The Nebraska
Foster Care Review Office
Quarterly Report

Submitted pursuant to Neb. Rev. Stat. §43-1303 (4)

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In Appreciation

As described throughout this document, the work done on the Barriers to Permanency Project would not have been possible without the collaboration and cooperation of the following:

- Office of the Inspector General for Child Welfare, especially Julie Rogers.
- The Department of Health and Human Services, especially:
    - Vicki Maca, Deputy Director.
    - Doug Beran, Research, Planning and Evaluation Administrator.
    - Lindy Bryceson, Filed Operations Administrator.
    - Jerrilyn Crankshaw, Western Service Area Administrator.
    - Kathleen Stolz, Central Service Area Administrator.
    - Mike Puls, Northern Service Area Administrator.
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    - Camas Steuter, Eastern Service Area Administrator.
    - All the supervisors and case managers for the children involved.
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- The Court Improvement Project, especially Staff Attorney Kelli Hauptman.
- Intern Leanne Hinrichs, who assisted with some spreadsheets.

Please accept our thanks
on behalf of the Foster Care Review Office
and
Nebraska's abused or neglected children.

Executive Summary

The Foster Care Review Office's (FCRO) role under the Foster Care Review Act is to independently track children in out-of-home care, review children's cases, collect and analyze data related to the children, identify conditions and outcomes for Nebraska's children in out-of-home care, and make recommendations on any needed corrective actions. The FCRO is an independent state agency, not affiliated with the Department of Health and Human Services, the Courts, the Office of Probation, or any other child welfare entity.

This Quarterly Report focuses on the collaborative work done by the Barriers to Permanency Project and features the recently completed report by the collaborative.

One of the recommendations from the FCRO's June 2013 Quarterly Report was the creation of a collaborative process to review cases of children that had lingered in foster care in order to determine their individual characteristics and what was preventing the children from reaching a timely permanency.

By August 2013, the Barriers to Permanency Project (hereinafter referred to as the Project) had been created and a collaborative was formed including the Nebraska Inspector General of Child Welfare, the Department of Health and Human Services (DHHS), Nebraska Families Collaborative (NFC), the Court Improvement Project (CIP), and the Foster Care Review Office (FCRO).

The group looked at children that at a point in time were in out-of-home care for three years or longer. As the group reviewed the cases, they collected data regarding the children's characteristics. It was found that children with serious or chronic conditions tend to remain in an impermanent situation longer than other children, while having some of the highest levels of needs. (page 11)

Then there were staffings with the children's worker and supervisor in which pairs of members of the collaborative interviewed those workers to determine the top barriers to permanency for each case. Final statistics were tabulated.

In summary, the top five barriers to permanency identified by the group included: (page 27)

1. Past case management/supervision issues and practices.
2. County attorney would not, or could not, file a termination of parental rights petition.
3. Court delays, continuance, full dockets, scheduling issues, and related matters.
4. Need for a relative search at the time of removal.
5. Length of time to an appellate decision on a termination of parental rights.

After reflecting on the data collected and the comments made by workers and supervisors, we began to organize and draft this Report. From the beginning we were clear that we wanted this Report to not only help the children who met Project criteria but also to prevent other children from facing prolonged out-of-home care experiences.

Based on discussions of the barriers, the members of the collaborative were asked to provide their input on the top systemic changes that must occur if we are to achieve timely permanency for all children.

Top Systemic Changes Needed

1. **Change to a true rehabilitative model for child welfare.** Nebraska is in the position of having juvenile courts that should be of the rehabilitative model having to work within a prosecutorial or adversarial framework. By definition this puts parents on the defensive when their children are removed from the home – which is precisely the period when you want to engender the most collaboration and problem-solving so that issues can be resolved quickly.

   Nebraska should look at how other states structure their child welfare systems to be rehabilitative. For example, one area to consider is the transfer of legal responsibility from the County Attorney to DHHS attorneys after adjudication. Since DHHS attorneys represent the case manager, the primary person responsible for recommendations to the legal parties, cases could proceed quicker through the legal system. That would require a change in statute to allow DHHS attorneys to file certain legal proceedings such as termination of parental rights petitions.

2. **Improve access to funding, resources, and services throughout all parts of the service array. Do so in a way that does not require an out-of-home placement in order to access services. Reserve out-of-home placements for true safety concerns.**

   a. **Expand prevention services, including those outside the formal system,** so that more children can be safely maintained in the home while addressing issues before they reach a crisis level**.** This is also a key component of a rehabilitative system.

   b. **Find a practical way to blend or braid funding so that families can get the services they need.** Funding is an obstacle to serving children at home, to getting children and families needed therapies, treatments, and services, and to supporting reunification. Funding comes from a variety of different "silos," each with their own often contradictory requirements.

   c. **Develop a crisis/emergency response unit** to work with families that have reunified or at risk for a removal. A crisis tends to happen at night or on the weekends when therapists are not working. Families in crisis need immediate access to defuse the situation until they can get into on-going help. This could help keep more families intact and reduce the trauma for children.

   d. **Re-assess the way that Nebraska interprets Medicaid rules**. The rules are currently interpreted in the narrowest way, restricting access to services. In other states, Medicaid reimburses providers more adequately and will pay for expenses that are denied by Nebraska. Service provider capacity is always an issue, and Nebraska would likely have more providers and different services if it could be more flexible on how it spends available funds.

3. **Stabilize the case management workforce. Determine why vacancies occur**, especially in the rural areas. Use what is learned to stabilize the workforce, and reduce the burden placed on remaining staff when vacancies occur.

4. **Create better case management practices.**

    a. **Put a stronger focus on SDM assessments**[1] for decisions and case progression both within the judicial system and case management system.

    b. **Assure that decisions made by the judicial and the case management systems are trauma informed**.

    c. **Identify and address mental health issues early on,** whether that is for infants, toddlers, or older children.

    d. **Ensure that an extensive family search and engagement process begins immediately upon removal.** Locate and engage non-custodial fathers and extended family/relatives. Determine their suitability as placements.

    e. **Create more placement options** based upon the unique needs of the child**.** We need Nebraska providers to commit to serving all youth and the judicial system needs to stop ordering them out of state. The farther away such placements are, the more difficult to reunify with family or achieve other forms of permanency in a timely manner. Rural areas in particular have a lack of treatment foster homes and professional resource family care.

    f. **Hold parents accountable** and ensure that all services are goal-oriented so that an appropriate decision can be made as to whether substantial changes have been completed to safely care for their children.

    g. **Increase availability of child/adolescent mental health resources.** Children who need higher levels of care often have to leave their communities and support networks to receive the care they need. Also, in rural areas there is a lack of mental health providers. This results in children and families having to travel at some distance, causing children to miss school and activities and sometimes being placed in out-of-home care.

5. **Address legal issues.**

    a. **Improve timely access to the court dockets,** especially in Omaha, for termination of parental rights (TPR) trials, requests for hearings, and to set aside more time for hearings.

    b. **Assist areas of the State where it is difficult for county attorneys to file a termination of parental rights petitions due to the amount of labor or costs.** For example the Western Service Area has difficulty in being able to get more than one TPR filed at a time in some jurisdictions because of the labor intensive requirements. We also have some areas that are concerned about the costs of the TPR and court proceedings.

    c. **Continue to monitor the time for an appellate decision.**

[1] SDM, or Structured Decision Making, is a proprietary set of assessments which has been shown to standardize response to child abuse and neglect reports.

6. **Examine how the state could look at data and information in a continuous, consistent manner.** Develop means for DHHS to have more flexibility and the ability to report out data easily. Start discussions of a possible data warehouse to enable a broader view of data on children in out-of-home care. Information sharing among separate data systems must occur with the goal of determining outcomes and whether children are better off when they exit the child welfare system than when they entered.
7. **Replicate this Project in a few years to determine the extent of any improvements and to identify any new issues.**

In addition to the above recommendations, in this Report you will find a description of common characteristics of children who met Project criteria (3 or more years in out-of-home care), how those characteristics impact children's needs, and a description of each of the top barriers to permanency that were identified by Project participants.

We also point your attention to the next section on changes that have already occurred due to the Project.

CHANGES THAT HAVE ALREADY OCCURRED DUE TO THE PROJECT

In addition to increasing the amount of collaborative brain-storming that is occurring in a number of different venues, some important system improvements have been planned and/or implemented as a result of this Project.

Children whose cases have closed

More than half, **252 (55%) of the Project children achieved permanency or otherwise left foster care** by February 2, 2015. The chart below shows why they exited the system.

	Central	Eastern	Northern	Southeast	Western	Total
Adopted	2	88	4	11	21	**107 (43%)**
Reached age of majority	2	46	2	12	1	63 (25%)
Return to parent or guardian	1	32	1	2	1	37 (15%)
Guardianship	2	25	0	6	2	**35 (14%)**
Transferred to another agency (often Probation)	0	1	1	2	1	5 (2%)
Transferred to adult court	0	3	0	0	0	3 (1%)
Runaway, dismissed by court	0	1	0	0	0	1 (<1%)
Total	**7**	**196**	**8**	**33**	**7**	**251**
Percent of children in the Project that left care	*29%*	*64%*	*29%*	*40%*	*41%*	*55%*

It is critical to note here that the Eastern Service Area was done first (December 2013) and thus those cases have had the most time to return home. The Southeast Service Area was done next (March 2014). The Central, Northern, and Western were then done at the same time (late summer 2014).

Therefore, it would be expected that more children from the Eastern and Southeast areas would have achieved permanency in the period since the Project review of their cases.

Relative search documentation made easier to find

Project members, including DHHS staff, had difficulty finding documentation about searches for relatives, the results of those searches, and whether certain relatives needed to be re-contacted to determine if they might now be suitable placements for the child.

However, during the course of the Project, DHHS developed and has now implemented several computer system improvements including:

- Mechanizing the required notification to the court of worker's contacts with family and making that easier to find.
- Automating the contact letter to selected family members.
- Standardizing where to document family response.
- Providing a visual depiction of family relationships.
- Creating reports to supervisors regarding whether family contacts have been documented on the system in required timeframes.

