"IT'S TIME TO PROTECT OUR CHILDREN"

20th ANNUAL REPORT OF THE NEBRASKA FOSTER CARE REVIEW BOARD

DECEMBER 31, 2002

Mike Johanns
Governor

Carolyn K. Stitt
Executive Director

"IT'S TIME TO PROTECT OUR CHILDREN"

20TH ANNUAL REPORT OF

THE NEBRASKA STATE FOSTER CARE REVIEW BOARD

2002

Submitted Pursuant to

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State Foster Care Review Board

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"IT'S TIME TO PROTECT OUR CHILDREN"

20TH ANNUAL REPORT OF THE NEBRASKA STATE FOSTER CARE REVIEW BOARD

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

PREFACE

A PREVIEW AND COMMENTARY

In order to reduce printing and postage costs, the Foster Care Review Board included in the print edition of the annual report only the most requested tables and sections.

Additional information will be available on the Foster Care Review Board's website: www.nefcrb.state.ne.us - or by calling 402.471.4420.

PREFACE

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"Children are the world's most valuable resource and its best hope for the future."

–John F. Kennedy

The State Foster Care Review Board

would like to express its appreciation to

James Ganz, Jr., Kay Lynn Goldner, and Barbara Heckman

for editing this annual report

"Loneliness and

the feeling of being unwanted

is the greatest poverty"

– Mother Theresa

IT'S TIME TO PROTECT OUR CHILDREN

A PREVIEW AND COMMENTARY

It's Time to Protect Our Children

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

"The salvation of the state is the watchfulness in the citizen."
--Aristotle (as engraved on the Nebraska State Capitol)

The Foster Care Review Board finds that the following decisions made by the Department of Health and Human Services (HHS-CPS), law enforcement, or county attorneys, literally can be the difference between life and death for children. These decisions also dramatically affect a child's quality of life and future productivity.

- **Whether to investigate reports of abuse or neglect, and how to prioritize the response;**
- **Whether or not charges are filed on a child's case;**
- **If a child is not removed from the home, whether a safety plan is in place;**
- **If a child is removed from the home, where a child is placed and how safety in the placement and during visitation is assured;**
- **What services a child needs and receives;**
- **The most appropriate plan for the child; and,**
- **Decisions that affect how long a child remains in the system, and whether that child ever lives in a safe, permanent home.**

The Foster Care Review Board has identified numerous critical system breakdowns in these areas and therefore is calling for major reform of the Nebraska child welfare system.

The Board bases its conclusions on:

- Collective findings from the 78,238 comprehensive reviews of children's cases conducted during the Board's 20-year history;
- Data from the 6,378 reviews conducted in 2002, and preliminary information from the 2003 reviews;
- Preliminary findings on research the Board is conducting, with the permission of the Governor, on all reports of abuse received by HHS-CPS from July 2002-July 2003; and,
- Research on the cases of 32 children who died violent deaths between 1997-Sept. 2003.

Major Changes the Foster Care Review Board Recommends to Ensure Children's Safety and Well-Being

The following is a summary of the Board's major recommendations, which are described in greater detail throughout this commentary.

1. **Increase Prevention:** Implement additional prevention services statewide to stop potential abuse or neglect, and to reduce the number of children who must be removed from their homes.

2. **Establish Locally-Based Centers Investigation and Prosecution:** Move the responsibility for investigation and prosecution of child abuse under the auspices of the County Attorney in densely populated counties, and the Attorney General's office in non-metropolitan areas.

   House specially trained and selected Child Protection Service (CPS) and law enforcement officers in newly created Investigation and Prosecution Centers. All calls related to child abuse would be received and dispatched from these offices. Calls made to local law enforcement agencies or HHS offices would be immediately forwarded to the centers. The centers would be responsible for informing HHS of any calls related to access to HHS services.

   This would: facilitate a 24/7 joint response to child abuse; increase supervision and oversight of decisions that impact children's safety; provide stronger petitions due to better evidence collection and documentation; and, although joint investigations would not occur in all cases, increase coordination.

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

4. **Create Specialized Case Management**: Implement specialized case management for young children and for children who have experienced severe or chronic abuse, building on the successes of the current ICCU[1] Units. Reduce caseloads of specialized caseworkers, enabling them to pursue intensive supervision of the cases, and ensure that each child's developmental and safety needs are met. Enhance caseworker supervision to increase the caseworker's ability to create positive outcomes for children.

5. **Analyze Workloads:** Analyze caseworker workloads to ensure they have sufficient time to interact with the children and ensure their safety, and to work with the families. Strengthen supervision so performance issues do not negatively impact children.

6. **End Many Service Contracts:** End the practice of HHS contracting for visitation, transportation, and family support. The dollars saved should be used for case managers and case aides. During implementation of the change, provide for HHS to develop and implement a clear process for oversight of contractors providing placements, treatments, visitation monitoring, and transportation; and provide for enhanced communication between HHS and contractors.

[1] ICCU units are HHS Intensive Care and Coordination Units, with specialized case management for difficult cases.

7. **Increase Foster Placements:** Develop additional foster placements and retain quality foster parents.

8. **Reduce Multiple Placements:** Minimize moving children to new placements. This is especially crucial for children from birth through age five who can be further damaged by multiple moves. Before moving children, consider whether that particular placement will be able to meet that particular child's needs. Better placement matches will result in more stable placements.

9. **Minimize Restraints:** Continue to implement measures to monitor and reduce the number of restraints that children experience while in state custody.

Basis of the Recommendations

The Foster Care Review Board is a state agency created to oversee children in out-of-home care in our state. Typically, children's cases are reviewed every six months by one of the 62 community-based volunteer local boards. After careful review and research, a board itemizes their concerns and provides recommendations for the ongoing care and safety of the child.

Findings are then forwarded to the judge and other legal parties (i.e., guardian ad litem, attorney) responsible for the child's care and well being. The findings and updated statistical information subsequently are entered into the Board's computer system for analysis.[2]

The Board bases its analysis and recommendations in this document on the collected results of the **6,378 reviews** that were conducted on the cases of **4,242 children** during 2002, and on its 20-year history of analyzing the Nebraska child welfare system.

It is important to recognize societal changes that have greatly affected the foster care system. Throughout this commentary are references to conditions that existed 5, 10, 15, or 20 years ago. Negatively impacting the child welfare system over the past two decades, and children's lives today, are: the proliferation of substance abuse among parents and teens, increased violence in homes and communities, families lacking stability, economic pressures, other societal ills, and changing cultural norms.

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

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

Goals of This Report

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

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

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

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

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

Preliminary Research Findings on Child Deaths Due to Abuse

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

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

- **26 of the 32 children killed (81%) were newborn through five years old.**
  - The Board continues to recommend that reports of abuse involving young children be prioritized. See Section III (page 35) for details.

- **14 of the 32 children killed (44%) were not known to the system before their death.** Either their abuse was not identified, or it was identified but not reported.
  - The Board recommends that proven prevention efforts need to be implemented statewide to ensure fewer children suffer abuse. The Board continues to recommend that the system work toward educating the public on how those involved can identify abuse, the public's duty to report abuse and who to contact if abuse is suspected. See Section I (page 15) for details.

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

- **3 of the 32 children killed (9%) were state wards at the time of their death.**
  - The Board continues to recommend that there be greater oversight and monitoring of placements, and that foster parents be given greater accessibility to support services and training.
  - The Board's recommendations to improve system response, improve oversight, and assure appropriateness of placements and services for children placed out of the home are interwoven throughout this report.
  - See Section IV (page 39) for details on the effects of separation on children and their behaviors, Section V (page 43) for case management issues, Section VI (page 46) for issues with contracts, Section VII (page 50) for placement issues, Section VIII (page 62) for issues regarding restraints, and Section IX (page 65) for other persistent child welfare concerns.

For each of the tragic deaths summarized above there were countless other children who did not die but needlessly suffered broken bones, burns, welts, bruises, torture, or sexual exploitation, or whose basic survival needs were ignored – either because the adults around them did nothing to intervene or because the system failed to protect them. Sadly, some children and youth currently in the foster care system were not spared this level of abuse prior to their removal from the home.

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

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

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

Public officials responded aggressively to the unarguable need to improve the child abuse investigation system. Examples as of Sept. 2003, include:

- In Sept. 2003, **Governor Mike Johanns formed a panel of experts to consider the Board's recommendations, and asked the Board's Executive Director to be a member**. The Governor gave the panel approximately 60 days to develop its recommendations.

- **Attorney General Jon Bruning joined the Governor in speaking publicly on the issue.** He has also reviewed cases to strengthen prosecution and agreed to focus resources to improve prosecutions statewide.

- **Senator Bromm and Senator Wehrbein** indicated their determination to make system improvements when speaking to the press and the public.

- **Many other senators have come forward to build on Senator Aguilar's 2003 legislative resolution to study Nebraska's response to child abuse reports** and to offer the Board their willingness to look at these difficult issues.

- **Many judges, county attorneys, and guardians ad Litem (children's attorneys) have come forward** to work together to improve the system.

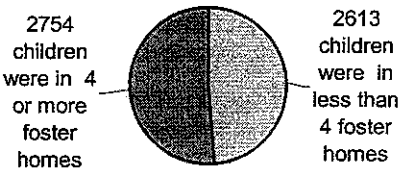
- **The HHS Director and members of HHS management have sought increased communication with the Board, and there is a new urgency to changing practice.**

The Foster Care System Works for About Half of the Children Who Have Been Removed From the Home

The Foster Care Review Board completed 6,378 comprehensive reviews on the cases of 4,242 children during 2002[3], and worked within the child welfare system to achieve progress in a number of vital areas.

After analyzing the child welfare system, the Board finds that the system currently works for about half of all children in out-of-home care. The chart to the right illustrates one of the measures used to make this finding. Additional measures are found throughout this commentary.

Children in Out-of-Home Care 12-31-2002



The Board finds it reasonable to believe that many more children in out-of-home care can realize positive outcomes if the following measures would be consistently implemented. It is important to understand that when these measures are not in place, needless and avoidable tragedies can and do result.

Reasons Children Enter Out-of-Home Care

The summary table that follows shows why children reviewed during 2002 were removed from their home of origin. During the reviews up to six reasons for entering out-of-home care may be identified for each child. These reasons may be from one or more categories. Table 5 contains a more comprehensive list with details.

% Children Reviewed	Condition	Important Facts
48%	Neglect[4]	Neglect has serious consequences. Nationally, almost as many children die each year from neglect as from physical abuse.[5]
14%	Inability to cope with children's behaviors	Many behaviors stem from unrecognized abuse or neglect.

chart continued on next page...

[3] Children are typically reviewed when they have been in out-of-home care for six months and every six months thereafter until either returned home or placed in another permanent living situation. Therefore, many children may receive two reviews during a calendar year.
[4] If a child has not been provided for physically, medically, and/or emotionally, it is considered neglect.
[5] National Clearinghouse on Child Abuse and Neglect, www.calib.com/nccanch/, July 2003.

% Children Reviewed	Condition	Important Facts
18%	Parental Substance Abuse	12% of the reviewed children had parental substance abuse recognized as an initial reason for entering care, with another 6% having parental substance abuse issues disclosed after the child's removal from the home. In recent years, the methamphetamine epidemic has substantially increased the number of children in out-of-home care who come from families highly resistant to change.
10%	Physical Abuse	
10%	Sexual abuse	Sexual abuse is often not disclosed until after the children are in care. 4% of reviewed children had sexual abuse recognized as an initial reason for entering care, with another 6% disclosing sexual abuse after entering care.
6%	Inability to cope with children's physical or emotional needs	
3%	Emotional abuse	

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

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

Every Child Abuse or Neglect Victim Bears the Effects – The Question is: How Deep And Debilitating Are The Scars

Child development experts recognize that in spite of the best efforts of the system, children will have to deal with the impact of abuse or neglect for the rest of their lives. How deeply each of the 10,880 children who were in out-of-home care in 2002 were impacted depends on:

- Severity level
- Type of abuse or neglect
- How long the abuse occurred
- Child's age at onset of abuse or neglect

- Extent to which growth and development of the child's brain was affected[6]
- Child's other physical or mental challenges
- Child's personality and ability to cope
- Whether the child received services to address the abuse
- If the child had his or her own law-violating behaviors
- Foster placement stability and capacity to meet the child's needs (for children removed from the home).

The majority of children reviewed were negatively impacted in several of the above areas. Since each child reacts differently to abuse, but definitely is impacted, it is important that plans and services be individually structured to address the individual child's particular needs.

One particularly troublesome consequence of the combination of caseworker turnover, use of contracted services for visitation and transportation, and children experiencing frequent moves between foster placements, is that children who were already damaged by the abuse or neglect in the home of origin are further damaged by the system. Especially for very young children, being cared for by an ever-changing group of strangers is likely to further compound their trauma and impede their normal development.

As federal researchers have found:

> "The impact of abuse is far greater than its immediate, visible effects. Abuse and neglect are associated with short-and long-term consequences that may include brain damage, developmental delays, learning disorders, problems forming relationships, aggressive behavior, and depression. Survivors of child abuse and neglect may be at greater risk for problems later in life—such as low academic achievement, drug use, teen pregnancy, and criminal behavior—that affect not just the child and family, but society as a whole."[7]

The Board uses knowledge of the impact of abuse and neglect when developing recommendations for individual children's cases and when recommending ways the system can better respond to children's needs.

Separation from Parents or Caregivers Compounds the Effects of the Original Abuse or Neglect

In addition to dealing with past abuse or neglect, each of the children who were removed from the home had to cope with the confusing and deeply powerful process of separation from their parents and integration into a world of different temporary caretakers, new rules, and new persons with whom they must interact. Children removed from the home may also be torn between conflicting feelings of love and anger towards their parents.

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[6] Stress hormones such as cortisol can impair brain growth and synapse development.
[7] U. S. Health & Human Services, Administration for Children & Families, www.acf.dhhs.gov, Aug. 2003.

This process is especially difficult for children who are very young, who have developmental disabilities, or who have with attachment or behavioral disorders.

Children may also be separated from foster caregivers several times as they are moved between placements.[8] This separation can be equally difficult for the children.

More than half of the children in out-of-home care at the end of 2002 (2,754 of 5,367 children) had been moved to four or more different foster placements. Every move recreates the original trauma of being separated from family. Based on child development studies, it is reasonable to expect that this level of instability negatively impacted each of these children.

The Board recognizes the effects of separations on the bonding and attachment needs of the children and uses this information to advocate for the reduction of the number of moves that children experience.

During their childhood, all children need a strong, consistent relationship with at least one nurturing adult in order to develop properly. More detailed information on this need of all children can be found in the section on grief and attachments. It is to protect the attachments of children that "permanency planning" was developed.

[8]A placement may be a foster family home, a kinship/relative's home, a group home, an emergency shelter, or a specialized facility. It may also include "home" if the child has been in care more than once.

Local Board Findings On Key Child Welfare Indicators

Individuals involved in Nebraska's child welfare system worked hard trying to meet the needs of the 10,880 children who entered out-of-home care during 2002. However, as the following chart shows, considerable work remains to be done if safe, appropriate placements, appropriate plans, and access to needed services are to become the norm for all children.

System Working for the Children	Work to Be Done to Improve System
Complete, Written Plans 66.5% (2,821 of 4,242) of children reviewed had a complete permanency plan as required by Nebraska statutes. Note: this is an 8.2% improvement over 2001.	Incomplete or No Current Written Plans 33.5% (1,421 of 4,242) of children reviewed did not have a complete plan as required by Nebraska statutes.
Less Than 2 Years in Care 51.3% (2,028 of 4,242) of children reviewed had been in care for less than two years at the time of their last review.	Over 2 Years in Care 48.7% (2,064 of 4,242) of children reviewed had been in care for more than 2 years at the time of their last review.
No Prior Removals from the Home 58.4% (3,110 of 5,321) of those entering care during 2002 had been placed in out-of-home care only one time and had not suffered a premature reunification.	Previous Removals from the Home 41.6% (2,211 of 5,321) of children entering care had been placed in out-of-home care at least once before. Note: The effect of an HHS interpretation of the reasonable efforts clause (when it became standard practice to pursue reunification in all cases) can be seen in the following comparison statistics. • 2.1% of children entering care in 1989 had been in care previously • 13.9% of children entering care in 1992 had been in care previously.
Stable Placements 36.0% (1,934 of 5,367) of children in out-of-home care at the end of 2002 had experienced one or two placements.	Multiple Placements (moves) 64.0% (3,433 of 5,367) of children in out-of-home care at the end of 2002 had experienced five or more placement moves.

Most Frequently Cited Barriers to Permanency

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

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

However, this type of permanency is not always the case. At each review, local Board members can identify up to ten barriers that remain to the achievement of safe, permanent homes for the children.[9] The chart below summarizes major barriers.

3 Most Frequently Identified Parental Barriers to Permanency

- Parental unwillingness or inability to safely parent their children
  37.1% (1,577 of 4,242 children reviewed)
- Past histories of abuse, neglect and violence
  23.8% (1,010 of 4,242 children reviewed)
- Parental substance abuse
  21.6% (915 of 4,242 children reviewed)

3 Most Frequently Identified System Barriers to Permanency

- Lack of current, written plans for the child's future
  14.7% (623 of 4,242 children reviewed)
- Length of time in care, with reduced likelihood of successful permanency
  14.5% (616 of 4,242 children reviewed)
- Lack of documentation of case progress
  9.3% (393 of 4,242 reviewed)

Each Issue Affects Many Parts of the System

It is important to recognize that the problems described throughout this report do not occur in isolation. Each issue affects many other parts of the child welfare system. Many changes need to occur to move the system from a crisis mode to one that can offer the best possible future for abused and neglected children. The following sections detail the identified obstacles to children having their needs met or achieving permanency, and give the Board's recommendations for removing such obstacles.

[9] See Table4 for more information on identified barriers to permanency.

The System Can Help Children When It Functions Well

The following examples illustrate the positive things that can happen for children when the system works well. Again, the Board commends the parties that make this happen. The first case shows a recent positive reunification.

> "*Simone*"[10] and "*Tessa*" entered care due to their mother's mental health issues (she had become seriously delusional and dangerous) and their father's failure to protect them. Their father had completed all of the goals of the case plan. He had secured a house for them to live in, had a regular job, and completed therapy. Yet, because of language and cultural issues, he was not calling the case manager and asking for increased visits or for the children to return home. As a result, the case manager was not facilitating this for the children. The Foster Care Review Board intervened, and the children have since been able to successfully return home.

The second case illustrates a recently completed adoption.

> "*Cathy*" was a baby abandoned at birth. Due to the diligent efforts of the county attorney's office, parental rights were terminated less than seven months later. The couple that had been providing "*Cathy's*" care from birth adopted her. The adoption was finalized before "*Cathy*" was 10 months old.

The two examples above illustrate how the child welfare system can facilitate children attaining stability and reaching permanency. In these cases there were clear, well written case plans, active case management, good communication between parties, and timely decision making with a focus on permanency. Yet, in spite of the good work being done by many professionals in the system, there are a number of issues that often obstruct these kinds of successes.

[10] Throughout this commentary children's names that appear in quotes in case summaries were modified to preserve confidentiality.

Commendable Efforts

Improvements need to take place in every element of the system in order for it to protect and benefit every child entrusted to its care, yet there are some positive efforts being made that deserve special notice, as shown below:

1. **Governor Mike Johanns** is commended for publicly examining the problems in the investigation system, for prioritizing the needs of abused and neglected children and educating the public on those needs, and for minimizing budget cuts to the child welfare system in the last legislative session.
2. **The Nebraska Legislature** is commended for coming forward to work on the issues regarding investigations and on-going cases, and for striving to ensure that front line caseworker positions were not cut when making difficult budget decisions.
3. **The Department of Health and Human Services** is commended for expressing an openness to identify problems and move towards solutions. HHS is also commended for increasing the number of cases with written plans, for involving the Board in its quality assurance, and for responding to concerns expressed in the Federal Child and Family Services Audit.
4. **Attorney General Jon Bruning** is commended for prioritizing prosecution of child abuse cases and seeking stiffer penalties for those who kill and maim children.
5. **The Judiciary, especially in Douglas and Lancaster Counties,** is commended for providing additional information that helped assure children that had not been reported by HHS were not lost in the system, in fact these children were tracked and able to receive timely reviews, and the judiciary is thanked for helping the Board develop procedures that increased effective communication with the courts.
6. **The Nebraska Foster and Adoptive Parents Association** (NFAPA) is commended for its mentoring and educational programs, and for distributing information through an excellent newsletter.
7. **Foster Parents and Placements** are commended for showing their concern and dedication by providing children the nurturing attention needed to overcome the children's past traumas.

The Board strongly believes that **the work of the above individuals and groups can be built upon to assist the system to better serve all children,** especially children ages newborn through five who are recognized by researchers as being extremely vulnerable to abuse and neglect.

The Board encourages all those in the system to recognize that sustained nurturing relationships are vital if young children are to develop normally, a finding confirmed by leading researchers on child development. Applying this principle is particularly important when determining where young children will be placed, whether they should be moved, and what the plan will be for their future.

Section I – Child Abuse Prevention Efforts

Child Abuse and Neglect Affects Too Many Nebraska Children

All responsible Nebraskans should be concerned that **each day an average of 15 Nebraska children and youth are removed from their home of origin, primarily due to abuse or neglect** (5,321 children were removed in 2002). **On any day of 2002, there were between 5,300 and 5,700 Nebraska children in out-of-home care.**[11]

Unfortunately, these 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;
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. (There were about 10,880 Nebraska children in this category during calendar year 2002).

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.

Additional Child Abuse Prevention Efforts Needed

Concern/Rationale for Recommendations: During 2002, 10,880 individual Nebraska children were in out-of-home care for some or all of the year. Clearly, too many Nebraska children have suffered child abuse, child neglect and/or child sexual abuse; efforts must be made to prevent as many instances of abuse as possible.

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:

- Early intervention,
- Intensive services over a sustained period,

[11] All statistics are from the Foster Care Review Board independent tracking system unless otherwise noted.

- Development of a therapeutic relationship between the visitor and parent,
- Careful observation of the home situation,
- Focus on parenting skills,
- Child-centered services focusing on the needs of the child,
- Provision of concrete services such as health care or housing,
- Inclusion of fathers in services, and
- Ongoing review of family needs to determine frequency and intensity of services.[12]

Nebraska needs to build on the positive experiences of other regions. For example, the William Penn Foundation funded 14 child abuse prevention demonstration programs in Philadelphia in the 1990's and sponsored one of the most comprehensive evaluations of parent education services. The National Committee for the Prevention of Child Abuse evaluated the outcomes. They found that parents' potential for physical child abuse decreased significantly, with those at highest risk on the pre-test showing the greatest improvements. Similar gains were found in providing adequate supervision of children, and responding to children's emotional needs.[13]

In Hawaii, the rate of substantiated cases of child maltreatment for families receiving program services was found to be less than half that of the control group (3.3% vs. 6.8%). Healthy Families Maryland had only two indicated reports of child maltreatment among 254 families served in 4 years of program operation (a rate of 0.8%).[14]

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%"[15]

Based on the research of the CDC and the experience of other states, it is reasonable to conclude that if Nebraska consistently used proven prevention services, the incidence of child maltreatment should decrease – saving the children involved from harm and freeing resources for families more resistant to change. The CDC study looked at cost savings and found "In the study subsample of low-income mothers, the analysis showed a net benefit of $350 per family."[16]

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

Recommendations:

1. Legislate a mandatory in-hospital risk assessment at birth by hospital social worker staff, offering parents information on bonding and attachment, and at least three follow up visits to the home, longer if risk is identified or parents request services. Utilize public service agencies and volunteer organizations to provide in home safety checks and to provide printed materials for handouts at doctor's offices, Social Service offices, WIC offices, and other child related offices.
2. Conduct intensive home visitation for high-risk populations (birth-2) and universal visitation with focus on school readiness (birth-5).[17]
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[18] 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 to promote this project.
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.

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

[18] Kids Connection is a program that during 2001 provided free 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).

Section II-Response to Reports Alleging Child Abuse or Neglect

Decisions on Whether, When, and How to Investigate Child Abuse Reports Can Be the Difference Between Life and Death

For years the Foster Care Review Board has raised concerns about Nebraska's Child Protective Services system. Through the research on children's deaths and the Board's research on cases, the Board has identified the following concerns:

1. Most law enforcement officers, the first wave of child protection in Nebraska, have little or no training on how to evaluate a child's immediate risk for harm; rather they are trained to investigate crimes. This system exists even though very few criminal charges are filed even when children have suffered extreme abuse;
2. CPS[19] no longer investigates, but "assesses safety," often without interviewing either the perpetrator or the child.
3. The problems within CPS are so entrenched that responsibility for child abuse investigations and risk assessments needs to be moved to a single state investigative entity.
4. Some of serious breakdowns within CPS include:
   a. CPS lacks the supervision needed to assure abuse and neglect reports are answered, recorded, and appropriately communicated;
   b. Many abuse and neglect reports are not correctly prioritized, given scrutiny, or investigated, including:
      - Calls regarding children age birth to five (the majority of deaths from abuse occur to children in this age group);
      - Calls of serious abuse from relatives or ex-spouses, which are often dismissed as "custody issues";
      - Calls from medical, educational, and other professionals, even when the risk described is severe;
      - Calls describing multiple risk factors—such as children under five, domestic violence, drug/alcohol abuse, and an unrelated male in the household; and,
      - Calls involving known risk factors, such as drug/alcohol abuse, domestic violence, and isolation;
   c. Serious understaffing has over burdened workers, which in turn effects system response, especially during evening, night, weekend, and holiday hours;
   d. There is a often lack of communication between the parties and within CPS;
   e. The CPS computer system used to track incoming reports of abuse is unwieldy; and,
   f. CPS and law enforcement often do not ensure timely action on all reports.

[19] Child Protective Services, CPS, is a division of the Department of Health and Human Services.

Children can suffer maltreatment, physical injuries, sexual abuse, permanent physical damage, or death, because the system failed to respond appropriately. The Board has reviewed far too many cases where multiple deficiencies have handicapped the system's ability to keep children safe.

