that abused children endure, we can do more to make foster care safe, nurturing, and healing. The Board is grateful that more people are joining the effort to improve the lives of Nebraska's abused and neglected children.

The Board recognizes that some of those who read this Annual Report have a great deal of experience in the child welfare system, while others may not possess the same background information**,** or might have some questions. This 2005 Foster Care Review Board Annual Report seeks to be responsive to the first group by starting with the Board's perspective on the top priority concerns and recommendations, followed by on-going recommendations.

Readers who may be new to child welfare, are invited to turn to page 19 where the Board reports on how children enter the foster care system, and to page 129 where readers are introduced to the statutory functions of the Foster Care Review Board.

---

[6] Honorable John P. Icenogle before the Congressional Committee on Education and the Workforce Subcommittee on Education Reform, Hearing on Combating Methamphetamines through Prevention and Education, Nov. 17, 2005.

[7] The National Survey of Child and Adolescent Well-Being found that children placed in out-of-home care due to abuse or neglect tended to score lower than the general population on measures of cognitive capacity, language development, and academic achievement. U.S. Department of Health and Human Services 2003.

[8] According to report from the National Institute on Drug Abuse, as many as two-thirds of people in drug treatment programs reported being abused as children. Swan, 1998.

[9] Abused and neglected children have been found to be at least 25 percent more likely to experience problems such as delinquency, teen pregnancy, low academic achievement, drug use, and mental health problems. Kelley, Thornberry, & Smith, 1997.

[10] A National Institute of Justice study indicated being abused or neglected as a child increased the likelihood of arrest as a juvenile by 59 percent. Abuse and neglect increased the likelihood of adult criminal behavior by 28 percent and violent crime by 30 percent. Widom & Maxfield, 2001.

[11] It is estimated that as many as one-third of abused and neglect children will eventually victimize their own children. Prevent Child Abuse New York, 2003.

# Priority Recommendations

The Foster Care Review Board's statutory mandate under Neb. Rev. Stat. §43-1303(2)(d) and (3) is to report on conditions of children in foster care and to evaluate the data the Board collects. The Board makes the following recommendations to improve the child welfare system on behalf of Nebraska's abused and neglected children. These are listed in the order by which children move through the foster care system.

## I. Improve the front end of the system by strengthening the intake process, developing services to prevent removal, and by holding pre-trial conferences for children who are removed.

These conferences are an informal meeting where all the parties to the cases, including the parents, get together for the purpose of gaining the cooperation of the parents and problem solving.

The front end of the system includes processing child abuse cases and decisions made by law enforcement, child welfare workers, and the court, as each is involved in the receiving and responding to child abuse and neglect reports, assessment of risk to children, removing children from their homes when they are endangered in their surroundings, and retention of children in out-of-home placements, or else the return of children to their homes under specified conditions.

The front end of the child welfare system must be strengthened to assure that the only children removed from their homes are those whose circumstances make it absolutely necessary for their health and safety.

### A. Continue to improve the intake process by ensuring a consistent and appropriate response to child abuse and neglect reports across the state, and by increasing the availability of services that would allow certain family issues to be addressed without actually removing children from the home.[12]

**It is important to assure that all law enforcement officers who are involved in the removal of children from their homes should receive specialized training to help them make the best decisions when faced with the prospect of removal of a child from his or her home.**

**1. Numbers of Reports Received**:

a. HHS reports it received 27,896 child abuse reports in calendar year 2005, of which 24,374 involved allegations

[12] See page 43 and following for more information on CPS concerns.

of child abuse or neglect. Of these, 13,889 reports were investigated, and 3,324 cases were substantiated.

**2. History of the Board's Concerns with CPS**:

a. During 2003, at the request of Governor Johanns, and with the permission of the Director of Health and Human Services, the Board researched 33 child deaths. The Board's research demonstrated that CPS did not appropriately assess and respond to all calls it received reporting safety concerns or risk of harm to these children. Many of the reports made prior to children's deaths should have triggered investigations, especially in light of the circumstances of these children:
   - 19 (58%) were known to the system before their deaths.
   - 27 (82%) were newborn through five years old.
   - 3 (9%) were wards of the court at the time of their deaths.

b. Governor Johanns then appointed a Task Force to provide recommendations for improving response to child abuse reports.

c. Following the initial research, with the Governor's permission, the Board then examined more than 4,262 calls reporting abuse and neglect. (This sample was made in proportion to the calls made in each of the areas of the state). The Board found that 1,202 of these calls involved serious safety issues due to physical abuse, physical neglect, emotional abuse or sexual abuse. [13]
   i. Once again, the same pattern emerged**,** with 680 of the calls receiving no action or other appropriate response taken to insure the children's safety.

d. The Legislature approved funding for additional CPS workers, for skills development for child abuse investigators, and to allow for CPS and law enforcement to have better access to each other's computer systems.

**3. Rationale**:

a. The Board is required to make a finding on whether reasonable efforts were made to prevent the removal for each child reviewed. During the 4,984 case reviews conducted in 2005, the Board found that in some cases no action was taken to protect children for a considerable period of time prior to children's removals, despite the fact that there had been reports alleging serious abuse. The children involved included babies, toddlers, young

[13] See the 2004 annual report for more information on the research findings.

children, and children with mental or physical handicaps, all of whom are exceptionally vulnerable.

b. The Board is required to make a finding on whether the foster placement was safe and appropriate for each child reviewed. During the 4,984 cases reviews conducted in 2005, the Board found that in a significant number of the cases where abuse and neglect reports had been made to the CPS hotline alleging abuse by the foster parents, there was no investigation.

c. Most people call Child Protective Services (CPS) to report child abuse. However, under Nebraska statutes law enforcement is the first responder to calls. In some cases there is a lack of communication between these co-managed systems. The number of child abuse and neglect reports received, and the number of potential responders, further impacts the system.

   i. A law enforcement officer from any of the more than 200 different local enforcement agencies is usually the responder.

   ii. If the responder has had extra training, as occurs with specialist units such as Project Harmony in Omaha and the youth unit in Lincoln, there tends to be better results. However, officers from these units are not the first responder to most cases, even in Omaha and Lincoln.

## B. Make services available to prevent the removal of some children.[14]

### 1. Number of Children in Foster Care:

a. On Dec. 31, 2005, 6,204 children were in foster care in Nebraska.

b. The federal Centers for Disease Control found in connection to home visitation prevention programs: "*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%*"[15]

c. In Hawaii, the rate of substantiated cases of child maltreatment for families receiving prevention services was found to be less than half that of the control group.

[14] See page 121 for more information about prevention services.
[15] Centers for Disease Control, www.cdc.gov, October 2003.

d. Nebraska has one of the highest per capita ratios of children in foster care.[16]

**2. Rationale**:

a. Some children could remain safely at home if readily obtainable services were available across the State to assure the safety and well-being of these children, if those services were provided in a reliable, communicative, and coordinated system. Such a service network could prevent some removals and, where children have already been removed, could also support their safe return to the parents more quickly.

b. Often, services are not available to prevent the removal of some children from their homes. Documentation of the services made available to the family is often lacking in initial assessment reports or other caseworker reports.

## C. Utilize pre-hearing conferences[17] to ensure from the beginning that children who have been removed are safe while in foster care, that their essential needs are met, and that they exit foster care to safe, permanent homes as soon as possible.

**At the pre-hearing conference the parents and legal parties involved may identify any issues of paternity, assure compliance with the Indian Child Welfare Act, identify relatives and explore the feasibility of a relative placement, determine the children's out-of-home placement, schedule visitation, and identify and set up services for the parents and children.**

The Board acknowledges that many courts have already implemented this important tool.

**1. Statistics Supporting this Recommendation:**

a. 2,021 children had been in care two years or longer and 906 had been in care for five years or more in 2005.

b. Paternity had not been established for 745 (22.5%) of 3,309 reviewed children's cases. Paternity was undocumented, and therefore likely not determined, in another 551 (16.7%) of the 3,309 reviewed children's cases.[18]

---

[16] U.S. Department of Health and Human Services, Child Welfare Outcomes, 2001.

[17] These conferences are also referred to by some as pre-adjudication conferences or pre-trial conferences. See page 63 for additional information on pre-hearing conferences.

[18] Addition information on paternity can be found beginning on page 117.

c. Relatives cared for 1,104 of the 6,204 children in foster care on Dec. 31, 2005.

d. Early ascertainment of the parent's willingness and ability to cooperate with the court and the professionals, as well as monitoring actual compliance could decrease the length of time that children spend in foster care.

**2. Rationale**:

a. Studies show that parents are more motivated to work toward reunification and to address the reasons their children entered care within the first six weeks after their children are removed from their care.[19]

b. **The Board has found that when critical issues are not addressed at the outset of the case, children can potentially spend more time in foster care awaiting the resolution of these critical issues.**

d. Pre-hearing conferences are an effective way to move children towards permanency. These conferences can be scheduled within 30 days of the child entering out-of-home care, shortening the time when critical decisions are made, and allowing the family to receive needed services to address the reasons children entered care.

e. **Use of the pre-trial conference to "jump-start" the system would increase stability in children's placements and expedite their permanency. By adapting techniques learned from the drug court and family court models, front-loading the system would create a more comprehensive ability to monitor and improve parental compliance**.

## II. Stabilize the workforce and reduce caseworker turnover, by capping the number of cases for which a caseworker is responsible, adding supports and mentoring, and increasing pay for workers based on excellent performance. [20]

A. **Numbers of Foster Children Affected by Caseworker Turnover:**

1. During 2005, 1,400 (42.3%) of the 3,309 children reviewed by the Foster Care Review Board had four or more different case managers during their time(s) in foster care.

2. The Board reviewed cases of young children whose caseworker has changed multiple times, for example, a nine-month old baby who has had nine different caseworkers.

[19] One such study is "Crisis Intervention in Child Abuse and Neglect," by the U.S. Department of Health and Human Services Administration for Children and Families.

[20] See page 65 for more information about case management issues, including turnover.

B. **Rationale**:

1. Turnover can produce gaps in the evidence which case managers provide to prosecutors, breaches in essential communication with foster parents, therapists, and other service providers, lapses in monitoring parental compliance with case plans, and delays in making case progress.
2. Children are impacted if HHS documentation is incomplete due to the turnover, and if the service needs of children go unmet because the new workers are not familiar with the children's circumstances or service availabilities. Children are also impacted when experienced caseworkers are handling their own caseloads, plus a number of other cases from vacant positions.
3. Other states, such as Delaware and Illinois, found that by analyzing caseload sizes, supervision, and mentoring, and by reducing caseloads, they reduced caseworker turnover, and achieved better outcomes for children.
4. Case load and case coordination issues are complicated by the HHS decision to contract for placements, contract for transportation of children to and from visitation, contract for visitation supervision, and contract with a managed care company to control access to higher-level services.

## III. Create specialized units within HHS which focus on the special needs of children age birth through five who, due to their developmental needs, require consistency and stability.[21] Assure that persons assigned to 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.

A. **Number of Young Children in Foster Care:**

1. 1,388 infants and preschoolers were in foster care on Dec. 31, 2005.
   - 1,392 children under age six entered foster care during 2005.
   - 76.8% (53 of 69) of the children age birth through age two years whose cases were reviewed during 2005 entered care due to parental substance abuse, an issue which can have life-long consequences**,** even with treatment.

B. **Rationale**:

1. **"***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*

[21] Addition information on young children's issues can be found beginning on page 49.

*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.*"[22]

2. Stabilizing the placements of young children would tend to minimize the trauma of removal from the parental home, increase the number of children experiencing timely permanency, and decrease the number of children in foster care.
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, thereby enhancing the children's trauma.
4. Focusing on children age birth to five provides a long-range solution to the spiraling increases in the number of children in foster care, while simultaneously protecting that group of children most vulnerable to abuse and neglect.

## IV. Recruit more qualified placements, and increase monitoring and support for those placements, in order to improve children's foster care situations. Place young children in potential permanent placements at the time of their removal.[23]

A. **Number of Children With Multiple Changes:**

1. Children experiencing four or more placements are likely to be permanently damaged by the instability and trauma of broken attachments[24]. Yet, this is now a normal experience for nearly half of the children in foster care.
    - 45.9% (2,849 of 6,204) of the children in foster care on Dec. 31, 2005, had experienced four or more placement disruptions in their lifetime.
    - Some children experience even more disruptions, with 30.9% (1,915 of 6,204) having six or more disruptions, 15.1% (934 of 6,204) having 10 or more, and 2.9% (183 of 6,204)

[22] Ensuring the Healthy Development 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.

[23] Addition information on placement concerns can be found beginning on page 85.

[24] A common standard is that three or more moves (four or more placements) constitutes placement instability (Hartnett, Falconnier, Leathers & Testa, 1999; Webster, Barth & Needell, 2000). The American Academy of Pediatrics found that "*children need continuity, constituency and predictability from their caregiver. Multiple foster home placements can be injurious*." (News Release with Policy Statement on Developmental Issues for Young Children in Foster Care, November, 2000). The Washington State Institute for Public Policy, February 2001, found that "*even for children with few impairments, being moved from setting to setting often increases their problems.*" According to study from Children's Hospital of Philadelphia, 2004, "*Multiple placements and episodic foster care both increased the predicted probability of high mental health service use*."

experiencing over 20 placement disruptions throughout their lifetime.