This is an amazing amount of work in a short period of time. **We congratulate DHHS on this accomplishment**.

Changes in the Court of Appeals

As a result of the issues we have previously discussed and the annual report of the Office of Inspector General for Child Welfare, the Court of Appeals and Administrative Office of the Courts did conduct an internal review of the appeal processes within the appellate courts. As a result of their review, certain processes were changed and the length of time to an appellate decision has been reduced.

Cross-agency discussions on how to apply lessons learned to daily practice

Project findings have been a regular item of discussion in a monthly collaborative meeting with DHHS administration, the Court Improvement Project, the Inspector General for Child Welfare, the Office of Probation Administration, and the Foster Care Review Office. Discussions have been centered on the application of what was learned from the Project to practices in the field.

There have also been discussions between the Foster Care Review Office and Nebraska Families Collaborative (NFC).

Meetings with external stakeholders

DHHS has invited the FCRO to discuss statistical and other findings from FCRO reviews and the Barriers to Permanency Project at its regular meetings with external stakeholders who provide placements and/or services. Discussions will be centered on how external stakeholders are needed to truly impact systemic reform in this area.

ORIGINS AND DESCRIPTION OF THE BARRIERS TO PERMANENCY PROJECT

The Foster Care Review Office's June 2013 Quarterly Report focused on children that had been continuously in out-of-home care for more than two years. That report did not include the months spent in foster care during prior removals. It just considered their current removal from home. Some of the state-wide data in that report included:

- 870 (23%) of the 3,854 children in out-of-home care at that time had been in out-of-home care for 2 years or longer, with 432 of those in out-of-home care for 3 years or longer. [*By the time the Project reviewed cases, there were 455 in care 3 years or longer*.]
- The Eastern Service Area and Southeast Service Area had a significantly higher percentage of children in out-of-home care for two years or longer.

One of the recommendations from the FCRO's June 2013 Quarterly Report was the creation of a collaborative process to review each of these children to determine their individual characteristics and barriers to permanency.

By August 2013, the Barriers to Permanency Project (hereinafter referred to as the Project) had been created and a collaborative was formed including the Nebraska Inspector General of Child Welfare, the Department of Health and Human Services (DHHS), Nebraska Families Collaborative (NFC), the Court Improvement Project (CIP), and the Foster Care Review Office (FCRO).

Two points were considered:

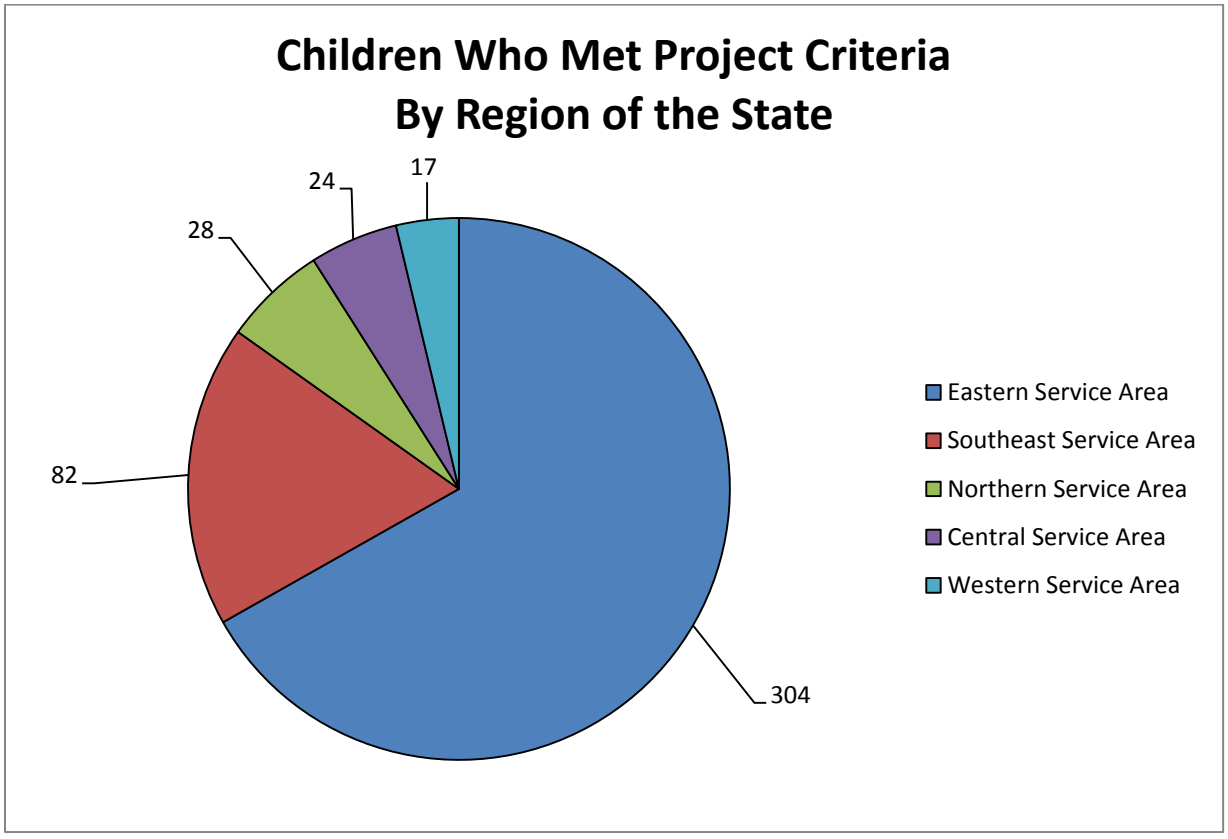
1. ***Were there particular characteristics common to many of the children who had been in out-of-home care for 3 years or longer? If so, what can we learn from that?***
2. ***What specific barriers still exist that impede permanency for these children?***

Due to the size of this undertaking, the Project started with the Eastern Service Area (Douglas and Sarpy Counties), continued with the Southeast Area, and then proceeded to the remainder of the state. Statewide, there was an intense examination of the cases of 455 children. Appendix A contains a description of the process used to review each of these children in the Project. The rest of this report describes the children who met Project criteria and the barriers identified.

At the beginning of the Project, it was the belief of the Project members that:

- Every system is set up to get the outcomes they are currently getting – meaning that to change the outcomes we will need to identify the "what" in the system that is helping to create those outcomes and then develop strategies to change the system. The outcomes are representative of the deeper system issues.
- Lessons learned from reviewing and assisting these children to achieve permanency can be applied to the cases of other children in the child welfare and juvenile justice systems.
- Lessons learned should be applied to the creation of policy recommendations to improve permanency outcomes for children in out-of-home care.

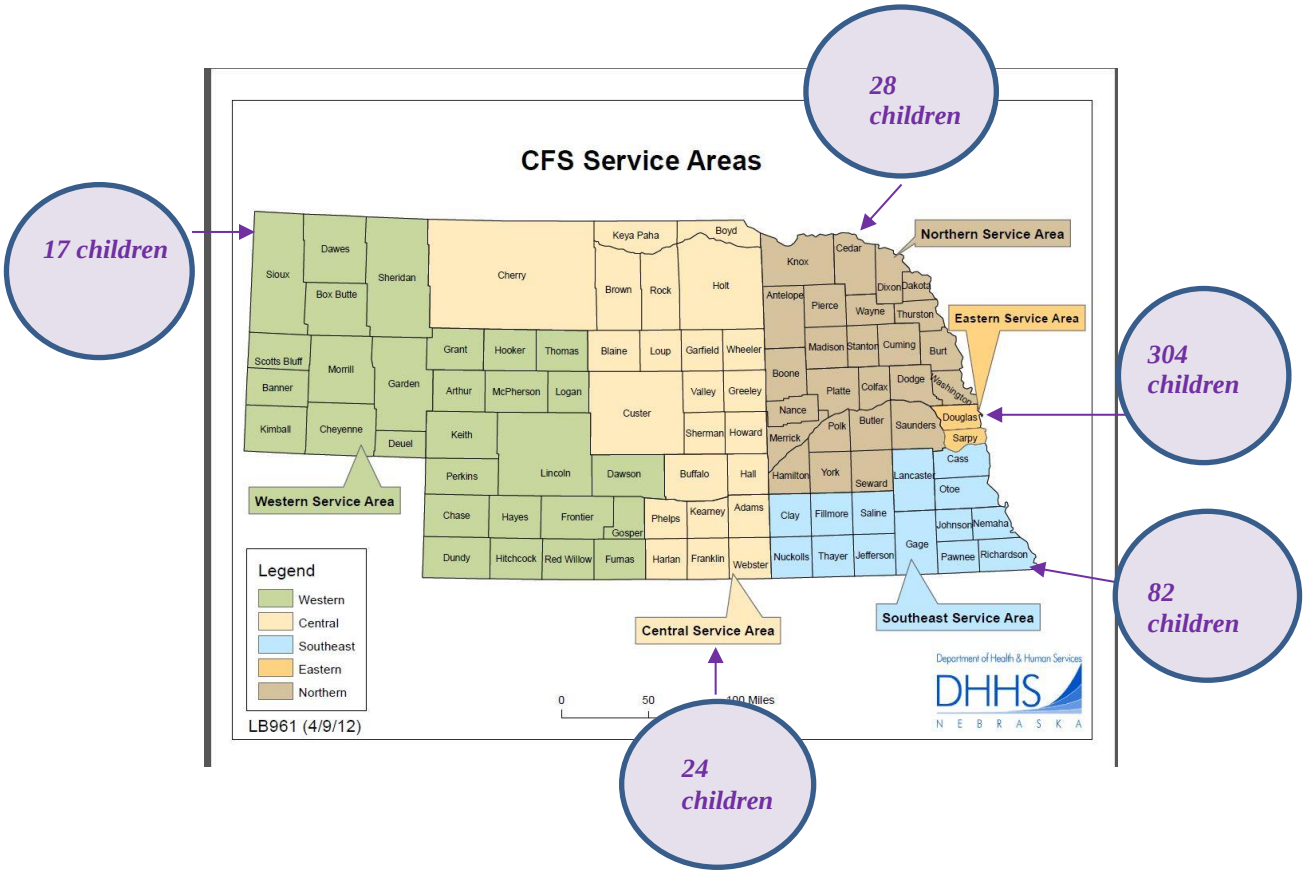
The chart below shows the geographic distribution of children who met the Project's criteria; that is, children who were in out-of-home care for 36 months or longer at a point in time.