The problems listed above are at the gateway to the system. Another problem, discussed later in this document, is that prosecution expertise varies widely across the state. This affects whether or not children's cases become "on-going" and whether the issues that brought the family to the attention of authorities can be addressed.

The child welfare system is like a chain – if one of the links does not work for whatever reason, then children are at substantial risk.

In order to assure child safety when there are allegations of parental abuse or neglect, several conditions must simultaneously be in place:

1. Professionals and the public must be able to identify possible child abuse, and they must be willing to report allegations of abuse and neglect, believing that the system will respond to the urgency of their observations.
2. The person/agency that receives the call must be willing and able to correctly assess the information provided to determine the level of risk and instigate an appropriate response.
3. Investigations that include a risk assessment need to take place as soon as possible based on the allegations presented.
4. Based on a complete investigation, children must either be removed from the home and placed into a safe environment, or, if conditions warrant, left in the home with sufficient supports, safeguards, and monitoring.

In practice these conditions are not consistently met, resulting in unnecessary harm and even some child deaths. The Board bases this conclusion on the 6,378 reviews the Board conducted during 2002, and additional research that the Board conducted in 2003 after a number of tragic child deaths and injuries due to system failures.[20]

The 2002 Federal Child and Family Services Audit came to the same conclusion as did the Board when it found that HHS "*did not respond to reports of child maltreatment in a timely manner*," and when child maltreatment was found to exist that there were "*delays in response to both low risk and high-risk maltreatment reports*."[21]

[20] See page 1 for additional details on this research.
[21] Final Report, Nebraska Child and Family Services Review, U.S. Dept. of Health and Human Services.

Too many reports have been put on the backburner, too many laws have been passed but not implemented, and too many regulations have gone unheeded. It is time to take action on behalf of our most vulnerable population segment. It is time to protect our children.

Breakdowns When Receiving Child Abuse and Neglect Reports

Concern/Rationale for Recommendations: CPS and law enforcement are not appropriately assessing and responding to all calls. It is essential – and nothing less should be acceptable – that CPS be more attentive to, and ensure timely action on, all reports.

Particularly close scrutiny must be given to reports regarding very young children, newborn to age five, who are at the greatest risk of injury/death from abuse. The majority of children killed by violent acts from 1997 – Aug. 2003 (26 of the 32 children or 81%) were in this age group. This sad statistic does not include the unknown numbers of children who were seriously injured or had their health and well-being jeopardized as a result of holes in the safety net.

CPS Issues

The Board has identified the following major CPS barriers to effectively receiving, and responding to, reports alleging abuse or neglect.

Concern: Response is often not timely or does not occur. The Board is aware of children with child abuse reports that are a year old and are still pending. The 2002 Federal Child and Family Services Review also found a lack of timeliness of investigations is a problem in Nebraska.

Recommendation:

1. The Board recommends that the state begin a program to put the responsibility for investigation and prosecution of child abuse under the auspice of the County Attorney in larger counties, or the Attorney General's office in non-metropolitan areas. This person would be the director of an Investigation and Prosecution Center, where specially trained and selected CPS and law enforcement officers would be housed.

   All calls related to child abuse would be received and dispatched from these centers. If a law enforcement agency or local HHS office was contacted in regard to an abuse allegation, they would immediately forward the caller to the appropriate center. This would facilitate 24/7 joint response to child abuse, increase supervision and oversight of decisions that impact children's safety, and provide stronger petitions due to better evidence collection and documentation.

The centers would be responsible for forwarding to HHS any calls related to access to HHS services.

The Board recommends that the program start in Omaha, Lincoln, and North Platte due to population, and due to the number of children killed.

- 15 of the 32 children killed were from Omaha.
- 5 of the 32 children killed were from Lincoln.
- 2 of the 32 children killed were from North Platte.

After the pilot projects had been successfully implemented, then regional offices would be established across the state.

2. Due to the amount of legislative changes and time that will be necessary to implement recommendation 1, in the interim hire more Child Protective Service workers and supervisors to handle the intake and investigations of abuse reports, to assess safety and risk, and to care for any additional children who must be removed from the home.

Concern: CPS has a long-standing philosophy that places more value on reducing the number of child abuse reports that receive response than on child safety. The role of HHS in responding to abuse/neglect reports is not clearly defined at all levels.

Recommendation:

1. Continue and intensify efforts within HHS to create an agency-wide philosophy where child safety is the first priority, and where the norm is to use all diligence and speed to protect children.
2. Implement the Investigation and Prosecution Centers previously described.

Concern: Workers assigned to receive child abuse reports do not consistently accept and/or prioritize the reports. When this happens no investigation takes place and children remain at risk. This includes both high-priority and lower-priority reports made by professionals such as law enforcement, physicians, medical institutions, nurses, school employees, social workers, home visitation staff, guardians ad litem, CASA's, Foster Care Review Board staff, and other involved professionals. Some children in high-risk situations remain at high risk until a "low-priority" investigation can be conducted. The vulnerability of young children and domestic violence in the home is also not always appropriately considered when assessing children's risk.

The following true case examples illustrate that there can be severe consequences to inaction:

A four-year-old child's therapist had recommended immediate removal from the home of the child and his siblings. No action was taken on this recommendation and within a few days the child died.

A three-year-old child died from blunt trauma. At the time of her death, she had many different wounds in various stages of healing. Numerous relatives had called CPS that the child was unsafe, and law enforcement had been called on numerous occasions due to domestic violence. The child was never removed from the home.

Recommendations:

1. Implement the Investigation and Prosecution Centers previously described.
2. Recognize that children from birth to five years old are the most vulnerable to abuse and react accordingly.
3. Prioritize reports made by professionals.
4. Provide additional training and oversight so that all known risk factors are considered when responding to reports.

Concern: Some reports are not properly tied to the family; therefore, the reports are not available to provide a family history or to show a pattern if future reports are received. As a result, events that seem isolated are not accurately seen to be part of a larger pattern of risk to the child.

Recommendations:

1. The HHS N-FOCUS system will need to be used to tie reports to families whether investigations are done through Investigation and Prosecution Centers or under the current system. Therefore, amend the N-FOCUS computer system to better facilitate tying cases to families and children.
2. Assure that full communication occurs and cross-reporting, as mandated by law, occurs.

Concern: Some reports are not shared with law enforcement, so no criminal investigation takes place. If a report is later made to law enforcement, the responding officer often will not have the full history of the reports against the family that he or she needs to determine the child's risk if left in the home. Cross reporting between agencies remains critical and should occur on a 24-hour basis.

An 18-month old child died of shaken baby syndrome. Law enforcement had been contacted, but did not have the full history of mother's drug addiction and having other children removed from her home, so they returned her to the mother. Within a few days she died.

Recommendations:

1. Implement the Investigation and Prosecution Centers previously described.
2. Create one central reporting and computer system that would allow access for CPS and law enforcement to integrate their information. The screener would complete a basic intake form of "Who – Where- When and What Happened", along with a number at the top of the page, which would state how many previous reports had been received. Both entities would be trained to understand and respond to this form and a mandatory call back to the reporter within forty-eight

hours would have to be made. Ensure that information is promptly entered into this system.

3. Until the Investigation and Prosecution Centers are operational, establish a clear, consistent, and effective communication system with other components of the system, most particularly law enforcement.

Concern: HHS-CPS does not have a policy requiring automatic review of field decisions not to investigate specific reports of abuse. [Note: As of Sept. 2003, HHS was working on ways to possibly incorporate this into daily practice.]

Recommendation:

1. Implement the Investigation and Prosecution Centers previously described, where a policy should be enacted to mandate review of decisions not to investigate or refer reports of abuse.
2. Until the centers are operational, continue recent HHS efforts to establish more effective supervision and review of caseworker decisions regarding abuse reports.
   - Add to the training and supervision available for all child welfare workers, whether they are assigned to review incoming calls of abuse, handle new cases, or handle on-going cases, to increase the support available to these workers and to better monitor performance.
   - Review all decisions not to accept a report of child abuse and neglect.
   - Re-examine the roles of front-line CPS caseworkers and supervisors. Identify and remove barriers to effective worker productivity as a part of the process when evaluating worker performance.

Concern: Even if risk is assessed, there are few appropriate service interventions available to address the risk or safety issues once they are identified. [The Board's recommendations regarding services for children are found throughout this report.]

Law Enforcement Issues

Law Enforcement also receives some calls alleging abuse. For a variety of reasons, law enforcement agencies improperly do not accept some abuse reports, thus, no investigation takes place and children remain at risk. Also, some law enforcement dispatchers have not been trained in the assessment of children's safety, prioritization of calls, or on confidentiality issues.

Recommendations:

1. Implement the Investigation and Prosecution Centers previously described.
2. Until the Centers are operational, establish a clear, consistent, and effective communication system with HHS. Work with HHS to develop experts at intake could receive the calls, prioritize the response, and assure that all relevant agencies are contacted, and provide supervision to assure this occurs.

Breakdowns With Investigations and Safety/Risk Assessments

Concern/Rationale for Recommendations: To understand the breakdowns with investigations it is necessary to understand the difference between a CPS assessment and a comprehensive investigation. A CPS safety assessment may involve only collateral contacts with reporting parties and/or law enforcement, and does not always include a face-to-face contact with the child. Safety assessments often focus solely on the child whose abuse was reported, and fail to consider the risks to the siblings.

An investigation, on the other hand, should involve a face-to-face contact with the child and any siblings or other children in the home, interviews with the alleged perpetrators, and interviews with others in the household, neighbors, and any other concerned parties. There should be a focus on current and future safety for all children, as well as developing evidence for a possible prosecution. This does not always happen in practice.

It is important to understand the distinction between the assessments and investigations because the child protection system in Nebraska has been split, with investigation of child abuse allegations done by local law enforcement agencies and safety assessments done by CPS.

Ideally, investigations should occur jointly—with CPS assessing the children's safety/risk in the home and minimizing the children's trauma if a removal from the home is necessary, and with law enforcement looking for evidence of a crime so responsible parties are held accountable. Unfortunately, this often does not occur in practice.

One of the reasons that joint investigations are not occurring is that CPS believes it is only to assess safety and not to investigate. Thus, it does not always participate in investigations with law enforcement, even when asked. The result is that investigations are often incomplete, safety/risk is not always properly analyzed, and there are some serious delays due to a lack of coordination between law enforcement and CPS.

Further, the split functions have led to confusion by all about which agency(s) should be called to report abuse, which agency should accept reports alleging abuse, and what their proper response should be.

Quality investigation relies on the availability of properly trained and experienced investigators statewide working within law enforcement, CPS, and the medical community. These professionals must work cooperatively and relate effectively with traumatized children, including those with limited language ability or limited understanding of English.

When the law changed and assigned the task of child abuse investigations to local law enforcement agencies, the agencies were not provided the training or expertise to fully assess safety/risk and were not provided training on how to conduct the investigations in a way that minimizes the trauma to the child.

Other key deficiencies the Board has identified with the current system include:

1. The first response officer may not have the specialized skills for interacting with children and for completing quality child abuse investigations. This is especially true in cases involving infants, pre-verbal children, children with speech or language deficiencies, and children who do not speak English.

2. Officers are trained to determine if a crime has already occurred, rather than ascertaining the risk of future harm.

3. Even in metropolitan areas where Juvenile Units exist, the first responders are often street officers who may have had little specialized training on child abuse/neglect investigations. Only four hours of training on child abuse investigations is offered during officer training in the Lincoln and Omaha police department training programs.

4. First response officers come from a variety of jurisdictions, including small towns and counties with a sparse population, where pay scales are often low. Therefore, it is difficult to attract officers who have received specialized training, and it can be difficult to send officers to receive this training.

5. Important information on the family that HHS may have is frequently not shared with law enforcement.

6. Due to the lack of training received by many in law enforcement:

   - Some abuse is not recognized, so the children remain at risk.
   - The way the investigation is handled can further traumatize the child.
   - Many times the investigation either does not provide the evidence necessary to successfully prosecute or provides evidence on some, but not all, of the conditions that must be regarded for children's safety (e.g., evidence on the dirty house, but not on the concurrent sexual abuse).
   - Some law enforcement officers have placed the person who made the abuse report at jeopardy by revealing their name during the investigation.

7. First responders have not received the specialized law enforcement training they need, including:

   - How to conduct a forensic interview traumatized children, including those with limited language ability or little understanding of English.
   - Normal child development patterns.
   - How to gather medical evidence.
   - How to determine whether children are at risk for future harm and whether they need immediate removal to be safe.
   - Why children at certain developmental stages (such as during toilet training) or with certain handicaps are more likely to be abused and what this means for risk assessments.

- How to consider whether the factors leading to domestic violence places the children at risk.

These breakdowns have resulted in many incomplete investigations where children have remained at risk because the officer(s) involved have not had a social worker's understanding of family dynamics, and risk factors for children in the home.

Recommendations:

1. The Board recommends that the state begin a program to put the responsibility for investigation and prosecution of child abuse under the auspice of the County Attorney in larger counties, or the Attorney General's office in non-metropolitan areas. This person would be the director of an Investigation and Prosecution Center, where specially trained and selected CPS and law enforcement officers would be housed.

   All calls related to child abuse would be received and dispatched from these centers. If a law enforcement agency or local HHS office was contacted in regard to an abuse allegation, they would immediately forward the caller to the appropriate center. This would facilitate 24/7 joint response to child abuse, increase supervision and oversight of decisions that impact children's safety, and provide stronger petitions due to better evidence collection and documentation. The centers would be responsible for forwarding to HHS any calls related to access to HHS services.

2. Provide consistent, thorough initial and continuing education on safety/risk assessments and technical aspects of investigations for all law enforcement officers (city, county, State Patrol) who conduct child abuse investigations.
3. Participate in multi-disciplinary training sessions and problem-solving meetings as a way of building expertise and enhancing communication between agencies.

In addition to increasing the abilities of law enforcement, it is absolutely essential that CPS, with its specialized training in child development, family dynamics, and risk assessments re-engage in child abuse investigations and re-prioritize child safety.

Recommendations:

1. Put CPS investigators under the Attorney General at regional Investigation and Prosecution Centers.
2. Emphasize child safety as the overriding concern in all CPS decision-making.
3. Until the Investigation and Prosecution Centers are functional, HHS CPS should re-engage in investigations.
   - Modify existing practice to ensure that mandatory face-to-face risk assessments are conducted under certain conditions, such as calls from

professionals[22] or when serious risk of maltreatment or neglect is alleged. These assessments should occur within 24 hours of receipt. HHS should provide Child Protective Service workers on a 24-hour on-call basis across the state for immediate face-to-face risk assessments to ensure children's safety.
   - Require CPS to participate in joint investigations with law enforcement so that safety/risk is assessed in a timely manner and so that investigations are as least traumatic as possible for the children.
   - Expedite response to reports of abuse and neglect involving young and disabled children and ensure that interviews of these children are completed at a child friendly location, away from the perpetrator or situation.
   - Mandate that investigations/assessments cannot be closed until all parties of the case have been interviewed or located. Extreme efforts should be made to locate individuals who have left the state or went underground.
   - Require CPS workers to spend two weeks (80) hours of training time with the local Police Department investigating and handling child abuse and neglect investigations. Build an integrated relationship that can continue after training. Encourage continued relationship building with law enforcement and Court Staff, to increase communication and understanding.
4. Hire more Child Protective Service workers and supervisors to handle the intake and investigations of abuse reports, to assess safety and risk, and to care for any additional children who must be removed from the home. It is estimated that 100 additional staff are needed for this function.
5. Identify and remove barriers to effective worker productivity as a part of the process of evaluating worker performance.
6. Fix N-FOCUS so that vital information from reports is routinely and accurately entered. Make complete, accurate reports, both on paper and on computer, the norm.

Insufficient Placements Keep Children At Risk

Concern/Rationale for Recommendations: Even if there has been an exemplary investigation, the child may remain unsafe because he/or she cannot be placed in a foster home or group home that can meet their needs due to the shortage of available placements.

Recommendations:

1. Increase the number of placements available so that "*we need foster homes*" is not used as an excuse for allowing questionable placements to remain open.
2. Prioritize retention efforts so that high-quality placements continue to serve Nebraska's children
3. Create and maintain sufficient capacity of shelter beds to accommodate all children entering out-of-home care, so that during the children's two-week or less

[22] Professionals include such professions as law enforcement, physicians, medical institutions, nurses, school employees, social workers, home visitation staff, guardians ad litem, CASA's, Foster Care Review Board staff, and other involved professionals, such as probation officers.

stay, appropriate long-term placements can be obtained. Shelters need to be age appropriate.

4. Develop more therapeutic placements for all children—especially for the increasing numbers of young children who have been traumatized and need this level of care.
5. Restrict the number of children in a placement. The Board remains concerned about the number of young children placed in situations where they compete for attention with many other children, where their needs are not met, and where they do not achieve stability.
6. Provide adequate training and support for foster parents.

Special Issues Regarding Children Placed Out of the Home

Concern/Rationale for Recommendations: If a report of abuse involves a foster home, HHS often continues to use the home of concern, either because it is unaware of the concerns [due to no reports or inaccurate listings on the N-FOCUS computer system] or because of the lack of homes available. Neither reason is acceptable. The following true case illustrates the potential for tragic consequences.

> A three-year-old child died at the hands of his foster parent. There were prior reports alleging maltreatment in the foster home. The foster parent had requested that only children six years of age and older be placed in her home, yet much younger Quincy was placed with her. HHS workers reported being concerned about the home, but "there was no other home available."

Recommendations:

1. Require full investigative background checks on ALL applicants for foster care providers, including those applying as relative placements. Without complete clearance the system should not allow payment to that provider.
2. Investigation and Prosecution Centers should investigate calls regarding potential abuse in foster placements, and should contact the HHS caseworker(s) responsible for children in that placement. In addition an online file should be established to document the number and types of reports regarding that particular home/facility. These details should be available to any caseworker considering using that placement.
3. Neither HHS nor the Investigation and Prosecution Centers, when functioning, should allow any contractor to independently conduct or participate in any investigation of a foster home. Until the Investigation Centers are functioning, require the investigation to be completed by someone other than the on-going worker.
4. Use good recruitment strategies for attracting prospective foster parents and provide quality training that would allow for more therapeutic foster homes. All training of prospective foster parents would be conducted by HHS and now through private contractors.
5. Require HHS foster placement Resource and Development to cease contracting out their department or employees.

6. Establish paternity or guarantee paternity testing at the first appearance court hearing. Require child support be ordered for both parents at the first appearance hearing. This should be a mandatory state requirement, not county by county.
7. Increase communication. Case managers should make courtesy workers in other states and other counties aware of their expectations, which would include seeing the child on a monthly basis.
8. Provide foster parents greater accessibility to support services.

Special Issues Regarding State Wards Placed in the Parental Home

Concern/Rationale for Recommendations: HHS needs to provide families the services needed to assure families have enhanced their capacity to provide for their children's needs before children are transitioned home and must continue those services as needed.

Children who have recently transitioned home need to be monitored closely by HHS, as do children who remain in the home after removal of one child.

> A 22-month old child who was placed in the parental home died of head trauma. There had been numerous calls of concern with the mother's ability to protect the child from her boyfriend. The boyfriend has been charged with the crime.

The Current Child Protection System Effects Public Response to Child Abuse

Concern/Rationale for Recommendations: The Foster Care Review Board has a number of concerns regarding public response to child abuse and neglect. First, the Board has received reports from persons who have tried unsuccessfully to access the Child Protection System with serious allegations. These persons are very frustrated with the system and feel that it is useless to continue to make reports. In the meantime, an unknown number of children remain at risk. Persons calling the hotline have reported getting answering machines rather than speaking directly to a worker.

In addition, the board has identified the following concerns:

- The public is still confused about when, how, and who to contact to report suspected child abuse or neglect; thus, it is likely that much abuse is not reported.
- There remains some public confusion over what constitutes probable maltreatment.
- When abuse reporters have not seen action taken in response to their call(s), they may not make continued reports, since it appears that no one is interested in making sure the children are safe. There is often no feedback to the reporter of what action is, or is not, being taken.

Recommendations:

1. Increase response to child abuse reports so that professionals and the public will be encouraged to report because they can be assured that proper response will follow.
2. Report suspected abuse. Nebraska law requires *anyone* who suspects child abuse to report this to authorities. Child abuse should be reported to your local law enforcement agency. It is not necessary for the child to be seriously injured before a report is made to law enforcement. Public service announcements should be implemented to reinforce this concept.
3. Develop assessment services and programs to address problems or potential problems early, before serious abuse or neglect occurs.
3. Create a statewide, 24-hour telephone number that is easy to remember to report child abuse, and have this number posted in the front of every Nebraska telephone directory. This system would be available to anyone that needs to report any type of child related abuse or problem. A statewide advertising campaign should publicize this number.
4. Educate professionals, daycare operators and youth in middle/high school on criteria that CPS looks for when assessing risk, the need to be specific, and mandatory reporting requirements.

Death Review Team Issues

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

Recommendations:

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

Drug Courts

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

Recommendations:

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

Guardians Ad Litem Role in Assuring Safety

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

Recommendations:

- Guardians ad litem should be mandated to see their children on a monthly basis or to make telephone contact with children out of state. This would require a change of statute.
- 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.

Prosecution of Child Abuse and/or Neglect and the Handling of Cases in Juvenile Courts Remains Problematic

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

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

Both types of cases are important, and there are flaws in both systems.

The Board has several concerns regarding prosecutions in juvenile and criminal courts that can be summarized as follows:

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

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

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

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

The Board acknowledges that it can be very difficult to prosecute when the primary witness is a child. Nevertheless, it is important for the safety not only of the child in question but also other children that may have contact with the perpetrator that prosecutions occur. **Sound investigations are important.**

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

> The petition against *"Mr. and Mrs. Blue"* alleged only a filthy house, but did not address the parental alcohol abuse. Therefore, the court cannot adjudicate on the parental alcohol issue or order the parents into alcohol treatment, even though that is the root cause for the filthy house and the serious neglect of their toddlers. If the parents follow the plan to keep the house clean, the court may have no choice but to return the *"Blue"* children – even though the children may remain at risk because the parents are still not maintaining sobriety.

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 capable of testifying in court if the people working with the children know how to proceed.[23]

Recommendations:

1. The Board recommends that the state begin a program to put the responsibility for investigation and prosecution of child abuse under the auspice of the County Attorney in larger counties, or the Attorney General's office in non-metropolitan areas. This person would be the director of an Investigation and Prosecution Center, where specially trained and selected CPS and law enforcement officers would be housed. These Centers would facilitate communication between prosecutors and investigators, and should facilitate the better collection of evidence needed to file successful juvenile court petitions and prosecute child abuse.
2. Mandate training in child abuse prosecutions for newly elected prosecutors. Include in this training the technical aspects of prosecution of crimes against young children and a familiarity with the various other professionals who are involved in the cases and their roles.
3. Encourage county attorneys and judges to ask more questions of the worker regarding placements that trying to be court approved. In this report the worker should give a short synopsis of the plan for the child and the appropriateness of the placement or the judge should deny the placement change.
4. Examine why judges are not using the guidelines provided them to bypass reunification efforts on cases where reunification is not required.
5. Suggest that the County Attorney's Association remind county attorneys of the critical need to file supplemental petitions when new information arises so that the courts can address *all* the important issues in children's cases.
6. Allow the Attorney General's office to provide specialist attorneys who can file juvenile court cases to provide expertise for prosecutors. The Child Protection Unit of the Attorney General's Office has provided quality consultation and case

[23] 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.

assistance for felony child abuse cases throughout the state. The unit could be expanded or a similar unit established to provide assistance with child abuse and neglect prosecutions in juvenile courts. At the minimum, three attorneys, an investigator, and support staff are needed. This staff could also provide oversight and technical assistance to the child abuse investigation teams (a.k.a. 1184 teams).

7. Introduce legislation to replace the county attorney system with a publicly elected non-partisan district attorney system (for counties outside of Lancaster and Douglas Counties) with candidates for office who meet certain professional prosecution standards (such as five years experience prosecuting felony cases).
8. Increase accountability for prosecution of child abuse and neglect whether the state chooses to create a district attorney system or elects to augments the current county-by-county prosecution system.

Child Abuse Investigation Team (LB 1184 Team) Issues

Concern/Rationale for Recommendations: Per statute, Child Abuse Investigation Teams were to be formed in each county to reduce coordination problems between law enforcement, CPS, and county attorneys. However, the Board finds that:

a. Team formation has not solved the statewide problem of determining which entity has responsibility for what aspect of child abuse investigations, nor has it solved the problem of differences between what is actually done about child abuse in day-to-day practice and what is required by statutes and/or regulations.
b. Teams in some counties have not been formed, or have been formed but have not met/do not meet, and teams in some communities are made up of administrators and do not include front-line investigators.
c. Each of the above conditions limits team effectiveness.

Recommendations:

1. Eliminate the treatment team component of the 1184 teams (child abuse investigation teams). The function of these teams was not clear in the originating legislation.
2. The Attorney General should create an effective system for regularly monitoring the effective implementation and the ongoing functioning of child abuse investigation teams (also known as LB 1184 teams) and provide technical assistance.
3. Teams may include individuals from local law enforcement, HHS, education, the medical community, and other agencies involved in providing services to families (i.e., homeless shelters, crisis centers, and the like). Therefore, it would be valuable to strengthen the teams and increase communication between the individuals and agencies involved with the children and families.

Section III– Young Children's Issues

Placement and Planning Decisions for Young Children Must Promote Stable, On-Going Nurturing Relationships

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[24]

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

Research has also shown that when young children must cope with prolonged or multiple stressors, these vital connections can fail to form properly, resulting in temporary or permanent changes in the children's ability to think, to develop positive inter-personal relationships, and to process future stressors. High levels of stress hormones occurring during the period of ages newborn through three have been found to create life-long problems with impulse control, anxiety, hyperactivity, and learning disorders.[25]

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

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

- The attainment of full intellectual potential,

[24] Brazelton, Dr. T. Berry & Greenspan, Stanley, "Our Window to the Future," Newsweek Special Issue, Fall/Winter 2000.
[25] Sources include Karr-Morse, Robin, and Wiley, Meredith S. in Ghosts From the Nursery, c. 1997.