B. **Number of Reviewed Children Placement Concerns:**

1. Quality of care is also an issue.
   - 93 of the 3,309 children reviewed during 2005 lived in unsafe placements.
   - 132 of the 3,309 children reviewed during 2005 were in placements that were safe, but inappropriate to meet the needs of the individual child.
   - Some children are in overcrowded foster homes that are caring for a number of foster children, making it difficult for the foster parent(s) to provide each child with the care needed to heal from their past abuse or neglect experiences.

C. **Rationale**:

1. The Board finds that the 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 often harms the child further, resulting in even higher levels of need, and reducing the likelihood of a successful outcome for the child.
2. 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.
3. In Utah, young children are immediately placed where they are likely to remain should adoption become the goal.[25] There are also considerable efforts made to support and stabilize the placements. This has reduced the number of placement changes children experience and shortened the length of time in foster care.
4. Some children remain in an unsafe or inappropriate placement for some time before an appropriate placement can be found to meet their needs.
5. Necessary transitions between placements often are not well planned or not undertaken in a manner so as to minimize the trauma for the children. Children are often abruptly moved without consideration for their bonding and attachment needs.

[25] See page 49 for additional information about young children.

## V. Improve guardian ad litem (GAL) representation by ensuring that GALs see the children, by ensuring that GALs know who else is in the foster placement and how that affects the children they represent, and by ensuring that GALs submit independent reports of case progress directly addressing the best interests of the children to the Court.[26]

A. **Number of Children Not Seen by their GAL:**

1. There was documentation that for 494 (14.9%) of the 3,309 children reviewed in 2005 the guardians ad litem had not made contact with the children they represent per Nebraska law.
2. There was no documentation indicating if guardian ad litem-child contact occurred for another 1,053 (31.8%) of the 3,309 children reviewed during 2005.

B. **Rationale**:

1. According to Neb. Rev. Stat. 43-272.01, the guardian ad litem is to "*stand in lieu of a parent or a protected juvenile who is the subject of a juvenile court petition…"* and "*Shall make every reasonable efforts to become familiar with the needs of the protected juvenile which shall include…consultation with the juvenile.*" It is unclear how a guardian ad litem can discharge this function if he or she has not seen the child, nor determined the child's living circumstances.
2. An informed, involved guardian ad litem is the best legal advocate for the welfare of the foster child. That child has rights under Nebraska statutes, and the guardian ad litem is charged with the responsibility of making sure that those rights are represented.
3. Local board members reviewing cases and making Project Permanency home visits hear the complaints all too often "I don't know who my foster child's guardian ad litem is." "I didn't know he/she had one." "What is a guardian ad litem?"
4. Guardians ad litem especially need to see young children, and any children with physical or mental challenges, in their placements, because these children are particularly vulnerable.
5. Guardians ad litem must be aware of who else is placed in the same foster home or facility as the children they represent, and how those other placements may impact the children. The GAL is required to make recommendations to the court regarding the children's temporary and permanent placement.

[26] Additional information on guardians ad litem can be found beginning on page 126.

## VI. More effectively monitor services provided by contractors, whether that service is a placement, mental health, or other direct service, or a contract to manage the costs of such services. Oversight is needed to assure the quality of services rendered, and to provide a ready mechanism for the correction of deficiencies.[27]

A. **Number affected:**

1. The majority of the children in foster care are impacted by contracted placements and/or services.

B. **Rationale**:

1. The Board has found that there are insufficient means of oversight to ensure children are safe and are actually receiving services billed to the state. HHS has care, custody, and control of all wards, yet many times it relegates this responsibility with little oversight.
2. Problems identified that relate to services provided by contractors often are not addressed, even those involving child safety. Failure on the part of contractors does not result in corrective action against the responsible parties, and the deficiencies in service continue. Until this situation is resolved, children often remain at risk.
3. Contracting has inserted a layer of bureaucracy between the case managers and the children. Although outside entities contract with HHS to render specific services within cases, the ultimate legal responsibility for a child's case management resides with HHS. Reliance upon contracted services can result in a major disconnect in the communication of vital information between HHS and its subcontractors, as well as a shift in the perception of who is responsible for a child's case management. These factors increase the chances of poor outcomes for the children.
4. It remains unclear who within the system is to investigate concerns regarding contractors, and who has the authority to correct the concerns.
5. Managed care contracts were to monitor the costs associated with higher levels of services. The way these contracts work, however, results in children being unable to receive needed treatments. These children must then be placed at lower levels of care, where they often put at risk other children, staff, and the public, because their behavioral issues have not been adequately addressed.

[27] Addition information about contracts begins on page 69.

## VII. Eliminate contracts for visitation and transportation, and approve HHS hiring of permanent case aides to provide these essentials.[28] This would be revenue-neutral, and beneficial to the children.

A. **Numbers Affected**:

1. Contractors now transport substantial numbers of foster children – in some areas almost every child. Many of these people also supervise children's visitations with the parents.
2. A person from a contract agency monitors the majority of supervised visitations in the most populous areas of the state.

B. **Rationale**:

1. Parental compliance is the single most important indicator of whether reunification will be successful. In some cases, people with little training or understanding of family dynamics are monitoring and documenting parental, compliance. This can result in serious evidentiary issues which, in turn, can cause setbacks and delays in finding stable and permanent placements. Using HHS case aides would be revenue neutral while providing better case outcomes.
2. Companies with whom HHS contracts transport many children to visits with their parents. Each time a child is picked up it may involve a different driver. The Board documented a case of five and six year siblings who had at least 35 drivers in a two-year period.
3. Drivers often have no case knowledge and cannot help children cope with visitation issues.
4. Each supervised visitation between the child and parent(s) may have a different observer, often with little case knowledge, and this person may or may not be the same one who drove the child to the visitation.
5. Contract personnel follow company policies regarding which observations to report and how to report them. Often reports are illegible. It has been reported to us by some contractor staff that some contractors will not allow reports of negative interactions, because there are no financial incentives for contractors to report parental failure to appear or non-compliance.
6. The caseworker must create accurate documentation of parental compliance, including compliance with visitation orders. This is a critical piece of the evidence that is presented at juvenile court and used to determine if reunification could be successful, or not, and whether parental rights need to be terminated. This is difficult to do when accurate documentation is not received from a contractor.

[28] See pages 73-76 for additional information about visitation and transportation contract concerns.

## VIII. Expedite permanency and ensure children leave foster care in a timely manner. Ensure that the Court's permanency hearings are effectively determining appropriate case direction for children who have been in foster care for at least 12 months.[29]

A. **Statistics**:

1. 2,021 children (61.1%) reviewed during 2005 had been in foster care for 24 months or more.
2. 906 children (27.4%) had been in care for at least 60 months.

B. **Rationale**:

1. Foster care should be a temporary situation. However, in Nebraska far too many children remain in foster care for extended periods of time. This was an area of significant deficiency found in the last federal Child and Family Services Review audit.
2. As required by the federal Adoption and Safe Families Act, significant portions of which have been adopted by Nebraska, the permanency hearings are designed to be a critical point to determine whether the goal of reunification remains viable, or if termination of parental rights should be pursued.
3. Case delay creates a greater probability of more moves for the child to different placements, resulting in more negative consequences for the children.
4. Monitoring parental compliance with court orders, identification of paternity, and complete searches for relatives of the child, are all needed to achieve successful permanency hearings.

## IX. Hold perpetrators of extreme child abuse and neglect criminally accountable for their actions.[30]

A. **Rationale**:

1. When a child is the victim of extreme child abuse or neglect (i.e., abandonment, torture, sexual abuse, chronic abuse), that child has the right to have the perpetrator prosecuted to fullest extent of the law.
2. These cases can be very difficult to prosecute when the primary witness is a child. Nevertheless, it is important for the safety of the child in question, and of other children who may have contact with the perpetrator, that prosecutions occur.
3. Sound investigations are important because they are essential elements of successful prosecutions.

[29] Additional information about permanency hearings can be found beginning on page 119.
[30] Additional information on prosecution can be found beginning on page 115.

## X. Fund the positions the Foster Care Review Board lost during the budget cuts so that all children in foster care can receive the benefit of citizen review.[31]

A. **Rationale**:

1. The Board acknowledges the need for the State of Nebraska to be financially sound. At times, that need leads to budget cuts to align expenditures with available funds.
2. Along with many other agencies, the Foster Care Review Board experienced cuts to its recent budget requests. This caused the Board to fall behind the increased number of children in foster care who deserve the benefits of citizen review of their cases.

## XI. Address these additional ongoing issues, all discussed in more detail later in this Annual Report:

**A. Learning from other states' experiences.** (see pages 66, 106, 117, 122)
**B. Addressing training for foster parents.** (see page 87)
**C. Addressing central registry issues.** (see page 81)
**D. Addressing the number of placement changes children experience.** (see page 90)
**E. Addressing kinship care issues.** (see page 93)
**F. Closing communication breaks between licensure types.** (see page 99)
**G. Reducing the use of physical, chemical, and/or isolation restraints of children in foster care.** (see page 101)
**H. Increasing service availability.** (see page 105)
**I. Addressing the special issues of youth under the Office of Juvenile Services.** (see page 113)
**J. Utilizing what has been learned from drug courts.** (see page 119)
**K. Increasing prevention efforts.** (see page 121)
**L. Increasing efforts to find runaway youth.** (see page 125)
**M. Addressing the issues related to status offenders.** (see page 125)
**N. Addressing foster payment equity issues.** (see page 127)

[31] Additional information about the Foster Care Review Board can be found beginning on page 129

# Basis for Recommendations/Potential Benefits

The Foster Care Review Board's[32] analyses and recommendations in this Annual Report are based on the collected results of the **4,980 reviews** conducted on the cases of **3,309 children** during 2005. The Board's 23-year history of analyzing the Nebraska child welfare system also provides a substantial basis for its recommendations.

In addition, readers 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 From Following the Board's Recommendations?

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

1. Improve support for caseworkers and reduce turnover.
2. Increase prevention efforts.
3. Create units to focus on the special developmental needs of young children in foster care**,** with the goal of making permanency decisions within 15 months of the children coming into care.
4. Eliminate contracts for children's transportation and visitation monitoring.
5. Improve oversight for all contracted services and placements.
6. When parents cannot or will not safely parent their children, put the cases on the fast track to permanency. Criminally prosecute the parents in cases of severe abuse and neglect so that permanency can be expedited and the abuse and neglect stopped.

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

[32] See pages 129-142 for a more complete description of the structure of the Board and the case review process.

# General Questions About Foster Care

## How Many Children are in Foster Care?

Nebraska has one of the highest per capita ratios of children in foster care[33] with 10,797 children in foster care for one or more days during 2005.[34] On Dec. 31, 2005, there were 6,204 children in foster care, 1,341 more children than the same date in 1995.

## How Do Children Come Into Foster Care?

The following is a simplified version of the steps in a child's case.

1. A medical professional, educator, neighbor, family member, or other person makes a report of abuse or neglect. This call can go to law enforcement or to HHS-CPS.
2. A decision is made whether or not to investigate the report.
3. Law enforcement is the first responder, and makes the removal. Rarely, a CPS caseworker may join in the investigation.
4. The County Attorney files a petition with the Court detailing the allegations. The Court makes a ruling whether the evidence supports the Court's jurisdiction over the child and the parents.
5. HHS makes placement decisions, and writes the plan for the child. HHS provides services to children and their families.
6. Court hearings are held at predetermined intervals as required by law.
7. If the evidence shows parental compliance with the expectations of the court in the form of a court-ordered "plan," then reunification may continue to be pursued as a goal, and the child returned to the parents.
8. If there is no compliance, or compliance is substantially inadequate, either the State or the child's guardian ad litem may request the court to terminate parental rights**.** The court decides this issue at a hearing at which the parents, their lawyers, the child's guardian ad litem, and the county attorney are present. If the Court terminates rights, and if no appeal is taken, or if the appeal is denied, then the child may be placed for adoption. Adoption is finalized by a ruling by the Court.

Breakdowns at any stage of this process impede the child's immediate safety, and the ability to achieve a safe, permanent living arrangement for the child in a timely manner.

## Does Foster Care Have Risks?

Just as there are risks to leaving a child in the parental home, there are risks to placing a child in foster care. As Dr. Coyne of the University of Nebraska Omaha, School of Social Work so eloquently stated:

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

"*The decisions in child welfare are not between good and bad. They are between worse and least worse. Each decision will be harmful. What decision will do the least amount of damage? We all have a tendency to under rate the risk to the child of being in the foster care system and over rate the risk to the child of living in poverty in a dysfunctional family*."