CHARACTERISTICS OF CHILDREN IN THE PROJECT

GEOGRAPHIC DISTRIBUTION

All five DHHS service areas were included in the Project, with the number who met the Project criteria of continuous out-of-home care for three years or longer from each area shown below.



Data was collected from each service area. It was found that there were some commonalities in the barriers to permanency and in the child characteristics, and some distinct regional differences. One example of differences can be found in the next chart, which compares children in care 3 years or longer to the population of all children in out-of-home care in that respective Service Area.

	Central	Eastern	Northern	Southeast	Western
All Children in out-of-home (OOH) care on7/1/2014, regardless of how long	11%	**46%***	13%	24%	9%
3 years or more in OOH care at the time Project criteria was applied (spring/summer 2014)	5%	**67%***	6%	18%	3%

*** The Eastern area had 46% of all Nebraska children in out-of-home care, but had 67% of the children in care for 3 years or longer.**

DEMOGRAPHICS

Age

Since only children older than 36 months of age could be included in the Project (they needed to be in out-of-home care that long), it was assumed that few children age three to five would be in this group. Nonetheless, **9% of the children in the Project were under age six,** which would be most of their life in out-of-home care; 34% of the children were age 6-12; and, 57% of the children were age 13-18.

The following chart shows the age groups of each child in out-of-home care by individual service areas.

Age group	Central	Eastern	Northern	Southeast	Western	Total
Age 3-5	1	32	1	6	1	41 (9%)
Age 6-12	10	115	8	19	2	154 (34%)
Age 13-18	13	157	19	57	14	259 (57%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

So the natural question is how the above percentages compare to the general population in out-of-home (OOH) care. The following chart shows this for each region. The percentages will not equal 100 because children age 0-2 could not have been in out-of-home care for 3 years or longer.

Age group	Central		Eastern		Northern		Southeast		Western	
	% in Project	% in OOH care 2/1/2015	% in Project	% in OOH care 2/1/2015	% in Project	% in OOH care 2/1/2015	% in Project	% in OOH care 2/1/2015	% in Project	% in OOH care 2/1/2015
Age 3-5	4%	13%	11%	10%	4%	11%	7%	12%	6%	12%
Age 6-12	42%	30%	38%	35%	29%	32%	24%	32%	12%	34%
Age 13-18	54%	28%	52%	29%	68%	29%	68%	29%	82%	24%

*The percentages above do not equal 100 because ages 0-2 did not meet the Project criteria.

Race

Minority children are overrepresented in the out-of-home population as a whole, and thus it was expected that they would be overrepresented in the Project as well (see the December 2014 FCRO Annual Report and the September 2014 FCRO Quarterly Report for more information on racial overrepresentation in out-of-home care).

However, as outlined next we did find **some differences** that were beyond what was expected. This first chart looks at race for each of the Service Areas.

Race	Central	Eastern	Northern	Southeast	Western	Total
American Indian	3 (13%)	16 (5%)	1 (4%)	3 (4%)	3 (18%)	26 (6%)
Asian	0	0	0	1 (1%)	0	1 (<1%)
Black	4 (17%)	129 (42%)	6 (21%)	11 (13%)	0	150 (33%)
Hispanic	3 (13%)	0	1 (4%)	NA	0	4 (1%)
Mixed	NA	13 (4%)	NA	7 (9%)	NA	20 (4%)
Unknown	1 (4%)	15 (5%)	0	10 (12%)	0	26 (6%)
White	13 (54%)	131 (43%)	20 (71%)	50 (61%)	14 (82%)	228 (50%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

Ethnicity	Central	Eastern	Northern	Southeast	Western	Total
Hispanic	6 (25%)	32 (11%)	1 (4%)	2 (2%)	1 (6%)	42 (9%)
Non-Hispanic	18 (75%)	272 (89%)	27 (96%)	80 (98%)	16 (94%)	413 (91%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

The next analysis was to compare the general population of all children in Nebraska (census data); the population of all children in out-of-home care regardless of length of time; and the population of children that had been out-of-home three years or longer. In the next chart, only the four races available in U.S. Census data are included, so the totals do not add up to 100%. As depicted in the chart, Black children are removed at a higher rate and remain in out-of-home care at a significantly higher rate.

Race	**% of all Nebraska Children per Census**	**% of all children in out-of-home care 2/1/2015** (regardless of time in care)	**% of the children in out-of-home care for 3 years or longer**
American Indian	2%	8%	6%
Asian	2%	<1%	<1%
Black	6%	19%	**39%**
White	86%	62%	53%

Looking specifically at Black children from Douglas County (just Douglas County, not the full Eastern Service Area):

Race	% of all Douglas County Children per Census	% of all in out-of-home care 2/1/2015 (regardless of time in care)	% in the 3 years in care group
Black	13%	21%	48%

Due to this disparity, we have included a special section on Douglas County later in this report.[2]

PARENTAL MARITAL STATUS

After reviewing children from the Eastern Service Area, it was determined that the Project should collect information on parental marital status for the rest of the state. The Project found that for the 151 children from the Southeast, Northern, Central, and Western Service Areas:

- 49% of the parents were single, never married.
- 41% of the parents were divorced, widowed, or separated.
- 10% of the parents were married.

PARENTAL RIGHTS

Under Federal statutes, as codified in Neb. Rev. Stat. 43-292.02, when children have been in out-of-home care for 15 of the past 22 months the courts must hold a hearing to determine if a termination of parental rights should be sought. Under the federal/state law, the only exceptions are: 1) if it is documented it is not in the best interests of the child, 2) if the only reason the child is in care is parental incarceration; 3) if the child is placed with a relative; 4) if the parent has not been given opportunity to address the issues that caused the child to be removed from the home; and 5) if the only reasons that the child is in care is the parent is financially unable to provide health care needed by the child. Otherwise the county attorney (prosecutor) must consider bringing forth a petition to terminate the parental rights.

Before a termination trial can ensue, the prosecutor needs to make sure there is sufficient evidence to prove: 1) that termination is in the child's best interests, and 2) that one or more of the grounds of parental unfitness described in Neb. Rev. Stat. 43-292 exist. Parents have full due process rights, as one would expect with so serious a matter. After the termination trial, it is common for there to be an appeal of the decision.

The following charts, one for the mother and one for the father, show the status of parental rights on the date of the Project review.

One third of the parents had intact parental rights even though their children had been in out-of-home care for 36 months or longer. The collaborative did not collect data on whether an exception to filing a termination had been granted. **Over half of the parents no longer had parental rights.**

[2] **See Appendix C for more information about the children from Douglas County.**

Mother's Rights Status	Central	Eastern	Northern	Southeast	Western	Total
Intact	7 (29%)	94 (31%)	10 (36%)	27 (33%)	8 (47%)	146 (32%)
Relinquished	11 (46%)	80 (26%)	7 (25%)	32 (39%)	1 (6%)	131 (29%)
Terminated	5 (21%)	79 (26%)	8 (29%)	19 (23%)	7 (41%)	118 (26%)
Mother deceased	0	9 (3%)	1 (4%)	3 (4%)	1 (6%)	14 (3%)
Unable to determine at time of Project review*	1 (4%)	40 (13%)	2 (7%)	1 (1%)	0	44 (10%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

*Documentation of parental rights was not found at the time of the file reviews.

Father's Rights Status	Central	Eastern	Northern	Southeast	Western	Total
Intact	8 (33%)	102 (34%)	9 (32%)	24 (29%)	6 (35%)	149 (33%)
Relinquished	7 (29%)	39 (13%)	7 (25%)	23 (28%)	4 (24%)	80 (18%)
Terminated	5 (21%)	86 (28%)	10 (36%)	23 (28%)	4 (24%)	128 (28%)
Father deceased	1 (4%)	21 (7%)	1 (4%)	6 (7%)	2 (12%)	31 (7%)
Unable to determine at time of Project review*	3 (13%)	56 (18%)	1 (4%)	6 (7%)	1 (6%)	67 (15%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

*Documentation of parental rights was not found at the time of the file reviews.

PRIMARY PERMANENCY OBJECTIVE

The following shows the primary permanency objective for the children on the day of the in-person Project review with the child's caseworker. The permanency objective is the stated goal of the plan that is written by DHHS and presented to the court. The court may accept the plan as written, modify that plan, or wholly replace that plan.

In almost two-thirds of the children's cases, the permanency objective was adoption/guardianship which leads one to question why these children have still not achieved permanency.

Plan objective	Central	Eastern	Northern	Southeast	Western	Total
Adoption	13 (38%)	118 (39%)	12 (43%)	42 (51%)	6 (35%)	191 (41%)
Guardianship	3 (13%)	58 (19%)	4 (14%)	28 (34%)	6 (35%)	99 (22%)
Reunification	3 (13%)	54 (18%)	4 (14%)	5 (6%)	2 (12%)	68 (15%)
Independent Living	5 (21%)	38 (13%)	5 (18%)	6 (7%)	2 (12%)	56 (12%)
Other/unknown	0	36 (12%)	3 (10%)	1 (1%)	1 (6%)	41 (9%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

CHRONIC CONDITIONS OR IMPAIRMENTS, AND TRAUMA

The Project population had a higher percentage of children with a mental health diagnosis, behavioral health issue, physical/orthopedic impairment, or developmental disability than is found in the general population of children in out-of-home care. **As shown in this section, children with serious or chronic conditions tend to remain in an impermanent situation longer than other children, and they also have some of the highest levels of needs**.