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

As Dr. Urie Bronfenbrenner, then a psychologist at Cornell University, said many years ago in the videotaped lecture, *The American Family: Who Cares*, **all children require the same thing: "the enduring, irrational involvement of one or more adults. Someone who is crazy about the kid...a love affair that lasts a lifetime."**[26]

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

- On a normal day about 1,200 children ages five and under are in foster care in Nebraska. By any standard, this number means that a lot of preschoolers have been abused or neglected to the point of needing removal from the parental home.
- It could be expected that a child have a maximum of two placements (an emergency placement and then an on-going placement.) Every move beyond those two can be considered excessive and damaging.
- The Board commends efforts by child welfare professionals to ensure that the majority of preschool children do not experience excess moves, yet the Board remains concerned that **451(36.5%) of the 1,235 preschool children in out-of-home care on Dec. 31, 2002, had been in more than two foster homes and 241 (19.5%) had been in more than three foster homes.**
- 155 (13.7%) of the 1,132 preschool children who entered foster care during 2002 had been removed from the home at least once before.

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

> Federal researchers have found "The risk of maltreatment is highest for children under four years of age. Moreover, children with a prior history of victimization were more than three times as likely to experience recurrence compared with children without a prior history."[27]
>
> 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."[28]

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

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

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

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

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

Recommendations:

1. Provide intensive services to parents with the intent to assess their long-term willingness and ability to parent. Ensure that, rather than merely measuring "compliance," every assessment of the parents' on-going progress measures true behavioral changes.
2. Minimize placement disruptions by recruiting and working with foster care families for infants, toddlers and preschool children and identifying appropriate relative placements (e.g. aunt, grandmother) early in the child's case.
3. Provide specialized training on the importance of bonding and attachment to parents, foster parents, case managers and supervisors.
4. Work with foster parents to minimize the amount of daycare for foster children, and ensure that foster children receive adequate amounts of the foster parent's attention.
5. Develop specialized units where highly trained professionals focus on providing permanency[29] for children who have been identified as unable to return home due to parental inability or unwillingness to provide long term care. Reduce the caseloads for these specialized case managers.
6. Increase awareness amongst foster parents of the mentoring program available through the statewide foster parent association.

[29] 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.

Parental Visitation Schedules Must Not Harm the Children

Concern/Rationale for Recommendations: The Board is concerned that many young children reviewed show the negative effects of erratic or poorly planned parental visitation. In addition, the high turnover rate for case managers, case aides, and contract employees who monitor visitation and provide transportation, means that young children are expected to cope with an ever-changing group of strangers during the stressful time of reconnecting to their parents at visitation, and the traumatic time when separating from the parents at the end of the visit. During this particularly difficult time, children need stability.

Recommendations:

1. Enable case managers to monitor parental visitation for young children and to act quickly if the visitation schedule unduly stresses the children.
2. Require that visitation reports be provided to the judge.
3. Provide in-depth training or hire experts in child development to supervise visitation when mandated by the court.
4. Provide the same visitation worker for mandated supervised visits whenever possible.

Section IV– Children Grieve Upon Each Separation from Parents or Trusted Caregivers/Foster Parents

Professionals Must Recognize the Effects of Separating Children from Parents or Trusted Care Givers/Foster Parents

Concern/Rationale for Recommendations: The Board finds that some professionals in the child welfare system, including some case managers, guardians ad litem, foster parents, and group home staff, do not understand that it is normal for children to grieve for lost attachments to parents and/or foster parents, nor are these professionals able to recognize common grief symptoms or the serious consequences that can occur if children are moved. This knowledge is absolutely essential if children's best interests are to be met.

A marriage counselor once wisely noted, "*Whatever you grew up with is your normal.*" For foster children, "normal" is neglect, parental alcohol/drug abuse, chronic family violence, parental mental illnesses, living without sanitation, or whatever brought the family to the attention of authorities. So, although a removal from the home may be necessary to keep children safe, child welfare professionals cannot afford to forget that by doing so, the system is taking the children away from everything they view as "normal." This is a loss that must be grieved if healing is ever to begin.

It is important for child welfare professionals to recognize that grief over removal from parents or trusted foster parents is as traumatic to children as if the parent or caretaker had suddenly died.

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

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

Children of any age who are removed from a foster parent to whom they have attached will grieve the loss of the foster parents. They may also simultaneously need to revisit the grief over the separation from their parents or they could have more intense reactions to reminders of that grief. Good transition plans can certainly help children better cope with the loss, but the need to grieve will remain.

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

- Regressive behaviors (e.g., return to baby talk, lapse of toilet training, bed-wetting)
- Distracted easily, thinking disorganized, memory lapses, learning difficulties
- Problems with judgment and cause/effect, increased mischievous behavior
- General anxiety, separation anxiety, alarm, panic, fears
- Food issues, including hoarding food or refusing to eat
- Abnormal displays of anger to normal situations
- Sadness, depression, despair, self-esteem problems, feeling they've been "thrown away," yearning and pining for the lost caregiver
- Physical symptoms such as sleep disturbances, rapid or irregular heart rates, and lower resistance to infection
- Blaming others or themselves for the situation
- Denial of events
- Avoidance of future relationships.[30]

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 actions.

Many children experience a recurrence of grief as they enter new developmental stages, and this must be taken into consideration as well.

Recommendations:

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

Necessary Transitions Should Be Done In Way That Helps Children to Cope With the Life-Changing Events

Concern/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.

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

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

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

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

Helping Children in Transition

By Nancy Thompson, M.S.W., L.M.H.P.

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

- Encourage repetition of previous patterns for personal care, such as bedtimes with rituals, food preferences, types and times of bathing (shower or bath). Caretakers should note this information so it can be passed on.

- If possible, take Polaroid® or instant pictures of the previous family, the house, and the pets; otherwise, see if copies of photos can be obtained for the child to keep.

- Whenever possible, encourage transitions that include a visit at the present home, a visit at a neutral place (park, restaurant, etc.) and an overnight or daylong visits with discussions about the habits of the new household.

- Older children should take active part in packing and unpacking their own belongings and putting them away.

- Provide a duffel bag or other luggage for transporting the child's personal belongings. Do not use a plastic bag, garbage bag, or cardboard box.

- Whenever possible, arrange periodic contact by phone, visit, or mail with the previous caretakers. This becomes more important if the child is moving after a long period of time.

- Encourage new caretakers to exchange food information, and even recipes for favorite dishes, and prepare them early in the transition process and again when requested by the child.

- ▷ At the first visit before transition encourage new caretakers to give the child a token gift that goes with the child back to their current placement. The child can bring this gift with them at the next visit or upon permanent relocation.

- ▷ New caretakers should provide a secure place for the child's belongings and allow the child to adjust to the new placement before expecting sharing with other children in the home.

- ▷ Children under stress often show regressive behaviors. They need patience and kindness as they struggle to regain their normal developmental level. Tolerating whining, crying, and withdrawal along with thumb-sucking etc., will help the process move along and tolerance will be more effectual than consequences or criticism. Most children will regain their former skills within a few days or weeks.

Recommendations:

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

Section V– Case Management Issues

Lower Case Worker Turnover Rates Are Needed In Order To Create Case Continuity for Children

Concern/Rationale for Recommendations: The Board is concerned that it was more common for children being reviewed to have had several different HHS case managers while in care, than to have had stability. **During 2002, 2,386 (56.2%) of the total 4,242 children reviewed had 4 or more different case managers while in out-of-home care. For children age newborn through five, 560 (55.1%) of the 1,1016 reviewed during 2002 had 4 or more different case managers** while in out-of-home care.

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

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

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

> *"Crissy"* who is 18 months old, entered care at birth after testing positive for cocaine. The mother has never participated in services, and has had a total of eight visits with *"Crissy"* during the 18 months of her life. *"Crissy's"* case has had 6 changes of caseworkers, including two periods with no caseworker assigned. Although NDHHS is supposed to notify the county attorney of cases where children have been in care for 15 of the past 22 months, this has not yet occurred, and is several months overdue. It is unclear if the various caseworkers have created sufficient documentation for the county attorney to file a termination of parental rights petition. In the meantime, *"Crissy"* is growing up without a permanent home and stability.

Recommendations:

1. Make caseloads equitable.
2. Increase levels of support and supervision for case managers.

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

Case Managers Need to Maintain Contact With the Children

Concern/Rationale for Recommendations: The Board is concerned that some case managers have not had timely face-to-face contact with the children, as shown below:

- 612 (14.4%) of the 4,242 children reviewed during 2002 had no documentation regarding case manager/child contacts and thus likely did not have any contact.
- 96 (2.3%) of the 4,242 children reviewed during 2002 had documentation showing that no contact had taken place.
- 3,534 (83.3%) of the 4,242 children reviewed in 2002 had documented case manager contact within 60 days prior to the review.

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."[31]

The Board notes the number of children who had documented case manager contact *significantly increased* in 2002– up from 68.5% in 2001 to 83.3% in 2002. The Board attributes this positive increase to HHS Director, Ron Ross' directive that all caseworkers are to see the children on a monthly basis, and to federal findings that echoed the Board's concerns.

While this is positive news, it is still a concern that 612 children presumably had no contact since none was documented and that another 96 had documentation that no contact occurred.

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.

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

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.

Recommendations:

1. Reduce caseloads and encourage case managers to maintain and document their contacts with the children.
2. Eliminate barriers that keep case managers from seeing the children on their caseload.
3. Use visits by the children's guardians ad litem, CASA workers, and/or Foster Care Review Boards as an opportunity to assure safety.

Section VI – Contract Issues

Contracted Services Need More Clearly Defined Lines of Authority and Communication

Concerns/Rationale For Recommendations: The Board is concerned that core case management duties have been contracted out to the private sector, especially visitation monitoring, transportation, and agency-based placements. About 1,025 (21%) of HHS wards are in agency-based placements. Contractors also provide visitation monitoring and transportation services for children in traditional and agency-based placements. Contractors also may provide therapy services.

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

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

- 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.
- In some cases, contracted staff have the only contact with the children, yet have few contacts with the case managers, and case managers often discount their observations. Contractors have reported having difficulty getting phone calls returned, which appears to be endemic.
- The cost of contracting with for-profit organizations limits the funds available to provide permanent case management for the children's cases.
- Children's cases do not achieve stability in a timely manner.

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

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

5. Until the situation is resolved, children often remain at risk.

Recommendations Regarding All Contracted Services:

1. Review the cost-effectiveness, efficiency, and wisdom of contracting for essential case manager duties. Eliminate the use of private contracts for case management and increase the number of case managers. Define a reasonable caseload for HHS caseworkers.
2. Until contracts can be eliminated:
    a. Oversight must be increased. Recommit to aggressively monitoring the services and placements that are currently contracted to private agencies.
    b. Implement immediate, proportional consequences for agencies that fail to meet strict guidelines regarding children's safety.
    c. 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 for any incidents/complaints.
    d. Clarify all existing service provider contracts to include clear expectations regarding performance, lines of authority, and communication. Look at how communication now takes place between the case manager, the agency, and the agency-based provider. Examine communication breakdowns, and monitor performance.
    e. Review communication protocols and procedures for use when a child is injured in an agency-based service.
    f. Withhold pay from service providers until their reports are provided to the case managers.
3. 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 complete including the supervision of private contractors.

The following is a brief overview of concerns with specific types of contracted services and the Board's recommendations for improvement.

Agency-Based Contracts for Placements

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

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

A. Case managers for some reviewed children could not identify where the children were placed—only that the children were in the custody of a particular contract provider. Some case managers did not know which other children were placed in the same home or how the other children's needs and behaviors could impact the child being reviewed. Without all this information safety cannot be assessed.
B. Serious abuse (severe burns, broken bones, concussions) has occurred in some agency-based placements as a result of a lack of supervision and misuse of restraints. (See the separate section on restraints in this commentary).
C. Even after a clear pattern of abuse or neglect has been detected in certain agency-based placements, agencies have continued to place the child and/or other children in the questionable placement without resolving the placement problems.
D. Many agencies fail to develop child-specific placements geared to meeting the physical, emotional, or behavioral needs of an individual child. Some children in out-of-home care have experienced several placement moves while in agency-based care without the knowledge or consent of the case manager, guardian ad litem, or Court. Again, the abdication of control is significant, and any progress is too often reversed.
E. In many reviewed cases, case managers did not have a copy of the agency-based foster home's home study—important background information needed for assessing appropriateness. In other cases, the agency's home studies have been seriously outdated (e.g., over 20 years old). Often, case managers have not reviewed the home studies.
[*Editor's note: in 2002 new contracts were issued with a clause requiring contractors to provide HHS with a copy of the home studies; however, as of late 2002 there were still some agencies that were not providing home studies.*]
F. In some cases, case managers have never met the agency-based foster family.
G. Procedures for licensing have been problematic. HHS has granted some licenses for agency-based foster homes without a review of the home study.
H. 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.
I. 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 Regarding Contracts for Placements:

[Note: All the oversight recommendations from the previous "all contracts" section above also applies].

1. Increase oversight of private agencies' decisions concerning the placement and services for children.
2. Provide a method of evaluating the effectiveness of agency-based placements.
3. 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. Assure home studies completed by another entity are provided to HHS in a timely manner and included in the child's permanent file.
4. 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.

Visitation and Transportation Contracts

Concern/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.

It is very important that the persons delivering this service understand the emotional trauma that children experience where visits do not occur as planned or are disrupted, and that the service providers understand how children of different development stages may express this trauma. It is also important that these incidents be appropriately reported to the children's foster placement so the placements can correctly interpret children's behaviors and can help children deal with situations regarding visitation. Often this does not happen.

Recommendations Regarding Visitation or Transportation Contracts:

[Note: All the oversight recommendations from the previous "all contracts" section above also applies].

1. Hire permanent case aides to complete visitation.
2. Provide case aides extensive instruction on how to correctly interpret parental actions, how to interpret the children's reactions at visitation, and how to help children deal with the trauma of moves to new facilities/homes.

Section VII – Placement Issues

Additional Placements Need to be Developed, Especially Specialized Placements

Concern/Rationale for Recommendations: The Board is concerned 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.

The Board is also concerned that the mixture of children in shelters 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.

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.

Compounding the situation:

- Many children already in the system are denied services at the level of care needed due to financial reasons, denials of care by private contractors, and/or due to placement and service deficits.
- 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.

  [*Editors note: During 2002, Group Home II's were eliminated. A new level of care- Enhanced Treatment Group Homes - was developed. The Board will monitor these placements and report the outcomes.*]
- Many treatment placements have closed or accept only private-pay placements due to the number of treatment denials by ValueOptions, the private company with which the State contracted for managed mental health care services for children and youth until HHS allowed its contract to expire in 2002.

Recommendations:

1. Increase HHS' focus on placement development to meet the following special needs:
   - Therapeutic placements for violent or aggressive children;
   - Treatment placements for sexual abuse victims or children sexually acting out;
   - Placements equipped to handle disabled children;

- Therapeutic placements for emotionally disturbed or traumatized children;
- Placements that specialize in the needs of children who have committed law violations;
- Treatment placements for children with a dual-diagnosis (e.g., substance abuse and mental health issues);
- Placements able to handle the medical and emotional needs of pregnant girls and adolescents; and
- Placements for children with severe behavioral problems.

2. Diligently work to recruit and retain therapeutic foster homes, group homes, and residential care facilities, especially in the western part of the state. This goal is also in the 2001 HHS Nebraska Family Portrait Initiative.
3. Explore the possibility of using state resources, such as using the Nebraska Center on Children and Youth (NCCY) campus as a child-caring facility.
4. 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.
5. Improve consistency of licensing practices and standards to ensure safety for children in out-of-home care. This goal was also in the 2001 HHS Nebraska Family Portrait Initiative.
6. Assure that shelters are used appropriately, as short-term placements while a more permanent placement is being recruited or located.

Foster Parents Need Case Managers to Give Them Sufficient Information and Support

Concern/Rationale for Recommendations: The Board is concerned that 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, and/or
3. Sufficient respite care[32] was unavailable.

Communication with Case Managers is Vital to Foster Parent Retention

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

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

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

Foster Parents Need to Be Given Essential Background Information on the Children

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 in over one-third of the cases (1,448 of 4,242 children's cases or 34.1%) foster parents were either not given medical records or it was unable to be determined whether they received them, and in 1,525 of 4,242 cases (36.0%) foster parents were either not given education records or it was unable to be determined whether they received them.

The statistics below are on medical records for the 1,016 children age birth through five reviewed during 2002.

- 118 (11.6%) pre-school children's foster parents had *not* been given the child's medical records.
- 146 (14.4%) pre-school children's HHS file documentation did not indicate if the foster parents were given the child's medical records and the foster parents were unable to be reached at the time of review to clarify this, and
- 752 (74.0%) pre-school children's foster parents *had* been given the child's medical records,

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

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

Foster Parenting is a Specialized Job; Requests for Assistance Should be Expected

The Board has had similar findings to the 2002 federal Nebraska Children and Family Services review which found that "In cases in which foster family placement disruptions

occurred, there was no indication that the NHHSS caseworker had made efforts to prevent the disruptions."

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

Foster parents 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.

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

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

Recommendations:

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

Reunification Attempts (Placements with Parents) Must Be Well Planned So They Do Not Put Children at Risk

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

THE CYCLE OF FAILED REUNIFICATION ATTEMPTS

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

- 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.
- 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).
- Children are removed from the home and reunification occurs prematurely, before the parent(s) is ready to reassume the responsibilities of parenthood.
- Children are removed from the home and then reunified because appropriate placements cannot be found.
- Young children who were in care act out later as adolescents, and subsequently are returned to care.
- Case managers assume the standard is to attempt reunification with *all* parents, even when it can be predicted to be unsuccessful.

Failed reunification can cause serious, life-long harm to children and youth's ability to grow, develop, cope, and adapt. The Board has repeatedly expressed its concern about the practice of attempting to reunify families in which the parents show little or no interest and/or ability in parenting their children. Of special concern are chronically violent families where the children's safety is at risk.

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

Recommendations:

1. Write clear, appropriate plans with services, goals, and timeframes and carefully document parental compliance with the plan so that if parents are non-compliant, alternative permanency can be pursued. Include biological families in the planning process and provide them and their attorneys a clear explanation of what the family must accomplish to get the children returned.
2. Conduct better assessments of the families and focus reunification efforts on families who have expressed a desire to change.
3. Eliminate the practice of attempting reunification with parents who cannot or will not parent in order to eliminate failed reunifications, further abuse, and repeat episodes in out-of-home care.
4. Provide appropriate remedial services to families who are identified as willing to work on new behaviors.
5. Continue implementation and monitoring of the guidelines outlined in the federal Adoption and Safe Families Act, where child protection and best interests replace family reunification as the primary guiding policy for child welfare agencies.
6. Follow the guidelines outlined in the Adoption and Safe Families Act where reunification need not be pursued in:
    - Cases of murder or voluntary manslaughter of another child by the parent,
    - Felony assault that results in serious bodily injury to a child,
    - Abandonment,
    - Torture,
    - Chronic abuse,
    - Sexual abuse, or
    - Previous involuntary termination of parental rights of a sibling.
7. Reduce the time given parents whose children are re-removed from the home to show significant progress before consideration is given to termination of parental rights[33] and moving the case to alternate permanency. This time should be reduced to six months and the system should move to ensure services are in place to accelerate this timeframe.
8. Prevent children who have been adopted or in guardianships from having to return care in order to access services.

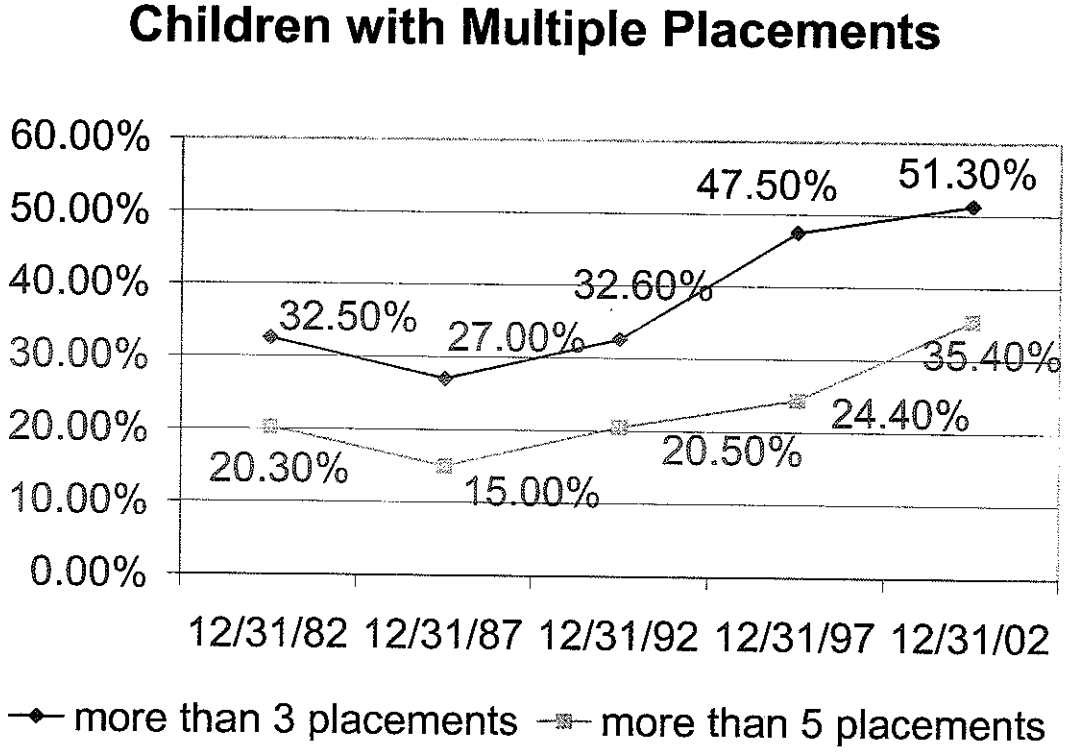
Children Need to Be Stabilized in Foster Care

Concern/Rationale for Recommendations: The Board is concerned that 51.3% (2,754 of 5,367) of the children in care on Dec. 31, 2002, had experienced four or more

[33] 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)*

placement disruptions and 1,902 (35.4%) had experienced six or more placements during their short lifetimes.

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



Children who experience a number of 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."***[34]

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

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

The damage done to children by multiple changes in caregivers can be severe and life-long. Research shows that many of the adolescents and young adults who are violent, lack empathy, or are severely mentally ill started their lives as one of these children who experienced multiple losses. Conversely, research has shown that the presence of even one positive attachment figure can be a protective factor to promote resilience in children who suffer trauma or separation[35].

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

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

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

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

Recommendations:

1. Identify relatives and non-custodial parents within the first 120 days of a child's placement so that delayed identification does not result in unnecessary moves.

[35] Susan Downs et al, Child Welfare and Family Services Policies and Practice, c. 1991, page 280.

2. Adapt the model Utah is using, in which children under age six must be placed into a prospective foster/adoptive home when they enter care to reduce children's placement disruptions should the case plan change to adoption.
3. Recruit, develop, and retain child-specific placements for young children, especially those with special physical, emotional, or behavioral needs.
4. Provide on-going specialized training to all foster parents, case managers and supervisors on the importance for children to bond and form attachments to their caregivers.
5. Implement foster parent retention steps such as:
   - Recognition that foster parents are a vital component of the system;
   - Access to round-the-clock immediate and effective support when issues arise;
   - Provision of health and educational records to foster parents upon placement or within a few hours of placement;
   - Provision of other background information, such as likely behaviors (e.g. sexual acting out, fire starting, rages) when children are placed in foster homes and facilities;
   - Continuation of work to create "professional foster parents" that is, foster parents who are provided enough in wages and benefits to be in the home providing daily care for a limited number of young children in a home setting and assure that the children can remain in this home as long as needed regardless of whether Medicaid will continue to pay for this level of care; and
   - Additional training offered on child development, bonding and attachment, and effective methods of behavior modification, with specialized training as needed.
6. Award grants or contracts with entities to provide Multidimensional Treatment Foster Care (MTFC). The objectives of a MTFC program are to provide children and youth who have serious and chronic behavioral problems with close supervision, fair and consistent limits, predictable consequences for rule breaking, a supportive relationship with at least one mentoring adult, and limited exposure and access to delinquent peers. MTFC is based on the philosophy that, for many children and youth who exhibit antisocial behavior, the most effective treatment is likely to take place in a community setting, in a family environment in which systematic control is exercised over the children's behaviors.
7. Build the capacity of out-of-home placements to match the population of children, their location, and their needs.
8. Develop a sufficient capacity of shelter beds to accommodate all children entering out-of-home care, for a stay of up to 30 days. This would ensure a thorough assessment of the child's placement needs and increase the likelihood of an appropriate ongoing placement.
9. Monitor placement providers closely and consistently.
10. Develop placements for children and youth with multiple or specialized needs.
11. Implement guidelines designating who should make placement, treatment, and service decisions for children and youth in out-of-home care and put into practice effective means to monitor and review these decisions.
12. Require relative caregivers to pass the same standards as other foster care providers to ensure that children are safe and well cared for.

13. Recognize that while the goal is to reduce the number of placements that children experience, this goal should never be met at the expense of children's safety.

Kinship Care Decisions Need to Focus on Maintaining Children's Existing Relationships with Safe, Appropriate Family Members

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

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

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

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

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

> *"Bobby,"* age 15 months had been placed with his paternal grandmother at 5 months of age and was there until 14 months old. There had never been a home study to determine suitability even though the grandmother had not done a good job of parenting the baby's father. *"Bobby's"* young father had been involved numerous times as a juvenile in the system for law breaking behaviors. There were concerns that grandmother was allowing the father contact with the baby outside of the court ordered visits, which were to be supervised. Several abuse

reports were made against the grandmother, whose house was found to be filthy. When *"Bobby"* was removed from the grandmother, it was discovered that he had never been to the doctor for well-baby checks or immunizations and was showing signs of neglect.

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

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

Recommendations:

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

Stable Foster Placements Can Produce Amazing Results

The Board has reviewed cases where stability in placements has proved extremely beneficial for the child. In the case below, one can only wonder how this girl's life would have been different if she had achieved this level of stability and grief intervention at an earlier age.