## Why Are So Many Children in Foster Care?

There are numerous intertwining issues that affect how many children are in foster care. These include, but are not limited to, the following:

1. Nebraska lacks prevention programs to address problems before they are so severe that a child must be removed for the home.
    a. States such as Vermont and Hawaii have reduced the number of children in foster care by 20-30 percent or more by implementing prevention measures.
    b. The Centers for Disease Control have found that, compared with controls, the median effect of home visitation programs was a reduction of approximately 40% in child abuse or neglect.
2. Nebraska does not have a single entry point for children entering care. Children may be taken into temporary custody of the State in one of two ways: either by a local law enforcement officer without a warrant or order of the court, based upon the judgment of that officer that certain conditions are present;[35] or by means of a court order obtained from the juvenile court by the county attorney at the same time a petition is filed seeking the child's protection.
3. About 20-25% of the cases involve extreme or chronic abuse. County Attorneys often do not criminally prosecute extreme abuse. A criminal conviction helps to expedite permanency for children in cases of severe abuse or neglect**.** Even when the law allows for expedited permanency, HHS continues reunifications – even when it is clear that the children cannot safely return home.
4. Caseworkers caseloads are often too high, and there is a high turnover rate leading to instability and inconsistency in case management. During periods of time when there are vacancies or while new staff are learning their cases, there is often no documentation regarding parental compliance.
5. Contracting without outside entities for services such as visitation monitoring and placements has added a layer of bureaucracy between caseworkers and the children, without providing commensurate oversight or monitoring of these services. 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.

[35] Neb. Rev. Stat. Sec. 43-248 outlines several circumstances where a law enforcement officer is authorized to take a child into temporary custody without a warrant or an order of the court. Primary among these is the situation where the juvenile is seriously endangered in his or her surroundings and immediate removal appears necessary for the juvenile's protection.

6. Children are often not placed in placements that are therapeutic or meet their needs. When this becomes apparent, the usual result is that the children 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 can lengthen their time in care.
7. When parents are non-compliant with court orders, with the expectations for their rehabilitation, or with the case professionals, there is often little action to change the direction of the case until it is too late.

## How Does Moving Children Compound the Effects of Abuse?

As described in more detail in the section on Separation and Grief Issues, on page 57, children who are separated from parents or trusted caregivers will experience grief. Placement disruptions are extremely stressful for children of any age, but are especially stressful for children age birth to five, due to their developmental levels.

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*."[36]

Dr. Elisabeth Kubler-Ross, noted researcher on grief, has found that the younger the child was at the time of the loss, the longer the grief period can be expected to take. Her 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.

Grief in children is not just sadness. During the grief period, children are likely to exhibit regressive behaviors, learning difficulties, mood swings, sleep disturbances, and anxiety, and during this time their developmental progression will be slowed or stopped. Children may be punished in school, day care, or homes for exhibiting these predictable grief reactions, which further adds to their trauma.

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.

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

Good transition plans can certainly help children better cope with the loss, but the need to grieve will remain. Unfortunately, the system often moves to children to new foster homes without giving them any preparation for this major, life-changing event.

## 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. This is due to:

1. A lack of resources,
2. An overwhelming number of inter-connected issues and structural barriers within the system,
3. Restrictions, based on confidentiality, preventing information on individual case and systems failures from being available to those outside the system, and,
4. A lack of voluntary or compulsory accountability measures for some parts of the system.

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

## Why Are Children Removed From Their Homes?

The following summary table demonstrates why children reviewed during 2005 were removed from their homes of origin. During the reviews, as many as ten reasons for entering foster care may be identified for each child. These are predominant reasons. Table 5 on page 158 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.

**Reasons that Reviewed Children Were Removed from the Parental Home**

| Percent of Children Reviewed | Condition | Important Facts |
|---|---|---|
| 64.4% | Neglect | Neglect has serious consequences. Nationally, almost as many children die each year from neglect as from physical abuse.[37]<br><br>[*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.*] |
| 17.2% | Children's behaviors | Many child and youth behaviors stem from unrecognized abuse or neglect. |
| 46.8%<br><br>(76.8% of children under three) | 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).<br><br>In recent years, the methamphetamine epidemic has substantially increased the number of young children in foster care who come from families highly resistant to change. 76.8% of the children reviewed in 2005 who were under three years of age had parental substance abuse as a factor in their case. |
| 19.1% | Physical Abuse | This can include bruises, lacerations, broken bones, concussions, and brain damage. |
| 22.0% | Unsafe or substandard housing | Parental substance abuse and mental health issues often contribute to housing issues. |
| 11.6% | Abandonment | |
| 6.9%<br>(or 12.4%, including disclosures made after removal) | Sexual abuse | Sexual abuse is often not disclosed until after the children are in care. In 6.9% of the children reviewed, sexual abuse was recognized as an initial reason for entering care, with another 5.5% 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 reasons leading to removal, in most cases the parents were unwilling or unable to give children the care necessary to grow, thrive and be safe. So

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

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 explicit charge and duty of the child welfare system 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 4,984 comprehensive reviews on 3,309 children's cases in 2005.[38] 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. 2,021 reviewed children (61.1%) had been in foster care for at least two years of their lives, an increase from the 45.5% in 1995.
2. 902 children (27.3%) 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 51.7% in 1995 who had no complete, written plans.
3. 837 children (25.3%) had a plan objective which the Board found did not meet the children's best interests, a substantial decrease from the 53.6% in 1995 with plans not meeting the children's best interests.
4. 225 children (6.8%) were in unsafe or inappropriate foster placements and there was insufficient documentation for 622 children (18.8%) to assure their safety.
5. In 927 reviewed children's cases (28.0%) the Board found that no progress was being made towards permanency. This has increased substantially from the 14.8% in 1995.

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 hard to meet the needs of the 10,797 children who were in foster care during 2005. 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.

**These indicators were chosen because:**

- Written case plans with a stated objective (such as reunification with the parents or adoption), are critical in determining whether the parents are complying as required by state and federal, law. Such written plans are the means by which to measure progress and to provide solid direction for how the case should proceed.
- Federal guidelines, as well as State law, require that when a child has been in care for 15 of the last 22 months, a decision must be made on whether

[38] Children are normally reviewed every six months while in foster care, thus many children have more than one review during a calendar year.

reunification remains a practical goal, and whether a termination of parental rights should be pursued in order to achieve permanency for the child.

- Premature reunification can lead to additional abuse and result in yet another traumatic removal from the parental home. 32% of the children in foster care on Dec. 31, 2005, had been removed from the parental home more than once.
- Each move between placements represents a traumatic experience for children. The cumulative effects of multiple moves can lead to permanent damage. 1,246 of the children in foster care on Dec. 31, 2005, were moved between 4-6 times, and 935 children were moved 10 or more times during their foster care experience(s).

**System Working for the Children**

Complete, Written Plans

72.7% (2,407 of 3,309) of children reviewed in 2005 had a complete permanency plan as required by Nebraska statutes.

Less Than TwoYears' in Care

38.9% (1,288 of 3,309) of children reviewed in 2005 had been in care for less than two years at the time of their last review.

No Prior Removals from the Home

70.4% (3,328 of 4,724) of those entering care during 2005 had been placed in foster care only one time and had not suffered the effects of a premature reunification.

Stable Placements

58.9% (3,656 of 6,204) of children in foster care at the end of 2005 had experienced between 1 and 3 placement changes.

**Work to Be Done to Improve System**

Incomplete or No Current Written Plans

27.3% (902 of 3,309) of children reviewed in 2005 did not have a complete plan as required by Nebraska statutes.

More than Two Years in Care

61.1% (2,021 of 3,309) of children reviewed in 2005 had been in care for more than 2 years at the time of their last review.

Previous Removals from the Home

29.6% (1,396 of 4,724) of children entering care had been placed in foster 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% |
| 2004 | 33.7% |

Multiple Placements

41.1% (2,548 of 6,204) of children in foster care at the end of 2005 had experienced four or more placement moves.

## What do the Statistics Mean for An Individual Child?

The 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.

> *"Brittany,[39]" age eight, has been in foster care twice. Both times involved parental substance abuse, and issues with her brothers being aggressive and physically violent. Brittany has been in a foster care a total of four years. The plan is now adoption, but the foster parents report they have experienced very poor case management services. They have been unable to reach the different caseworkers that have been involved in the case, and the current caseworker has never been to their home. They were not told of Brittany's exposure to substances in utero, or the effect this has had on her behaviors and educational needs. Due to the lack of support and Brittany's challenging behaviors they have asked to have her removed from their home. Brittany has been in foster care for over half her young life, has escalating mental health needs, and has no one willing to be her permanent home.*

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.

## What are the Most Frequently Cited Barriers to Permanency?

At each review, local Board members identify the main barriers that remain to the achievement of safe, permanent homes for the children (multiple barriers are allowed).[40] The following summarizes major barriers.

**Most Frequently Identified Parental Barriers to Permanency**

1. Parental unwillingness or inability to safely parent their children
   34.6% (1,1465 of 3,309 children reviewed in 2005)
2. Parental substance abuse
   27.9% (922 of 3,309 children reviewed in 2005)
3. Past histories of abuse, neglect and violence
   26.2% (866 of 3,309 children reviewed in 2005)

**Most Frequently Identified System Barriers to Permanency**

1. Length of time in care, with reduced likelihood of successful permanency
   22.2% (734 of 3,309 children reviewed in 2005)
2. Lack of case progress
   13.8% (457 of 3,309 children reviewed in 2005)
3. Lack of current, written plans for the child's future
   10.2% (336 of 3,309 children reviewed in 2005)
4. Lack of documentation of parental compliance/non-compliance
   11.2% (368 of 3,309 children reviewed in 2005)

[39] Name changed to retain confidentiality.
[40] See Table 4 on page 153 for more information on identified barriers to permanency.

## TABLE 1

## SOME CHARACTERISTICS OF CHILDREN IN FOSTER CARE - 2005

(A Ten-Year and One-Year Comparison)

### ***Who are the Children?***

### Children in Foster Care on Dec. 31st – A Comparison

| 1995 | 2004 | 2005 |
|---|---|---|
| 4,563 | 6,083 | 6,204 |

### Children in Foster Care on Dec. 31st By Age on That Date

| 1995 | | 2004 | | 2005 | | |
|---|---|---|---|---|---|---|
| 1,086 | 23.8% | 1,534 | 25.2% | 1,388 | 22.4% | Infants & Preschoolers (0-5) |
| 1,182 | 25.9% | 1,415 | 23.3% | 1,456 | 23.5% | Elementary School (6-12) |
| 1,026 | 22.5% | 1,275 | 21.0% | 1,315 | 21.2% | Young Teens (13-15) |
| 1,269 | 27.8% | 1,856 | 30.5% | 2,040 | 32.9% | Older Teens (16+) |
| 0 | 0.0% | 3 | >0.1% | 5 | >0.1% | Age not reported |
| 4,563 | 100.0% | 6083 | 100.0% | 6,204 | 100.0% | Total in care Dec. 31st |

### Children in Foster Care on Dec. 31st By Race

| 1995 | | 2004 | | 2005 | | |
|---|---|---|---|---|---|---|
| 2,600 | 57.0% | 3,984 | 65.5% | 4,084 | 65.8% | White |
| 768 | 16.8% | 980 | 16.1% | 1,026 | 16.5% | Black |
| 224 | 4.9% | 424 | 7.0% | 447 | 7.2% | Native American |
| 196 | 4.3% | See below | | See below | | Hispanic as race |
| 59 | 1.3% | 76 | 1.2% | 28 | 0.5% | Asian |
| 716 | 15.7% | 619 | 10.2% | 619 | 10.0% | Other or Race Not Reported |
| 4,563 | 100.0% | 6,083 | 100.0% | 6,204 | 100.0% | Total in care Dec. 31st |
| see footnote | | 633 | 10.4% | 686 | 11.0% | Hispanic as ethnicity[41] |

continued...

**Explanation of Table 1**—This table compares some characteristics of children in foster care from 1995, 2004, and 2005. Most categories are taken from the 6,204 children who were in foster care on 12-31-2005, unless otherwise marked. Some percentages in this table may not equal 100% due to rounding. All statistics on this table are from the Foster Care Review Board Tracking System.

[41] 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.

## TABLE 1 (continued)

### ***Who are the Children?*** *(continued…)*

### *Children in Foster Care on Dec. 31st By Gender*

| 1995 | | 2004 | | 2005 | | |
|---|---|---|---|---|---|---|
| 2,396 | 52.5% | 3,321 | 55.0% | 3,375 | 54.4% | Male |
| 2,058 | 45.1% | 2,720 | 44.7% | 2,801 | 45.1% | Female |
| 109 | 2.4% | 42 | 0.3% | 28 | 0.5% | Gender not reported |
| 4,563 | 100.0% | 5,522 | 100.0% | 6,204 | 100.0% | Total in care Dec. 31st |

### Children in Foster Care on Dec. 31st By Lifetime Number of Placements Experienced[42]

| 1995 | | 2004 | | 2005 | | |
|---|---|---|---|---|---|---|
| 4,563 | 100.0% | 6,083 | 100.0% | 6,204 | 100.0% | Total in care Dec. 31st |
| 1,907 | 41.8% | 2,855 | 49.7% | 2,849 | 45.9% | # in 4 or more foster homes |
| 1,172 | 25.7% | 1,890 | 33.6% | 1,915[1] | 30.9% | # in 6 or more foster homes |

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

| 1995 | 2004 | 2005 |
|---|---|---|
| 29 local boards | 55 local boards | 52 local boards[43] |

### Children Reviewed by the Foster Care Review Board and Total Reviews

| 1995[44] | 2004 | 2005 |
|---|---|---|
| 2,162 children reviewed | 3,819 children reviewed | 3,309 children reviewed |
| 3,159 reviews conducted | 5,828 reviews conducted | 4,984 reviews conducted |

### Reviewed Children by Length of Time in Foster Care

| 1995 | | 2004 | | 2005 | | |
|---|---|---|---|---|---|---|
| 2,162 | 100.0% | 3,819 | 100.0% | 3,309 | 100.0% | Children reviewed |
| 934 | 45.5%[3] | 1,780 | 46.6%[5] | 2,021 | 61.1% | # In care at least 2 years |
| 387 | 17.9%[3] | 458 | 12.0%[5] | 906 | 27.4% | # In care at least 5 years |

continued...