Childhood trauma has been linked to many acute and chronic conditions, such as those mentioned above. About childhood trauma:

- Experts in childhood trauma recognize that some mental health issues can stem from adverse childhood experiences such as abuse, neglect, and instability in caregivers.
- Behavioral issues can be an understandable reaction to past traumatic experiences, including experiences in the foster care system – such as being moved from caregiver to caregiver, having to discuss sensitive details of their lives over and over again every time the caseworker attached to their case changes, the uncertainty of when or if they will see their parents or siblings, frustration over educational delays, and the like.
- Behavioral issues are not always related to a mental health diagnosis, though they can be linked in some cases.
- Mental health and/or behavioral issues can make it more difficult to parent the child, and can create issues in finding persons to adopt or provide guardianship if the parents are unable or unwilling to provide care.
- Although measuring the extent of trauma each child experienced was beyond the scope of the Project, trauma was certainly an underlying issue.

More research is needed to determine if the children in the Project who had mental health or behavioral issues entered out-of-home care with these issues or if those issues were exacerbated by the length of time in the uncertainty of "temporary" foster care. The Southeast Service Area was the only service area where caseworkers and supervisors recognized and identified that the after effects of children's trauma was a barrier to permanency and included it with other barriers statistically identified; however, children's trauma was a recurrent theme throughout all the Project reviews.

Funding or subsidy issues were often seen for children with chronic or recurrent mental health, medical, or developmental needs.

Mental health/behavioral health

Impact – Half (48%) of the children's cases in the Project involved a child with a mental health diagnosis by a professional as documented in the DHHS/NFC file.
In comparison, 32% of all children in out-of-home care reviewed statewide by the FCRO during the first half of 2014 (regardless of time in care) had a mental health diagnosis.

Mental health diagnoses cover a range of conditions. A few of the more common include: depression, oppositional/defiant disorder, attention deficit and disruptive behavior disorders,

feeding/eating disorders, separation anxiety disorders, mood disorders, dissociative disorders, sleep disorders, etc.

The following shows the distribution of children with a mental health diagnosis by service area.

Child with a mental health diagnosis	Central	Eastern	Northern	Southeast	Western	Total
Yes	5 (21%)	142 (47%)	14 (50%)	45 (55%)	11 (65%)	217 (48%)
No	19 (79%)	162 (53%)	14 (50%)	37 (45%)	6 (35%)	238 (52%)
Total	24	304	28	82	17	455

There were regional differences in the distribution by age group for children found to have mental health issues. It is unclear why the age group differences exist but it could be that the older the child is the more time to collect assessment data to support a diagnosis.

A larger concern is that 7 (3%) children aged 3-5 had a mental health diagnosis and 66 (30%) children aged 6-12 had a diagnosis. We do need to question the reason and basis for these types of diagnosis at such a young age of the child.

Age group of child with a mental health diagnosis	Central	Eastern	Northern	Southeast	Western	Total
Age 3-5	0 (0%)	7 (5%)	0 (0%)	0 (0%)	0 (0%)	7 (3%)
Age 6-12	0 (0%)	53 (38%)	4 (29%)	8 (18%)	1 (9%)	66 (30%)
Age 13-18	5 (100%)	82 (58%)	10 (71%)	37 (82%)	10 (91%)	144 (66%)
Total	5	142	14	45	11	217

Mental health diagnosis is not always related to a behavioral issue, though they are linked in some cases. Behavioral health is discussed next.

Behavioral health

Impact – Half (47%) of the children's cases involved a child with a behavioral health issue/diagnosis.
In comparison, 37% of children reviewed statewide by the FCRO during the first half of 2014 had a diagnosed trauma condition that could lead to behavioral issues.

Behavioral issues are not always related to a mental diagnosis, though they are linked in some cases. These are not children who are occasionally "naughty," rather these are children who are reacting to some very negative early life experiences and need help coping.

Behavioral issues can include: inappropriate actions/emotions under normal circumstances; tantrums uncommon for children of that age; difficulties with developing normal relations with teachers, peers, or caregivers; feelings of fear and anxiety; being hostile, irritable or

uncooperative; obsessive-compulsive behaviors; panic attacks; refusing to follow rules; being aggressive; being withdrawn; and general unhappiness.

Behavioral issues can make it more difficult to parent or give care to the child, and can create issues in finding persons to adopt or provide a guardianship for the child if the parents are unable or unwilling to provide care.

The following shows the distribution of behavioral health diagnosis by service area.

Behavioral issue	Central	Eastern	Northern	Southeast	Western	Total
Yes	8 (33%)	128 (42%)	19 (68%)	51 (62%)	10 (59%)	216 (47%)
No	16 (67%)	176 (58%)	9 (32%)	31 (38%)	7 (41%)	239 (53%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

There were regional differences in the distribution by age group for children with behavioral issues. For example, the teenage population was 57% of the children in the Project, but 71% of them had a behavioral health issue.

Age group of child with a behavioral issue	Central	Eastern	Northern	Southeast	Western	Total
Age 3-5	0	6 (5%)	0	2 (4%)	0	8 (4%)
Age 6-12	1 (14%)	35 (27%)	7 (37%)	10 (20%)	1 (10%)	54 (25%)
Age 13-18	7 (88%)	87 (68%)	12 (63%)	39 (76%)	9 (90%)	154 (71%)
Total	8	128	19	51	10	216

Medical - Physical/orthopedic impairment

Impact – A quarter (24%) of the children in the Project had a physical or orthopedic impairment.

In comparison, 6% of children reviewed statewide by the FCRO during the first half of 2014 had a speech or language impairment, and 2% had a physical or orthopedic impairment.

The following shows the distribution of physical/orthopedic impairment by service area.

Medical or physical issue	Central	Eastern	Northern	Southeast	Western	Total
Yes	4 (17%)	70 (23%)	7 (25%)	20 (24%)	6 (35%)	107 (24%)
No	20 (83%)	234 (77%)	21 (75%)	62 (76%)	11 (65%)	348 (76%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

Some of the differences in percentages between areas may be a result of the small number of children in the Project from some of the service areas.

There were some regional differences in the distribution by age group for children with physical/orthopedic issues.

Age group of children with a medical or physical issue	Central	Eastern	Northern	Southeast	Western	Total
Age 3-5	0	7 (10%)	0	2 (10%)	0	9 (8%)
Age 6-12	2 (50%)	29 (41%)	4 (57%)	4 (20%)	0	39 (36%)
Age 13-18	2 (50%)	38 (54%)	3 (43%)	14 (70%)	6 (100%)	63 (59%)
Total	4	70	7	20	6	107

Development disabilities

Impact – One seventh (13%) of the children in the Project not only experienced abuse and/or neglect, but also the challenges of developmental delays and/or disabilities.

In comparison, 2% of children reviewed statewide by the FCRO during the first half of 2014 were found to have a confirmed clinical developmental disability diagnosis. This does not mean that the child had been found DD eligible at the time of the FCRO review, but does lead to the question as to whether the DD system is more appropriately situated to meet the needs of these children.

Children with disabilities may not be able to express the trauma they have experienced, and they may not be able to benefit from many therapies that are based on a certain level of cognition. The following shows the distribution of developmental disabilities in the Project by service area.

Developmental disability diagnosis	Central	Eastern	Northern	Southeast	Western	Total
Yes	3 (13%)	29 (10%)	6 (21%)	16 (20%)	4 (24%)	58 (13%)
No	21 (88%)	275 (90%)	22 (79%)	66 (80%)	13 (76%)	397 (87%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

Some of the differences in percentages between areas may be a result of the small number of children in the Project from some of the service areas.

As shown in the following chart, there were some regional differences in the distribution by age group for children with developmental disabilities, but this does appear to be a state-wide issue.

Age group of children with a developmental disability	Central	Eastern	Northern	Southeast	Western	Total
Age 3-5	0	1 (3%)	0	2 (13%)	0	3 (5%)
Age 6-12	1 (33%)	12 (41%)	2 (33%)	5 (31%)	0	20 (34%)
Age 13-18	2 (67%)	16 (55%)	4 (67%)	9 (56%)	4 (100%)	35 (60%)
Total	3	29	6	16	4	58

Serious learning issues

Impact – One-fifth (21%) of the children had a critical learning issue as described in the caseworker narratives on N-FOCUS.

We have no directly comparable statistic for the general population of children in out-of-home care.

Critical learning issues can impact not only those with a developmental disability diagnosis but also additional children whose level of impairment does not meet the strict criteria for a developmental disabilities diagnosis.

Why do so many children in foster care have learning problems? Most children in foster care have lived in chaotic, stressful environments prior to their removal from the home. Some have had pre-natal and/or post-natal exposure to alcohol and/or drugs. Some moved often, even during the school year. Some did not get the early childhood stimulation needed to grow and thrive – such as parents reading to children or teaching concepts like colors, letters, and numbers. Some, even in early elementary school, had parents that did not ensure their regular school attendance. These children often begin their formal education at a significant disadvantage.[3]

Further, children that are experiencing separation from their parents, adjusting to a new living environment, and often adjusting to a new school, can experience too much stress to properly concentrate on their education.

The following describes some targeted educational services for children that many of the children in this category may qualify for.

- **Special education**. About 9% of the nation's school children receive special education.[4] For children reviewed by the FCRO during the first half of 2014, we found that 26% of school-aged children were enrolled in special education.
    - Although children are placed in out-of-home care, in Nebraska their parents retain legal rights to determine aspects of their children's education. This causes delays

[3] The Nebraska Department of Education found in school year 2011-12 that fourth grade students who were absent less than 10 days averaged a score of 108/200 in their standardized math test, while children who were absent over 20 days averaged 83/200. Similarly in reading children absent less than 10 days scored 113/200 while students absent over 20 days averaged 91/200. By grade 8 the differences are even more pronounced.