"Kylie," age 14, was diagnosed with severe reactive attachment disorder. Children with this diagnosis have difficulty forming lasting relationships and

often show a nearly complete lack of ability to be genuinely affectionate with others. They typically fail to develop a conscience and do not learn how to trust. Children with this diagnosis can be some of the most difficult to parent. In spite of these challenges, her foster parents have worked with her for over a year, and *"Kylie"* is thriving. *"Kylie"* has won awards at school for academic achievement, and she recently chose to join a school-sponsored club, where she has excelled and is developing friends.

The Board calls again for a focus on safety and stability for children in out-of-home care.

Section VIII – Restraint Issues

Policies Need to be Implemented to Reduce the Number of Restraints Used on Children and Youth

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

Concern/Rationale for Recommendations: The Board is concerned **that 191 children (4.5%) of the 4,242 children reviewed had file information indicating restraints were used on them during the six months prior to the review. This is especially concerning given that there is no requirement that a restraint against a child be documented.** It can reasonably be concluded the actual number of children being restrained was significantly higher.

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

Some of the 191 children restrained experienced more than one type of restraint, and/or restraints in more than one facility.

- 189 children were physically restrained,
- 69 children were placed in confined isolation,
- 16 children were chemically restrained, and
- 2 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 that is used only when all other forms of behavioral controls have failed and the children's or the staff's safety is in jeopardy.

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

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

Restraints convey the message that it is acceptable for those with power to use physical force to get what they want from those without power, which has alarming implications for those youth who go on to have families of their own. **In many ways excessive restraints are little different than the abusive treatment many were receiving in the parental home.**

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

Reasons for the Increased Reliance on Restraints

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. The "no eject, no reject" clause in HHS contracts has resulted in some inappropriate placements. This clause states that facilities cannot turn down a youth being placed at the facility and cannot have the child removed if the facility is not appropriate. Because this negatively affects the need levels and mixtures of youth at facilities, the use of restraints to respond to incidents has increased.
5. In some instances, lack of appropriate staffing levels and lack of staff training have led to the inappropriate use of restraints.
6. 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, which in many cases are college students not much older than the youth for whom they are providing care. Group homes also experience a high rate of turnover with staff leaving for higher paying positions before they are able to develop any expertise in dealing with troubled young people. Thus, some group home staff are unable to de-escalate a troubled child's behaviors without resorting to physical measures.

There are reasonable alternatives to restraints. Research, and the experience of group homes that rely on de-escalation techniques, proves that even with the most violent youth, de-escalation techniques often greatly reduces the need for physical restraint. Some group homes have made an effort to incorporate these de-escalation techniques into

expected staff behavior and training. In these facilities restraints are very rare. Some group homes have clear policies on how they monitor any restraints in their facilities, while others do not.

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

Recommendations:

1. Include clear expectations regarding the use of de-escalation techniques and a requirement for proof of training in prevention and de-escalation techniques in all contracts for service and placement providers. Review HHS standard contracts to address concerns regarding restraints. Develop restraint-free therapeutic care environments and programs with the intent to eliminate the use of physical restraints.
2. Develop, implement, and monitor a policy to ensure appropriate use of restraints. Develop uniform documentation of all restraints and review both internally and externally by trained professionals for safety and appropriateness. Subject every restraint incident to mandatory outside review.
3. Implement programs that address youth's behaviors.
4. Provide training to group home staff emphasizing alternatives to restraints, including comprehensive de-escalation techniques.
5. Set competitive salary guidelines and qualifications for staff dealing directly with children in group settings to attract quality staff.
6. Re-examine the "No Eject – No Reject"[36] clause in HHS contracts and re-examine the ability of placements to cope with the needs and behaviors of certain mixes of children and youth. If the facility is unable to provide for the safety or other needs of a proposed new resident due to mixture of children or youth in the placement or other factors, the facility must be able to decline.
7. Implement clearer guidelines for placement decisions, treatment decisions, and service decisions and put into practice effective means to monitor and review these decisions.
8. Implement the measures described elsewhere in this document to ensure that children's needs are met at a younger age.

[36] This clause states that facilities cannot turn down a youth being placed at the facility and cannot have the child removed if the facility is not appropriate.

Section IX – Other Persistent Child Welfare Issues

Ensure that All Child Have Appropriate, Current, Written Plans

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

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

Concern/Rationale for Recommendations: Case plans are the road map home for the children. **The Board is highly concerned when children have plans that are clearly inappropriate and do not reflect their needs or situations.** For example, 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).

> *"Betty,"* age 8, has been removed from the home 3 times, for the same reasons (parental drug use, child being given pornographic materials, filthy living conditions). Sexual abuse has been reported, but never confirmed. *"Betty"* has been in care for over 12 months this time, and is telling her foster mother that she 'just wants a family' but 'she has been through this before.' *"Betty"* has begun soiling and wetting herself. On a recent supervised visit, the parents provided an X-rated pornographic movie for *"Betty"* to watch. The plan remains reunification.

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."[37]

The Board is concerned for children when there is no current, complete written permanency plan. Only 2,821 (66.5%) of the 4,242 children reviewed had complete written permanency plans with services, timeframes, and tasks, and **1,421 children**

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

reviewed (33.5%) did not have complete written permanency plans, as shown below:

- 703 children had no current plan;
- 86 children had only verbal plans, not plans documented in writing;
- 10 had more than one plan; and
- 622 had incomplete written plans (missing one or more essential elements needed to establish what is to happen and how this will be accomplished).

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

It is also important to recognize that if the parents cannot do what the plan states (i.e. if the services needed are not available in a geographic area or if the parents are too low functioning to ever comply) then the plan is not realistic and not truly "reunification." Rather, it is a plan for parents to fail and for children to remain in the system far longer than necessary.

The above scenarios slow the progress of the child's case and lengthen a child's time in out-of-home care. As stated before, stability and permanency are critical to a child's well being. **Time is a precious commodity for a child.**

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.

Make Appropriate, Effective Services Available

Concern/Rationale for Recommendations: The Board is concerned 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 1,841 of 4,242 (43.4%) of the children reviewed in 2002.

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 case illustrates a particular lack of service availability.

> *"Carla,"* is the daughter of a legal alien who has very limited English skills. Since the case started the father wanted to do what was necessary to get her back, but there were no therapists who spoke his language in his mid-size Nebraska town. Thus, he had to drive nearly 2 hours each way to see the nearest available therapist with a translator. The family support worker who supervised his visits with *"Carla"* did not speak his language, so she could not provide any parenting education. There were no parenting classes in his language in his section of the state. *"Carla"* is placed in an English speaking home and is losing her ability to speak her father's language – which will make reunification more difficult. *"Carla's"* father is very discouraged.

Recommendations:

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

Give Youth Under the HHS Office of Juvenile Services (OJS) Better Access to Services and Placements

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

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

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

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

Recommendations:

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

Make Concerted Efforts to Find Runaway Children and Youth

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

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

Recommendations:

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

Achieve Permanency in a Timely Manner

Concern/Rationale for Recommendations: The Board is concerned that nearly half (2,064 of 4,242 – 48.7%) of the children reviewed in 2002 had been in care for at least 2 years without achieving permanency and 12.8% (541 of 4,242) had been in care for 5 years or more without achieving a safe, permanent home. Even though foster care is by definition to be a short-term solution, it is inevitable that many children are remaining in out-of-home for extended periods of time given the number of unresolved barriers to permanency.

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

Recommendations:

1. Provide intensive services to parents with the intent of assessing their long-term willingness and ability to parent.
2. Utilize provisions of the Adoption and Safe Families Act to move immediately to termination of parental rights in cases of serious or chronic abuse or where the parents lost their parental rights to siblings for the same condition.
3. Provide intensive case management for all young children (age 0-5 plus siblings) through additional case managers who would provide focused stability, services, and care for these young children. Each case manager should have a caseload not exceeding 15 children and each supervisor should have a staff not to exceed eight case managers.
4. Develop specialized units where highly trained professionals focus on providing timely permanency for school age children who have been identified as not being able to return home due to parental inability or unwillingness to provide long term care.
5. Create permanency units to serve children age six or older who have been in care for two or more years or who have suffered extreme abuse, and their siblings. Families would be evaluated, and if it were identified that the likelihood of a child being returned to the parents is small, these units would work to create permanency for that child.
6. Explore the use of family group conferencing, where the extended family works to help develop the safety plans for the children under certain circumstances. Assure that if family group conferencing is used that there is adequate supervision to ensure children's safety. (Family group conferencing was piloted as part of the 2001 HHS Nebraska Family Portrait Initiative).

Establish Paternity Promptly

Concern/Rationale for Recommendations: The Board is concerned that paternity had not been established for 554 (13.0%) of 4,242 reviewed children's cases. Paternity was undocumented, and therefore likely not determined, in another 681 (16.1%) children's cases. Nearly all of these 1,235 children had been in care for more than six months at the time of review, yet paternity was not established.

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

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

The following case illustrates this point.

> *"Chip,"* entered out-of-home care when he was 2 years old. He is now 6 years old. His mother relinquished her rights over a year ago. Although *"Chip's"* father was not involved in his early life, he did become involved when the case manager contacted him. *"Chip's"* father intends to work for "reunification" even though he remains incarcerated, has many more months before he may be eligible for release, and has never parented his son. *"Chip"* has a half-sister whose parental rights are terminated. Due to the HHS policy of not finalizing permanency for one sibling if another sibling is not yet free for adoption, *"Chip's"* sister is also in a limbo.

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

Recommendations:

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

Examine Why Some Children are Adjudicated as Status Offenders When Child Abuse or Neglect Is the Root Cause of the Behaviors

Concern/Rationale for Recommendations: The Board has reviewed a number of status offenders[38] whose behavior was a result of abuse or neglect, yet due to the adjudication status the abuse or neglect is not addressed. A system should be developed and put in place to provide services for the families of children who are adjudicated as status offenders, who often come into care due to family situations. When child abuse or neglect is the root cause of the behavior, the court petition should address these issues.

Recommendations:

1. Develop programs to allow HHS to work with the families of children adjudicated as status offenders.
2. Decrease the number of children and youth charged by county attorneys as status offenders whose actions are a result of being abused or neglected and file charges instead on the parents for the abuse or neglect.
3. File petitions that address each of the family member's issues when children are adjudicated as status offenders.
4. File supplemental petitions if new evidence on abuse surfaces.
5. Clarify the court's jurisdiction over families of status offenders and delinquents with appropriate legislation.

Make Foster Care and Group Home Payments Equitable

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

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

[38] 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.

Recommendations:

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

Improve Reliability of HHS Reports from the N-FOCUS Computer System

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

Recommendations:

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

Conclusion

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

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

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

MAJOR ACTIVITIES OF THE BOARD

AND

OVERVIEW TABLES

MAJOR ACTIVITIES OF THE FOSTER CARE REVIEW BOARD DURING 2002

- Completed 6,378 reviews on 4,292 children, an increase from the 6,015 reviews on 4,092 children completed in 2001.
- Issued 44,646 case specific reports with recommendations to the courts, agencies, attorneys, guardians ad litem, and county attorneys, an increase from 42,105 reports issued in 2001.
- Facilitated local board members volunteering 35,776 hours of service.
- Utilized the authority derived from legal standing statutes to advocate in court for 3 cases involving 3 children, and to advocate for about 620 additional children through team meetings, meetings with legal parties, special correspondence, and the like.
- Tracked 10,880 children who were reportedly in out-of-home care during the year.
- Researched and verified the out-of-home care status, and then closed the cases of, approximately 617 children whose cases had been closed without HHS issuing a report.
- Passed the review portion of the federal Child and Family Services Review.
- Worked to enable the Board to attend more court hearings.
- Toured several facilities to assure that individual physical, psychological, and sociological needs of the children are being met.
- Organized a joint release of the Annual Report with Governor Mike Johanns.
- Worked to compensate for omitted or inaccurate reports from HHS to the Board's Tracking System.
- Met with the HHS Director, Service Area Administrators, and other top HHS staff to address specific children's cases and to address system issues.
- Made numerous presentations on the Board and on the status of children in out-of-home care to focus groups, community groups, college classes, and foster parent training classes.
- Provided statistical and other information to researchers, grant seekers, and child advocates.
- Revised the Directory of Service Facilities for Nebraska Youth (Group Home Directory).

After 20 years of serving children in out-of-home care, the Board has:

- Tracked over 65,655 children.
- Conducted over 78,238 reviews of the cases of children in out-of-home care.
- Issued over 550,102 reports.
- Volunteered over 299,274 hours reviewing plans of children in out-of-home care and advocating for their best interests.
- Taken legal standing to advocate in court for over 300 children.
- Toured numerous facilities to make sure that the children were safe and to better understand the programs strengths and weaknesses as compared to individual children's needs.
- Provided or assisted with education programs for District, Juvenile and County Court judges, county attorneys, law enforcement personnel, guardians ad litem, state senators, service providers, and communities.
- Co-sponsored Legislative Caucuses for Children.
- Provided statistical and other information to researchers, grant seekers, and child advocates.
- Supported legislation favorable to abused and neglected children in foster care, including open adoption, funding for additional caseworkers, foster parent training, the 18-month bill, the confidentiality bill, the Child Protection Unit in the Attorney General's office, and the Adoption and Safe Families Act.
- Planned and co-sponsored the 1998 Adoption Summit with the Governor's office and the Department of Health and Human Services.

The Board attributes each success to its dedicated volunteers and committed staff.

Every success in helping children and their families through case reviews or through endeavors to improve the functioning of the child welfare system as a whole makes these efforts worthwhile.

TABLE 1

SOME CHARACTERISTICS OF CHILDREN IN FOSTER CARE - 2002

(A Ten-Year and One-Year Comparison)

Who are the Children?

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

1992	2001	2002
5,679	5,559	5,367

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

1992		2001		2002		
1,397	24.6%	1,293	23.3%	1,235	23.0%	Infants & Preschoolers (0-5)
1,357	23.9%	1,271	22.9%	1,263	23.5%	Elementary School (6-12)
1,249	22.0%	1,285	23.1%	1,285	23.9%	Young Teens (13-15)
1,676	29.5%	1,670	30.0%	1,579	29.4%	Older Teens (16+)
0	0.0%	40	0.7%	5	>0.1%	Age not reported
5,679	100.0%	5,559	100.0%	5,367	100.0%	Total in care Dec. 31st

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

1992		2001		2002		
3,879	68.3%	3,332	59.9%	3,259	66.7%	White
920	16.2%	993	17.9%	898	16.7%	Black
267	4.7%	383	6.9%	405	7.5%	Native American
233	4.1%	295	5.3%	265	4.9%	Hispanic
97	1.7%	99	1.8%	64	1.2%	Asian
288	4.9%	457	8.2%	476	8.9%	Other or Race Not Reported
5,679	100.0%	5,559	100.0%	5,367	100.0%	Total in care Dec. 31st

continued...

Explanation of Table 1—This table compares some characteristics of children in foster care from 1992, 2001, and 2002. Most categories are taken from the 5,367 children who were in out-of-home care on 12-31-2002, unless otherwise marked. Some percentages in this table may not equal 100% due to rounding.

TABLE 1 (continued)

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

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

1992		2001		2002		
3,226	56.8%	3,050	54.9%	2,885	53.8%	Male
2,453	43.2%	2,431	43.7%	2,375	44.3%	Female
0	0.0%	78	1.4%	107	2.0%	Gender not reported
5,679	100.0%	5,559	100.0%	5,367	100.0%	Total in care Dec. 31st

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

1992		2001		2002		
1,851	32.6%	2,860 [1]	51.4%	2,754 [1]	51.3%	# in 4 or more foster homes
1,164	20.5%	1,992 [1]	35.8%	1,902 [1]	35.4%	# in 6 or more foster homes
5,679	100.0%	5,559	100.0%	5,367	100.0%	Total in care Dec. 31st

Number of Local Foster Care Review Boards

1992	2001	2002
27 local boards	59 local boards	62 local boards

Children Reviewed by the Foster Care Review Board

1992	2001	2002
1,827 children [2, 3]	4,092 children [3]	4,242 children [3]

Reviewed Children by Length of Time in Foster Care

1992		2001		2002		
897	49.1%	1,998	51.9%	2,064	48.7%	# In care at least 2 years
285	15.6%	553	16.9%	541	12.8%	# In care at least 5 years
1,897 [3]	100.0%	4,092 [3]	100.0%	4,242 [3]	100.0%	Total children reviewed

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

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

[3] Children are normally reviewed every 6 months while in out-of-home care, thus many children may have more than one review during a calendar year.

continued...

TABLE 1 (continued)

Where are the Children?

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

1992		2001		2002		
1,639	27.8%	2,392	43.0%	2,350	43.8%	Foster home & fos/adopt homes
420	7.3%	1,195	21.5%	1,025	19.1%	Group homes & residential treatment facilities
453	7.9%	690	12.4%	802	14.9%	Relatives
424	7.5%	583	10.3%	548	10.2%	Jail/Youth Development Center
201	3.5%	126	2.3%	165	3.1%	Emergency Shelter
558	9.8%	211	3.8%	104	1.9%	Adoptive home, not final (private)
47	0.8%	112	2.0%	112	2.1%	Runaway, whereabouts unknown
140	2.7%	74	1.3%	43	0.8%	Psychiatric Treatment or substance abuse facility
10	0.2%	23	0.4%	14	0.3%	Center for Develop. Disabled
87	1.5%	45	0.8%	66	1.2%	Independent living
0	0.0%	30	0.5%	50	0.9%	Foster/Adoptive homes
52	0.9%	43	0.8%	64	1.2%	Medical facility, nursing home
182	3.2%	2	>0.1%	0	0.0%	Child Care Agency
1,466	25.8%	41	0.7%	24	0.4%	Other or type not reported
5,679	100.0%	5,559	100.0%	5,367	100.0%[1]	Total in care Dec. 31st

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

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

1992		2001		2002		
2,345	41.3%	2,719	48.9%	2,724	50.8%	In same county
761	13.4%	866	15.6%	883	15.9%	In neighboring county
449	7.9%	1,084	19.5%	1,162	20.9%	In non-neighboring county
Combined below		219	3.9%	138	2.5%	Child in other state
Combined below		116	2.1%	99	1.8%	Parent in other state
176	3.1%	See above		See above		Either parent or child in another state
1,948	34.3%	555	10.0%	361	6.7%	Proximity not reported
5,679	100.0%	5,559	100.0%	5,367	100.0%	Total in care Dec. 31st

continued...

TABLE 1 (continued)

What Happened to the Children?

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

1992		2001		2002		
1,939	51.8%	2,373	49.8%	2,608	53.3%	Returned to parents
Included in 'other' category below		874	18.4%	743	15.7%	Released from corrections (no further information given)
261	7.0%	383	8.0%	322	6.6%	Reached Age of Majority (19th birthday)
286	7.6%	225 [1]	4.7%	277 [1]	5.7%	Adopted
504	13.5%	140	2.9%	140	2.9%	Court terminated (no specific reason given)
91	2.4%	107	2.2%	277	5.7%	Guardianship
217	5.8%	2	>0.1%	4	>0.1%	Custody transferred
10	0.3%	1	>0.1%	3	>0.1%	Marriage or Military
438	11.7%	657 [1]	13.8%	522 [1]	10.7%	Other/reason not reported
3,746	100.0%	4,762	100.0%	4,896	100.0%	Total left care during year

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

2000		2001		2002		
3,693	58.7%	3,292	59.2%	3,168	59.0%	In care - initial removal
2,593	41.3%	2,267	40.8%	2,199	41.0%	In care - had prior removal
6,286 [2]	100.0%	5,559	100.0%	5,367	100.0%	Total in care Dec. 31st

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

2000		2001		2002		
2,876	54.5%	2,994	57.2%	3,110	58.4%	Entered care - initial removal
2,405	45.5%	2,238	42.8%	2,211	41.6%	Had prior removal
5,281 [2]	100.0%	5,232	100.0%	5,321	100.0%	Total entered care during year

[1] The number of adoptions completed is likely understated due to the number of reports from HHS indicating children left care, but not indicating the reason for leaving care. The number of adoptions indicated for 2002 is greater than 2001 due to the efforts of the Board's contract researcher who, among other duties, attempted to determine if children who were reported to have left care did, in fact, leave care, and the reason for case terminations.

[2] The number of children in out-of-home care on Dec. 31, 2000, was overstated and the number leaving care was understated due to problems with HHS not reporting when many children returned home or otherwise achieved permanency. Verification efforts during 2001 indicated that approximately 5,800 children were actually in out-of-home care at that time.

TABLE 2

COST OF OUT-OF-HOME CARE ROOM AND BOARD BY PLACEMENT TYPE 2002

Placement Type	No. of Children	Costs	Minimum Monthly
Foster Home	2,350	$222 - $1,200, or $1,875 [1]	681,940 [2]
Group Home or Residential T. C.	1,025	$1,935, $2,670, or $5,794 [3]	1,983,375 [4]
Relative Placement	802	$222-$1,200 [5]	223,854 [6]
Jail/Youth Development Center	548	$3,300-7,500 [7]	2,140,222 [8]
Emergency Shelter	165	$839, 1,785, 3,225 [9]	321,668 [10]
Runaway/Whereabouts Unknown	112	n/a	n/a
Adoptive Home Not Final - Private	104	n/a	n/a
Independent & Semi-Ind. Living	66	$352	23,232
Adoptive Foster Home – Not Private	50	$222 - $1,200, or $1,875 [11]	13,020 [12]
Assisted Living Facility	49	$2,250 (est.)	110,250
Psychiatric Treatment Facility	43	$4,920 [13]	211,560
Medical Facility	15	$26,697 [14]	400,455
Center for Developmentally Disabled	14	$2,400	33,600
Special School - boarding	10	$1,935 (est.)	19,350
Other	14	$222 (est.)	3,108
Children in Care on Dec. 31, 2002	**5,367**		**$6,165,634**

Minimum Annual Cost for Room and Board $73,987,608

Explanation of Table—This table shows the number of children on 12-31-2002, and would be representative of the number of children and mix of placements on any given day. In cases where there is a range of costs, the lowest amount has been used unless otherwise noted.

Costs reflect only the basic board rate for the children. Medical expenses, counseling fees, special needs amounts, school tuition, case worker/supervisor salaries, judicial system costs, and other non-room and board costs are not included in the above amounts.

Facts on Fees and Calculations

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

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

[2] Minimum monthly costs were calculated as follows:

- 768 children age 0-5 @ minimum $222 per month = $170,496
- 757 children age 6-11 @ minimum $292 per month = $ 221,044
- 825 children age 12 or older @ minimum $352 per month = $290,400

TABLE 2 (Continued)

[3] HHS group home rates are determined by the group home level. According to an HHS official who confirmed the rates 11/3/2003, the following rates have been the same since Feb. 1998:
- Basic group homes are paid $64.50 per day ($1,935 per month),
- Group Home A's are paid $89.00 per day ($2,670 per month),
- Treatment Group Homes (formerly Group Home II's) are paid $193.12 per day ($5,794 per month). Group Home II's were discontinued 9-1-2002.

[4] Calculated as follows: 1,025 children @ $1,935 per month.

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

[6] Calculated as follows:
- 313 children age 0-5 @ minimum $222 per month = $69,486
- 296 children age 6-11 @ minimum $292 per month = $86,432
- 193 children age 12 or older @ minimum $352 per month = $67,936

[7] The following per diem rates were in effect as of 2002:
- Geneva Youth Rehabilitation and Treatment Center - $141.51.
- Kearney Youth Rehabilitation and Treatment Center - $123.63.
- Douglas County Youth Center - $123.60 for Douglas County wards, $170.00 for state wards.
- Lancaster County Youth Service Center ranges from $170 to $200 depending on the contract. The contract for state wards is $170.00.
- Northeast Nebraska Juvenile Services in Madison ranges from $110 to $250 depending on the contract and the level. The contract for state wards is $170.00 per day.

[8] Calculated as follows:
- 159 youth at Kearney at $123.63 per day times 30 days = $589,715.10.
- 107 youth at Geneva @ $141.51 per day times 30 days = $454,247.10.
- 223 youth at Douglas County at $124 per day times 30 days = $829,560
- 40 youth at Lancaster at $170 per day times 30 days = $204,000
- 19 youth at other facilities at $110 per day times 30 days = $62,700

[9] HHS emergency shelter rates are determined by the level. According to an HHS official who confirmed the rates 11/3/2003, the following rates have been the same since Feb. 1998:
- Individual Emergency Shelter homes are paid $27.95 per day.
- Agency Based Emergency Shelter homes are paid $59.50 per day.
- Emergency Shelter Centers are paid $107.50 per day.

[10] Calculated as the sum of 1/3 of the youth at each level.
- 55 children at $27.30 x 30 days ($838.50) = $46,118.
- 55 children at $59.50 x 30 days ($1,785.00) = $98,175.
- 55 children at $107.50 x 30 days ($3,225.00) = $177,375.

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

[12] Calculated as follows:
- 26 children age 0-5 @ minimum $222 per month = $5,772
- 20 children age 6-11 @ minimum $292 per month = $5,840
- 4 children age 12 or older @ minimum $352 per month = $1,408

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

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

20 YEARS OF ACCOMPLISHMENTS –

RECOGNIZING
THE FOSTER CARE REVIEW BOARD'S
20TH ANNIVERSARY

20 Years of Accomplishments

A Brief History of the Nebraska Foster Care Review Board

In 1982, the Nebraska Legislature passed LB714 creating the Foster Care Review Board (FCRB). Over the past 20 years, the agency never has forgotten its constituency...the most vulnerable of children, or its purpose...to serve the best interest of each child.

Its many accomplishments, which have earned the agency a national reputation, are too numerous to present. We list a few here for this celebration of the Board's 20th anniversary.

1982-1986
The Formative Years

* From 1983 through 1986....
  - Total reviews increase nearly 1,000% (151 to 1,654).
  - Children on the tracking system increase 195% (4,633 to 13,649).

* During this time, the agency develops:
  - The nation's first state-wide, comprehensive, independent tracking system to track all children in out-of-home care; the only one in the nation to track children in both private and public agencies, and having the capability to report data on a county-by-county, regional, or statewide basis.
  - The comprehensive review process, where staff go into HHS offices to obtain all file information.