[42] The number of children experiencing multiple lifetime 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.

[43] 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. The Board prioritized reviewing children eligible for federal title IV-E funds and children under age 6.

[44] This was prior to LB 642 (1996) that increased the scope and funding for the FCRB.

## TABLE 1 (continued)

### *Where are the Children?*

### Children in Foster Care on Dec. 31st By Type of Placement

| 1995 | | 2004 | | 2005 | | |
|---|---|---|---|---|---|---|
| 1,774 | 38.9% | 2,704 | 44.5% | 2,767 | 44.6% | Foster home & fos/adopt homes |
| 542 | 11.9% | 1,062 | 17.5% | 1,104 | 17.8% | Relatives |
| 577 | 12.6% | 1,027 | 16.9% | 996 | 16.1% | Group homes & residential treatment facilities |
| 458 | 10.0% | 574 | 9.4% | 566 | 9.1% | Jail/Youth Development Center |
| 276 | 6.0% | 276 | 4.5% | 362 | 5.8% | Emergency Shelter |
| 49 | 1.1% | 109 | 1.8% | 159 | 2.6% | Runaway, whereabouts unknown |
| 228 | 5.0% | 105 | 1.7% | 13 | 0.2% | Adoptive home, not final (private)[45] |
| 26 | 0.5% | 88 | 1.4% | 81 | 1.3% | Medical facility, nursing home |
| 33 | 0.7% | 82 | 1.3% | 93 | 1.5% | Independent living |
| 179 | 3.9% | 34 | 0.6% | 54 | 0.9% | Psychiatric Treatment or substance abuse facility |
| 12 | 0.3% | 6 | >0.1% | 9 | 0.1% | Center for Develop. Disabled |
| 46 | 1.0% | 0 | 0% | 0 | 0.0% | Child Care Agency |
| 303 | 6.6% | 16 | 0.3% | 0 | 0.0% | Other or type not reported |
| 4,563 | 100.0% | 6,083 | 100.0% | 6,204 | 100.0% | Total in care Dec. 31st |

### Children in Foster Care on Dec. 31st By Closeness to Home (Proximity to Parent)

| 1995 | | 2004 | | 2005 | | |
|---|---|---|---|---|---|---|
| 2,724 | 59.7% | 3,291 | 54.1% | 3,247 | 52.3% | In same county |
| 680 | 14.9% | 1,013 | 16.7% | 953 | 15.4% | In neighboring county |
| 757 | 16.6% | 1,259 | 20.7% | 1,422 | 22.9% | In non-neighboring county |
| 68 | 1.5% | 158 | 2.6% | 203 | 3.3% | Child in other state |
| 333 | 7.3% | 84 | 1.4% | 166 | 2.7% | Parent in other state (Indicates that parents moved out of Nebraska after the child was placed in custody) |
| 0 | 0.0% | 278 | 4.6% | 2134 | 3.4% | Proximity not reported |
| 4,563 | 100.0% | 6,083 | 100.0% | 6,204 | 100.0% | Total in care Dec. 31st |

continued…

[45] A number of private adoptive children shown as active at the end of 2004 had actually been adopted before Jan. 1, 2005. This adjustment was made during 2005.

## TABLE 1 (continued)

### *What Happened to the Children?*

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

| 1995 | | 2004 | | 2005 | | |
|---|---|---|---|---|---|---|
| 3,280 | 65.9% | 2,789 | 67.4% | 2412 | 63.8% | Returned to parents |
| N/A | N/A% | 9 | 0.2% | 1 | >0.1% | Released from corrections (no further information given or found in research) |
| 324 | 6.5% | 413 | 10.0% | 654 | 17.3% | Reached Age of Majority (19th birthday) |
| 353[1] | 7.1% | 305[1] | 7.4% | 347[1] | 9.2% | Adopted[46] |
| 45 | 0.9% | 103 | 2.5% | 107 | 2.8% | Court terminated (no specific reason given) |
| 100 | 2.0% | 226 | 5.5% | 190 | 5.0% | Guardianship |
| 100 | 2.0% | 22 | 0.5% | 107 | 2.8% | Custody transferred |
| 15 | 0.3% | 2 | >0.1% | 1 | >0.1% | Marriage or Military |
| 761 | 15.3% | 271 | 6.5% | 66 | 1.7% | Other/reason not reported |
| 4,978 | 100.0% | 4,140 | 100.0% | 3,778 | 100.0% | Total left care during year |

### Children in Foster Care on Dec. 31st By Number of Times Removed From Home

| 2000[47] | 2003 | 2004 | 2005 | |
|---|---|---|---|---|
| 3,693 (54.5%) | 3,349 (60.6%) | 3,916 (64.4%) | 4,126 (66.5%) | Initial Removal |
| 2,593 (45.5%) | 2,173 (33.7%) | 2,167 (35.6%) | 2,078 (33.5%) | Had Prior Removal(s) |
| 6,286 | 5,522 | 6,083 | 6,204 | Total in care Dec. 31st |

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

| 1995 | | 2004 | | 2005 | | |
|---|---|---|---|---|---|---|
| 2,861 | 62.7% | 3,208 | 66.3% | 3,328 | 70.4% | Initial removal |
| 1,702 | 37.3% | 1,631 | 33.7% | 1,396 | 29.6% | Had prior removal |
| 4,563 | 100.0% | 4,839 | 100.0% | 4,724 | 100.0% | Total entered care |

[46] The number of adoptions completed may be somewhat understated due to the number of reports from HHS indicating children left care, but not indicating the reason for leaving care.
[47] 1995 figures were not available for this category.

## TABLE 2

## 2005 COST OF FOSTER CARE ROOM AND BOARD BY PLACEMENT TYPE

| Placement Type | # of Children | Monthly Reimbursement Cost or Range | Minimum Monthly |
|---|---|---|---|
| Foster Home | 2,767 | $226 - $1,224, $1,913, or $3,021 | $4,753,832 |
| Relative Placement | 1,104 | $226 - $1,224, $1,913, or $3,021 | $1,898,880 |
| Group Home | 754 | $1,974, $2,723, $4,799, or $6,083 | $2,943,136 |
| Jail/Youth Development Center | 566 | $4,350 - $6,675 | $2,564,490 |
| Emergency Shelter | 362 | $855, $1,820, or $3,290 | $913,200 |
| Runaway/Whereabouts Unknown | 159 | n/a | n/a |
| Adoptive Home Not Final - Private | 13 | n/a | n/a |
| Independent & Semi-Ind. Living | 93 | $359 | $33,387 |
| Skilled or Assisted Living Facility | 33 | $8,234-$18,009 | $271,725 |
| Psychiatric Treatment Facility | 54 | $14,630 | $790,020 |
| Medical Facility | 48 | $26,000 | $1,248,000 |
| Center for Developmentally Disabled | 9 | $2,400 (est.) | $21,600 |
| Residential Treatment Center | 242 | $8,734 | $1,938,948 |
| **Children in Care on Dec. 31, 2005** | **6,204** | **Minimum monthly total** | **$17,377,218** |

**Minimum Annual Cost for Room and Board only $208,526,616**

**Explanation of Table – The costs above reflect only the minimum basic board rate for the 6,204 children in foster care on 12-31-2005** – medical expenses, counseling fees, special needs amounts, school tuition, transportation provided by contractors, 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 and hospitals where nursing care is part of the daily rates**.** The minimum costs above are calculated to be representative of the number of children, ages, and mix of placements on any given day. These estimates likely under represent the true costs.

### Details Regarding Payment Rates:

**Foster Home/Relative Foster Care rates**: 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, **which is completed by the foster parents**. Rates for state fiscal year 2006 are as follows:

- Foster home payments for children from age 0-5 ranged from $226.44 - $1,091.40 per month.
- Foster home payments for children age 6-11 ranged from $359.04-$1,186.06 per month.
- Foster home payments for children age 12-18 ranged from $359.04-$1,224.00 per month
- Agency based foster care began reimbursement at $63.75 per day (about $1,913 per month), with continuity care at $40.80 per day (about $1,224 per month).
- Treatment foster care is paid the minimum foster home payment for the child's age plus $100.71 per day (about $3,021.30 per month)

**HHS Group Home rates**: are determined by the group home level. Rates for state fiscal year 2006:

- Basic group homes are paid $65.79 per day (about $1,973.70 per month),
- Group Home A's are paid $90.78 per day (about $2,723.40 per month),
- Treatment Group Homes are paid $159.95 per day ($4798.50 per month
- Enhanced Treatment Group Homes are paid $202.76 per day ($6,082.80 per month).

**Residential Treatment Centers**: according to the Medicaid managed care facility rates effective July 1, 2006, the per diem varies on the number of days in the facility. Days 1-90 are reimbursed at $291.14 per day, days 271+ are reimbursed at $259.95 per day (about $8,734 per month during the first three months of care).

**Rehabilitation Centers/Youth Jails**:

- 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 (about $5,100 per month).
- Lancaster County Youth Service Center contract for state wards is $222.50 ($6,675 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 $145.00 per day ($4,350 per month)
- Western Nebraska Juvenile Services contract for state wards is $170.00 per day ($5,100 per month).

**Emergency Shelters**: HHS emergency shelter rates are determined by the level. Rates for state fiscal year 2006:

- Individual Emergency Shelter homes are paid $28.51 per day ($855.00 per month).
- Agency Based Emergency Shelter homes are paid $60.69 per day ($1,820.70 per month).
- Emergency Shelter Centers are paid $109.65 per day ($3,289.50).

**Skilled Living, Assisted Living, or Nursing Facilities**: is based on the 2006 per diem rate that ranges from $274.47-$600.31 per day ($8,234.10-$18,009.30 per month) depending on level of care needed, which includes provision of skilled nursing care.

**In-Patient Psychiatric/Substance Abuse**: according to the Medicaid managed care facility rates effective July 1, 2006, the per diem is based on which day of hospitalization, with the first two days being reimbursed at the highest rate, $618.67 per day, and days 7+ reimbursed at $519.89 per day (about $14,629.71 per month).

**Hospitalization of Newborns**: The Nebraska Hospital Association provided the following statistics: The average hospital charge for normal newborns was $1,502 for CY 2005, while the average hospital charge for newborns with problems was $6,102. Costs are figured based on a three-day stay for normal newborns. ($1,502/3 or $500 per day).

# Commendations

**Governor Dave Heineman** is commended for his leadership in taking steps to improve the lives of foster children. The Governor is also commended for meeting with the Board for a briefing on issues affecting foster children, and for discussing concerns with lack of oversight by HHS or its contractors.

In addition, the Governor has provided clear directives to improve the children's lives. The Board wholeheartedly supports the directives outlined in the following quote the Governor provided for this Annual Report.

> *I have directed Health and Human Services System to take a series of immediate and specific actions to ensure we continue to improve the services we provide to children and their families. Our goal is to begin decreasing caseloads while prioritizing cases for maximum impact. First, I have told the management of HHS that they will place an immediate priority on resolving the cases of children from the ages of zero through five. These are by far the most vulnerable and impressionable children our workers encounter. Second, I have directed that the system will set and meet a goal of focusing on the permanent placement of children who have spent 15 or more of the last 22 months in our care. This is an important federal standard by which all states are measured, and we in Nebraska have failed by keeping children in state care for far too long.*
>
> Dave Heineman, Governor of Nebraska

**Chief Justice John Hendry** is commended for his leadership in the creation of the Judicial Commission on Children whose purpose is looking at several issues concerning foster children including the reduction of the length of time for an appeal to be processed in termination of parental rights cases and the review of guardian ad litem representation. He is also commended for exploring ways to implement the National Council of Juvenile and Family Court Judges recommendations to improve court practice in child abuse and neglect cases.

The Board commends his commitment to children's issues and to changing the foster care system.

**Members of the Legislature** are commended for continuing to prioritize issues of child abuse prevention and care of children in foster care. Especially, **Senator Don Preister** for his focus on contract oversight and **Senators Dennis Byars and Gwen Howard** for their forward thinking in the reorganization of the child welfare system. **Senator Gwen Howard** is commended for her bill to provide meaningful caseload caps.

**Juvenile and County Court Judges** are commended for their responsiveness to the issues identified by the Board and for their actions to monitor and, when necessary,

expedite timeframes when scheduling court hearings to help achieve permanency for children in a timely manner.