[4] US Dept. of Education, The Condition of Education, 2009.

in a child's receiving special education services, especially if the child does not remain in the same school system. Parents that are upset with the system may refuse to authorize educational testing or services, especially if they suspect it was an educator that reported the abuse that led to the child's removal. While a surrogate parent can be appointed to represent the child, this involves delays.

- **IEP**. The IEP, or individualized educational plan, is part of the Individuals with Disabilities Education Act (IDEA). A team considers the strengths of the child, concerns of the parents, results of the most recent assessments, and the academic, developmental, and functional needs of the child, and develops a plan to assist the child.
- **Early development network (EDN)**. A child is eligible for EDN services if he or she is not developing typically, or has been diagnosed with a health condition that will impact his or her development. Parents must consent to an EDN referral for children age birth through three years of age. Often parents of children in out-of-home care refuse to provide their consent.

The following shows the distribution of learning issues by service area.

Learning issue	Central	Eastern	Northern	Southeast	Western	Total
Yes	4 (17%)	54 (18%)	11 (39%)	19 (23%)	6 (35%)	94 (21%)
No	20 (83%)	250 (82%)	17 (61%)	63 (77%)	11 (65%)	361 (79%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

Some of the differences in percentages between areas may be a result of the small number of children in the Project from some of the service areas.

There were some regional differences in the distribution by age group for children with learning issues, but this does appear to be a state-wide issue that greatly impacts the teen-age population.

Age group of children with a learning issue	Central	Eastern	Northern	Southeast	Western	Total
Age 3-5	0	1 (2%)	0	0	0	1 (1%)
Age 6-12	0	13 (24%)	3 (27%)	4 (21%)	1 (17%)	21 (22%)
Age 13-18	4 (100%)	40 (74%)	8 (73%)	15 (79%)	5 (83%)	72 (77%)
Total	4	54	11	19	6	94

PLACEMENT INFORMATION

Placement type

If children cannot safely live at home, then they need to live in the least restrictive, most home-like temporary placement possible in order for them to grow and thrive. The following chart shows the restrictiveness of placement on the date of the Project review for the 455 children and compares the percentages for each type to the entire population in out-of-home care at a point in time.

Type	Project children	In OOH June 30, 2014
Least restrictive *	329 (72%)	88%
Moderately restrictive **	43 (9%)	5%
Most restrictive ***	47 (10%)	5%
Runaway	2 (<1%)	1%
Other/unable determine	34 (7%)	<1%
Total	455	

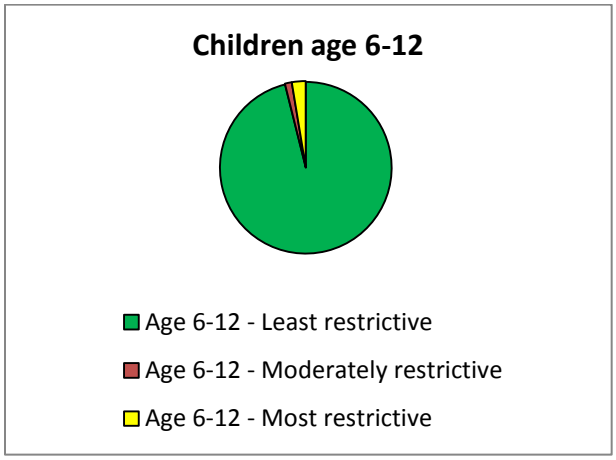
* Least restrictive includes relative placements, foster family homes, agency-based foster homes, developmental disability homes, and supervised independent living.

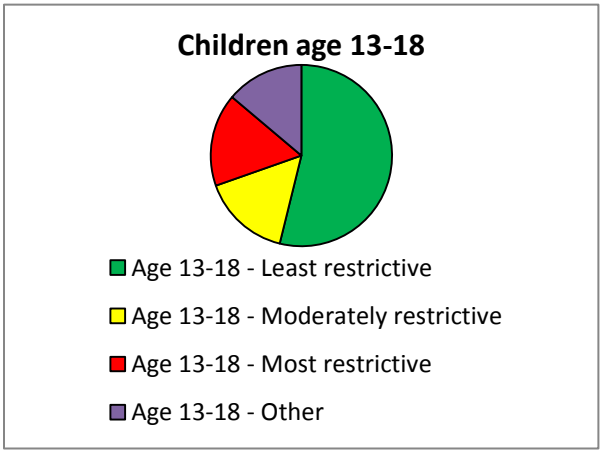
** Moderately restrictive includes group homes and boarding schools.

*** Most restrictive includes medical facilities, psychiatric residential treatment facilities, youth rehabilitation and treatment centers at Geneva and Kearney, youth detention centers, and emergency shelters.

As expected, more of the children that had been in care for 36 months or longer would be in the more restrictive settings than would be true for the general population in out-of-home care. For example, children who qualified for the Project were in the more restrictive placements at double the rate of the group of all children in out-of-home care.

There are differences by age group, as the following pie charts illustrate.[5] Children do best in families, so the use of congregate (group) care for the teen-age populations needs to be further analyzed. For example, is the level of treatment driven by the needs of the child or the lack of less restrictive placements such as foster homes that are equipped to meet these children's needs.





[5] **Additional information is available in Appendix D.**

The next chart gives the placement numbers by service area. It is positive that 100% of the children age 3-5 and 96% of the children age 6-12 were in foster homes,

Least Restrictive	By Service Area					Total
	Central	Eastern	Northern	Southeast	Western	
Age 3-5	1	32	1	6	1	41
Age 6-12	10	112	6	18	2	148
Age 13-18	10	85	9	28	8	140
Moderately Restrictive						
Age 3-5	0	0	0	0	0	0
Age 6-12	0	1	1	0	0	2
Age 13-18	0	26	3	10	2	41
Most Restrictive						
Age 3-5	0	0	0	0	0	0
Age 6-12	0	2	1	1	0	4
Age 13-18	2	24	2	12	3	43
Other/unknown						
Age 13-18	1	22	5	7	1	36

Placement changes

Impact – 82% of the children have been moved between caregivers (foster placements) 4 or more times, and 42% have experienced 10 or more such changes.

In comparison, 30% of all children in out-of-home care Feb. 1, 2015, had 4 or more placements, and 9% had 10 or more changes.

National research indicates that children experiencing 4 or more placements over their lifetime are likely to be permanently damaged by the instability and trauma of broken attachments.[6] Broken attachments may include more than just to their caregivers as children who change placements are also likely to change schools, teachers, and peers.

In contrast, children that have experienced consistent, stable, and loving caregivers are more likely to develop resilience to the effects of prior abuse and neglect, and more likely to have better long-term outcomes.

Members of the collaborative were able to gather information on the number of placements per child (as of the date of the Project review) for 374 children of the 455 children in the Project. This is a valid sample as they came from each of the service areas and represent 82% of the children in the children in the Project.

As part of the process, the placement histories for the children were printed out. Project reviewers manually verified the number placements, excluding placements with parents and

[6] Some examples include: Hartnett, Falconnier, Leathers & Tests, 1999; Webster, Barth & Needell, 2000.

duplicative placements. An example of a duplicative placement would be if the child was placed with the "Smith" foster family as an emergency placement, and after a few days the "Smith" foster family became the on-going caregivers – in such a case, "Smith" would not be counted twice. The types of placements that were counted included foster family homes, agency-based foster homes, developmental disability homes, supervised independent living, group homes, boarding schools, medical facilities, psychiatric residential treatment facilities, youth rehabilitation and treatment centers at Geneva and Kearney, youth detention centers, emergency shelters, and runaway episodes that were over 24 hours in duration.

The statistics below are based on the 374 children whose placement history was available.

- As expected, **most children in the Project had experienced high numbers of placements, with an average of 11 placements and a median of 8 placements**. Many also had a high number of placements in the moderately or restrictive categories, such as group homes, PRTF's and other institutional types of care.
- Even the youngest children have had their placements disrupted many times during their time in out-of-home care (**20 of 32 young children, or 63%, were moved more 4 or more times**).

The charts below give more details.

	By Age Group			
Number of Placements	**Age 3-5**	**Age 6-12**	**Age 13-18**	**Total children**
1-3 placements	12 (38%)	36 (27%)	13 (6%)	61 (16%)
4-9 placements	18 (56%)	78 (59%)	59 (28%)	155 (41%)
10-19 placements	2 (6%)	15 (11%)	66 (31%)	83 (22%)
20-29 placements	0	3 (2%)	54 (26%)	57 (15%)
30 or more placements	0	0	18 (17%)	18 (5%)
Totals	**32**	**132**	**210**	**374**

The next chart shows the same children by service area.

	By Service Area					Total
Placements	**Central**	**Eastern**[7]	**Northern**	**Southeast**	**Western**	**children**
1 placement	0 (0%)	7 (3%)	2 (7%)	4 (5%)	1 (6%)	14 (4%)
2-3 placements	4 (18%)	34 (15%)	0 (0%)	-9 (12%)	0 (0%)	47 (13%)
4-9 placements	12 (55%)	105 (45%)	6 (21%)	27 (36%)	5 (29%)	155 (41%)
10-19 placements	4 (18%)	43 (19%)	11 (39%)	17 (23%)	8 (47%)	83 (30%)
20-29 placements	1 (5%)	31 (13%)	8 (29%)	14 (19%)	3 (18%)	57 (15%)
30 or more placements	1 (5%)	12 (5%)	1 (4%)	4 (5%)	0	18 (5%)
Totals	**22**	**232**	**28**	**75**	**17**	**374**

[7] **NFC provided some CFSR data for the Eastern Service Area. These placement counts utilizing CFSR data would not have included detention or runaway episodes and, therefore, are not included here as that would not be consistent with the way that placements were counted in all the areas of the State or the way placements are counted in the above charts. See Appendix E for this CFSR placement count data.**

It makes sense that the longer a child is in out-of-home care the greater the likelihood of that child experiencing multiple changes in caregivers/placements. The following summarizes some of the reasons children move from one foster home, group home, or specialized facility[8] to another.