* In addition, the agency:
  - Conducts a study, finding that 30 percent of male and 32 percent of female inmates had been in court-ordered out-of-home placements as children.
  - Works with the Nebraska Bar Association and the Permanency Planning Task Force to co-sponsor guardian ad litem training across the state.

* Nebraska sees the value of citizen review...
  - Evaluations conducted by Dr. Ann Coyne of the University of Nebraska-Omaha find that children whose cases were reviewed by the FCRB were 3.6 times more likely to have finalized adoptions and 1.6 times more likely to be in more home-like foster care placements than non-reviewed children.
  - For four consecutive years, citizens defeat attempts to dismantle the agency.

1987-1990
Citizen Review Impacts the System

* From 1987 through 1990, the number of children on the tracking system increases over 36% (16,374 to 22,357).

* In legislative activity, the agency:
  - Successfully initiates and promotes the creation of a Child Protection Unit in the attorney general's office to investigate and prosecute criminal child abuse cases, and mandatory child abuse training for county attorneys.
  - Is granted legal standing, and receives funding for four additional local boards.
  - Is authorized to review children's cases at the time they enter out-of home care (a result of the early review project).
  - Supports successful funding for foster parent education, and additional caseworkers and juvenile court judges.
  - Works to extend the statute of limitations on child sexual abuse.
  - Supports membership changes to the agency's state board, and expansion to include three local board chairs.

* The FCRB provides education for child welfare professionals and policy makers:
  - In a rare move, the legislature cancels committee hearings so senators can attend a FCRB sponsored symposium on child sexual abuse, which also is attended by district and county court judges, and child welfare professionals.
  - The National Council of Juvenile and Family Court Judges recognizes the FCRB for its work with the court administrator's office to conduct workshops on child sexual abuse for county judges; the first such workshop in the nation. With the assistance of the FCRB, the Council duplicates the workshops nationwide.
  - The FCRB also sponsors an educational program for guardians ad litem on sexual abuse; and conferences on sexual and ritualistic abuse, and the Indian Child Welfare Act.
  - The FCRB is asked to testify at congressional hearing on Nebraska's implementation of PL 96-272 and the FCRB's tracking system.

* The FCRB acts on specific system concerns as it:
  - Studies barriers to adoption of developmentally disabled children, and finds that behaviorally impaired children were significantly more likely to have been physically or sexually abused before coming into foster care than mentally or physically disabled children.
  - Participates in the Intergovernmental and Community Planning Process in a cooperative effort to streamline access to services for children.

* The FCRB Implements participant reviews, beginning with the Early Review Boards.

* Dr. Ann Coyne again studies citizen review and finds that children reviewed by the FCRB were 4.7 times more likely to have adoption in their permanency plan than children not reviewed.

* In addition, Executive Director Carolyn Stitt:
  - Speaks on the FCRB's tracking system at the National Association of Foster Care Reviewers convention in Baltimore MD.
  - Is elected president of the National Association of Foster Care Reviewers.
  - Consults on the creation of review boards in Alaska, Washington State, and Chicago.

1991-1994
Continued Progress for Children

* From 1991 through 1994, the number of...
  - Children on the tracking system increase 32%(29,011 to 38,403).
  - Volunteer hours increase 145% (6,045 to14,802).

* The FCRB works on legislation to:
  - Create limited open adoption contracts; a death review team; a statewide district attorney system; and a study commission to review problems in the juvenile justice system.
  - Require county attorneys to consider termination of parental rights when a child has been in foster care for 18 months.
  - Establish guidelines for sharing confidential information.
  - Add attorneys to the Child Protection Unit in the Attorney General's office.

* The FCRB provides education for child welfare professionals and policy makers:
  - Sponsors programs on sexual abuse in Chadron and Grand Island; a symposium for judges and senators on child welfare issues; an orientation for new senators; and in-service trainings on sexual and ritualistic abuse, gang violence, and fetal alcohol syndrome in seven communities.
  - Assists with a conference on extreme abuse at Boys Town, and an education program for district court judges.
  - Works with the Crime Commission and Law Enforcement Training Center to provide training on recognizing, investigating, interviewing and gathering evidence in child abuse cases; and assists the Permanency Planning Task Force with guardian ad litem training.

* The FCRB acts on specific system concerns as it:
  - Identifies concerns, and assists with improvements at Northeast Nebraska Juvenile Services.
  - Works with DHHS to improve conditions at two problematic group homes.

- Works with rural state senators and Voices for Children to plan and coordinate Legislative Caucus for Children community meetings in 13 communities on locally resolving problems in the child welfare system.

* The FCRB uses its data and ensures data accuracy:
  - Works with reporting agencies to improve reporting to the tracking system, and develops a system to eliminate duplications caused by children being reported under different names.
  - Conducts data analysis revealing two disturbing trends: 1) an increased number of children in foster care who had been in foster care previously, and 2) the progression from foster care to the juvenile justice system.
  - Provides statistics, beginning in 1993, for the each year's annual "Kids Count" report coordinated by Voices for Children.

* The FCRB celebrates the agency's 10th anniversary in 1992, planting a tree on State Capitol grounds to symbolize "Giving Roots to Nebraska's Children."

* Nebraska's Foster Care Review Board is proven valuable...
  - Executive Director Carolyn Stitt testifies before a congressional committee on the FCRB and its tracking system, and issues in Nebraska's foster care system.
  - The FCRB participates in a study to examine duplications in the review process, which leads to LB642 in 1996 to designate the FCRB as the party responsible for reviewing the cases of all children in out-of-home care.

* Volunteers form the non-profit Friends of Foster Children Foundation, Inc. to raise money to provide important items to enrich the lives of foster care. Many of the organizers were, and still are, local board members of the FCRB.

1995-1998
The Board is Funded to Conduct All Required Reviews

The years of 1995 through 1998 proved to be pivotal for the FCRB beginning with the passage of LB642 in 1996. The bill, in part, provided funding for an additional 22 local review boards, increasing the total number to 50. This enabled the FCRB to review the cases of all children in out-of-home care. Prior to the legislation, lack of funding prevented the agency from extending its protection and oversight to all children in the system.

The challenge was great. The FCRB had to recruit and train volunteers, and implement and support the additional board. But, the timing of the expansion was fortuitous as a startling trend became evident... children were entering the system at a higher rate, meaning more needed the oversight of the agency.

In that same year (1996), the legislature approved a dramatic change in the state's agency structure (the Partnership Project). Five agencies (the Departments of Social Services,

Public Institutions, Health, Aging, and the Office of Juvenile Services) were merged into a mega-agency, the Department of Health and Human Services (DHHS). The FCRB expressed concerns that the merger would take resources from services for children and families. The transition was far from smooth, dramatically affecting the agency's operations and the lives of children under the state's care.

These difficulties would pale in comparison to the chaos created in 1998 when DHHS converted to a new Child Welfare Information System called N-FOCUS. Although the FCRB had worked with DHHS during the conversion, multiple errors resulted in the system failing, among other things, to produce mandated information necessary to review children's cases.

During this time, DHHS also began to contract with the private sector to provide core case management duties. The practice has placed many children at risk because of fragmented case management, diminished accountability, and deterioration in the quantity and quality of services. It is a practice that the FCRB is aggressively working to alter. Despite the exceptional challenges, the FCRB did not relax its mission to address children's needs through numerous avenues as evidenced by the following summary.

* The FCRB's 1996 expansion is reflected in the statistics. From 1995 through 1998, significant increases are realized in the number of...
  - Children reviewed: 73% (2,162 to 3,742).
  - Total reviews: 87% (3,159 to 5,907).
  - Children on the tracking system: 27% (41,835 to 53,024).
  - Local boards: 792% (28 to 50).
  - Volunteers: 80% (202 to 364).
  - Volunteer hours: 276% (14,076 to 53,024).

* Legislative activity, in addition to the aforementioned, includes:
  - Assisting with the drafting and promotion of the state ASFA.
  - Supporting legislation to clarify safety needs in the Family Policy Act.
  - Lobbying for additional juvenile court judges.

* The FCRB provides education for child welfare professionals and policy makers:
  - Hosts the 10th annual conference of the National Association of Foster Care Reviewers in Omaha. More than 250 volunteers attend the event for which volunteers raise over $8,000 to defray costs.
  - Plans and co-sponsors an Adoption Summit with the Governor's office and DHHS.
  - Facilitates a meeting on concerns with Child Protective Services.
  - Conducts workshops in three communities on recognizing, investigating, and treating child sexual assault in cooperation with the Crime Commission and the Law Enforcement Training Center.
  - Assists Boys Town in presenting workshops on children with development disabilities in three communities.
  - Assists the Permanency Planning Task Force with guardian ad litem training.

* The FCRB acts on specific system concerns as it:
  - Begins working closely with Gov. Johanns who responds to the FCRB's concerns about N-FOCUS; directs the agency to tour group homes; and asks Executive Director Carolyn Stitt to lead his study on improving the system.
  - Meets with Options, Inc., a managed health care company, regarding the denial of services to children.
  - Works with DHHS and group homes to improve facility operations.
  - Drafts a memorandum of agreement with DHHS to improve the working relationship.

* The FCRB uses its data and ensures data accuracy:
  - Develops a new plan to track and review cases in response to changes in the child welfare system, and works with agencies to improve their reporting to the tracking system.
  - Makes adjustments in review procedures related to child safety and permanency plans as mandated by ASFA.
  - Provides data to Boys Town National Research Hospital for a study on the relationship between children with disabilities and abuse/neglect.

In addition, the FCRB:
  - Establishes a toll-free number to facilitate responses to questionnaires.
  - Updates the Directory of Group Homes and Child Caring Facilities.
  - Speaks at a clerk magistrate's conference on the tracking system.
  - Receives a technology grant to convert the agency's word processing computers to a popular platform.

* The Foster Care Review Board is again shown to be valuable...
  - A legislative evaluation, mandated in LB642, found the FCRB's reviews to be effective and of high quality, and the costs reasonable.
  - Nebraska's FCRB is the only FCRB in the country asked to testify before a congressional committee on the federal Adoption and Safe Families Act (ASFA) because of its stance in opposition to mandatory reunification. Executive Director Carolyn Stitt assists in forming a national work group, and the FCRB provides information for the drafting of the bill, which President Bill Clinton signed into law in1997.

* Director Carolyn Stitt travels to Helena, Montana to speak on "The Benefits and Challenges of Including Citizens Reviews and the Court Process." She provides technical assistance to advocates for conducting a pilot project, and on drafting and passing legislation.
* Local board members in Omaha participate with the League of Women Voters in a System Watch initiated by juvenile court judges to help legal parties identify strengths and weaknesses in the Douglas County Juvenile Courts.
* In 1998, over 100 board members, staff, and children join Gov. Ben Nelson in the FCRB's15th anniversary celebration. The celebration continues with five educational

programs across the state on ASFA. Attendees include local board members, DHHS staff, judges, county attorneys, and guardians ad litem.

1999-2002
Responding to Changes in the Child Welfare System

* In 2000, 2001 and 2002, the FCRB and Gov. Mike Johanns jointly release the agency's annual report. The 2000 report includes a Special Section on Young Children (ages birth to five).

* In 2002, the FCRB issues 44,646 case specific reports with recommendations to the courts, agencies, attorneys, guardians ad litem, and county attorneys, a 24 percent increase from the 35,854 reports issued in 2000.

* Legislative activity includes supporting:
  - Mandatory autopsies in suspicious child deaths.
  - Funding for additional caseworkers and juvenile court judges.

* The FCRB provides education for child welfare professionals and policy makers:
  - Sponsors educational programs on brain research, and bonding and attachment in communities across the state, attracting over 750 attendees.
  - Conducts six educational programs for local board members, DHHS staff, judges, county attorneys, guardians ad litem, and interested persons; and an education program in Omaha on commonly used psychotropic medications.

* The FCRB acts on specific system concerns as it:
  - Meets with DHHS to identify the top child welfare system concerns, and develops recommendations for improvements. Concerns include: the need for child abuse prevention; system-wide training; case management problems, including turnover rates; the lack of appropriate placements; the lack of oversight of contracted services and placements; and the expenditure of child welfare funds in ways that do not directly benefit children.
  - Expresses concerns regarding an over reliance on restraints in many facilities for children and youth. State Board Chair Barbara Heckman and staff participate in DHHS work groups on ways to reduce restraints.
  - Meets with DHHS to address specific children's cases and system issues, including: professional foster care, funding a foster parent association, encouraging peer-to-peer mentoring, and conducting joint tours of child-caring facilities.
  - Develops a protocol with DHHS to ensure that all children in child-caring facilities are reviewed; and updates the memo of agreement between the two agencies.
  - Works with DHHS to create a statewide self- assessment, a report on statewide child welfare strengths and weaknesses as federally required.

- Tours several facilities to assure individual physical, psychological, and sociological needs of the children are being met.

* The FCRB uses its data and ensures data accuracy:
  - Continues to work with DHHS to correct serious flaws in the state's N-FOCUS computer system which require FCRB staff to verify all case information provided by the agency:
    - In the last quarter of 2001, N-FOCUS reports have a 41% error rate.
    - While verifying information, FCRB staff finds that DHHS closed over 700 cases without issuing a report.
    - DHHS agrees to hire a temporary employee to help verify report information.
    - In 2002, 56% of issued reports contain errors or omissions.

In addition, the FCRB:
- Using the authority of legal standing, advocates in court for eight children in four cases, and approximately 620 additional children through team meetings, meetings with legal parties, and special correspondence.
- Streamlines the agency's recommendation process.

* Staff and volunteers make numerous presentations on the FCRB and the status of children in out-of- home care to a variety of groups, including the National Association of School Psychologists, focus and community groups, college classes, and foster parent training classes.
* Executive Director Carolyn Stitt receives the "Outstanding Advocate Award" from the National Association of School Psychologists for her notable work on behalf of children and youth.
* As a recipient of IVE funds, the FCRB undergoes a federal audit, which finds reviews to be timely, and reinforces many of the agency's top concerns.
* The economic downtown, worsened by the Sept. 11, 2001 terrorist's attacks on the World Trade Center and the Pentagon and the continued drought, results in a dramatic decrease of state revenues. The legislature is forced to make substantial budget cuts. Over a nine-month period, the FCRB's budget is reduced by 10.6%.

20-Year Statistics Show the FCRB's Increased Ability to Improve Conditions for Children

* From 1983 through 2002, the number of...
  - Children reviewed yearly increases from 151 to 4,242
  - Total reviews yearly increases from 151 to 6,378
  - Volunteers serving each year increase from 20 to 383.
  - Local boards increases from 2 to 62.
  - Volunteer hours yearly increases from 2,631 to 35,776.
  - Children on the Tracking System increases from 4,633 to 65,655.

Conclusion

For 20 years, the FCRB has advocated for children in out-of-home care, working to ensure their safety, and that plans are made for their futures. The agency was the first in the nation to develop an independent tracking system. And, unprecedented is the recruitment and training of hundreds of volunteers who review and make recommendations regarding individual cases. This has proved to be, not only an effective method of protecting children's interests, but has enabled the agency to function in a cost-effective manner.

Since its inception, the FCRB has worked tirelessly on system reform through lobbying, education, and training, and the creation of partnerships. Our many accomplishments have led to national recognition as evidenced by the fact that, on more than one occasion, the FCRB has been asked to present testimony to congressional committees. Additionally, other states, have sought the direction and advice of the FCRB when seeking ways to improve or create oversight agencies.

All has been accomplished because of tenacious and knowledgeable staff, committed and educated volunteers, and the numerous entities with which the FCRB has created working relationships. Among our partners have been the Nebraska Legislature, county and juvenile court judges, the County Attorneys Association, National Council of Juvenile and Family Court Judges, Voices for Children, Boys Town Research Institute, and the Nebraska Bar Association.

By any criteria, Nebraska's FCRB has been an exceptional agency. It is a local and national leader in the most honorable of missions. Envision a protective mother and father wrapping their arms around a child...this is the FCRB, its staff, its volunteers, and its partners.

We cannot always build the future for our youth,
but we can build our youth for the future.

Franklin D. Roosevelt

SPECIAL SECTION

DEPARTMENT OF HEALTH AND HUMAN SERVICES REPORTS TO THE

FOSTER CARE REVIEW BOARD'S TRACKING SYSTEM

Problems Continue with Children's Information on the HHS N-FOCUS CWIS Computer System

The Foster Care Review Board receives reports from HHS (and the Courts) in order to fulfill the mission of independently tracking children in out-of-home care and to obtain information needed to properly schedule and conduct reviews (i.e., when the child entered care, where to find the child's HHS file, where the child is placed).

Since HHS converted to the N-FOCUS computer systems in late 1997, HHS reports to the Board have been problematic. It has been over five years since this change, yet there continues to be a high rate of inaccurate, untimely, or incomplete data. For example, in order to maintain accurate information on the Board's separate system and know which children were in care, during 2002 the Board needed to verify nearly half (45.2%) of the 68,352 reports on children in out-of-home care received from HHS.

The situation not only affects the Board, but also affects HHS' ability to know the following critical information:

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

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

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

The following provides a summary of what the Board found in 2002, based on its analysis of the reports received, its verification efforts, and information received from other sources, such as the Courts.

Summary of 2002 HHS N-FOCUS Report Problems

Over 30,909 (45.2%) of the 68,352 reports HHS issued to the Board in 2002 could not be used without further research or verification by the Board staff because:

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

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

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

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

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

The following figures give some idea of the staff time needed to assure accuracy. Verification was needed on reports of children entering care (689 of the 3,276 reports received), changing status while in care (29,176 of the 62,140 reports received), and leaving care (1,044 of the 2,936 case closure reports received). This is only part of the story. Additional verification was needed in the many instances when:

- Information was received from the courts that had not yet been reported by HHS,
- Information was received from courts that showed that N-FOCUS was in error,

- Corrections were made during the case review process, or
- Legal parties, such as guardians ad litem or others provided information that either had not been input on N-FOCUS or was input in error.

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

Board Response to HHS N-FOCUS Report Problems

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

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

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

- Generating lists of children in out-of-home care that courts were asked to verify.

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

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"If you bungle raising your children, I don't think whatever else you do well matters very much."

Jacqueline Kennedy Onassis

INFORMATION ON THE

FOSTER CARE REVIEW BOARD

AND CASE REVIEWS

THE FOSTER CARE REVIEW BOARD

MISSION STATEMENT

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

The Board attempts to accomplish this by and through:

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

AGENCY VISION

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

Unique and Beneficial Aspects of Citizen Review in Nebraska

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

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

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

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

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

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

- **The Board is required under Nebraska statute to maintain an independent tracking system.** The Nebraska system is a national model, both for the information compiled and for its ease of use. The independent tracking system enables the Board to both track and report on indicators of how the system is responding to children's needs. Information from this system was given in testimony to Congress on several occasions. For instance, Nebraska's Foster Care Review Board was invited to give testimony before Congress on what became the 1997 Adoption and Safe Families Act. Information from this system is used to compile the statistics for the agency's annual report.

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

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

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

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

The Structure of the State Foster Care Review Board

The State Foster Care Review Board is responsible for governing the agency and setting agency policy. The State Board consists of nine members selected by the Governor and approved by the Legislature. Two members are chosen from each of the three Congressional Districts. These members serve three-year terms and are selected on a staggered basis. Three additional Board members are appointed from the Local Review

Board chairpersons, one from each Congressional District. These members serve two-year terms. Terms are staggered so that a change in Governor does not automatically mean a change in the makeup of the State Board.

The responsibilities of the State Board include:

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

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

Local Foster Care Review Boards

During 2002 there were 62 Local Boards composed of 383 unpaid volunteer citizens from the community who have completed required training and meet monthly to review the cases of children in out-of-home care. In order to provide maximum input on a child's case, an attempt is made to select board members from a variety of different occupations and viewpoints. A typical board might include an educator, a medical professional, an attorney, a mental health practitioner, and a foster parent.

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

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

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

The following is a list of the cities as of the end of 2002 that have one or more local foster care review boards (number of local boards in parentheses):

Alliance (1), Auburn (1), Beatrice (1), Bellevue (1), Columbus (1), Elkhorn (1), Fremont (1), Grand Island (3), Hastings (2), Kearney (2), LaVista (1), Lexington (1), Lincoln (10), Norfolk (1), North Platte (2) O'Neill (1), Ogallala (1), Omaha (23), Papillion (1), Pierce (1), Scottsbluff/Gering (3), Seward (1), South Sioux City (1), and York (1).

Thousands of Unpaid Hours are Donated Annually

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

In addition to attending their regular meetings, State and Local Foster Care Review Board members attend initial and ongoing training sessions, tour foster care facilities (including group homes and institutions), increase their knowledge at seminars and conferences, visit with Legislators, and volunteer in the Review Board's office. Local and state board members donated over 35,776 hours of service.

State and local board members represent a variety of professions and occupations, such as law, education, medicine, business, and social services. **The value of the time that state and local board members donate to assisting the abused and neglected children of Nebraska, taken at a very conservative estimate of $15 per hour, was $536,640 for 2002, at $20 per hour it would be $715,520.**

Use of Limited Legal Standing

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

- Reasonable efforts were not made to prevent a child from entering care,
- There is no permanency plan,
- The permanency plan is inappropriate,
- The placement is inappropriate,
- Regular court hearings are not being held,

- Appropriate services are not being offered,
- The best interest of the child is not being met, or,
- The child is in imminent danger.

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

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

Since the Board was granted legal standing in 1990 through the end of 2002:

- 529 cases involving 875 children have been acted upon or utilized legal standing.
- Most (701 of 875) children's cases were handled through meetings with the county attorney and/or other parties to the case.
- An attorney was hired to represent the Board for 163 children.

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

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

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

The Board's Tracking System Database

Per statute, the Board maintains an independent computerized tracking system, which is housed in its main office in Lincoln. Since this system began in 1983 through the end of 2002, 65,655 individual Nebraska children in out-of-home care have been tracked.

[1] For explanation of the steps in a child case, see the Appendix for the chart "Following a Case Through Juvenile Court."

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

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

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

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

Why Citizen Review Was Enacted in Nebraska

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

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

At the time that citizen review in Nebraska was initially proposed, many children had languished in the child welfare system for years, and many children had been "lost" in

system; that is, due to poor tracking methods no one knew where some of the children in foster care were placed. Some of these children were never found.

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

Important Milestones in the History of the Board

A. Studies on the Effectiveness of Citizen Review

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

B. Additional Mandatory Findings on Placement Appropriateness

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

C. Legislative Study of 1994

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

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

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

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

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

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

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

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

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

E. Additional Mandatory Findings Added - 1998

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

The National Association of Foster Care Reviewers

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

"Life affords no greater responsibility, no greater privilege, than the raising of the next generation."

Dr. C. Everett Koop

CASE REVIEW PROCESS

The Foster Care Review Board completed 6,378 reviews on 4,242 children in 2002, and issued approximately 44,646 reports with recommendations regarding reviewed children's cases to courts, agencies, guardians ad litem, attorneys, and county attorneys.

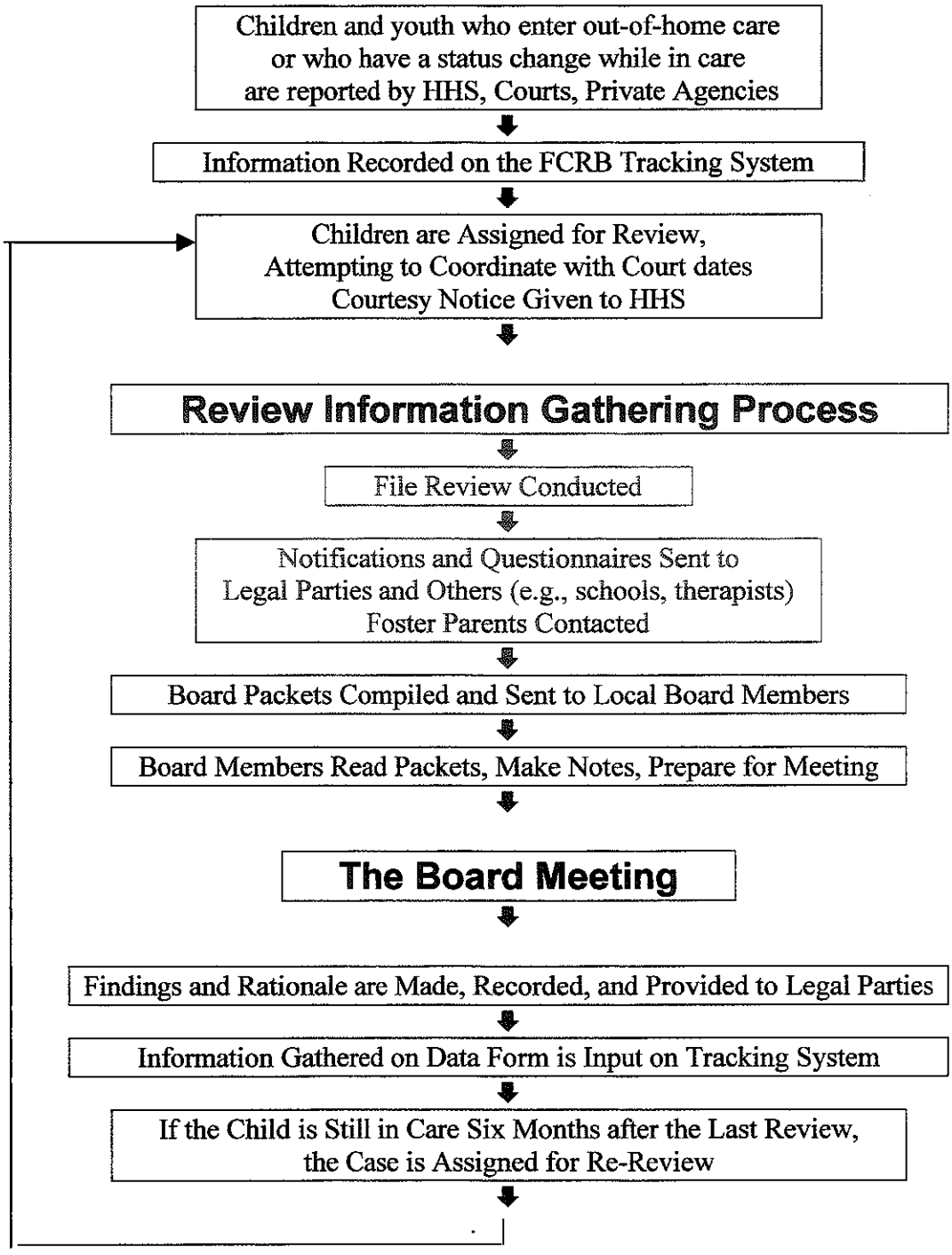
Each report included a case history of the child with the reasons why the child was placed in foster care; court dates; information on services, education, and visitation; recommendations and findings on the placement, services, and plan; and remaining barriers to permanency.