**Mike Heavican, US Attorney for the District of Nebraska** is commended for joining with the Foster Care Review Board in co-sponsoring several trainings regarding Methamphetamines abuse across Nebraska.

**Attorney General Jon Bruning** is commended for his leadership and focus on children's issues and for co-sponsoring several trainings regarding methamphetamine abuse across Nebraska. In addition, the Attorney General has encouraged the system to work together, as shown in the following quote he provided for this Annual Report.

> *"Our children are our future, but many are broken by drug use and domestic violence in the home. The foster care system is a critical part of keeping children safe in Nebraska, and when state and local agencies cooperate, the system is stronger."*
>
> *Attorney General Jon Bruning*

**Former Health and Human Services Director Nancy Montanez**, and **Protection and Safety Administrator Todd Reckling** are commended for partnering with the Board to establish statewide staffings with the Foster Care Review Board of those cases with serious concerns.

**Health and Human Services Caseworkers and Supervisors** are commended for the increased number of children with complete written plans, for the increased number of permanency objectives the Board could find in the child's best interests, for maintaining last year's high rate of caseworker contact with the children, and for their service to foster children and families.

**Foster Care Review Board Volunteers** who serve on local boards are commended for their time, care, concern and commitment to Nebraska's foster children.

**Foster Parents and Placements** are commended for showing their concern and dedication by providing children the nurturing care and attention they need to overcome their past traumas.

**County Attorneys** are commended for their many efforts to assure that Nebraska's children are safe.

**Guardians ad litem** who do an outstanding job of advocating for their clients are commended. In particular we commend the work of Lynnette Boyle, Jim Ruby, Steve Williams, Mariclare Thomas, Steve Guenzel, Laura Low, Dave Lepant, Jane Burk, Rex Moats, Steve Williams, Jon Braaten, Angela Onowha (aide), Nick Valle, Jason Ossian, Mike Burns, Steve Scherr, and Bob Goodwin.

**CASA Volunteers** are commended for their time and dedication to the individual children and families they serve and for participating in local board meetings.

**Project Permanency** [48] is a project that has touched the hearts of many individuals and groups across the state. The Board sincerely commends all local board members who have contributed to bringing educational materials to foster parents, providing them with parents a small "thank-you" for their service, and/or providing toys, blankets, and backpacks for the children

**Project Permanency Contributors** are commended - particularly Project Linus, The Omaha Community Foundation, Dr. Dvorak through Blue Cross/Blue Shield Foundation, the Columbus United Way and the monetary and in-kind donations from local board members, Creighton University, and the Lincoln financial group.

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.

**Professor Ann Coyne** is commended for freely giving many hours of consultation advice on how best to collect statistical data on changing conditions in the child welfare system, and for developing education programs and research on issues concerning foster children.

**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.

**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 of all Nebraska children.

**Adoption Day Volunteers and Contributors** are commended for make Adoption Day in Nebraska a very special day for Nebraska's foster children by providing gifts, food, and fun for participants. Adams, Clay, Douglas, and Lancaster Counties sponsored adoption days in their Courts and facilitated the adoptions of 76 foster children.

[48] A further description of Project Permanency is found on page 55.

*“Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has."*

Margaret Mead, American anthropologist (1901-1978)

# Foster Care Review Board
# Major Activities of 2005

## 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 10,421 children who were in foster care during 2005 as reported to the Board by HHS, the Courts, and private agencies.

B. Researched and verified the foster care status, and then closed the cases of approximately 122 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 4,980 cases for review by citizen review board across the state.

E. 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 4,980 reviews on 3,309 children during 2005. (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 34,860 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 27,000 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 8 group home and detention facilities to assure that the individual physical, psychological, and sociological needs of the children are being met.

B. Conducted 95 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. Many of these visits were to homes caring for more than one child so that over 247 children received the benefits of these visits.

C. 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 639 times during 2005, 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. Discussed the lack of accountability in the child protection system and the serious communication gaps between CPS and law enforcement.

B. Met with Governor Heineman shortly after he assumed office to brief him on several concerns in the child welfare system and the Board's recommendations to improve these concerns.

## 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. Discussed ways to improve CPS response.
4. Discussed problems identified with private contracts for transportation of children and supervision of visitation between parents and children.
5. 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.
6. Worked to address systemic issues that affect permanency and safety for children.
7. Participated in the HHS Performance Improvement Plan team.
8. Encouraged increased HHS participation in reviews.

B. FCRB Work In Cooperation with Members of the Legislature

1. Continued to respond immediately to case concerns brought forward by State Senators on behalf of constituents.

C. FCRB Work In Cooperation with the Attorney General

1. Met with the Attorney General to discuss child protection issues.
2. Referred cases of concern to the special unit of the Attorney General's office.

D. FCRB Work in Cooperation with the Judiciary

1. Met with the Chief Justice to describe court-related issues and to recommend a commission on the courts
2. Served on the Supreme Court's Commission on Children.
3. Provided statistics to Judges on the foster children they serve.

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. Co-Sponsored educational programs regarding Methamphetamine abuse in Scottsbluff, North Platte, Kearney, Omaha and Norfolk.
4. 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.
5. Made numerous presentations about the Board and the status of children in foster care to focus groups, community organizations, service clubs, college classes, and foster parent training classes.

◈◈◈◈◈

# A Description of Foster Care Issues

## With the Foster Care Review Board's Findings, Recommendations, and Rationale

**(Arranged by How Children Move Through the Foster Care System)**

# Receiving Reports of Child Abuse or Neglect

There has been increased attention on child abuse investigations since we all have learned of the tragic deaths of so many of Nebraska's children. In 2003, at the request of Governor Johanns and with the permission of the Director of Health and Human Services the Board researched 33 child deaths. The results of this research showed that:

- 19 children (58%) had been reported to either Child Protective Services (CPS) or law enforcement, or the perpetrator had other violent offences, yet either no investigation took place or the investigation was seriously flawed.
- 27 (82%) were newborn through five years old.
- 3 (9%) were wards of the court at the time of their deaths.

In response, Governor Johanns created the Governor's Children's Task Force in 2003 to review these deaths. Subsequent recommendations were made to improve the CPS system.

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

Notwithstanding these efforts, in order to create a more responsive child protection system it is essential that improvements continue so that every Nebraska child will have the best possible future.

At a minimum, CPS and law enforcement must be more consistent and attentive to reports of abuse, especially for children age birth to five, who are at the greatest risk of injury and/or death from abuse. Reports must be given greater scrutiny, investigations must be timely, and the decision on whether or not to investigate must be subject to supervisory review.

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

## How Many Child Abuse Reports Are Received Per Year?

HHS reports it received 27,896 child abuse reports in calendar year 2005, of which 24,374 involved allegations of child abuse or neglect. Of these, 13,889 reports were investigated, and 3,324 cases were substantiated.

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

**Background information:** Following the Board's initial research on 33 child deaths, with the Governor's permission, the Board examined more that 4,262 calls reporting abuse and neglect. This sample was made in proportion to the calls made in each of the areas of the state). The Board found that 1,202 of these calls involved serious safety issues due to physical abuse, physical neglect, emotional abuse or sexual abuse. One again, the same pattern emerged, with 680 of the calls receiving no action or another appropriate response taken to insure the children's safety.

Through this research and through the Board's own continued attempts to access the CPS system regarding children who are placed in foster care, the Board found that 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.

**Intake Process:** When a child abuse report is received CPS performs an "intake" process, which is the process of gathering sufficient information from the reporter and agency records in order to complete an intake report. The worker must then assess the seriousness of the child's situation, accept the call for assessment, or "screen out" the call (choosing to not respond to the incident). When a call is accepted for assessment or if the child is determined to be in immediate danger, law enforcement is contacted.

**Structural Problems**: Most people call Child Protective Services (CPS) to report child abuse; however, under Nebraska statutes, law enforcement is the first responder to calls.

**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).

In some cases there is a lack of communication between these co-managed systems. The number of child abuse and neglect reports received and the number of potential responders further impacts the system. As a result, there continues to be serious problems with intakes and investigations and 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.

The following cases illustrates some of the consequences that poor response to child abuse reports can have on children.

> Case 1: *"Alice,"*[49] *came into foster care at age 6, after she was in a car accident where her mother was driving. At the time of the accident her mother tested positive for opiates and alcohol. This was not the first time the family had come*

[49] Names are changed to preserve confidentiality.

*to the attention of authorities. CPS has received numerous reports over many years alleging abuse and neglect due to the mother's drug abuse with the first occurring before "Alice" was born regarding an older half-sibling. Each was marked "unfounded," so no services were offered the family. The half-sibling has since been placed with his biological father. "Alice's" mother is struggling to overcome years of addiction, and is incarcerated due to the accident and possessing drug paraphernalia. The goal for "Alice" remains reunification, but it is unclear if this will ever be possible.*

Case 2: *"Lori,"[50] age 14, "Tony," age 15, and "Mark," age 17 entered care after CPS had received 20 intakes over an eight-year period alleging neglect and physical abuse by caretakers. Most of the intakes were not accepted for initial assessment or were deemed unfounded. Some of the allegations included reports that the children asked for food at neighbor's homes and were being physically abused. After several years of "screening out" these reports, law enforcement removed the children for substantiated abuse and neglect.*

**Rationale for the Board's Concerns:**

1. During the 4,984 case reviews conducted in 2005, the Board made specific findings in each case on whether reasonable efforts were made to prevent the child's removal. During these comprehensive statewide reviews, the board found that in some cases no action was taken to protect children for a considerable period of time.
2. During the 4,984 case reviews conducted in 2005, the Board made specific findings on whether the foster placement was safe and appropriate for each child reviewed. The Board found that in a significant number of the cases where abuse and neglect reports had been made to the CPS hotline alleging abuse by the foster parents, there was no investigation.

**Recommendations:[51]**

1. Require mandatory training on child maltreatment for professionals who work with children and who are licensed to practice in the State of Nebraska[52]
2. Encourage HHS to move toward accreditation of workers through the Council on Accreditation for Agencies servicing Children and Families (COA). In addition to assuring a certain level of quality of services provided to children and families, gaining accreditation through COA would help to address issues of accountability.[53]
3. Put in place supervision and review of all critical decisions regarding children.
4. Assure that the persons receiving the reports are well-trained professionals who are assigned this function based on expertise.

[50] Ibid.
[51] See Priority Recommendation I-A on page 5 for a summary of recommendations concerning the intake process.
[52] Governor's Children's Task Force Recommendation 1.6
[53] Governor's Children's Task Force Recommendation 5.3

*"I implore you to see with a child's eyes, to hear with a child's ears, and to feel with a child's heart."*

Former United States Surgeon General
Dr. Antonia C. Novello (1944- )

# 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 can be failures and miscommunications 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 little or 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 pre-verbal 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 or the time the call is made, 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 individuals.
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 share 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.

**Recommendations:**[54]

a. Assure that all law enforcement officers who are involved in the removal of children from their homes receive specialized training to help them make the best decisions when faced with the prospect of removing a child from his or her home.

b. Child maltreatment reports involving children under the age of six are given priority for a response[55].

c. State law should be amended to require CPS and law enforcement to investigate reports alleging children are in the home where they witness domestic violence or children are in a home where drugs are used, manufactured, or available to the children. HHS policy regarding domestic violence and substance abuse allegations should be changed accordingly.[56]

d. Require coordinated investigations by CPS and law enforcement.[57]

e. Facilitate and enhance the exchange of information between law enforcement and CPS through a shared database that can be accessed by both parties and through clearer statutory provisions for the mandated sharing of information relevant to child abuse and neglect investigations.[58]

[54] See Priority Recommendation I-A on page 5 for a summary of recommendations concerning the intake and investigation process.
[55] Governor's Children's Task Force Recommendation 2.1
[56] Governor's Children's Task Force Recommendation 2.2
[57] Governor's Children's Task Force Recommendation 3.3
[58] Governor's Children's Task Force Recommendation 3.4

# Young (Birth-Five) Children's Issues

## How Can Placement and Planning Decisions for Young Children Support Stable, On-Going Nurturing Relationships? What is the Consequence if They Do Not?

**National Research:** Research on children's physical and emotional development indicates that, especially for the preschool population, it is critical to have stability and continuity of care. Children in this age group are developing the physical connections of the brain.

In their research, Drs. T. Berry Brazelton & Stanley Greenspan identified the essentials needed if children are to develop higher-level emotional, social and actual abilities:

*Fundamental Building Blocks for Children*[59]

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.*

Others, such as the Judicial Commission on Zero to Three, have recognized this as well.

> **"***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."*[60]

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.[61]

---

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

[60] 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.

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

Separation from parents, sometimes sudden and usually traumatic, coupled with the difficult experiences that have precipitated foster placement can leave infants and toddlers dramatically impaired in their emotional, social, physical, and cognitive development.[62] Children who have been abused and neglected often lack empathy and truly do not understand what others feel like when they do something hurtful.[63]

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.[64] (76.8% of the children birth-two reviewed by the Board during 2005 entered care due to parental substance abuse.)