1. It can be challenging to be the caregiver of a traumatized child, and to manage the traumatized child's reactive behaviors. Behaviors that were adaptive and protective in the home of origin where there were threatening situations may be maladaptive when children are in a safe environment. Without an understanding of the effects of past traumas, behaviors can be misinterpreted as pathologic.[9] As children are moved from placement to placement, children may exhibit more and more challenging behaviors.
2. There may not be an appropriate placement available that is equipped to meet that child's particular needs when the child needs to be removed, so inevitably those children end up being moved, sometimes multiple times.
3. At times there are delays in making permanency decisions. This increases the probability that the child will experience more transitions to different placements. "Placement drift" has detrimental effects to children's sense of stability, to their educational progress, and to their mental and physical health. Therefore, any delay to decision-making needs to be purposeful and temporary.
4. There may be issues with getting treatment approvals for children that need to be in a higher level of care, or that appropriate transition services where not put into place when a child moves from a treatment level of care to a lower level of care.
5. Some children are moved because a relative has been identified, sometime months after the child was placed into care. The children may, or may not, have a relationship with this person.
6. Some relative placements have not been given explicit information about whether, or to what extent, parents can have contact with their children while under the relative's supervision, or on how to deal with other common inter-familial issues. This has led to some children being moved from the relative's care.
7. Some foster parents "retire" or withdraw from serving as a foster parents. They do so for a variety of reasons. For example, some quit after years of service to reach other life goals, some quit because of changing family situations, and some quit due to frustration with what they perceive as a lack of support.
8. Some placements changes are ordered by the legal system based on the children's behaviors rather than upon the well-being of the child.

[8] See the prior section on placement types for a more complete explanation as to types of placements that may be included.

[9] Helping Foster and Adoptive Families Cope with Trauma, the American Academy of Pediatrics.

All stakeholders in the "child welfare system" need to ask themselves, if a child was moved to different caregivers 10-40 times, how much damage did the system itself inflict on these children?

Therefore, is it any wonder that some of these children are unable to trust adults or develop the positive bonds with caregivers that are necessary for permanency to be possible?

BASED ON CHILD CHARACTERISTICS THE FOLLOWING NEEDS STILL EXIST

1. The need to acknowledge and mitigate as best as possible the impact of trauma on children.
2. The needs to improve access to mental health and behavioral health services that utilize trauma-informed practices for children so that issues can be addressed prior to becoming a crisis and to prevent removals that occur only to access services. Consideration should be given to ensure that some of the funds available to the Behavioral Health Regions are earmarked for children services.
3. The need to ensure there are appropriate services provided based on children's assessments as early as possible including the development of appropriate in-home community-based services.
4. The need to ensure that payment sources are available for children and youth with a wide array of behavioral problems, regardless of managed-care/Medicaid denials. Consideration should be given to the use of braided and blended funding alternatives.
5. The need to continue and develop a quality assurance system for all services that are goal and outcome-driven.
6. The need to work with providers and the judicial system to determine the reasons for a change in placement and what services should be available to stabilize placements. If a placement move is needed, ensure that all stakeholders are conducting these moves to minimize trauma to the child including the educational impact a move might have on a child.
7. The need to continue to develop and implement a more individualized approach to foster parent recruitment and training.
8. The need to identify appropriate relative and kinship placements at the time of the children's initial placement in foster care, and provide those placements with needed supports.

MOST FREQUENT BARRIERS TO PERMANENCY

The purpose of the Project was to determine the systemic barriers to children reaching "permanency" – that is, returning to their biological family that have been equipped to provide them safety and well-being, or if that is not possible to provide the children an adoptive or guardianship family or other permanent arrangement.[10] The point was not to "point fingers" but rather to learn what actions could be taken to reduce impediments to permanency in the future, and to reduce unnecessary time in out-of-home care.

Barriers to permanency generally fell into the following categories:

- Casework.
- Legal and court process issues.
- Difficulties in meeting the child's needs.
- Parental actions/inactions.
- Funding/subsidy.
- Other issues.

Multiple barriers (up to 3) could be selected for each child reviewed in the Project. Only barriers currently impacting the children's cases were selected.

The following describes the top five barriers to permanency statewide. Regional variances, if significant, are also described for each of the particular barriers. In many cases the parents were no longer involved with the child's case, either through relinquishment or termination of rights, thus the number of children with current permanency barriers due to parental action/inaction was low and did not fall within the top five barriers.

BARRIER #1	**Past case management/supervision issues and practices** **Impact: 30% of the children in the Project**

Stable case management with adequate supervision is critical to ensuring children's safety while in out-of-home care, and is critical for children to achieve timely and appropriate permanency. A stable workforce reduces the number of times that children must discuss very private and often painful issues with a stranger. It allows workers time to ensure children's safety, and help children achieve a timely and appropriate permanency.

Many children in the Project had been in care since before privatization began in November 2009. The rapid nature of changes within the child welfare system between November 2009 and mid-2012 de-stabilized case management and supervision in many ways.[11] Vacancy rates increased. During vacancies other workers were asked to take on overly heavy caseloads. As a

[10] The definition of "permanency" has been agreed to by both DHHS and the FCRO.

[11] A timeline of major changes can be found in Appendix H of the FCRO Annual Report issued December 1, 2013.

result, those workers understandably were only able to focus on the crisis situations, and had little time to work towards permanency or foster parent support in their other cases. With a rapid influx of new workers, supervision became more difficult. Roles changed throughout privatization resulting in periods of confusion and re-training, some resources were lost due to payment and other issues, and infrastructures needed to be built or re-built.

Any and all significant changes in legislation can and usually does impact workforce stability. For example, LB561 and LB464 did directly impact case managers within the child welfare system. Any legislative changes must be viewed through the lens of how it could impact this important workforce.

During the Project, we interviewed the current caseworker for each child's case. It was all too common for these workers to say something to the effect of "I don't know what happened in the beginning, I've only had the case for the last few months."

Some examples of case management issues/practices could include:

- Lacking knowledge of case history needed to determine service provision and creating appropriate case plans and goals based on the family's needs.
- Creating case plans that lacked the specificity needed regarding services, timeframes, and tasks to hold parents and the system accountable.
- Being unfamiliar with the quality and availability of needed services.
- Gaps in the transmission of information between staff assigned to the case.
- Not providing courts information needed to improve case progression or requesting needed court hearings.

Nothing can be done to change the past – but lessons can be learned to improve case management, and efforts can be made to go forward as expeditiously as possible with cases stymied by past issues.

The following chart shows by service area the number of children in the Project whose case was still being impacted by past case management issues and practices.

	Central	Eastern	Northern	Southeast	Western	Statewide
Past case management	14 of 24 (58%)	60 of 304 (20%)	22 of 28 (79%)	33 of 82 (40%)	9 of 17 (53%)	138 of 455 (30%)

While the percentages do vary by service area, much of that variance is a function of the low number of children from rural areas who met Project criteria. Nonetheless, every area of the state is still impacted by past case management practices.

The following needs still exist:

1. The need to address initial worker training and on-going worker training to ensure it provides the practical knowledge needed by workers on a day-to-day basis.

2. The need to determine caseworker vacancy rates and effective ways to increase worker retention which could include adequate public and private supports and mentoring.
3. The need to determine how to mitigate the impact on families when vacancies occur so that knowledge transfer occurs seamlessly and children and families have the least disruption possible by the change in caseworker.
4. The need to make use of exit interviews to determine measures that could impact caseworker change.
5. The need to ensure that supervisors have adequate supports and training so they, in turn, can better support their staff.
6. The need to determine supervisor vacancy rates and how to mitigate the effect of supervisor changes on the workforce.
7. The need to consider and implement recommendations and observations offered by the Workforce Development Workgroup of the Children's Commission. [12]
8. The need to consider the caseworker retention recommendations made by the Office of Inspector General of Nebraska Child Welfare in its September 2014 Report, such as:
    a. Create salaries that are competitive with states in the region.
    b. Provide incentives for workers and administrators to pursue formal education in social work.
    c. Increase continuing education opportunities.
    d. Ensure caseloads are manageable.
    e. Ensure caseloads are consistent with statutory requirements.

BARRIER #2	**County attorney would not, or could not, file a termination of parental rights (TPR) petition** **Impact: 22% of the children in the Project**

Parents have a fundamental right to the care, custody, and control of their children – but that right must be balanced with children's critical need for safety, stability, and permanency. Termination of parental rights is the most extreme remedy for parental deficiencies. With a termination, the parents have lost all rights, privileges, and duties regarding their children and the child's legal ties to the parent are permanently severed. To ensure due process and that parental rights are not unduly severed, the level or degree of evidence needed is higher than in other parts of abuse or neglect cases. There are also different provisions for children that fall under the Indian Child Welfare Act (ICWA).

[12] The Workforce Development Workgroup is charged with fostering a consistent, stable, skilled workforce serving children and families. As part of this mission, the group is to benchmark the state with the lowest worker turnover, develop a plan for retention of frontline staff, develop a retention plan for workers, address morale and culture, address education and training, clearly define point persons and roles, conduct a comprehensive review of caseworker training and curriculum, develop a pilot project for guardians ad litem, and hire and adequately compensate well-trained professionals.

Severing parental ties can be extremely hard on children, who in effect become legal orphans; therefore, in addition to proving parental unfitness under Neb. Rev. Stat. §43-292 the prosecution must also prove that the action is in children's best interests.

There are a number of related factors that were identified for this barrier, including:

1. Termination trials require extensive trial preparation. Some have likened it to the time needed for a murder trial.
2. There are capacity (training and resource availability) issues for county attorneys. Some county attorneys are part-time and don't have the hours available to pursue these actions, and some do not have a high level of experience or training in this complicated field.
3. Caseworkers (DHHS or NFC) did not effectively document the evidence the county attorney needed to make a termination of parental rights petition successful or due to case manager changes were not available. County attorneys need to provide evidence of both parental unfitness and the action being in the best interests of the child.
4. Guardian ad litems failure to file a termination of parental rights petition as permitted under Nebraska statutes.