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

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

The following chart shows this process in graphic format.

The Foster Care Review Board – Review Process



STATISTICAL MEASURES OF CHILD WELFARE EFFICACY TABLES 3-14

(Tables 1 and 2 are at the end of the Preview and Commentary)

TABLE 3

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT
LOCAL BOARD FINDINGS FOR CHILDREN REVIEWED DURING 2002

Is there a written permanency plan	# Children	Percent
•There is no plan or the plan is incomplete.....	1,421	33.5%

Included in Above	# Children	Percent
No plan.	703	16.6%
Verbal plan, not in writing.	86	2.0%
Incomplete plan.	622	14.7%
Multiple plans.	10	0.2%
	1,421	33.5%

•There is a written plan with services, timeframes, and tasks.....	2,821	66.5%
Total	4,242	100.0%

Board agreement with child's permanency plan	# Children	Percent
•The Board disagrees with the plan, or there is no plan.....	2,392	56.4%

Included in Above	# Children	Percent
Board disagrees with the plan.	1,007	23.7%
Board partially agrees with the plan.	437	10.3%
No current written plan.	635	15.0%
Plan unclear, multiple plans.	12	0.3%
Plans unclear, recent transition.	24	0.6%
Plan unclear, no documentation.	105	2.5%
Plan unclear, other reasons.	172	4.0%
	2,392	56.4%

•The Board agrees with the child's permanency plan.....	1,850	43.6%
Total	4,242	100.0%

continued...

Explanation of Table—This table shows compliance with the Foster Care Review Act as determined through the findings of the local Foster Care Review Boards that reviewed the children's cases during 2002.

TABLE 3 (continued)

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT

Services in the plan	# Children	Percent
•Needed services not provided, or not utilized.....	1,851	43.6%

Included in Above	# Children	Percent
Some services are in motion.	597	14.1%
Services offered, not utilized.	863	20.3%
Unclear what is being provided.	326	7.7%
No plan, no services provided.	65	1.5%
	1,851	43.6%

•No plan has been developed, but services are being provided.....	550	13.0%
•All services in the plan are presently in motion.....	1,841	43.4%
Total	4,242	100.0%

Progress being made toward permanency plan objective	# Children	Percent
•No progress, partial progress, or progress unclear.....	3,045	71.8%

Included in Above	# Children	Percent
No progress towards permanency.	834	19.7%
Partial progress.	1,175	27.7%
Unclear due to lack of written plan	650	15.3%
Unclear due to other reasons.	386	9.1%
	3,045	71.8%

•Progress is being made towards the permanency objective.....	1,197	28.2%
Total	4,242	100.0%

continued...

Explanation of Table—This table shows compliance with the Foster Care Review Act as determined through the findings of the local Foster Care Review Boards that reviewed the children's cases during 2002.

TABLE 3 (continued)

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT

Is current placement appropriate and safe	# Children	Percent
•Placement inappropriate, unsafe, or it is unclear.....	1,113	26.2%
•Current placement appears appropriate and safe.....	3,128	73.7%
Total	4,242	100.0%

Included in Above	# Children	Percent
Unsafe, thus inappropriate.	59	1.4%
No documentation/homestudy.	642	15.1%
Safety and appropriateness unclear.	299	7.0%
Safe, but not appropriate..	113	2.7%
	1,113	26.2%

Safety evaluation by department or custodial agency	# Children	Percent
•Custodial agency has not fully evaluated safety or it is unclear...	1,285	30.3%
•Custodial agency evaluated the safety of the child and taken the necessary measures in the plan to protect the child.....	2,957	69.7%
Total	4,242	100.0%

Included in Above	# Children	Percent
Custodial agency has not evaluated the safety/taken action.	68	1.6%
Unclear if custodial agency has evaluated safety.	1,040	24.5%
Custodial agency partially evaluated safety	177	4.2%
	1,285	30.3%

continued...

Explanation of Table—This table shows compliance with the Foster Care Review Act as determined through the findings of the local Foster Care Review Boards that reviewed the children's cases during 2002.

TABLE 3 (continued)

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT

Reasonable efforts toward reunification	# Children	Percent
•Reasonable Efforts are not being made to return the child home or it is unclear what efforts are being made or there is no longer a need for out-of-home placement.....	651	15.3%

Included in Above	# Children	Percent
No Reasonable Efforts/continued need for out of home placement.	81	1.9%
Unclear Reasonable Efforts, unclear need for out-of-home placement	45	1.0%
Unclear Reasonable Efforts, continued need for out-of-home placement.	446	10.5%
Reasonable Efforts are being made and there is not a continued need for out of home placement.	79	1.9%
	651	15.3%

•Reasonable Efforts are being made and there is a continued need for out of home placement.....	1,889	44.5%
•Reasonable Efforts are no longer being made because the plan is no longer reunification, however, there is a continued need for out of home placement.....	1,685	39.7%
•Reasonable Efforts to return the child home are no longer being made because there has been a judicial determination of aggravating circumstances, however, there is a continued need for out of home placement.....	17	0.4%
Total	4,242	100.0%

continued...

Explanation of Table—This table shows compliance with the Foster Care Review Act as determined through the findings of the local Foster Care Review Boards that reviewed the children's cases during 2002.

TABLE 3 (continued)

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT

Parent-child visitation arrangements	# Children	Percent
•Parental visitation arrangements are not optimal for the child....	1,261	29.7%

Subtotals	# Children	Percent
Arrangements made, but		
...do not allow adequate parent - child contact.	52	1.2%
...not regularly occurring due to parental unwillingness.	357	8.4%
...not regularly occurring due to other barrier(s).	168	4.0%
...no visitation is occurring due to parental unwillingness.	239	5.6%
...no visitation is occurring due to other barrier(s).	131	3.1%
...allow too much contact or the contact is otherwise not in the best interest of the child.	250	5.9%
Arrangements not made	64	1.5%
	1,261	29.7%

•Unclear parental visitation arrangements.....	376	8.9%
•Parental visitation arrangements have been made and allow adequate parent-child contact.....	1,611	38.0%
•Parental visitation is not applicable because:.....	901	21.2%
•No parental visitation arrangements due to court order.....	93	2.2%
Total	4,242	100.0%

continued...

Explanation of Table—This table shows compliance with the Foster Care Review Act as determined through the findings of the local Foster Care Review Boards that reviewed the children's cases during 2002.

TABLE 3 (continued)

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT

Sibling visitation	**# Children**	**Percent**
•Sibling visitation arrangements are not optimal for the child.....	1,640	38.7%

Included in Above	# Children	Percent
Arrangements unclear.	1,182	27.9%
Arrangement made, but do not allow adequate sibling contact.	43	1.0%
Arrangement made, but visitation is not occurring on a regular basis.	52	1.2%
Arrangement made, but no visitation is occurring.	17	0.4%
Sibling visitation is occurring, but inappropriately.	17	0.4%
No sibling visitation made by contractor of services or casemanager	87	2.1%
•No sibling visitation arrangements made due to other barrier(s).	242	5.7%
	1,640	38.7%

•Sibling visitation arrangements have been made and allow adequate sibling contact.....	1,198	28.2%
•Sibling visitation is not applicable. (no siblings or placed together)....	1,213	28.6%
•No sibling visitation arrangements made due to court order.....	16	0.4%
•No sibling visitation due to the severance of legal ties.....	67	1.6%
•No sibling visitation due to a lack of relationship between siblings.....	108	2.5%
Total	4,242	100.0%

continued...

Explanation of Table—This table shows compliance with the Foster Care Review Act as determined through the findings of the local Foster Care Review Boards that reviewed the children's cases during 2002.

TABLE 3 (continued)

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT

Reasonable efforts prior to entering care	# Children	Percent
•Reasonable efforts were not made or are unclear.....	358	8.4%
Included in Above	# Children	Percent
Reasonable efforts were not made to prevent the child's removal from the home.	57	1.3%
It is not clear what efforts were made to prevent the child's removal from the home.	185	4.4%
Reasonable efforts to prevent the child's removal from the home unclear due to child being incarcerated.	116	2.7%
	358	8.4%
•Reasonable efforts were not made to prevent the child's removal because an emergency situation existed.....	2,491	58.7%
•Reasonable efforts were made to prevent the child's removal from the home.....	1,368	32.2%
•Reasonable efforts to prevent the child's removal were deemed no necessary due to a judicial determination of aggravating circumstances per Neb. Rev. Stat. §43-254, section 24.....	27	0.6%
Total	4,242	100.0%

continued...

Explanation of Table—This table shows compliance with the Foster Care Review Act as determined through the findings of the local Foster Care Review Boards that reviewed the children's cases during 2002.

TABLE 3 (continued)

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT

Grounds for Termination of Parental Rights	# Children	Percent
•Per §43-1308(1)(b) the Board finds that grounds for termination of parental rights appear to exist under.....	937	22.1%
•Per §43-1308(1)(b) the Board finds that grounds for termination of parental rights do not appear to exist under.....	1,262	29.8%
•Per §43-1308(1)(b) the Board finds that grounds for termination of parental rights cannot be determination due to the lack of information on the following.....	130	3.1%
•Per §43-1308(1)(b) the Board is unable to make a finding on whether grounds exist to terminate parental rights as it is unclear if the termination of parental rights is in the child's best interest.....	240	5.7%
•Per §43-1308(1)(b) the Board finds that grounds for termination of parental rights appear to exist for one parent, but not for the other.....	50	1.2%
•Per §43-1308(1)(b) the Board finds that grounds for termination of parental rights appears to exist, however, it is not in the best interests of the child due to.....	743	1.7%
•Per §43-1308(1)(b) the Board's finding on whether grounds for termination of parental rights appears to exist is not applicable.....	880	20.7%
Total	4,242	100.0%

continued...

Explanation of Table—This table shows compliance with the Foster Care Review Act as determined through the findings of the local Foster Care Review Boards that reviewed the children's cases during 2002.

TABLE 3 (continued)

COMPLIANCE WITH THE FOSTER CARE REVIEW ACT

The Board's recommended plan if return of the children to the parents is unlikely			**# Children**	**Percent**
•There was insufficient information to make an accurate finding..			839	19.8%
Included in the Above	# Children	Percent		
Unable to determine if return is likely or unlikely	669	15.8%		
Unable to make finding due to other circumstances	75	1.8%		
Return of the children to the parent is not likely, but cannot recommend a specific permanency option due to lack of information	95	2.2%		
	839	19.8%		
•Return of the children to the parents is unlikely, and the Board recommends the following			2,877	67.8%
Included in Above	# Children	Percent		
referral for termination of parental rights and/or adoption.	709	16.7%		
adoption as parental rights are no longer intact due to termination, relinquishment, or death.	620	14.6%		
referral for guardianship.	487	11.5%		
referral for placement with a relative.	132	3.1%		
referral for a planned, permanent living arrangement other that adoption, guardianship, or placement with a relative.	929	21.9%		
	2,877	67.8%		
•The Board finds that the return of the child to the parents is likely, therefore findings under §43-1308(1)(c) do not apply..			526	12.4%
		Total	4,242	100.0%

Explanation of Table—This table shows compliance with the Foster Care Review Act as determined through the findings of the local Foster Care Review Boards that reviewed the children's cases during 2002.

TABLE 4

BARRIERS TO PERMANENCY FOR CHILDREN REVIEWED DURING 2002

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

The following is a compilation of the barriers identified during 2002. Categories appear in order of the number of barriers identified. The most frequently identified barriers are parental barriers.

Category	Number of Children[1]
Parental Barriers	
Ability/willingness to parent child	1,577
Past history of abuse/violence/neglect	1,010
Substance abuse problems of parents	915
Resistant/uncooperative to services	583
Relationship among family members	531
Lack of visitation	466
Inadequate/inappropriate housing	232
Mental illness	229
Possible sexual abuse if returned	213
Incarceration	190
Economic stress	184
Parent(s) whereabouts unknown	176
Noncompliance with Court Order	171
Bonding problems	153
Distance between family members	151
Low functioning parent	152
Inability to cope with child's disability	140
Failure to pay child support	72
Number of times child placed in foster care	71
Lack of job training/skills	69
Chronic health problems of parent	48
Lack of transportation	33
Illiteracy	10
Other parenting barriers	200

continued...

[1]This table compiles the barriers to permanency identified by the local boards for each of the 4,042 individual children reviewed during 2002. There can be up to 10 barriers identified for each child. Barriers may be in any of the categories, and more than one barrier can be in the same category.

TABLE 4 (continued)

BARRIERS TO PERMANENCY FOR CHILDREN REVIEWED DURING 2002

Category	Number of Children[1]
Implementation Barriers	
Length of time in care	616
Lack of progress	365
Number of disruptions/placements/moves	219
Delay in home study	85
Inadequate casework services	56
Inadequate preparation for independence	46
Inadequate contact with child	18
Worker not facilitating visitation with siblings	9
Inadequate contact with foster parents	7
Inadequate contact with parent(s)	7
Worker not facilitating visitation with parents	5
Other implementation barriers	31

Category	Number of Children[1]
Planning Barriers	
No plan	623
Plan inappropriate	153
Inappropriate timeframe (too long or too short)	100
Plan unclear	53
No timeframe	26
Inappropriate objectives	26
No objectives	22
Multiple plans	15
No parent/agency contract/agreement with father	6
No parent/agency contract/agreement with mother	1
Other planning barriers	42

continued...

[1]This table compiles the barriers to permanency identified by the local boards for each of the 4,042 individual children reviewed during 2002. There can be up to 10 barriers identified for each child. Barriers may be in any of the categories, and more than one barrier can be in the same category.

TABLE 4 (continued)

BARRIERS TO PERMANENCY FOR CHILDREN REVIEWED DURING 2002

Category	Number of Children[1]
Management Barriers	
Lack of documentation	393
Case transfer interrupts service	52
Caseload too large	52
Poor monitoring of contracting agencies (purchased services)	20
Inadequate supervision of caseworker	22
Inadequate knowledge of case by case manager	9
Lack of awareness of policy by worker	6
Policy inappropriate to case	5
Uncovered case	2
Other management barriers	51

Case Manager Contact with Children

During the review process Board staff members document whether or not the child's case manager has visited the child within the 60 days prior to the most recent review. Of the 4,242 children's files reviewed during 2002:

- 3,534 (83.3%) *had documentation of case manager contact* with the children within the 60 days prior to review. This is a significant, positive, increase from the 68.5% in 2001.

- 96 (2.3%) *had documentation that there was no contact* between the case manager and the children within the 60 days prior to review.

- 612 (14.4%) *had no file documentation* to indicate whether or not the case manager had visited the children within the 60 days prior to review.

Local Boards have expressed concern that many case managers are not visiting the children and witnessing the interaction of the children with their caregivers. It is concerning that about 15 percent of the files have no documentation on this vital safety indicator.

continued...

[1]This table compiles the barriers to permanency identified by the local boards for each of the 4,042 individual children reviewed during 2002. There can be up to 10 barriers identified for each child. Barriers may be in any of the categories, and more than one barrier can be in the same category.

TABLE 4 (continued)

BARRIERS TO PERMANENCY FOR CHILDREN REVIEWED DURING 2001

Category	Number of Children[1]
Legal Barriers	
Parent's rights override children's rights	184
Guardian ad litem not taking active role	141
Lack of legal action to pursue permanency	81
Court delays	74
Clarification of child's legal status	29
Conflict with Indian Child Welfare Act	21
No guardian ad litem	14
No court involvement	7
Court does not enforce orders	6
No court reviews	5
Court orders conflict with agency plan	3
Other legal barriers	103

Category	Number of Children[1]
Resource Barriers	
Lack of independent living skill training	80
Lack of adoptive homes for special needs children	36
Lack of specialized foster homes in community	30
Support services not available	28
Residential treatment facility not available	16
Lack of foster homes in community	7
Lack of adoptive resources/recruitment	6
Counseling services not available	6
Group homes not available	6
Lack of home-based services	5
Parenting classes not available	3
Inadequate health care services	3
Other resource barriers	79

continued...

[1]This table compiles the barriers to permanency identified by the local boards for each of the 4,042 individual children reviewed during 2002. There can be up to 10 barriers identified for each child. Barriers may be in any of the categories, and more than one barrier can be in the same category.

TABLE 4 (continued)

BARRIERS TO PERMANENCY FOR CHILDREN REVIEWED DURING 2001

Category	Number of Children[1]
Placement Barriers	
Placement does not meet special needs (physical, mental, emotional)	66
Problems in foster home	61
Placement does not meet educational needs	17
Group home/institutional placement	6
Other placement barriers	160

Category	Number of Children[1]
Coordination Barriers	
Inadequate coordination/communication between agencies	22
Interstate compact delays	9
Inadequate coordination/communication w/tribe	6
Inadequate coordination/communication within agency	4
Inadequate coordination/communication between agency & court	4
Other coordination barriers	15

Other Barriers in Categories Not Listed Above	950 identified barriers [1,2]

No Barriers Identified	484 children [3]

[1]This table compiles the barriers to permanency identified by the local boards for each of the 4,042 individual children reviewed during 2002. There can be up to 10 barriers identified for each child. Barriers may be in any of the categories, and more than one barrier can be in the same category.

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

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

TABLE 4B

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

Health Records Given to Foster Parent or Caregiver	**Total Children Reviewed**		**Ages 0- 5**	**Ages 6-12**	**Ages 13-15**	**Age 16+**
Yes	2,122	50.0%	485	564	404	669
No	1,838	43.3%	463	529	307	539
Unknown	266	6.2%	67	89	40	70
Not applicable	16	0.5%	1	6	5	4
Total	4,242	100.0%	1,016	1,188	756	1,282

Education Records Given to Foster Parent or Caregiver	**Total Children Reviewed**		**Ages 0- 5**	**Ages 6-12**	**Ages 13-15**	**Age 16+**
Yes	2,360	55.6%	394	667	476	823
No	1,475	34.8%	408	436	238	393
Unknown	243	5.7%	67	76	39	61
Not applicable	164	3.9%	147	9	3	5
Total	4,242	100.0%	1,016	1,188	756	1,282

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

TABLE 5-A

SUMMARY OF REASONS CHILDREN ENTERED OUT-OF-HOME CARE FOR CHILDREN REVIEWED DURING 2002

This table shows the reasons why children and youth reviewed by the Foster Care Review Board were placed in out-of-home care. Each of the 4,242 children reviewed during 2002 had one to six reasons for entering out-of-home care identified, with a total of 8,721 reasons identified for these children. Reasons could be identified in more than one category.

This table also shows the differences between children in out-of-home care for the first time as compared to children who had experienced prior removals from the home. 2,457 of the 4,242 children reviewed were in their first removal from the home, for these children 5,238 reasons were identified. 1,785 of the 4,242 reviewed children had been removed from the home at least once before, for these children 3,483 reasons were identified.

	Number of Reasons for Entering Out-of-Home Care Identified for...					
Major Category	**All Children Reviewed** [1]		**Reviewed children who were in foster care for the first time** [1]		**Reviewed children who had been in foster care at least once previously** [1]	
Neglect	4,147	47.6%	2,720	51.9%	1,427	41.0%
Children's Behaviors	1,256 [2]	14.4%	477 [2]	9.1%	779 [2]	22.4%
Parental Substance Abuse	1,049	12.0%	738	14.1%	311	8.9%
Physical Abuse	845	9.7%	552	10.5%	293	8.4%
Children's Physical or Emotional Needs	487	5.6%	207	4.0%	280	8.0%
Sexual Abuse	336 [3]	3.9%	225 [3]	4.3%	111 [3]	3.2%
Emotional Abuse	285	3.3%	189	3.6%	96	2.8%
Other issues	316	3.6%	130	2.5%	186	5.3%
Total reasons identified	*8,721*	*100.0%*	*5,238*	*100.0%*	*3,483*	*100.0%**

[1] Up to six reasons for entering out-of-home care could be identified for each child reviewed. Reasons could be from one or more categories.

[2] Many of the behaviors identified as a reason for children and youth to enter out-of-home care are predictable responses to prior abuse or neglect.

[3] Children and youth often do not disclose sexual abuse until after removal from the home. This figure includes only sexual abuse identified as an initial reason for removal and does not reflect later disclosures. See Table 5C for later identified issues.

Category detail follows →

TABLE 5-B

DETAIL ON THE REASONS ENTERED OUT-OF-HOME CARE FOR CHILDREN REVIEWED DURING 2002

NEGLECT CATEGORY	**Total children affected for each reason[1]**	**Percent[2]**	**Children in care for the first time[1]**	**Percent[3]**	**Children with past removals from the home[1]**	**Percent[4]**
Parenting skills inadequate	718	8.9%	431	8.7%	287	20.1%
General neglect - including inadequate child hygiene	875	8.9%	564	9.7%	311	21.8%
Abandonment, absent parent, throwaway, desertion, etc.	471	5.3%	340	6.4%	134	9.4%
Housing and/or utilities inadequate, or homelessness	440	4.9%	286	5.2%	154	10.8%
Homemaking skills and/or home sanitation inadequate	422	4.7%	286	4.7%	136	9.5%
Incarceration of parent	273	3.2%	181	3.6%	92	6.4%
Children's supervision inadequate	227	2.5%	149	2.6%	78	5.5%
Failure to protect child	157	2.5%	115	2.6%	42	2.9%
Unwilling to provide care or parent child	169	1.8%	104	1.9%	65	4.6%
Mental limitations of parent	116	1.2%	85	1.3%	31	2.2%
Criminal activity by parent or parent's friends in child's presence	91	0.9%	70	1.1%	21	1.5%
Voluntary placement in out-of-home care by parents	92	0.8%	52	0.4%	40	2.8%
Failure to thrive	38	0.6%	18	0.5%	20	1.4%
Parental physical illness or disability	34	0.3%	26	0.3%	8	0.6%
Voluntary placement of child for adoption	21	0.2%	13	0.2%	8	0.6%
Totals This Category	*4,147*	*46.2% of all reasons identified*	*2,720*	*49.3% for 1st time in care*	*1,427*	*41.9% for multiple times in care*

[1] During reviews 1-6 reasons why each child entered out-of-home care are identified. These reasons can be from more than one category or can be from within the same category.
[2] Percent = number identified for this reason/8,721 total reasons for all reviewed;
[3] Percent = number identified for this reason /5,238 total reasons for children in care the first time;
[4] Percent = number identified for this reason /3,483 total reasons for children previously in care

continued...

TABLE 5-B (continued)

DETAIL ON THE REASONS ENTERED OUT-OF-HOME CARE FOR CHILDREN REVIEWED DURING 2002

PHYSICAL ABUSE CATEGORY	**Total children affected for each reason[1]**	**Percent[2]**	**Children in out-of-home care for the 1st time[1]**	**Percent[3]**	**Children with past removals from the home[1]**	**Percent[4]**
Physical abuse	498	5.7%	332	6.3%	166	4.8%
Chronic family violence	289	3.3%	173	3.3%	116	3.3%
Sibling severe injury	36	0.4%	30	0.6%	6	0.1%
Severe injury of one parent by other parent	18	0.2%	13	0.2%	5	0.1%
Sibling death	8	0.1%	4	0.1%	4	0.1%
Totals This Category	*845*	*9.7% of all reasons identified*	*552*	*10.5%*	*293*	*8.4%*

[1] During reviews 1-6 reasons why each child entered out-of-home care are identified. These reasons can be from more than one category or can be from within the same category.
[2] Percent = number identified for this reason/8,721 total reasons for all reviewed;
[3] Percent = number identified for this reason /5,238 total reasons for children in care the first time;
[4] Percent = number identified for this reason /3,483 total reasons for children previously in care

PARENTAL SUBSTANCE ABUSE CATEGORY	**Total children affected for each reason[1]**	**Percent[2]**	**Children in out-of-home care for the 1st time[1]**	**Percent[3]**	**Children with past removals from the home[1]**	**Percent[4]**
Drug/alcohol abuse by parents	981	11.2%	678	12.9%	303	8.7%
Born drug addicted	65	0.7%	58	1.1%	7	0.2%
Fetal alcohol effects (FAE)	2	>0.1%	1	>0.1%	1	>0.1%
Fetal alcohol syndrome (FAS)	1	>0.1%	1	>0.1%	0	0.0%
Totals This Category	*1,049*	*12.0% of all reasons identified*	*738*	*14.1%*	*311*	*8.9%*

[1] During reviews 1-6 reasons why each child entered out-of-home care are identified. These reasons can be from more than one category or can be from within the same category.
[2] Percent = number identified for this reason/8,721 total reasons for all reviewed;
[3] Percent = number identified for this reason /5,238 total reasons for children in care the first time;
[4] Percent = number identified for this reason /3,483 total reasons for children previously in care

continued...

TABLE 5-B (continued)

DETAIL ON THE REASONS ENTERED OUT-OF-HOME CARE FOR CHILDREN REVIEWED DURING 2002

CHILDREN'S BEHAVIORS CATEGORY	**Total children affected for each reason[1]**	**Percent[2]**	**Children in out-of-home care for the 1st time[1]**	**Percent[3]**	**Children with past removals from the home[1]**	**Percent[4]**
Incorrigible, ungovernable behaviors of child	486	5.6%	192	3.7%	294	8.4%
Delinquency --includes misdemeanor, felony, gang activities, cult activities, and truancy	487	5.6%	198	3.7%	289	8.3%
Runaway behaviors of child	132	1.5%	42	0.8%	90	2.6%
Drug/alcohol abuse by child	92	1.1%	31	0.6%	61	1.8%
Suicide attempts by child	59	0.6%	14	0.3%	45	1.3%
Totals This Category	*1,256*	*14.4% of all reasons identified*	*477*	*9.1%*	*779*	*22.4%*

[1] During reviews 1-6 reasons why each child entered out-of-home care are identified. These reasons can be from more than one category or can be from within the same category.
[2] Percent = number identified for this reason/8,721 total reasons for all reviewed;
[3] Percent = number identified for this reason /5,238 total reasons for children in care the first time;
[4] Percent = number identified for this reason /3,483 total reasons for children previously in care

Children's behaviors were more heavily identified as a reason for entering care for children with prior removals from the home (9.1% for first time in care versus 22.4% for those with prior removals).

continued...