**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.[65]

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.[66]

**Findings/Rationale for Recommendations:** The Board is concerned that too many Nebraska preschool children are being abused or neglected.[67] 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 attachment 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,

[62] Permanent Judicial Commission on Justice for Children, Zero to Three Policy Center, July 2004.
[63] Understanding the Effects of Maltreatment on Early Brain Development, National Clearinghouse on Child Abuse and Neglect Information, October 2001.
[64] Understanding Substance Abuse and Facilitating Recover: A Guide for Child Welfare Workers, U.S. Department of Health and Human Services, 2005, page 7.
[65] 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.
[66] Understanding the Effects of Maltreatment on Early Brain Development, National Clearinghouse on Child Abuse and Neglect Information, October 2001.
[67] See page 121 on the need for child abuse prevention.

7. The ability to handle fear and worry, and
8. The ability to correctly interpret and handle any perceived threat to self.

As Dr. Urie Bronfenbrenner, then a psychologist at Cornell University, said many years ago in the videotaped lecture, *The American Family: Who Cares*, all children require the same thing: *"the enduring, irrational involvement of one or more adults. Someone who is crazy about the kid…a love affair that lasts a lifetime*."[68]

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 2005 about 1,388 children ages five and under were 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. **567 (41.4%) of the 1,368 preschool children who were wards of HHS and in foster care on Dec. 31, 2005, had been in more than two foster homes.**
        - This compares to 35.0% in 2004, 38.0% in 2003, and 36.5% in 2002.
    b. **141 (10.3%) of the 1,368 HHS preschool children in foster care on Dec. 31, 2005, had been in more than three foster homes.**
        - This compares to 19.5% in 2004, 21.4% in 2003, and 19.5% in 2002.
4. **184 (13.5%) of the 1,368 HHS preschool children in foster care on Dec. 31, 2005, had been removed from the home at least once before**. This compares to 13.8% in 2004, 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. More information on parental methamphetamine abuse can be found on pages 2-4 of this Report.

During 2005, **76.8% (53 of 69) of the children under age three that the Board reviewed had parents with a documented substance abuse problem.**

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

The Board strongly supports the Douglas County 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 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."*[69]

In 2005, the pilot dealt 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

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

stabilized, that they obtain permanent homes, and that a long-term plan is made that will optimize 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 were more than three times as likely to experience recurrence compared with children without a prior history."*[70]
>
> 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."*[71]

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.

Focusing on children age birth to five provides a long-range solution to the spiraling increases in the number of children in foster care, while simultaneously protecting that group of children most vulnerable to abuse and neglect.

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.

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

2. Develop specialized units where highly trained professionals focus on providing permanency[72] 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.
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.

## How Can Case Management Be Structured to Facilitate Attention to the Special Issues of Children Age Birth to Five?

**Findings/Rationale for Recommendations:** As stated in the previous question, young children, due to their developmental needs, require consistency and stability. If there were specialized units within HHS that could focus on case management for this population, the following could be accomplished:

1. Case managers and other parties to the cases could receive specialized training on bonding and attachment, and child development. Case managers and other parties could better understand the impact that placement disruptions can have on young children.
2. Caseloads in the unit should be reduced to allow for the following:
    a. An increase in the quality of the foster care experience for young children.
    b. The stabilization of young children's placements through additional efforts to recruit, support, and monitor placements.
    c. A more timely identification of paternity and relatives, and a more timely determination of whether a relative placement is appropriate for the children.

[72] 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.

d. An increase in the time that caseworkers have to be in contact with the children and parents. This could reduce the time that children spend in foster care.
e. The number of young children in foster care could decrease as children move through the system more quickly.

**Recommendations:**[73]

1. Create specialized units within HHS which focus on the special needs of children age birth through five.

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

The Board's Statutory Authority to conduct Project Permanency visits is listed below:

> *Nebraska Revised Statutes Section §43-1303 (3) states "The State Board" may visit and observe foster care facilities. Nebraska Revised Statute Section 43-1302 (2) allows the State Board "to employ or contract for services…as necessary to aid it in carrying out its duties."*

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, so 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.

[73] See Priority Recommendation 3 on page 10 for a summary on the need for specialized units for cases of young children.

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 but necessary project if young children are to obtain permanency in a timely manner.

# 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.*"[74]

**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, foster parents and/or siblings,
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***

[74] 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***."[75]

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 for 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., 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
9. Physical symptoms such as sleep disturbances, rapid or irregular heart rates, and lower resistance to infection

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

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*."[76]

> "*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*."[77]

[76] 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.
[77] Simms, quoted in the American Academy of Pediatrics Policy Statement on Developmental Issues for Young Children in Foster Care, November 2000.

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.**

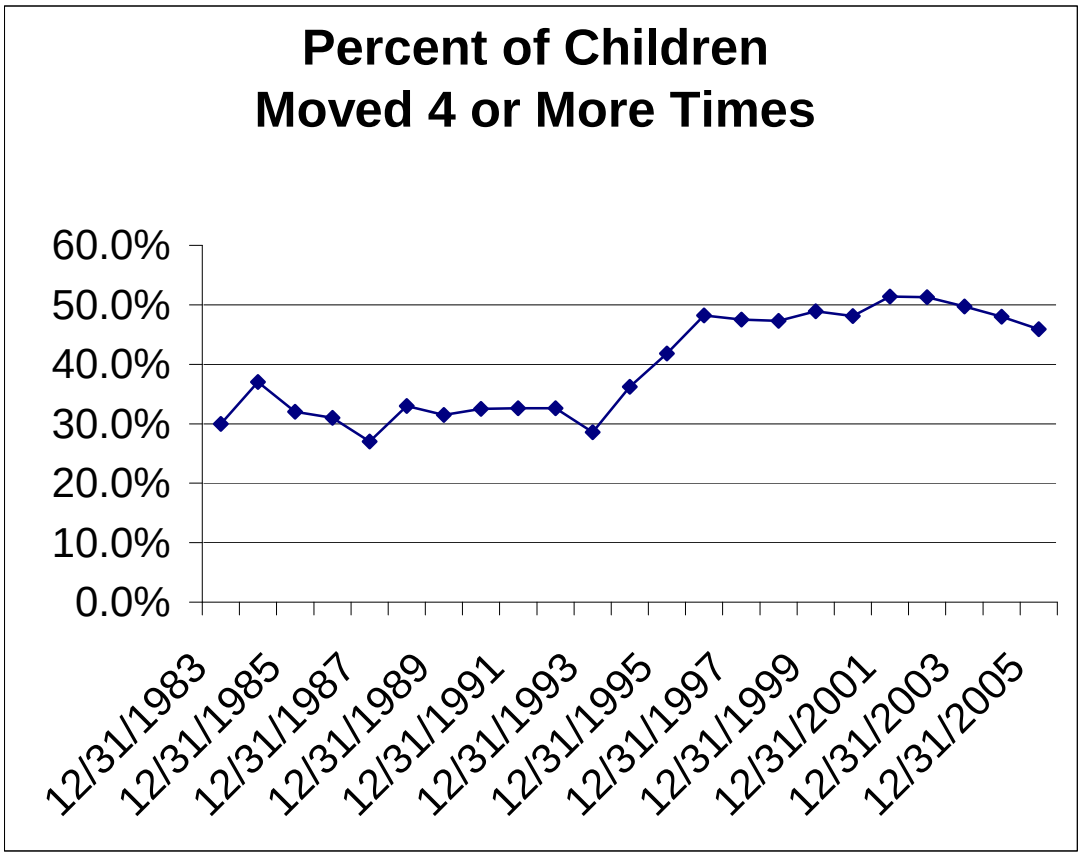
- Early in the transition process obtain a special object such as a blanket, teddy bear, etc. For older children this may be a clothing item, toy, or pillow. If it is impossible to secure the original item, replicate the item as closely as possible and as early as possible in the transition process.
- Encourage repetition of previous patterns for personal care, such as bedtimes with rituals, food preferences, types and times of bathing (shower or bath). Caretakers should note this information so it can be passed on.
- If possible, take Polaroid® or instant pictures of the previous family, the house, and the pets; otherwise, see if copies of photos can be obtained for the child to keep.
- Whenever possible, encourage transitions that include a visit at the present home, a visit at a neutral place (park, restaurant, etc.) and an overnight or daylong visits with discussions about the habits of the new household.
- Older children should take active part in packing and unpacking their own belongings and putting them away.
- Provide a duffel bag or other luggage for transporting the child's personal belongings. Do not use a plastic bag, garbage bag, or cardboard box.
- Whenever possible, arrange periodic contact by phone, visit, or mail with the previous caretakers. This becomes more important if the child is moving after a long period of time.
- Encourage new caretakers to exchange food information, and even recipes for favorite dishes, and prepare them early in the transition process and again when requested by the child.
- At the first visit before transition encourage new caretakers to give the child a token gift that goes with the child back to their current placement. The child can bring this gift with them at the next visit or upon permanent relocation.

- New caretakers should provide a secure place for the child's belongings and allow the child to adjust to the new placement before expecting sharing with other children in the home.
- Children under stress often show regressive behaviors. They need patience and kindness as they struggle to regain their normal developmental level. Tolerating whining, crying, and withdrawal along with thumb-sucking etc., will help the process move along and tolerance will be more effectual than consequences or criticism. Most children will regain their former skills within a few days or weeks.

---

**Recommendations:**

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


Percent of Children
Moved 4 or More Times
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
12/31/1983
12/31/1985
12/31/1987
12/31/1989
12/31/1991
12/31/1993
12/31/1995
12/31/1997
12/31/1999
12/31/2001
12/31/2003
12/31/2005

# Pre-Hearing Conferences[78]

## How Can Pre-Hearing Conferences Facilitate Case Planning and Permanency?

**Findings/Rationale for Recommendations:** Pre-hearing conferences are meetings where all the parties to the children's cases, including the parents, get together for the purpose of gaining the cooperation of the parent in a problem solving atmosphere. These conferences can be scheduled within 30 days of the children entering out-of-home care, shortening the time that critical decisions are made and allowing the family to receive needed services immediately to address the reasons that the children entered care.

At the pre-hearing conference the parents and legal parties involved may identify any issues of paternity, assure compliance with the Indian Child Welfare Act, identify relatives and explore the feasibility of a relative placement, determine the children's out-of-home placement, schedule visitation, and identify and set up services for the parents and children.

This is critical as studies show that parents are more motivated towards reunification and addressing the reasons their children within the first six weeks after their children are removed from their care.[79]

**The Board has found that when critical issues are not addressed at the outset of the case, children can potentially spend more time in foster care awaiting the resolution of these critical issues.** Utilization of pre-hearing conferences could reduce the number of children with extended stays in foster care. 2,021 of the 3,309 children reviewed in 2005 had been in care two years or longer and 906 had been in care for five years or more.

Pre-hearing conferences also address paternity. Paternity had not been established for 745 (22.5%) of 3,309 reviewed children's cases. Paternity was undocumented, and therefore likely not determined, in another 551 (16.7%) of the 3,309 reviewed children's cases.[80]

**Use of the pre-trial conference to "jump-start" the system is projected as a means by which to increase stability in children's placements and to expedite their permanency. By adapting techniques learned from the drug court and family court models, front-loading the system would create a more comprehensive ability to monitor and improve parental compliance**.

[78] These conferences are also referred to by some as pre-adjudication conferences or pre-trial conferences.
[79] One such study is "Crisis Intervention in Child Abuse and Neglect," by the U.S. Department of Health and Human Services Administration for Children and Families.
[80] Additional information on paternity can be found beginning on page 117.

**Recommendations:**

1. Utilize pre-hearing conferences to ensure from the beginning that children who have been removed are safe while in foster care, that their essential needs are met, and that they exit foster care to safe, permanent homes as soon as possible.
2. The Board acknowledges that many courts have already implemented this important tool.

# Case Management Issues

## What Is the Impact of Case Worker Turnover?

**Findings/Rationale for Recommendations**: Turnover can produce gaps in the evidence which case managers provide to prosecutors, breaches in essential communication with foster parents, therapists, and other service providers, lapses in monitoring parental compliance with case plans, and delays in making case progress.

**1,400 (42.3%) of the 3,309 children reviewed during 2005 had 4 or more different case managers during their time(s) in foster care.**

Children often pay the price for 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.

The Board acknowledges the difficulty of the caseworkers' task. The following quote illustrates the demands made on caseworkers:

> "*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].*"[81]

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 SACWIS 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.

[81] 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:**[82]

1. Make caseloads manageable by implementing case load caps.
2. Build in rewards for good performance and enhanced skills.
3. Increase levels of support, mentoring 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 six-year span, the percent of reviewed children that had documentation of recent caseworker contact increased significantly -- from 39.0% in 1999 up to 89.5% in 2004, and at 86.5% in 2005.

### The Board commends HHS caseworkers, supervisors, and administration for continuing to maintain a high number of contacts in spite of heavy caseloads.

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.

[82] See Priority Recommendation II on page 9 for a summary of recommendations regarding caseworker turnover issues.