The following chart shows by service area the number of children in the Project whose case was still being impacted by county attorneys or guardians ad litem not filing a termination of parental rights petition. While the percentages do vary by service area, much of that variance is a function of the low number of children from rural areas who met Project criteria.

	Central	Eastern	Northern	Southeast	Western	Statewide
TPR not filed	2 of 24 (8%)	67 of 304 (22%)	8 of 28 (29%)	17 of 82 (21%)	6 of 17 (35%)	100 of 455 (22%)

The following needs still exist:

1. The need to ensure that all legal parties including the juvenile courts are effectively utilizing the statutorily required 12 month permanency planning hearings and 15 month exception hearings. These hearings should be held on the record where all parties are held accountable so that the best interests of children are being met. Data should be collected on the utilization and outcomes from these hearings. The review of these outcomes should include the legal conflict that arises when a juvenile court makes a legal finding that reasonable efforts towards reunification are no longer required such as what must a county attorney or guardian ad litem do and how does this determination affect the juvenile court's ability to hear the termination trial.
2. The need to ensure that timely and relevant staffings are occurring between case managers and county attorneys when the child has been in out-of-home care 15 months to determine if sufficient evidence is present for the filing of a termination of parental rights pleading.
3. The need to ensure appropriate utilization of mediation services including termination of parental rights pre-hearing conferences and other alternatives such as counseling for parents.

4. The need to explore the ability of other legal parties, such as HHS attorneys, to proceed with termination of parental rights actions

BARRIER #3	Court delays, continuances, full dockets, scheduling issues, and related matters Impact: 20% of the children in the Project

This is a broad category that includes:

- Court dockets (schedules) being full so that it is not possible to schedule a court hearing in a reasonable timeframe.
- Sometimes only a limited, too-short, period of time is available for a hearing on any particular day so it must be continued, sometimes multiple times, delaying the finalization of court orders and case progression.
- When there are changes in the parties assigned to the case, such as when caseworkers or guardians ad litem change, these persons may not be ready for the child's next scheduled hearing, so hearings are rescheduled. This creates delays.
- Not using the 12-month permanency hearings as a pivotal point during which it is determined if reunification remains a viable option or whether alternative permanency for the child should be pursued. (See also barrier #2). The permanency hearing, whenever possible, should be the moment where case direction is decided. Each of the children in the Project should have had at least 3 such hearings, yet permanency has yet to be achieved.

Workers from the Eastern Service Area interviewed during the Project expressed that based on their experiences court delays and scheduling issues were a chronic issue. In other areas of the State, workers said that continuances could occur, but not as often or as chronically.

The following chart shows by service area the number of children in the Project whose case was still being impacted by court issues.

	Central	Eastern	Northern	Southeast	Western	Total
Court issues, such as delays, continuances, full dockets, etc.	2 of 24 (8%)	68* of 304 (22%)	3 of 28 (11%)	17 of 82 (21%)	2 of 17 (12%)	92 of 455 (20%)

*We looked more intensely into the court issues in the Eastern Service Area for some children (40 of the 68) where it was identified as a barrier. That information is found in Appendix B.

The following needs still exist:

1. The need to complete a more thorough study as to the reasons and solutions regarding court continuances and other delays.
2. The need to continue the work of the Court Improvement Project regarding the tracking of relevant judicial time limits.
3. The need to thoroughly study the impact of a prosecutorial model within a rehabilitative court system.

BARRIER #4	**Need for a relative search at the time of removal to find a placement that is willing to provide permanency and/or to maintain family connections** **Impact: 18% of the children in the Project**

The Nebraska Family Policy Act (Neb. Rev. Stat. §43-533) states that when a child cannot remain with their parent, preference shall be given to relatives as a placement resource. Relative care is in place to allow children to keep intact existing and appropriate relationships and bonds with appropriate family members, and to lessen the trauma of separation from the parents.

If a maternal or paternal relative or family friend is an appropriate placement, children suffer less disruption and are able to remain placed with persons they already know that make them feel safe and secure. Thus, relative care can be especially beneficial when children have a pre-existing positive relationship with a particular relative.

Relatives must be identified early in the case, rather than months or years after the child has been in out-of-home care. Even if there are reasons that they cannot be the primary caretaker for the child, there can often be a benefit to the child of maintaining contacts. For example, if the grandmother lacks the physical health to do the day-to-day care of a preschooler, that child may still have positive bonds with her that are important to maintain for that child's mental health and well-being.

During Project reviews of the case files from the Eastern Service Area there was no readily available documentation of relative searches for many of those children, but we had not compiled statistics on the frequency of this. We found that there was a lack of consistency to where information could be documented, some of which was deep into the narratives (written case notes) and thus not easy to find. We recommended that there be a consistent place for such documentation within N-FOCUS. Changes were made, and for future cases, some of the documentation issues have been resolved by changes to N-FOCUS and practice changes. Due to these changes, there will now be the ability to appropriately document this important case manager function.

After reviewing the case files in Eastern Service Area, we felt it was important that for the other areas of the state we compile figures regarding documentation.

This is what we found with regard to documentation on N-FOCUS:

Relative search Documented	Central	Eastern	Northern	Southeast	Western	Total
No	1		0	1	2	4 (3%)
Unable find doc	15		4	28	4	51 (34%)
Yes	8		24	53	11	96 (64%)
Total	**24**		**28**	**82**	**17**	**151**

After the case file research was completed, we then interviewed each assigned case manager. During that process we determined for how many cases the lack of relative searches was impacting permanency.

	Central	Eastern	Northern	Southeast	Western	Total
Lack of Relative Search	0 of 24	73 of 304 (24%)	0 of 28	11 of 82 (13%)	0 of 17	84 of 455 (18%)

The following needs still exist:

1. The need to ensure that a relative/kinship placement is not selected simply because of biological connections, but rather because it is a safe, appropriate placement that is in the child's best interest.
2. The need to identify and recruit relatives, kin and non-custodial parents within the first 60 days of a child's placement including assessing the appropriateness of their previous relationship with the children and their ability to safely care for the children, so that delayed identification of these prospective placements does not result in unnecessary moves.
3. The need to identify and establish paternity in a timely manner so the father and paternal relatives can be considered.

BARRIER #5	**Length of time to an appellate decision on a termination of parents rights** **Impact: 12% of the children in the Project**

After a juvenile court has found that there are grounds to terminate parental rights, in many cases the parent's attorney or county attorney will appeal the termination decision. This is entirely within their due process rights.

However, during the time (often months) between the juvenile court terminating parental rights and a decision from the appellate court, permanency is "on hold." Adoptions or guardianships cannot be finalized, putting the children and their potential adoptive/guardianship parents in limbo. Courts may not hold review hearings until the appellate decision is returned, even though

they should be monitoring the children's case during that time and ensuring that the children are receiving needed services.

The cases in which the appeals process delayed permanency by service area:

	Central	Eastern	Northern	Southeast	Western	Total
Time to appellate decision	1 of 24 (4%)	47 of 304 (15%)	0 of 28	7 of 82 (9%)	1 of 17 (6%)	56 of 455 (12%)

Many of the concerns regarding the length of the appeal process have been addressed by the appellate courts. The appellate courts did complete a thorough analysis of its appeal processes and changes were made that have greatly impacted the time period a case is on appeal. We commend the appellate courts for their prompt acknowledgement and resolution of this issue.

The following needs still exist:

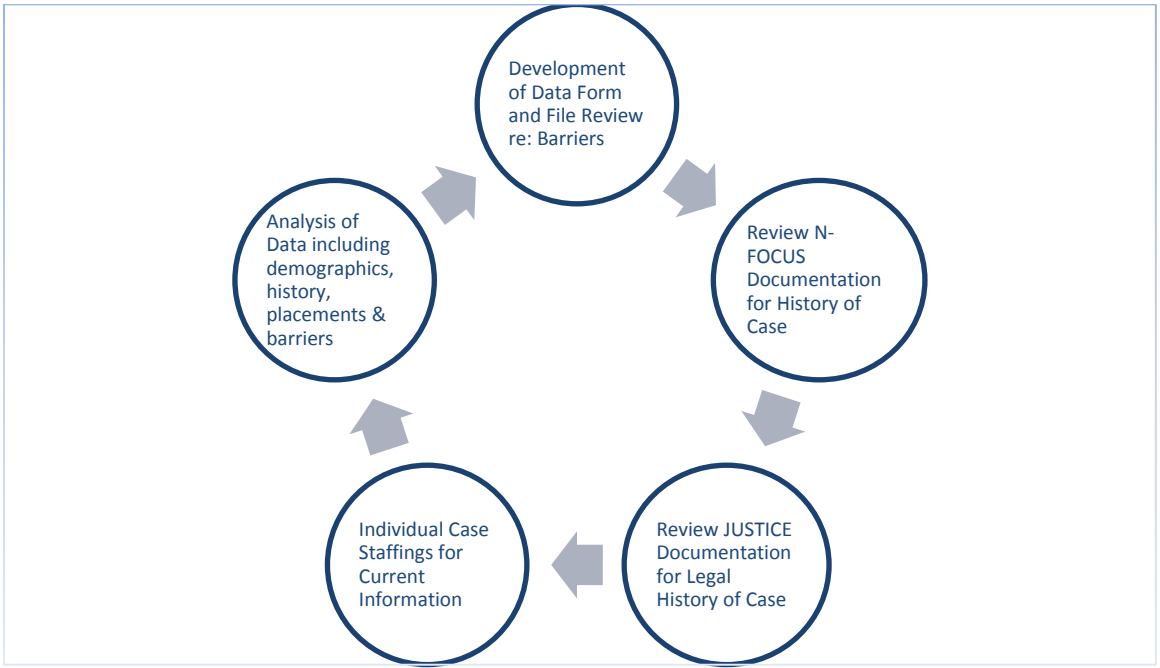
1. The need to continue efforts to prioritize the completion of appellate decisions and reduce the time before a decision is reached including a yearly analysis regarding the appeal time period.
2. The need to research the effectiveness and impediments of the Iowa appeal statutes with regard to juvenile court cases.