TABLE 5-B (continued)

DETAIL ON THE REASONS ENTERED OUT-OF-HOME CARE FOR CHILDREN REVIEWED DURING 2002

CHILDREN'S PHYSICAL OR EMOTIONAL NEEDS CATEGORY	**Total children affected for each reason[1]**	**Percent[2]**	**Children in out-of-home care for the 1st time[1]**	**Percent[3]**	**Children with past removals from the home[1]**	**Percent[4]**
Developmental/behavioral problems of child	308	3.5%	119	2.3%	189	5.4%
Emotional limitations of child	93	1.1%	30	0.6%	63	1.8%
Physical illness/disabilities of the child -- including AIDS/HIV, youth pregnancy, mental retardation of child, eating disorder	40	0.5%	33	0.6%	7	0.2%
Intensive evaluation	24	0.3%	9	0.2%	15	0.4%
Parent deceased	22	0.2%	16	0.3%	6	0.2%
Total This Category	*487*	*5.6%*	*207*	*4.0%*	*280*	*8.0%*

[1] During reviews 1-6 reasons why each child entered out-of-home care are identified. These reasons can be from more than one category or can be from within the same category.
[2] Percent = number identified for this reason/8,721 total reasons for all reviewed;
[3] Percent = number identified for this reason /5,238 total reasons for children in care the first time;
[4] Percent = number identified for this reason /3,483 total reasons for children previously in care

continued...

TABLE 5-B (continued)

DETAIL ON THE REASONS ENTERED OUT-OF-HOME CARE FOR CHILDREN REVIEWED DURING 2002

SEXUAL ABUSE CATEGORY	**Total children affected for each reason[1]**	**Percent[2]**	**Children in out-of-home care for the 1st time[1]**	**Percent[3]**	**Children with past removals from the home[1]**	**Percent[4]**
Sexual abuse[5]	209[5]	2.4%[5]	138 [5]	2.6%[5]	71[5]	2.5%[5]
Sexual abuse of a sibling	58	0.7%	47	0.9%	11	0.3%
Sexual perpetrator - child alleged to be	69	0.8%	40	.8%	29	0.8%
Total This Category	*336*	*3.9%*	*225*	*4.3%*	*111*	*3.6%*

[1] During reviews 1-6 reasons why each child entered out-of-home care are identified. These reasons can be from more than one category or can be from within the same category.
[2] Percent = number identified for this reason/8,721 total reasons for all reviewed;
[3] Percent = number identified for this reason /5,238 total reasons for children in care the first time;
[4] Percent = number identified for this reason /3,483 total reasons for children previously in care
[5] Often sexual abuse is not disclosed until *after* removal from the home. This figure includes only sexual abuse identified as an initial reason for removal, not any later disclosures.

EMOTIONAL ABUSE CATEGORY	**Total children affected for each reason[1]**	**Percent[2]**	**Children in out-of-home care for the 1st time[1]**	**Percent[3]**	**Children with past removals from the home[1]**	**Percent[4]**
Emotional problems of parent	230	2.6%	152	2.9%	78	2.2%
Emotional abuse, psychological abuse	55	0.6%	37	0.7%	18	0.5%
Total This Category	*285*	*3.2%*	*189*	*3.6%*	*96*	*2.7%*

[1] During reviews 1-6 reasons why each child entered out-of-home care are identified. These reasons can be from more than one category or can be from within the same category.
[2] Percent = number identified for this reason/8,721 total reasons for all reviewed;
[3] Percent = number identified for this reason /5,238 total reasons for children in care the first time;
[4] Percent = number identified for this reason /3,483 total reasons for children previously in care

continued...

TABLE 5-B (continued)

DETAIL ON THE REASONS ENTERED OUT-OF-HOME CARE FOR CHILDREN REVIEWED DURING 2002

OTHER CATEGORY	**Total children affected for each reason[1]**	**Percent[2]**	**Children in out-of-home care for the 1st time[1]**	**Percent[3]**	**Children with past removals from the home[1]**	**Percent[4]**
Adult-child conflict in the home--both parent and step parent/paramour	108	1.2%	42	0.8%	66	1.9%
Financial problems	57	0.7%	26	0.5%	31	0.9%
Welfare Reform Financial Problems	1	>0.1%	1	>0.1%	0	0.0%
Citizenship - lack benefits due to parent not citizen	1	>0.1%	1	>0.1%	0	0.0%
Adoption disruption	12	0.1%	1	>0.1%	10	0.3%
Guardianship disruption	33	0.4%	9	0.2%	24	0.7%
Other	105	1.2%	50	1.0%	55	1.6%
Total This Category	*316*	*3.7%*	*130*	*2.6%*	*186*	*5.4%*

[1] During reviews 1-6 reasons why each child entered out-of-home care are identified. These reasons can be from more than one category or can be from within the same category.
[2] Percent = number identified for this reason/8,721 total reasons for all reviewed;
[3] Percent = number identified for this reason /5,238 total reasons for children in care the first time;
[4] Percent = number identified for this reason /3,483 total reasons for children previously in care

TABLE 5-C

TOP 30 CONDITIONS IDENTIFIED or OCCURRING AFTER REMOVAL FROM THE HOME FOR CHILDREN REVIEWED DURING 2002

Children	Category
275	Drug/alcohol abuse by parents
258	Sexual abuse
221	Developmental/behavioral problems of child
199	Parenting skills inadequate
173	Abandonment, absent parent, throwaway, desertion, etc.
119	Incarceration of parent
111	Emotional problems of parent
110	Physical abuse
95	Housing and/or utilities inadequate - homelessness
98	Chronic family violence
71	Financial problems
68	Neglect - including hygiene of the child inadequate
60	Drug/alcohol abuse by child
49	Emotional limitations of child
45	Runaway behaviors of child
42	Incorrigible, ungovernable behaviors of child
41	Emotional abuse, psychological abuse
40	Child alleged to be sexual perpetrator
37	Homemaking skills inadequate and/or sanitation of home inadequate
36	Unwilling to provide care or parent child
36	Mental limitations of parent
35	Physical illness/disabilities of the child
34	Delinquency --includes gang activities, cult activities, and truancy
30	Supervision of children inadequate
25	Suicide attempts by child
24	Adult-child conflict in the home-- parent or step parent/paramour
20	Fetal alcohol effects (FAE)
20	Criminal activity by parent or parent's friends in child's presence
19	Physical illness/disabilities of parent
19	Fetal alcohol syndrome (FAS)

Explanation of Table—This table shows conditions identified after children's removal from the home that were not clear upon the child's removal or occurred after the removal. Each of the 4,242 children reviewed during 2002 could have one to six reasons such conditions recorded.

TABLE 6A

PERCENTAGE OF LIFE SPENT IN OUT-OF-HOME CARE FOR CHILDREN REVIEWED DURING 2002

Percent of Life In Care	Total Children Reviewed		Ages 0-5		Ages 6-12		Ages 13-15		Age 16+	
1-10%	1,060	25.0%	37	3.6%	239	20.1%	295	39.0%	489	38.1%
11-20%	950	22.4%	95	9.4%	306	25.8%	204	27.0%	345	26.9%
21-30%	609	14.4%	93	9.2%	233	19.6%	95	12.6%	188	14.7%
31-40%	458	10.8%	122	12.0%	161	13.6%	60	7.9%	115	8.9%
41-50%	346	8.2%	118	11.6%	127	10.7%	41	5.4%	60	4.7%
51-60%	204	4.8%	85	8.3%	55	4.6%	26	3.4%	38	3.0%
61-70%	162	3.8%	97	9.5%	23	1.9%	16	2.1%	26	2.0%
71-80%	114	2.7%	74	7.3%	20	1.7%	9	1.2%	11	0.9%
81-90%	110	2.6%	82	8.1%	14	1.2%	6	0.8%	8	0.6%
91-100%	229	5.4%	213	21.0%	10	0.8%	4	0.5%	2	0.2%
Total	4,242	100%	1,016	100%	1,188	100%	756	100%	1,282	100%[1]

[1] This column does not equal 100% due to the effect of rounding on individual items.

- **(19.3%) of the reviewed children have spent more than half of their lives in out-of-home care.** This includes 551 preschool children (ages 0-5), 122 elementary school aged children (ages 6-12), 61 middle school/junior high aged children (ages 13-15), and 85 youth over age 16 who will soon be aging out of the system and creating families of their own.

- **229 (5.4%) children and youth have spent nearly every day (over 90%) of their lives in out-of-home care.**

- **169 (4.0%) of the reviewed children have spent every day of their lives (100%) in out-of-home care.** This includes 166 preschool children and 4 elementary school aged children.

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

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

TABLE 6B

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

Months In Care	Children Reviewed	Ages 0-5	Ages 6-12	Ages 13-15	Age 16+
0-6 months	416	175	104	70	67
7-12 months	737	233	171	143	190
13-18 months	611	174	181	93	163
19-24 months	539	164	145	88	142
25-30 months	430	94	140	74	122
31-36 months	332	80	123	43	86
37-40 months	161	37	65	23	36
41-48 months	227	33	74	41	79
49+ months	789	26	185	181	397
Totals	4,242	1,016	1,188	756	1,282

- **2,478 (58.4%) of the reviewed children have spent more than 18 months in out-of-home care.** This includes 408 preschool children (ages 0-5), 275 elementary school aged children (ages 6-12), 213 middle school/junior high aged children (ages 13-15), and 257 youth over age 16 who will soon be aging out of the system and creating families of their own.
- **1,177 (27.7%) children and youth have spent over 3 years of their lives in out-of-home care.**
- **789 (18.6%) children and youth have spent over 4 years of their lives in out-of-home care.**

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

TABLE 6C

PATERNITY ESTABLISHMENT FOR CHILDREN REVIEWED DURING 2002

WAS PATERNITY ESTABLISHED

Paternity Established	Children	Age 0-5	Age 6-12	Age 13-15	Age 16+
Yes	3,007	697	845	521	944
No	554	192	159	86	117
Undocumented	681	127	184	149	221
Total	4,242	1,016	1,188	756	1,282

HOW PATERNITY WAS ESTABLISHED

	# of Children	Age 0-5	Age 6-12	Age 13-15	Age 16+
Born in Marriage	839	125	209	154	351
Birth Certificate	535	136	144	84	171
Acknowledgement of Paternity	270	91	99	36	44
Legal Adoption	80	0	7	12	61
Blood Test	94	61	21	5	7
District Court Order	68	19	32	8	9
Publication	16	7	7	0	2
Adjudication	32	8	10	7	7
Other	24	4	8	4	8
Unknown way, but established	672	171	206	130	165
Way not researched*	1,538	378	425	303	432
Paternity not established	74	16	20	13	25
Total	4,242	1,016	1,188	756	1,282

*FCRB review specialists were not required to go through volumes of files to record this information for children who entered out-of-home care before 1999.

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

TABLE 7

REPORT FROM THE TRACKING SYSTEM REGISTRY- 2002

Number of Children reported to the State Foster Care Review Board from 1983 through 2001	65,655
Children in out-of-home care on December 31, 2001	5,559 [1]
Children entered care during 2002	+ 5,321
Children whose case was active anytime during 2002	10,880
Children reported to have left care during 2002	-4,896
Children reported/verified in 2002 to have previously left care	- 617 [1]
Children in out-of-home care on December 31, 2002	5,367
Number of Children reviewed by the Foster Care Review Board during 2002	4,242
Number of Reviews conducted by the Foster Care Review Board during 2002	6,378 [2]

Agency with custody of children in out-of-home care Dec. 31, 2002:

Health and Human Services	4,886 [3]
Correction, Detention, Probation, Parole or Courts	187 [4]
Private Agencies (including pre-adoptive)	294
Total	5,367

[1] Prior to and during 2002, HHS frequently did not report when children left out-of-home care or reported the case closure weeks/months after the fact. Therefore, the FCRB made concerted efforts to research the status of children who have been reported to be in care and for whom there were no case closure reports. As a result, it was found that during 2002 over 600 children's case closures had not been reported to the FCRB in a timely manner. The FCRB continues to periodically verify each child's out-of-home care status.

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

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

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

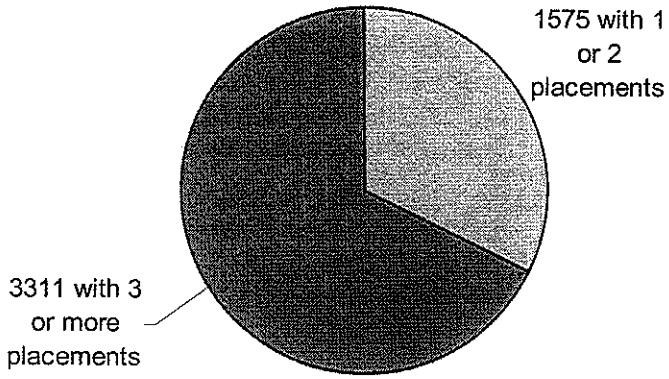
TABLE 8

CHILDREN IN OUT-OF-HOME CARE ON DECEMBER 31, 2002 BY AGE

Children's Age	Number of Children	Subtotals	Subtotal Percents	
under 1 year	236			
1 year	217			
2 years	222			
3 years	198			
4 years	178			
5 years	184			
		1,235	23.0%	Ages birth - 5
6 years	167			
7 years	168			
8 years	159			
9 years	165			
10 years	196			
11 years	177			
12 years	231			
		1,263	23.5%	Ages 6-12
13 years	306			
14 years	456			
15 years	523			
		1,285	23.9%	Ages 13-15
16 years	681			
17 years	584			
18 years	314			
		1,579	29.4%	Ages 16-18
Unreported Age	5	5	>0.1%	Unreported Age
Total	5,367	5,367	100.0%	

Explanation of Table—This table shows the number of active children on Dec. 31, 2002, by age. The majority of children in the 0-1 year age category are infants in adoptive homes awaiting finalization. Generally children up to approximately age 11 enter care due to their parent's inability to parent, abusive situations, neglect, or medical problems. After age 12, youth usually enter care because of the youth's actions in addition to the previously stated reasons. The actions of youth during the teenage years account for the increase in the number of youth entering care from age 13 to age 18.

Number of Lifetime Placements, HHS Wards, 12/31/2002



The chart above shows the number of lifetime placements for HHS wards as found in Table 25A.

TABLE 9-A

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

FOR CHILDREN IN OUT-OF-HOME CARE ON DECEMBER 31, 2002 WHO ARE WARDS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) [1]

Number of Placements	Total	Ages 0 to 5	Ages 6 –12	Ages 13- 15	Age 16+
1	761	327	206	119	109
2	814	354	212	133	115
3	619	206	169	127	117
4	452	99	138	109	106
5	383	67	113	92	111
6	300	33	96	70	101
7	227	17	61	74	75
8	202	11	46	70	75
9	170	7	41	61	61
10	128	2	31	45	50
11-20	649	3	91	201	354
21-30	138	0	3	32	103
31-40	34	0	1	10	23
over 40	9	0	0	0	9
Total	4,886	1,208	1,143	1,143	1,409

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

- 2,692 (55.1%) of HHS children had experienced 4 or more placements.
- 830 (17.0%) of HHS children had experienced more than 10 placements.

Explanation of Table—Both parts of this table shows the number of lifetime placements the children and youth who were in out-of-home care as of December 31, 2002 have experienced, the difference between the tables is who is the agency with custody.

The Board is especially concerned for the number of preschool children who have had multiple placements. **Brain development experts have indicated that young children are permanently damaged by multiple broken attachments to care givers, yet** 527 (43.6 %) **of the 1,208 HHS preschoolers have lived in three or more different homes, and an alarming number** (222) **have lived in five or more homes.**

TABLE 9-B

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

FOR CHILDREN IN OUT-OF-HOME CARE ON DECEMBER 31, 2002 AND ARE *NOT* WARDS OF HHS [1]

Number of Placements	Total	Ages 0 to 5	Ages 6 –12	Ages 13- 15	Age 16+	Age Not Reported
1	348	107	35	96	110	0
2	17	2	5	7	3	0
3	55	4	6	22	23	0
4	5	0	0	1	4	0
5	10	0	0	6	4	0
6	9	0	1	4	4	0
7	9	0	2	1	6	0
8	7	1	2	1	3	0
9	6	0	0	0	6	0
10	1	0	0	0	1	0
11-20	10	0	4	3	3	0
21-30	2	0	0	1	1	0
31-40	2	0	0	0	2	0
over 40	0	0	0	0	0	0
Total	481	114	55	142	170	0

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

Explanation of Table—Both parts of this table shows the number of lifetime placements the children and youth who were in out-of-home care as of December 31, 2002 have experienced, the difference is who is the agency with custody. The Board is especially concerned for the number of preschool children who have had multiple placements.

TABLE 10
Listing of Children by COUNTY OF COURT COMMITMENT

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

		# Removals		Gender			Age					Race						
County	**Total**	**1st**	**2+**	**Male**	**Female**	**Un**	**0–5**	**6–12**	**13–15**	**16+**	**Un**	**Blk**	**Wht**	**Hsp**	**Ind**	**Asn**	**Oth**	**Unr**
Adams	158	75	83	92	66	0	37	33	39	49	0	2	143	6	2	0	0	5
Antelope	23	19	4	14	9	0	10	5	3	5	0	0	22	0	0	0	0	1
Arthur	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Banner	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Blaine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Boone	10	8	2	0	10	0	1	2	2	5	0	0	8	2	0	0	0	0
Box Butte	10	5	5	8	2	0	1	0	2	7	0	0	4	1	5	0	0	0
Boyd	2	1	1	2	0	0	0	0	1	1	0	0	2	0	0	0	0	0
Brown	2	1	1	1	1	0	0	0	0	2	0	0	2	0	0	0	0	0
Buffalo	115	67	48	61	54	0	31	23	25	36	0	3	81	15	2	1	0	13
Burt	24	12	12	13	11	0	6	7	0	11	0	0	19	0	5	0	0	0
Butler	21	16	5	8	13	0	5	6	4	6	0	2	19	0	0	0	0	0
Cass	61	42	19	31	30	0	21	10	12	18	0	0	60	0	0	0	1	0
Cedar	14	11	3	7	7	0	4	5	1	4	0	0	14	0	0	0	0	0
Chase	4	3	1	0	4	0	1	0	2	1	0	0	3	0	0	0	0	1
Cherry	6	3	3	4	2	0	3	0	1	2	0	0	2	0	3	0	0	1
Cheyenne	29	18	11	13	16	0	5	9	4	11	0	0	22	2	4	0	0	1
Clay	18	7	11	11	7	0	3	7	4	4	0	1	16	1	0	0	0	0
Colfax	15	4	11	11	4	0	4	2	4	5	0	0	3	9	2	0	0	1
Cuming	10	4	6	4	6	0	0	0	4	6	0	0	5	2	1	0	0	2
Custer	26	13	13	18	8	0	3	8	5	10	0	1	22	1	2	0	0	0
Dakota	50	31	19	25	25	0	16	7	13	14	0	0	27	4	14	2	0	3
Dawes	6	3	3	4	2	0	1	1	3	1	0	0	3	0	3	0	0	0
Dawson	85	43	42	49	36	0	17	13	24	31	0	0	55	16	9	1	0	4
Deuel	2	1	1	1	1	0	0	1	1	0	0	0	2	0	0	0	0	0
Dixon	15	10	5	10	5	0	1	3	6	5	0	0	15	0	0	0	0	0
Dodge	148	78	70	88	60	0	36	41	35	36	0	10	127	5	1	0	0	5
Douglas	1,850	1,084	766	931	853	66	454	479	430	486	1	675	821	71	115	4	10	154
Dundy	1	1	0	1	0	0	0	1	0	0	0	0	1	0	0	0	0	0
Fillmore	21	10	11	10	11	0	3	5	8	5	0	0	17	0	1	0	1	2
Franklin	8	1	7	6	2	0	2	4	2	0	0	0	8	0	0	0	0	0
Frontier	2	2	0	0	2	0	0	0	0	2	0	0	2	0	0	0	0	0
Furnas	10	8	2	6	4	0	1	3	2	4	0	0	10	0	0	0	0	0

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

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

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

		Adjudication Status							# of Placements				Closeness to Home				
County	**Total**	**Misd**	**Fel.**	**Ab/n**	**Sta**	**Men**	**2+**	**Unk**	**1-3**	**4-6**	**7-9**	**10+**	**Same**	**Neigh**	**Non**	**0-C**	**Unc**
Adams	158	8	0	72	10	0	18	50	60	44	23	31	65	55	34	3	1
Antelope	23	0	0	15	1	0	1	6	17	2	2	2	15	5	1	0	2
Arthur	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Banner	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Blaine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Boone	10	0	0	7	1	0	2	0	6	1	2	1	0	2	8	0	0
Box Butte	10	2	2	1	0	0	3	2	4	2	0	4	1	0	8	0	1
Boyd	2	0	0	0	1	0	0	1	0	1	0	1	2	0	0	0	0
Brown	2	0	0	1	1	0	0	0	0	2	0	0	0	0	2	0	0
Buffalo	115	13	5	37	4	2	14	40	48	32	7	28	50	20	34	1	10
Burt	24	1	0	6	2	0	2	13	10	8	5	1	7	5	11	1	0
Butler	21	2	0	15	1	0	1	2	15	3	2	1	6	9	6	0	0
Cass	61	0	0	35	3	0	8	15	42	7	3	9	35	14	10	0	2
Cedar	14	0	0	4	1	0	2	7	8	3	2	1	2	5	6	1	0
Chase	4	0	0	2	0	0	1	1	2	1	1	0	1	0	1	1	1
Cherry	6	0	0	3	0	0	1	2	3	2	0	1	4	0	1	0	1
Cheyenne	29	0	0	13	4	0	10	2	13	4	5	7	12	3	14	0	0
Clay	18	1	0	8	3	0	2	4	6	0	6	6	5	9	3	0	1
Colfax	15	0	0	11	0	0	1	3	9	4	2	0	5	2	6	0	2
Cuming	10	0	2	2	1	0	3	2	3	6	1	0	1	2	7	0	0
Custer	26	3	1	10	1	0	4	7	12	4	4	6	9	3	10	2	2
Dakota	50	2	1	19	1	1	2	24	27	11	6	6	22	7	16	2	3
Dawes	6	1	0	0	0	0	3	2	2	2	0	2	1	1	3	0	1
Dawson	85	2	2	32	16	1	23	9	31	21	12	21	31	21	26	6	1
Deuel	2	0	0	1	1	0	0	0	0	1	1	0	1	1	0	0	0
Dixon	15	3	0	6	0	0	3	3	8	4	2	1	3	5	7	0	0
Dodge	148	6	3	57	6	1	18	57	67	39	15	27	57	43	37	7	4
Douglas	1,850	39	10	1,126	78	0	269	328	841	434	214	361	1,268	194	176	95	117
Dundy	1	0	0	0	0	0	0	1	0	1	0	0	0	1	0	0	0
Fillmore	21	0	0	7	1	0	1	12	11	5	3	2	10	5	6	0	0
Franklin	8	1	0	4	0	0	1	2	4	3	1	0	0	5	3	0	0
Frontier	2	1	0	1	0	0	0	0	1	1	0	0	1	1	0	0	0
Furnas	10	0	0	5	2	0	1	2	6	3	1	0	2	2	4	2	0

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

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

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

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

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

		# Times Removed		Gender			Age					Race						
County	Total	1st	2+	Male	Female	Un	0–5	6–12	13–15	16+	Un	Blk	Wht	Hsp	Ind	Asn	Oth	Unr
Gage	45	26	19	33	12	0	10	10	14	11	0	0	43	0	1	0	0	1
Garden	5	4	1	3	2	0	0	1	3	1	0	0	1	0	4	0	0	0
Garfield	1	0	1	0	1	0	0	1	0	0	0	0	1	0	0	0	0	0
Gosper	6	6	0	4	2	0	4	1	1	0	0	0	6	0	0	0	0	0
Grant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Greeley	10	5	5	4	6	0	2	3	2	3	0	0	10	0	0	0	0	0
Hall	194	125	69	108	86	0	63	48	37	46	0	3	144	18	12	4	0	13
Hamilton	12	4	8	10	2	0	5	1	2	4	0	3	8	0	0	0	0	1
Harlan	2	0	2	1	1	0	0	1	1	0	0	0	2	0	0	0	0	0
Hayes	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hitchcock	4	3	1	2	2	0	1	2	1	0	0	0	4	0	0	0	0	0
Holt	40	22	18	20	20	0	7	3	12	18	0	0	35	0	1	0	0	4
Hooker	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Howard	10	5	5	4	6	0	2	3	4	1	0	0	10	0	0	0	0	0
Jefferson	14	6	8	12	2	0	0	4	5	5	0	0	12	0	1	0	0	1
Johnson	8	8	0	5	3	0	1	2	2	3	0	0	6	0	1	0	0	1
Kearney	17	8	9	8	9	0	3	8	4	2	0	1	16	0	0	0	0	0
Keith	22	11	11	13	9	0	3	6	8	5	0	0	20	0	1	0	0	1
Keya Paha	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Kimball	14	9	5	9	5	0	8	3	3	0	0	0	12	0	1	0	0	1
Knox	12	8	4	5	7	0	3	2	4	3	0	0	6	1	4	0	0	1
Lancaster	770	458	312	430	338	2	154	208	167	241	0	138	516	27	64	4	2	19
Lincoln	181	89	92	104	77	0	31	48	55	47	0	1	143	17	11	0	0	9
Logan	3	3	0	1	2	0	1	1	0	1	0	0	3	0	0	0	0	0
Loup	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Madison	98	52	46	47	51	0	18	22	25	33	0	2	66	10	5	0	0	15
McPherson	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Merrick	9	7	2	5	4	0	2	2	1	4	0	0	5	4	0	0	0	0
Morrill	12	6	6	5	7	0	3	2	2	5	0	0	8	3	1	0	0	0
Nance	7	1	6	5	2	0	0	2	1	4	0	0	7	0	0	0	0	0
Nemaha	7	2	5	4	3	0	0	1	0	6	0	0	7	0	0	0	0	0
Nuckolls	16	9	7	7	9	0	3	4	5	4	0	0	12	0	0	0	0	4