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*."[83]

**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.

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

*"Many things can wait, the child cannot. Now is the time his bones are being formed, his mind is being developed. To him, we cannot say tomorrow his name is today."*

Nobel Prize Winning Author Gabriela Mistral

# Oversight, Quality, & Safety Issues Involving Contracted Services

## What is Contracted That Affects Children?

The majority of the children in foster care are impacted by contracted placements and/or services. Contract types include:

- Transportation,
- Visitation monitoring,
- Placements, and
- 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 many 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 agency-based 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.
3. Contractors have reported having difficulty getting phone calls returned, which appears to be endemic.
4. The cost of contracting with for-profit organizations limits the funds available to provide permanent case management for the children's cases.
5. 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 regarding a contracted placement, 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.

Some children are affected by multiple contracts, as the following case illustrates:

> *"Daniel,"[84] age 14, entered foster care due to be involved in a theft. "Daniel" doesn't respond well to change. He is on a number of medications for Impulse Control Disorder and ADHD. "Daniel" is placed in a contracted group home that has had a rapid succession of staff changes. He is to be transported to and from school by a contractor. There have been numerous issues with drivers not picking "Daniel" up from school, and with "Daniel" not making it to school, sports practice, and therapy appointments due to contract driver issues. "Daniel's" behaviors, which were progressing, are now showing the negative effects of these stressors.*

**Recommendations**:[85]

**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

[84] Name changed to preserve confidentiality.

[85] See Priority Recommendation "VI" on page 14 for a summary of the recommendations concerning contract oversight.

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.

## What Are the Concerns Specific to Contracts for Transportation and/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 1,861 of the 6,204 children in care on Dec.31, 2005.

**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 foster children. The following are some examples:

> *"Ellery,"[86] age 5 months, came into care at birth. He's had 15 different transportation workers.*
>
> *"Jackie,"[87] age 2, entered care shortly after her 1st birthday when her parents were arrested on drug charges. In the last 4 months she has had 7 different transportation workers.*

[86] Names changed to preserve confidentiality.
[87] Ibid.

> *"Cal,"[88] age 1, entered care after being born prematurely, after his putative father kicked his mother in the stomach. He has had 7 different visitation workers in the last 4 months.*

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.

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.

[88] Ibid.

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.[89] | For case aides, the State would pay about $3,451,968 annually, plus mileage.[90] |

**Recommendations:**[91]

1. Eliminate contracts for visitation and transportation and approve hiring 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.

## What Are the Concerns Specific to Placement Contracts?

**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.

[89] 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.

[90] 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.)

[91] See Priority Recommendation "VII" on page 15 for a summary of the recommendations regarding contracts for visitation and transportation.

Foster homes

1. Standard foster care is paid between $226-$1,224 per month per child, depending on the child's needs.
2. Agency based foster care is paid $1,913 per month per child.
3. Treatment foster care is paid about $3,021 per month per child, depending on the child's age.

Group homes

1. Standard group homes are paid $1,973 per month per child.
2. Group home level "A's" are paid $2,723 per month per child.
3. Treatment group homes are paid $4,799 per month per child.
4. Enhanced treatment group homes are paid $6,983 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[92] 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 foster 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.

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

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.

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.

## 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).<br><br>**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's name should be listed on the Central Registry with the label "inconclusive," which is the current term for, "likely that the abuse happened."**

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.

## 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 example.

> *"Jeff,"[93] who just had his 18th birthday, entered care 9 years ago, when the mother said she could not care for the children. The mother's rights were terminated 6 years ago. "Jeff" has expressed an abnormal interest in the act of rape. HHS obtained two expert opinions that "Jeff" needed a higher level of care as he is at high risk for committing a sexual assault. Magellan denied this due to "Jeff" having not yet actualizing his obsession. Therefore, "Jeff" was placed at a lower level of care, where he is a risk to youth and staff. Further, in just 11 months he will reach the legal age of majority, be released from foster care, and will be a risk to society.*

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.

[93] Name changed to preserve confidentiality.

> *"Jim,"[94] entered foster care after being charged with felony assault on a police officer. His case was transferred to Juvenile Court as he was only 12 years old at the time. The case manager has indicated that he is being sent home due to Magellan funding being used up. In the treatment facility where he is currently placed he has not been able to work through the levels to those allowing more freedom of movement. Based on his history of aggressive behaviors and lack of progress in treatment, placement at home may put "Jim," his mother, and the community at risk. It is unclear what type of safety plans will be in place, or how he will be transitioned back into the parental home.*

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.

[94] Ibid.

# Placement Issues [95]

## What Types of Additional Placements Need to Be Developed?

**Findings/Rationale for Recommendations**: Nearly half of the children in care of Dec. 31, 2005, had experienced four or more placement disruptions/moves (2,849 of 6,2047 children, or 45.9%).

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. 93 children reviewed in 2005 were found to be in unsafe placements.
2. 132 children reviewed in 2005 were found to be in placements that were inappropriate for the children's needs, even though the child was temporarily safe there.
3. 622 children reviewed in 2005 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.

[95] Contract issues affecting placements are discussed in the sections immediately prior, and issues related to abuse in foster placements are discussed on page 97.

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

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:**[96]

1. Recruit more qualified placements for foster children and increase monitory and support for those placements.
2. 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).
3. Diligently work to recruit and retain therapeutic foster homes, group homes, and residential care facilities, especially in the western part of the state.
4. 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.

[96] See Priority Recommendation IV on page 11 for a summary of recommendations concerning recruiting, supporting, and monitoring children's placements.

5. Place young children in potential permanent placements at the time of their removal and then support these placements to encourage stability while in foster care.
6. Explore the possibility of using state resources, such as using the Nebraska Center on Children and Youth (NCCY) campus as a child-caring facility.
7. 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.
8. Improve consistency of licensing practices and standards to ensure safety for children in foster care. This goal was also in the 2001 HHS Nebraska Family Portrait Initiative.
9. Assure that shelters are used appropriately, as short-term placements while a more permanent placement is being recruited or located.
10. 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.
11. 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[97] 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 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

[97]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.

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 foster 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…*"[98]

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.

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.

[98] 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.

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. **459 (13.9%) of the 3,309 children reviewed in 2005 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 627 children's cases (18.9%) it was not possible to determine whether the foster parents/placement had received medical records.
3. 2,092 (63.2%) of the 3,309 children reviewed had foster parents or placements that reported they had received the medical records for the child. This is less than the 72.9% in 2004.
4. **233 (17.2%)of the 1,352 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 219 young children.

In regard to **educational records**:

1. In 2005 1,341 reviewed children 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 **168 (12.5%) of the 1,341 children's foster parents or placement reported they had not been given educational records.**
3. For another 274 (20.4%) of the 1,341 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 or are on medications to treat behavioral/psychiatric issues.

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.[99]

**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, half of Nebraska's children in foster care do not experience this type of continuity of caregivers.

**The Board finds that 45.9% (2,849 of 6,204) of the children in care on Dec. 31, 2005, had experienced four or more placement disruptions and 30.9% (1,915 of 6,204) had experienced six or more placements during their short lifetimes.** Many experts

[99] See pages 49-56 for young children's need for stability, and page 90 for general information on stability.

believe that children who experience four or more placement disruptions can be irreparably harmed by the multiple broken attachments.[100,101]

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."*[102]

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.

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.

> *"**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.**"*[103]

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.

---

[100] A common standard is that three or more moves (four or more placements) constitutes placement instability (Hartnett, Falconnier, Leathers & Testa, 1999; Webster, Barth & Needell, 2000). The American Academy of Pediatrics found that "*children need continuity, constituency and predictability from their caregiver. Multiple foster home placements can be injurious.*" (News Release with Policy Statement on Developmental Issues for Young Children in Foster Care, November, 2000). The Washington State Institute for Public Policy, February 2001, found that "*even for children with few impairments, being moved from setting to setting often increases their problems.*" According to study from Children's Hospital of Philadelphia, 2004, "*Multiple placements and episodic foster care both increased the predicted probability of high mental health service use*."

[101] See pages 57-62 for more information on grief and broken attachments.

[102] March 29, 2004, editorial by a member of Pew Commission as it appeared on www.tallahassee.com.

[103] J. Freud Goldstein and A. J. Solnit, Beyond the Best Interests of the Child, c. 1973.

> "***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.*"[104]
>
> "*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***."[105]

Conversely, research has shown that the presence of even one positive attachment figure can be a protective factor to promote resilience in children who suffer trauma or separation.[106]

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.
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.[107]

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

---

[104] Vera I. Fahlberg, M.D., A Child's Journey Through Placement, page 176. Perspectives Press, c. 1991.
[105] Claudia Jewett Jarratt, Helping Children Cope with Separation and Loss. c. 1994.
[106] Susan Downs et al, Child Welfare and Family Services Policies and Practice, c. 1991, page 280.
[107] See page 93 for more information on kinship care.

**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.
2. Require relative caregivers to pass the same standards as other foster care providers to ensure that children are safe and well cared for.
3. Recruit, develop, and retain child-specific placements for young children, especially those with special physical, emotional, or behavioral needs. Build the capacity of foster placements to match the population of children, their location, and their needs.
4. Provide on-going specialized training to all foster parents, case managers and supervisors on the importance for children to bond and form attachments to their caregivers. 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.
5. Implement foster parent retention steps such as:
   a. Recognize that foster parents are a vital component of the system.
   b. Provide access to round-the-clock immediate and effective support when issues arise.
   c. Provide 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.
6. 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.
7. Monitor placement providers closely and consistently.

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

**Definition:** Some children in foster 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.

The Statutory reference for kinship care is the following:

> The Family Policy Act (§43-533) states that when a child cannot remain with parent, preference shall be given to relatives as a placement resource. It also requires that the number of placement changes that a child suffers shall be minimized and that all placements and placement changes be in the child's best interest.

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.

Some relatives, due to their relationships with the offending parent, are unable or unwilling to protect the child, as the following case illustrates:

> *"Mike,"[108] age 10, and "Jim," age 7, entered care a year ago due to the mother failing to get the children to school, and the boys reporting that their mother did not provide them food. The father has a history of incarceration on drug related charges. The boys are displaying sexualized behavior and need therapy. The children are placed with the paternal grandparents in an adjoining state. The grandparents refuse to take the boys to counseling, and refuse to supervise the boys' visitation with their father. There are difficulties in arranging visitation with the mother due to both distance and how the grandparents feel about the mother.*

**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,

[108] Names changed to preserve confidentiality.

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 example illustrates the consequences for the children.

> *"Trevor,"[109] who is now age two, came into care about a year ago due to his mother's methamphetamine abuse. He was placed with his maternal grandmother. His uncle (his mother's brother), who is a convicted sex offender, is reported to have been living in the relative home with "Trevor" and his grandmother. Although the grandmother was verbally told that the uncle could no longer live in the home, there is no safety plan in place to ensure that the situation is monitored. A plan needs to be in place to ensure that the uncle does not have access to "Trevor."*

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

> *"Tim"[110] and "Melissa," ages 10 and four respectively, have been placed with their maternal grandmother for about two years. The grandmother worked with the children's mother to try to facilitate reunification. It became apparent that, because of the mother's mental health issues, reunification would not be an appropriate plan for these children. The grandmother agreed to adopt the children. This placement was stable, and enabled the children's existing relationships with older half-siblings, cousins, and other appropriate relatives to continue.*

**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.

[109] Name changed to preserve confidentiality.
[110] Ibid.

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.

# 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. This should not be unexpected, as the following quote illustrates:

> *"The decisions in child welfare are not between good and bad. They are between worse and least worse. Each decision will be harmful. What decision will do the least amount of damage? We all have tendency to under rate the risk to the child of being in the foster care system and over rate the risk to the child of living in poverty in a dysfunctional family."*
>
> Dr. Ann Coyne,
> University of Nebraska Omaha, School of Social Work

**During 2005, the Board reviewed the cases of 93 children who were not in safe placements.** In another 622 children's cases there was insufficient documentation on which to base a safety finding. These figures do not include cases where children may be safe, but there are quality-of-care concerns.

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[111] 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 are not trained child abuse and neglect investigators and have no incentive to report abusive situations or to cease using such placements.

[111] See pages 69-84 for more information on contract concerns.

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 is an example:

> *The "Black"[112] siblings, ages, 9, 12, 13, & 15, entered care due to their mother's drug use. They are placed with a great-aunt. An exception was made for the placement due to the great-aunt's previous felony assault record, and her DUI from 4 years ago. There are guns in the home, and it was unclear if there were gunlocks in place and, if so, where the key was located. It is unclear how long the great-aunt has maintained sobriety.*

The Board is aware that HHS 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 of abuse is directed toward agency-based 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, calls alleging abuse of a foster child in a foster home 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.

[112] Names changed to preserve confidentiality.

2. Clearly identify the lines of supervision and means of monitoring to assure 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 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; and, some foster parents are also home daycare providers. A worker placing a child in an emergency placement 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,[113] 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 or vice versa.
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.

[113] See page 77 and following for more information on agency-based care.

# 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 deprivation 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. During 2005, the Board found that 183 children of the 3,309 children reviewed (5.5%) had file information indicating restraints were used on them during the six months prior to the review. It should be noted that because the Board is concentrating on children birth to five and who qualify for federal IV-E funding due to budgetary issues, the Board is not able to review as many older children in group placements who are more likely to be restrained. Therefore, the percentage in the total foster care population is likely to be higher.