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

Gender - male, female, unreported gender

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

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

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

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

		Adjudication Status							# of Placements				Closeness to Home				
County	**Total**	**Misd.**	**Fel.**	**Ab/n**	**Stat.**	**M.**	**2+**	**Un**	**1-3**	**4-6**	**7-9**	**10+**	**Same**	**Neigh**	**Non**	**0-C**	**Unc**
Gage	45	5	0	24	1	0	6	9	23	10	4	8	16	10	13	2	4
Garden	5	0	0	4	0	0	1	0	0	3	0	2	0	0	4	1	0
Garfield	1	0	0	1	0	0	0	0	1	0	0	0	0	1	0	0	0
Gosper	6	0	0	3	0	0	0	3	6	0	0	0	0	6	0	0	0
Grant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Greeley	10	0	0	9	1	0	0	0	5	1	2	2	1	4	5	0	0
Hall	194	11	1	92	6	2	14	68	104	38	21	31	96	32	62	1	3
Hamilton	12	1	0	5	1	0	3	2	4	4	2	2	4	6	2	0	0
Harlan	2	0	0	2	0	0	0	0	0	0	2	0	2	0	0	0	0
Hayes	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hitchcock	4	0	0	3	0	0	0	1	2	0	2	0	0	2	2	0	0
Holt	40	1	2	14	3	1	11	8	16	9	5	10	9	6	24	1	0
Hooker	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Howard	10	1	0	6	0	0	2	1	4	2	2	2	4	4	2	0	0
Jefferson	14	1	0	3	2	0	0	8	5	2	5	2	3	3	6	0	2
Johnson	8	0	1	2	1	0	0	4	6	1	1	0	2	1	4	1	0
Kearney	17	0	0	11	0	0	2	4	7	2	1	7	8	6	3	0	0
Keith	22	1	1	14	3	0	2	1	13	2	3	4	8	8	6	0	0
Keya Paha	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Kimball	14	0	0	8	0	0	1	5	10	0	3	1	8	4	1	1	0
Knox	12	0	0	7	0	0	0	5	6	5	1	0	6	2	4	0	0
Lancaster	770	53	7	428	29	0	101	152	370	162	87	151	497	54	182	21	16
Lincoln	181	10	0	77	23	0	41	30	69	41	36	35	93	24	50	8	6
Logan	3	0	0	0	1	0	0	2	2	1	0	0	0	2	1	0	0
Loup	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Madison	98	4	2	27	13	0	4	48	43	21	16	18	42	13	40	1	2
McPherson	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Merrick	9	2	0	4	0	0	1	2	6	2	0	1	1	7	1	0	0
Morrill	12	0	0	10	0	0	1	1	5	4	1	2	5	4	2	1	0
Nance	7	2	1	2	0	0	1	1	2	1	3	1	1	0	4	0	2
Nemaha	7	0	1	0	2	0	2	2	2	1	2	2	2	1	4	0	0
Nuckolls	16	0	0	4	2	0	2	8	7	5	0	4	6	4	6	0	0

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

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

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

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

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

		# Times Removed		Gender			Age					Race						
County	**Total**	**1st**	**2+**	**Male**	**Female**	**Un**	**0–5**	**6–12**	**13–15**	**16+**	**Un**	**Blk**	**Wht**	**Hsp**	**Ind**	**Asn**	**Oth**	**Unr**
Otoe	24	12	12	18	6	0	2	7	9	6	0	6	16	0	0	0	0	2
Pawnee	2	2	0	1	1	0	0	0	1	1	0	0	2	0	0	0	0	0
Perkins	2	2	0	0	2	0	1	1	0	0	0	0	2	0	0	0	0	0
Phelps	19	12	7	15	4	0	4	4	4	7	0	0	18	1	0	0	0	0
Pierce	6	4	2	5	1	0	0	3	2	1	0	0	5	0	0	0	0	1
Platte	54	25	29	31	23	0	2	5	15	32	0	1	45	2	4	0	0	2
Polk	4	3	1	3	1	0	0	2	1	1	0	1	3	0	0	0	0	0
Red Willow	24	17	7	12	12	0	8	4	4	8	0	0	22	1	0	0	0	1
Richardson	12	8	4	9	3	0	0	5	2	5	0	0	10	0	2	0	0	0
Rock	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Saline	21	14	7	12	9	0	4	4	4	9	0	0	20	1	0	0	0	0
Sarpy	267	138	129	130	127	10	44	41	75	107	0	36	195	8	3	2	2	21
Saunders	28	12	16	16	12	0	1	4	10	13	0	0	19	1	1	0	0	7
Scotts Bluff	157	82	75	97	60	0	40	42	45	30	0	0	68	30	48	0	0	11
Seward	30	13	17	14	16	0	3	6	8	13	0	0	27	0	1	0	1	1
Sheridan	18	14	4	11	7	0	9	2	4	3	0	0	4	1	12	0	0	1
Sherman	2	0	2	2	0	0	0	1	0	1	0	0	1	0	1	0	0	0
Sioux	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Stanton	4	4	0	3	1	0	1	0	1	2	0	0	2	0	1	0	0	1
Thayer	6	2	4	4	2	0	0	1	3	2	0	0	6	0	0	0	0	0
Thomas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Thurston	8	2	6	4	4	0	1	0	4	3	0	0	2	0	6	0	0	0
Valley	7	2	5	5	2	0	0	1	3	3	0	0	6	0	1	0	0	0
Washington	24	15	9	13	11	0	4	6	7	7	0	0	19	0	2	0	0	3
Wayne	5	4	1	3	2	0	0	3	1	1	0	2	2	1	0	0	0	0
Webster	8	7	1	5	3	0	4	1	1	2	0	0	8	0	0	0	0	0
Wheeler	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
York	46	27	19	24	22	0	9	8	13	16	0	0	45	0	0	0	0	1
Tribal	48	27	21	23	25	0	11	17	11	9	0	0	0	0	43	0	0	5
Unreported	152	141	11	83	41	28	4	19	59	67	3	4	21	0	1	0	0	126
Voluntary	124	121	3	64	59	1	93	12	2	16	1	6	53	4	3	46	3	9

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

Gender - male, female, unreported gender

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

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

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

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

		Adjudication Status							# of Placements				Closeness to Home				
County	**Total**	**Mis**	**Fel**	**Ab/N**	**Stat.**	**M.**	**2+**	**Unr**	**1-3**	**4-6**	**7-9**	**10+**	**Same**	**Neigh**	**Non**	**0-C**	**Unr**
Otoe	24	3	1	10	2	0	1	7	18	4	2	0	8	11	4	0	1
Pawnee	2	0	0	0	0	0	1	1	1	1	0	0	1	0	1	0	0
Perkins	2	0	0	2	0	0	0	0	2	0	0	0	2	0	0	0	0
Phelps	19	0	1	6	1	0	3	8	6	6	5	2	2	7	10	0	0
Pierce	6	0	0	2	0	0	0	4	2	3	1	0	2	3	0	0	1
Platte	54	5	1	21	7	0	6	14	21	10	9	14	13	12	28	1	0
Polk	4	0	0	0	0	0	2	2	2	1	0	1	0	2	2	0	0
Red Willow	24	1	0	4	6	0	4	9	8	9	4	3	10	2	12	0	0
Richardson	12	1	0	6	1	0	3	1	7	1	0	4	2	0	8	2	0
Rock	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Saline	21	1	0	10	0	1	5	4	14	2	4	1	3	11	2	0	5
Sarpy	267	6	2	88	21	0	88	62	115	54	29	69	88	121	29	13	16
Saunders	28	1	0	9	0	0	4	14	11	7	7	3	5	12	11	0	0
ScottsBluff	157	8	2	84	10	0	15	38	51	42	28	36	71	17	47	20	2
Seward	30	0	0	12	2	0	6	10	12	7	3	8	6	10	14	0	0
Sheridan	18	2	1	11	1	0	0	3	16	2	0	0	1	11	6	0	0
Sherman	2	1	0	1	0	0	0	0	0	2	0	0	0	1	1	0	0
Sioux	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Stanton	4	0	0	1	0	0	0	3	4	0	0	0	0	2	2	0	0
Thayer	6	0	2	2	1	0	1	0	1	2	0	3	0	2	4	0	0
Thomas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Thurston	8	0	1	3	0	0	1	3	2	2	2	2	2	1	4	1	0
Valley	7	0	0	5	1	0	1	0	2	4	0	1	0	0	4	2	1
Washington	24	5	1	4	1	0	1	12	15	7	0	2	7	9	6	2	0
Wayne	5	0	0	1	0	0	0	4	2	3	0	0	1	0	2	2	0
Webster	8	0	1	4	1	0	0	2	4	3	0	1	1	3	4	0	0
Wheeler	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
York	46	4	0	20	5	1	12	4	20	10	1	15	14	5	27	0	0
Tribal	48	1	1	16	0	0	1	29	32	6	7	3	29	2	14	3	0
Unreported	152	1	1	0	0	0	0	150	150	1	0	1	21	14	45	16	56
Voluntary	124	0	0	0	0	0	0	124	122	2	0	0	7	2	5	4	106

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

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

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

TABLE 11

NUMBER OF CHILDREN IN OUT-OF-HOME CARE ON DECEMBER 31, 2002 BY PLAN

Permanency Plan	HHS	Other Children
Return to Parent	2,260	37
Long Term Foster Care	356	8
Adoption	393	9
No Plan	293	4
Guardianship	217	4
Independent Living	132	2
Multiple Plans	93	0
Permanency	7	2
Semi-Independent Living	16	0
Relative Placement	6	1
Long Term Group	0	2
Other/Unknown	1,205	412
Total	4,886	481

Explanation of Table—This table shows the permanency plans for the children in out-of-home care and the number of children with each plan as of December 31, 2002. Children in the HHS column include children under Child Protective Services, children and youth under the Office of Juvenile Services (including Geneva and Kearney Youth Rehabilitation and Treatment Centers and Juvenile Parole), and children and youth at the Lincoln Regional Center.

"Other Children" would include non-HHS babies in pre-adoptive placements, children placed with private agencies, children privately placed in mental health facilities, and youth sentenced to county detention, correctional or probation facilities. For the Review Board's purposes, "Permanency" means adoption or guardianship is being considered; however, the legal process for termination of parental rights or relinquishment has not been completed.

TABLE 12

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

	Entering Care in 2002			Prior Years	
Age of child as of December 31st	First Removal from home In 2002	Prior premature, failed reunifications	Total Children Entering Care In 2002	Children entering care during 2001	Children entering care during 2000
Under 1	291	6	297	270	287
1 year	207	16	223	193	201
2 years	145	35	180	170	194
3 years	112	36	148	152	142
4 years	119	29	148	142	143
5 years	103	33	136	120	125
6 years	117	39	156	120	117
7 years	86	39	125	112	144
8 years	87	42	129	139	146
9 years	71	38	109	128	143
10 years	102	41	143	141	152
11 years	100	46	146	145	161
12 years	90	67	157	168	208
13 years	147	106	253	260	252
14 years	285	207	492	370	433
15 years	272	290	562	608	585
16 years	329	383	712	776	699
17 years	298	442	740	767	686
18 years	105	285	390	365	337
19 + years	40	31	71	49	52
Unknown age	4	0	4	37	74
TOTAL	3,110	2,211	5,321	5,232	5,281
# removed more than once			2,211	2,238	2,405
recidivist rate*			41.6%	42.8%	45.5%

*Recidivism rate here is computed as the percent of children entering care in the year who had been removed from the home at least once before, as in 2,221/5,321 = 41.6%)

Explanation of Table—This table shows the number of children who entered out-of-home care through both public and private agencies, and includes past years for comparison. Most children who enter care when age newborn through pre-adolescence enter care due to the parent's inability to parent, an abusive situation, neglect, or medical problems. Some are infants placed for adoption whose adoption has not been finalized. Older children may also enter care because of their own actions. This chart is based on the child's December 31st age, so children in the 19+ age group would have entered care while age 18 (19 is the age of majority).

The Board is particularly concerned with the number of young children experiencing premature, failed reunifications, due to brain research indicating that there can be physical changes to brain physiology caused by abuse, neglect, and separations from parents/caregivers.

TABLE 13

CASES TERMINATED IN 2002 BY REASON

Reason Left Care	No. of Children	
Custody Returned to Parent	2,513	
Released from Corrections (presumably to parents)	743	
Adoption Finalized	490	(277 HHS wards, 213 private)
Reached Age of Majority	322	
Guardianship Established	277	
Court Terminated (with no specifics given)	140	
Custody Transferred to Another Agency/State/Tribe	10	
Death of Child	6	
Emancipated by Military Service or Marriage	3	
No reason reported or other	392	
Total cases terminated	4,896	

Explanation of Table—This table shows the number of children whose cases were terminated (closed) for each reason during 2002.

TABLE 14

LIFETIME NUMBER OF TIMES IN FOSTER CARE (REMOVALS) FOR CHILDREN IN OUT-OF-HOME CARE ON DECEMBER 31, 2002

Summary

Lifetime Removals for Children in Care on 12-31-2002	Totals	Ages 0-5	Ages 6 –12	Ages 13- 15	Age 16+	Age Not Reported
In First Removal	3,168	1,048	811	637	667	5
Had Previous Removal(s)	2,199	187	452	648	912	0
Total	5,367	1,235	1,263	1,285	1,579	5

Details

Times in Foster Care (removals)	Totals	Ages 0-5	Ages 6 –12	Ages 13- 15	Age 16+	Age Not Reported
1	3,163	1,048	811	637	667	5
2	1,269	162	304	376	427	0
3	524	21	108	164	231	0
4	232	3	30	69	130	0
5	98	0	5	29	64	0
6	37	0	3	4	30	0
7	19	0	1	3	15	0
8	9	0	0	1	8	0
9	4	0	1	1	2	0
10	2	0	0	0	2	0
11 or more	5	1	0	1	3	0
Total	5,367	1,235	1,263	1,285	1,579	5

Explanation of Table – This table shows the lifetime number of times the child or youth has been removed from the parental home. Any number of times in care that is greater than one indicates that the child has experienced a premature or otherwise failed reunification attempt with the parents. 2,267 of the 5,559 children in care on 12-31-2002 had experienced one or more failed reunification attempts.

While failed reunifications can be detrimental for children at any age, the Foster Care Review Board is greatly concerned for the 145 preschool age children (birth through five years old) who have experienced one failed reunification attempt (2 times in foster care), the 28 preschool children who have experienced two failed reunifications (3 times in foster care), and the 4 preschool children who have experienced three failed reunifications (4 times in foster care).

Research shows that repeated early childhood traumas can impede normal growth and development, and can cause permanent changes in the physical makeup of children's brains. These changes can cause lifelong deficits in cognitive functions and response to normal stresses.

NOTES:

APPENDICES

Appendix A

Following a Case of Alleged Child Abuse/Neglect Through Juvenile Court

REPORT & INVESTIGATION -- A Case enters Juvenile court when a report of child abuse and/or neglect has been received by law enforcement, investigated, and substantiated. If the case is not diverted through voluntary services, law enforcement gives the evidence to the County Attorney.

↓

PETITION -- The County Attorney decides whether to file a petition. For abuse/neglect a petition would be filed under §43-247(3a). At this time the allegations of the problem/crime are stated. Nothing is determined, found, or ordered at this point. A petition must be filed within 48 hours of a child being removed or the child goes home.

↓

DETENTION HEARING -- Finds if probable cause exists to warrant the continuance of court action or the child remaining in out of home care. The case is either set for an adjudication hearing or the child is returned home and charges dropped. If set for adjudication, a Guardian ad Litem, also known as a GAL, [attorney representing the child's best interests] should be appointed at this time.

↓

ADJUDICATION HEARING -- By law this must occur within 90 days of the child entering out of home care. In practice the 90 day rule is not always adhered to. An adjudication hearing can be either contested or noncontested. Contested means that the parents deny the allegations and full trial with evidence ensues. At this hearing the finding of fact occurs, the allegations of the petition are found to be either true or false, and the child is either made a state ward or not.

↓

DISPOSITIONAL HEARING -- At this time a plan is ordered which addresses the reasons why the court action began. A rehabilitation plan for the parents is ordered.

↓

DISPOSITIONAL REVIEW HEARINGS -- Per PL 96-272, this hearing is to occur at least every six months to review the progress made on the dispositional order until conditions warrant the court terminating jurisdiction. The focus should be on whether progress is being made to correct the problem that brought the child into care or not. A Journal Entry should be filed recording what was ordered.

Following a Case
When the Case Involves the Actions of the Child
Through Juvenile Court

REPORT & INVESTIGATION -- A Case enters Juvenile court when a report of one of the following is received by law enforcement, investigated, and substantiated: status offense [an offense that would not be an offense for an adult, such as truancy], misdemeanor, or felony offense. If the case is not diverted through voluntary services, law enforcement gives the evidence to the County Attorney.

↓

PETITION -- The County Attorney decides whether to file a petition. For a status offense a petition would be filed under §43-247(3b). For a misdemeanor it would be under §43-247(1), for a felony under §43-247(2). At this time the allegations of the problem/crime are stated. Nothing is determined, found, or ordered at this point. A summons and charge could be issued, and a court date could be set.

↓

DETENTION HEARING -- Finds if probable cause exists to warrant the continuance of court action or the child remaining in out of home care. The case is either set for an adjudication hearing or the child is returned home and charges dropped. An attorney for the child may be appointed at this time.

↓

ADJUDICATION HEARING -- By law this must occur within 90 days of the child entering out of home care. In practice the 90 day rule is not always adhered to. At this hearing the finding of fact occurs, the allegations of the petition are found to be either true or false. At this hearing, the youth can admit or deny the allegation.

↓

DISPOSITIONAL HEARING -- At this time a plan is ordered which addresses the reasons why the court action began. A rehabilitation plan is ordered.

↓

DISPOSITIONAL REVIEW HEARINGS -- Per PL 96-272, this hearing is to occur at least every six months to review the progress made on the dispositional order until conditions warrant the court terminating jurisdiction. The focus should be if progress is being made to correct the problem that brought the child into care. A Journal Entry should be filed recording what was ordered.

Appendix B

STATE OF NEBRASKA
FOSTER CARE REVIEW BOARD
521 S. 14th Street, Suite 401
Lincoln, NE 68508-2707
(402) 471-4420

Applications for volunteers to serve on a local Foster Care Review Board as set in Nebraska Statue, Section 43-1301 to 43-1319, R.R.S. Employees of the State Foster Care Review Board or child caring and placing agencies or the Courts are ineligible to serve on local boards.

Name _____

Address _____ City _____ ZIP _____ Phone No. _____

Occupation Address _____ ZIP _____ Phone No. _____

I am available for training on the following (check all that apply)					**I am available to serve on a Board that meets on the following (check all that apply)**			
Day	Morning	Afternoon	Evening		Day	Morning	Afternoon	Evening
Mon.					Mon.			
Tues.					Tues.			
Wed.					Wed.			
Thurs.					Thurs.			
Fri.					Fri.			
Sat.			NA		Sat.			NA

Regular exceptions to the above schedule: _____

Nebraska Statute 43-1304 states: "The members of the Board shall reasonably represent the various social, economic, racial, and ethnic groups of the county or counties from which its members may be appointed." In order to comply with the Act, please answer the following:

Your age: 19-30 _____
31-45 _____
46 & older _____

Family income: $ 4,000-10,000 _____
$11,000-20,000 _____
$21,000-39,000 _____
$40,000 - above _____

Race: Caucasian ____ Black _____ Hispanic _____ Indian _____ Asian ____ Other _____

Marital status: _____ Number of children _____

I am presently a foster parent [this is not a requirement]: yes ____ no _____

continued➔

Please list current and past activities (you can use an additional sheet if more room is needed).

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

1. _____

2. _____

3. _____

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

FOR OFFICE USE ONLY:

Date application received _____

Part I Training _____ Part II Training _____

Date appointed to Board _____ Appointed to Board _____

STATE OF NEBRASKA

FOSTER CARE REVIEW BOARD

CONFIDENTIALITY

Foster Care, Chapter 43-1310. Records and information; confidential; unauthorized disclosure; penalty. All records and information regarding foster children and their parents and relatives in possession of the state board or local board shall be deemed confidential. Unauthorized disclosure of such confidential records and information and any violation of the rules and regulations of the Department of Social Services shall be a Class III misdemeanor.

Class III misdemeanor:	Maximum -	three months imprisonment, or five hundred dollars fine, or both
	Minimum -	none

CONSENT FORM

I, _____, agree to the rules and regulations set by the
(please print)
State Foster Care Review Board.

In particular, I promise not to disclose any information obtained from my participation in the Foster Care Reviews in accordance with confidentiality provisions.

I further promise not to use any information or data for my own personal, professional, or monetary advantage.

_____ _____
signature *date*

_____
address

_____, NE _____

Signed in the Presence of:

_____ _____
Signature *date*

NEBRASKA STATE FOSTER CARE REVIEW BOARD
521 S. 14th Street, Suite 401
Lincoln, NE 68508-2707
(402) 471-4420

Child Abuse/Neglect Central Register Release of Information

I hereby apply to serve on the Foster Care Review Board. I hereby give my permission and authorize any law enforcement agency, child protective service agency, governmental agency, or court to release to the State Foster Care Review Board, its agents or representatives, any documents, records, or other information pertaining to me.

I understand my name will be checked against the Nebraska Department of Health and Human Services Adult/Child Protective Services Central Registers. The purpose of this check will be to determine if my name is being maintained on either register as a result of previous abuse/neglect allegations that have been investigated and have not been determined to be unfounded. To the best of my knowledge, I do not have a conviction or prior history of adult or child abuse/neglect or maltreatment perpetration, neither have I been convicted of a crime involving moral turpitude.

I understand that my refusal to authorize the release of the above-mentioned information may adversely affect my application to serve as a member of the Foster Care Review Board.

I hereby release, discharge, and exonerate the State Foster Care Review Board, its agents and representatives, and any agency, court, or person furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, and other information, or the investigation made by the Foster Care Review Board.

_____ _____
Signature Date

Current Address _____ City_____State____ How Long? _____

Current Employer _____ How Long? _____

_____ _____ _____
Printed Name Birth Date Social Security Number

Other Names Used in Past Twenty (20) Years →
(Please Print or Type)
Use back of sheet if necessary

1. _____
2. _____
3. _____

1. _____
2. _____
3. _____

← Other Addresses Used in Past Twenty (20) Years
(Please Print or Type)
Use back of sheet if necessary

Names of Children Who Have Lived With You →
in Past Twenty (20) Years(Please Print or Type)
Use back of sheet if necessary

1. _____
2. _____
3. _____

Form revised 5-21-2001

Appendix C
ACKNOWLEDGEMENTS - 2002

The State Foster Care Review Board would like to acknowledge and thank the following churches, schools, hospitals, libraries, businesses, and community centers for allowing the local Foster Care Review Boards to use their facilities for monthly board meetings, prospective board member training programs, and on-going continuing education programs:

Abraham's Library, Omaha
All Saint's Parish, Omaha
Alliance Library, Alliance
Beatrice Community Hospital, Beatrice
Bennett Martin Library, Lincoln
Bergan Mercy Hospital, Omaha
Bess Johnson Library, Elkhorn
Calvary United Methodist Church, Lincoln
Children's Hospital Health Care, Omaha
Christ United Methodist Church, Lincoln
Columbus Police Department, Columbus
Douglas Co. Extension Office, Omaha
Educational Service Unit #16, Ogallala
First Christian Church, Omaha
First Lutheran Church, South Sioux City
Fremont Presbyterian Church, Fremont
Girls Inc., Omaha
Granton Township Library, O'Neill
Great Plains Medical Center, North Platte
Hastings Police Department, Hastings
Havelock United Methodist Church, Lincoln
Head Start Building, Fremont
Holling Center - Immanuel Hospital, Omaha
Immanuel Alegent, Omaha
Jewish Community Center, Omaha
Landmark Center, Hastings
LaVista Community Center, LaVista
Law Enforcement Center, Kearney
Lutheran Church of the Master, Omaha
Madonna Rehabilitation Center, Lincoln
Make-A-Wish Offices, Omaha
MidTown Business Center, Kearney
Morning Star Lutheran Church, Omaha
Nebraska State Bar Association, Lincoln
Nemaha County Hospital, Auburn
New Life Baptist Church, Bellevue
Odyssey III Counseling, Norfolk
Parkwood Terrace Apartments, Omaha
Pierce County Courthouse, Pierce
Rainbow House, Omaha
Regional West Medical Center, Scottsbluff
Seward Civic Center, Seward
Sheridan Lutheran Church, Lincoln
St. Francis Medical Center, Grand Island
St. Paul's United Methodist Church, Lincoln
St. Stevens Building, Grand Island
St. Timothy's Lutheran Church, Omaha
St. Wenceslaus Catholic Church, Omaha
State Office Building, Omaha
Sump Memorial Library, Omaha
Swanson Library, Omaha
Thanksgiving Lutheran Church, Bellevue
United Nebraska Bank - Lexington
University of Nebraska Medical Center, Omaha
Vine Congregational Church, Lincoln
York General Hospital, York

APPENDIX D

STATE FOSTER CARE REVIEW BOARD
FINANCIAL STATEMENT
Fiscal Year 2002-2003

Appropriations

General Fund	$1,169,559.96
Cash Fund	$12,791.57
Federal Funds	$651,667.42
TOTAL	$1,834,018.95

Expenditures

Staff Salaries & Benefits	$1,318,984.25
Postage	$42,098.70
Telephone and Communications	$23,155.44
Data Processing Fees	$28,893.73
Publications and Printing	$44,003.09
Rent	$49,616.41
Legal Fees	$4,262.80
Office Supplies & Miscellaneous	$30,767.66
Travel Expenses	$48,135.72
Data Processing & Office Equipment	$15,414.19
Other Administrative & Contractual	$117,647.05
TOTAL	$1,722,979.04