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 183 being under age 10.

Some of the 183 children restrained experienced more than one type of restraint, and/or restraints in more than one facility.

1. 131 of the children were physically restrained,
2. 37 children were placed in confined isolation,
3. 9 children were chemically restrained,
4. 0 children had food withheld, and

5. 6 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 children were receiving in the parental home. These children were moved from an abusive situation, only to be placed in another.**

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 prove 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. Competitive salary guidelines and qualifications for staff dealing directly with children in group settings can help 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.

# 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 which 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 few 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 72.7% of the cases reviewed in 2005.**

**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."*[114]

**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 foster 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 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

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

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 foster care.

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

1. 27.3% did not have complete written permanency plans (902 of 3,309 reviewed children).
   a. 401 children had no current plan.
   b. 501 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. These plans are missing what is needed to hold parents accountable.

**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 25.3% of the cases reviewed in 2005, the Board disagreed with the child's plan (837 of 3,309 children reviewed)
2. In 12.1% of the reviewed cases there was no plan (336 of 3,309 children reviewed).
3. The Board agreed with the plan in 56.6% of the cases (1,872 of 3,309 children reviewed).
4. 7.4% of the children who left care in 2005 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:

> *"Tad,"[115] age 7, was removed from the home 3½ years ago due to physical abuse by the mother's boyfriend. The boyfriend is to have no contact with "Tad," but the mother has allowed the boyfriend to remain in her life. Recently she allowed her boyfriend to have contact with "Tad" against the court order, even though the Court had previously warned her of the potential consequences if she allowed contact to occur. A maternal aunt who has a relationship with "Tad" has said*

[115] Name changed to preserve confidentiality.

*she would be interested in providing "Tad" a permanent home. The mother has chosen the boyfriend over her child, but the plan remains reunification.*

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[116], 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."*[117] 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 29.6% (1,396 of 4,724) of children removed from their home during 2005 had already gone through at least one failed reunification attempt.

This means **most of 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.

[116] See pages 69-84 for more information on contract issues.
[117] 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, there may not be legal grounds to prevent reunification. The Crawford decision impacts this situation as well.[118]
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.

[118] Crawford v. Washington, #02-9410, Argued Nov. 10, 2003. Decided Mar. 8, 2004. This case impacted the admissibility of children's testimony to law enforcement, medical personnel, and others outside of a court hearing.

**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.[119]

**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 foster 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.

[119] See page 47-48 for more information on the investigation process.

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[120] and moving the case to alternate permanency. This time should be reduced to six months and the system should move to ensure services are in place to accelerate this timeframe.
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 over half (61.1% or 2,021of 3,309) of the children reviewed in 2005 had been in care for at least two years without achieving permanency and 27.4% (906 of 3,309) 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 foster 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:

*"Jennie,"[121] age three, entered foster care nine months ago due to her mother's methamphetamine abuse. The mother has had previous relapses. The plan is for "Jennie" to reunify with her mother in the next four months. During review of her case, the Board found the following essential information, needed to determine if and when reunification should occur, was not documented:*

- *Status of pending criminal drug charges against the mother,*
- *Whether urinalyses were confirming the mother's sobriety,*
- *Whether mother was attending parenting classes and household management classes,*
- *What progress was made at the halfway house,*
- *Results from a psychological evaluation that was to have occurred approximately one month ago,*
- *Availability of drug treatment after-care for when the mother leaves the halfway house, and*
- *Availability of affordable daycare services for "Jennie."*

[120] 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)*

[121] Name changed to preserve confidentiality.

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

> *The two older "Samuels"[122] siblings, ages 12 and 10, have been in foster care for over six years. The two younger "Samuels" siblings, ages six and five, have been in care for over four years. The parental rights were terminated, and five months ago the Court of Appeals upheld the termination. The adoption has yet to be completed. The only thing preventing these children from achieving permanency is the lack of efforts to finalize the adoption.*

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,

[122] Ibid.

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 1,496 of 3,309 (45.2%) of the children reviewed in 2005.

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.

> *"Barry,"[123] age 4, has been in foster care for about a year. He is placed with a relative. He lives in the middle third of the state. He has serious, aggressive behaviors (choking, threatening to kill) that need to be addressed. "Barry's" relative placement has been transporting him to Lincoln every week to see a child psychiatrist. This is a hardship for the relative, and has made it difficult for "Barry's" mother to participate in his therapy.*

> *"Mary," age 14, has been in foster care for a total of three years. She has had several psychiatric hospitalizations, none of which she was able to progress in. Her mother lives in the western part of the state. "Mary" is now placed in a specialized facility in a state east of Nebraska. "Mary's" mother needs to be actively involved in her treatment if reunification is to be safe and/or realistic, but the distance is a barrier.*

**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

[123] Name changed to preserve confidentiality.

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.[124]

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 often this information does not follow the youth as they move from one placement type (such as detention) to another (such as a group home).

Many of the youth committed by the courts to OJS had been in foster 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.

[124] See page 83 for the impact of the managed care contract.

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.

# 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. 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, or others who abuse or neglect children 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.[125]

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.[126]

[125] Crawford v. Washington, #02-9410, Argued Nov. 10, 2003. Decided Mar. 8, 2004.
[126] 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.

In addition, the Board finds that:

1. The volume of cases often exceeds the capacity for effective response.
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. Some abuse victims are pre-verbal, and this, too, can present challenges.
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 more 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 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 pre-verbal 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 foster care where they can be safe.

**Recommendations:**[127]

1. Increase 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.
2. Encourage county attorneys and judges to ask more questions of the worker regarding placements that are 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.
3. Encourage appropriate permanency planning. HHS writes the plan and it is legally assumed to be in the child's best interests unless proven otherwise.
4. 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.
5. 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).
6. Increase accountability for prosecution of child abuse and neglect whether the state chooses to create a district attorney system or elects to augment the current county-by-county prosecution system.
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.

## How Do Paternity Issues Affect Children's Cases?

**Findings/Rationale for Recommendations:** The Board finds that paternity had not been established for 745 (22.5%) of 3,309 reviewed children's cases. Paternity was undocumented, and therefore likely not determined, in another 551 (16.7%) children's cases. Most of these children had been in care for more than six months at the time of review; and most 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.

[127] See also Priority Recommendation "IX" on page 16.

The following case illustrates what can happen when fathers are not included in the initial adjudication.

> *"Essie,"[128] age 14, and "Terry," age 9, came into care 6 months ago due to their mother's mental health issues. The alleged father was not included in the adjudication. However, the children have frequent, positive visits with their father, sometimes daily. The children want to reside with the father. The guardian ad litem and the foster mother, who is their maternal grandmother, support the children being placed with their father. The children's therapist does not believe the children could return to the mother's home safely. Until legal issues are resolved, the children will remain in foster care.*

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.

In some cases, fathers had not been contacted even though their address was relatively easy to find. The following case illustrates this point.

> *"Kelly," age nine, entered foster care due to the filthy conditions in the parental home and physical abuse of a younger half-sister. No father was listed on "Kelly's" birth certificate, although paternity had been established through Child Support. After "Kelly's" father received notice of the date for the Board's review, he contacted the Board's staff to report he had not been made aware that "Kelly" was in foster care. At that time "Kelly" had been out of the home for just over six months. The father reported he has been trying to locate "Kelly" for several years to no avail. He is married and would like to pursue a relationship with "Kelly" and provide him a home.*

The paternity identification problem had been especially acute in Douglas County, where 36.9% percent of the children in foster 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 are 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.

[128] Name changed to preserve confidentiality.

## How Can the Courts' Permanency Hearings Be More Effective?

**Findings/Rationale for Recommendations:** Foster care should be a temporary situation. However, in Nebraska far too many children remain in foster care for extended periods of time. 2,021 (61.1%) of the 3,309 children reviewed in 2005, had been in foster care for 24 months or more. 906 children (27.4%) had been in care for at least 60 months.

As required by the federal Adoption and Safe Families Act, significant portions of which have been adopted by Nebraska, the permanency hearings are designed to be a critical point to determine whether the goal of reunification remains viable, or if termination of parental rights needs to be pursued.

**Recommendations**:[129]

1. Ensure the Courts' permanency hearings are effectively determining case direction for children who have been in foster care for at least 12 months.
2. Expedite permanency and ensure children leave foster care in a timely manner.

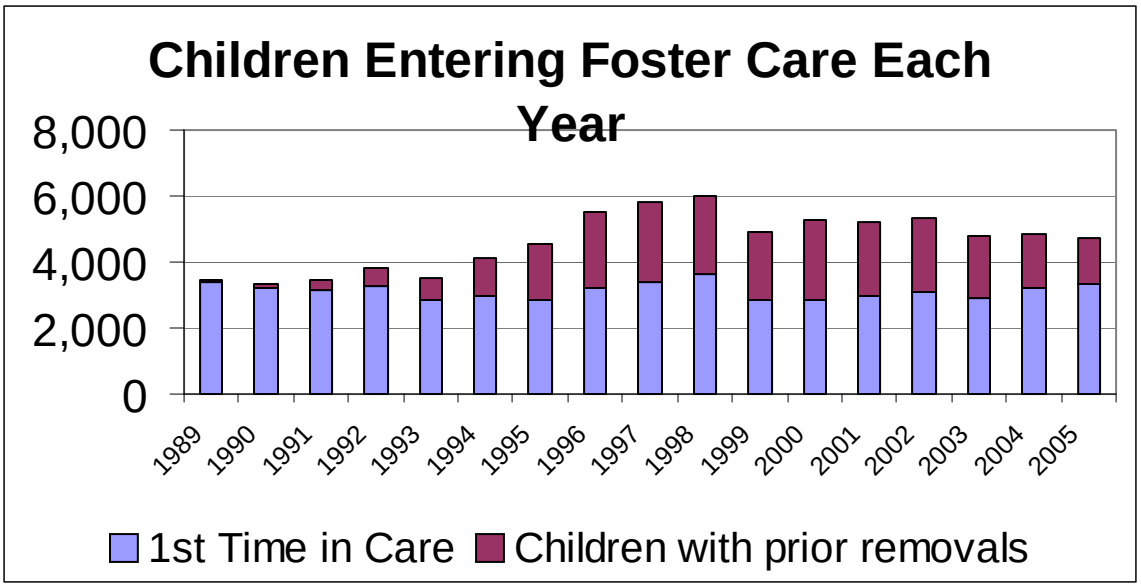
## Could Drug Courts Help Children and Families?

**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.[130]

**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.

[129] See Priority Recommendation "VIII" on page 16.
[130] See page 119 for additional information about the Douglas County Family Treatment Drug Court pilot that is targeted to children ages 0-3 and their parents.


Children Entering Foster Care Each Year
8,000
6,000
4,000
2,000
0
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
1st Time in Care
Children with prior removals

# Child Abuse Prevention Issues

## How Many Children Could 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** (4,714 children were removed in 2005). In 2005, the average daily population of Nebraska children in foster care was about 6,204 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 2003 study varied by District – with a high of 56.8 % in District 10 (Sandhills) and a low of 18.9 % in District 8 (Kearney).[131]
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. 10,797 children were in foster care for some or all of 2005.
      - 4,714 children were removed from the home during 2005.
      - 6,083 who had been removed from the home in prior years were in foster placements on Jan. 1, 2005.

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.

Home visitation programs need to include:

1. Early intervention,
2. Intensive services over a sustained period,

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

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.[132]

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.[133]

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%).[134] 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%*"[135]

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

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

found "*In the study subsample of low-income mothers, the analysis showed a net benefit of $350 per family*."[136]

A service network could prevent the removal of some children and, where children have already been removed, could also support children's safe return to the parents, and enable reunification to occur in a more timely manner.

**Recommendations:**[137]

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).[138]
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[139] 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.

---

[136] Ibid.

[137] See Priority Recommendation I-B on page 7 for a summary of recommendations regarding the need to make more services available to prevent the removal of some children.

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

[139] 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.

# 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. If the child is not found, 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.

On Dec. 31, 2005, there were 159 runaway children and youth from Nebraska's foster care system.

**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[140] 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.

[140] 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.

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:** According to Neb. Rev. Stat. 43-272.01, the guardian ad litem is to "*stand in lieu of a parent or a protected juvenile who is the subject of a juvenile court petition…*" and "*shall make every reasonable efforts to become familiar with the needs of the protected juvenile which shall include…consultation with the juvenile.*"

An informed, involved guardian ad litem is the best legal advocate for the welfare of the foster child. That child has rights under Nebraska statutes, and the guardian ad litem is charged with the responsibility of making sure that those rights are represented.

As shown in the commendation section,[141] many guardians ad litem are doing exemplary work. Yet, many guardians ad litem could play a more substantial role in assuring children's safety.

It is unclear how a guardian ad litem can "*stand in lieu of a parent*" if he or she has not seen the child, nor determined the child's living circumstances. Courts should hold guardians ad litem accountable.

**Recommendations**:[142]

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.

[141] Commendations are on page 33.
[142] See Priority Recommendation V on page 13 for a summary of recommendations regarding guardians ad litem.

## 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 $226 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 $1,974 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.

## 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.**

◈◈◈◈◈