BARRIERS 6-10

Other barriers identified in the top 10 included:

Ranking	Topic	Impact
6	The child's current mental health issues	11% of the Project children
7	The child's current behavioral issues	10% of the Project children
8	Paternity issues	10% of the Project children
9	Placement issues	7% of the Project children
10	Issues between separate juvenile courts/county courts and district courts regarding child custody decisions	7% of the Project children

Appendix A - Methodology
Process Utilized by the Barriers to Permanency Project



Data Collected by Barriers to Permanency Project

A common data form was jointly created and used in the Project review of each of these individual cases. The information was collected from N-FOCUS, JUSTICE and paper file reviews. The data collected included:

1. Basic case identifiers
2. Demographics of child and family
3. Legal status history
4. Reasons entered out-of-home care
5. Current permanency goals
6. Status of parental rights including fathers
7. Current placement type
8. Placement history
9. Number of removals from parental home
10. Child characteristics/services

The process also included the creation of a common set of barriers. Barriers fall into these categories:

1. Legal Barriers (ex: ICWA, custody, immigration, paternity or no termination of parental rights filed)
2. Court/Legal Parties Barriers (ex: appeal of termination, delays/continuances, fragmented court system)
3. Parent/Guardian Barriers (ex: mental health, substance abuse, incarceration, refusal to take child back)
4. Subsidy/Funding Barriers (ex: adoption, guardianship, DD funding)
5. Child Barriers (ex: severe mental health, DD, child behaviors)
6. Placement Barriers (ex: current placement unwilling to provide permanency; lack of support in placement, relatives unwilling to provide permanency)
7. Case Management Barriers (ex: number of case managers, need family finding, lack of effective case management throughout life of case, lack of effective current case management, lack of independent living services)

Once the Project review of the case files were completed, the Barriers to Permanency Project team met with the assigned case manager and his/her supervisor for each child reviewed in order to thoroughly discuss the progression of the case. These meetings included the use of a uniform questionnaire regarding the current status of the case and their opinions and concerns regarding the history on the case. The information gained from these interviews along and the completed data forms were used as the basis for determining the barriers for each child involved in this Project.

Appendix B –
Further Analysis of Eastern Service Area Cases
Involving Judicial Systemic Concerns

As part of these individual case file Project reviews of children in care for 3 years or longer, specific cases were identified as having a barrier of "fragmented court system" or "court delays".

A further analysis of cases identified with these specific barriers was completed by the FCRO and CIP for the Eastern Service Area. This further analysis involved 19 cases involving 40 children. More than one concern was found in some of these 19 cases.

The relevant data for the three main categories with subcategories are as follows:

Court Delays

No review hearings every 6 months	-	4
Review hearings started but not completed	-	2
No permanency hearing at 12 months	-	4
Hearings continued for more than 14 days	-	5
Time to complete adjudication Hearing	-	2
Time to complete TPR trial	-	2
Time to complete guardianship	-	1

County Attorney/Guardian ad Litem

Failure to file timely TPR	-	7
Failure to timely file Father's adjudication	-	5
Inactive legal parties	-	1

Miscellaneous

Child request to age-out	-	1

Based upon the above, some observations and considerations for changes include the following:

1. Identification of putative and bio-father's at the pre-conference hearing to include either timely legal proceedings regarding the father or placement of the children if appropriate.

2. Ensure all court review hearings and permanency hearings are meeting the statutory requirements to include when other legal matters are before the court and when a case is on appeal.

3. Accountability by the court ensuring that all legal parties to a case are meeting their ethical and statutory responsibilities.

Appendix C –
Racial Disproportionality in Eastern Service Area

There is racial disproportionality regarding children in foster care across the state. However, the difference was larger than expected in the Eastern service area. Consider the following:

- 13% of the children in Douglas County are Black per the US Census.[13]
- 21% of the children from the ESA in out-of-home care on an average day, regardless of length in time in care, are Black.
- **51% of the children in the Barriers to Permanency Project from the ESA are Black.**

The following details some possible explanations for this variance.

Poverty

One speculation as to why there is such disproportionality in Douglas County was that poverty might be a larger factor than in other areas. According to the most recent US Census[14] estimates:

- In Douglas County 48% of Black female householders with children are below the poverty line, compared with 30% of the White female householders.
- In Douglas County, 5% of the Black children were in married households, compared to 83% of White children.

- In comparison, in Lancaster County 64% of Black female householders with children are below the poverty line, compared with 42% of White female householders.
- In Lancaster County, 3% of the Black children were in married households, compared to 87% of White children.

A note here: there are far fewer Black families in Lancaster County as compared to Douglas County. Nonetheless, poverty alone may not explain the discrepancy.

Age

By age group within the Eastern Service Area:

- 47% of the children in the 0-5 age group were Black.
- 55% of the children in the 6-12 age group were Black.
- 49% of the children in the 13-18 age group were Black.

In other words, there were very slightly more Black children than expected in the 6-12 age group, and very slightly less in the 0-5 and 13-18 age groups. As one Project member said, "*it isn't all those naughty teenagers*."

[13] 2013 per American Fact Finder.
[14] 2013 per American Fact Finder.

Type(s) of barriers identified

Further delving into differences in the Eastern area, the Project found that:

- 75% with an issue regarding paternity identification were Black; 25% were other races.
- 69% whose placement was unwilling to provide permanency were Black; 31% were other races.
- 69% with an adoption subsidy issue were Black; 31% were other races.
- 66% who needed a relative search in order to locate possible relative placements were Black; 34% were other races.
- 63% of children where the county attorney had failed to file a TPR were Black; 37% were other races.
- 63% of children with their own law violation that needed to be addressed prior to permanency being achieved were Black; 37% were other races.

At the same time, for some barriers there were fewer Black children than expected. For example:

- 38% with an immigration barrier were Black; 62% were other races.
- 33% with current, severe mental health issues were Black; 67% were other races.
- 32% where court delays were an identified barrier were Black; 68% were other races.

Appendix D –
Further Details on Placement Types by Age

AGE 3-5

Age 3-5 Placement type	By Service Area					Total children
	Central	Eastern	Northern	Southeast	Western	
Least restrictive						
Relative foster home	0	6	1	2	0	9
Pre-adoptive foster home	0	4	0	2	1	7
Child-specific foster home	0	3	0	0	0	3
Licensed foster home	1	0	0	2	0	3
Agency-based foster home	0	19	0	0	0	19
Total	**1**	**32**	**1**	**6**	**1**	**41**

100% of the children age 3-5 were in the least restrictive forms of placement.

See the following pages for other age groups.

AGE 6-12

Age 6-12 Placement type	By Service Area					Total children
	Central	Eastern	Northern	Southeast	Western	
Least restrictive						
Relative foster home	3	15	1	2	1	22
Pre-adoptive home	0	11	0	7	1	19
Child-specific home	0	3	2	5	0	10
Licensed foster home	7	1	3	4	0	15
Agency-based foster home	0	80	0	0	0	80
Continuity foster care	0	2	0	0	0	2
Subtotal	**10**	**112**	**6**	**18**	**2**	**148**
Moderately restrictive						
Center for developmentally disabled	0	1	0	0	0	1
Group home	0	0	1		0	1
Subtotal	**0**	**1**	**1**	**0**	**0**	**2**
Most restrictive						
Residential treatment facility	0	0	1	1	0	2
Psych Residential Treatment	0	2	0	0	0	2
Subtotal	**0**	**2**	**1**	**1**	**0**	**4**
Total	**10**	**115**	**8**	**19**	**2**	**154**

96% of the children age 6-12 were in the least restrictive forms of placements.

AGE 13-18

Age 13-18, Placement type	By Service Area					Total children
	Central	Eastern	Northern	Southeast	Western	
Least restrictive						
Relative foster home	0	12	2	8	1	23
Pre-adoptive home	0	4	0	2	0	6
Child-specific home	1	4	2	3	2	12
DD family home	0	4	1	0	2	7
Licensed foster home	8	1	4	15	3	31
Agency-based foster home	0	60	0	0	0	60
Independent Living	1	0	0	0	0	1
Subtotal	**10**	**85**	**9**	**28**	**8**	**140**
Moderately restrictive						
Group home	0	20	3	10	2	35
DD Center	0	2	0	0	0	2
DD group home	0	3	0	0	0	3
Boarding school	0	1	0	0	0	1
Subtotal	**0**	**26**	**3**	**10**	**2**	**41**
Most restrictive						
Detention facilities or YRTC	0	17	0	5	1	23
Emergency shelter	0	4	0	1	0	5
Residential Treatment Facility	2	0	2	6	1	11
Pediatric Hospital	0	0	0	0	1	1
Psych Residential Treatment	0	2	0	0	0	2
Psychiatric hospital	0	1	0	0	0	1
Subtotal	**2**	**24**	**2**	**12**	**3**	**43**
Other						
Runaway	0	0	0	2	0	2
Other	0	0	3	5	1	9
Unclear	1	22	2	0	0	25
Subtotal	**1**	**22**	**5**	**7**	**1**	**36**
Total	**13**	**157**	**19**	**57**	**14**	**260**

54% of the children age 13-18 were in the least restrictive forms of placement; 16% were in moderately restrictive placements; 18% were in the most restrictive, and the remainder were runaways or their placement type as of the date of the Project review was undetermined.

Appendix E –
Eastern Service Area Alternative Placement Counts

The following is information provided by NFC as an alternative way to count placements based upon federal CFSR data for the Eastern Service Area. Unlike the measures used elsewhere in this report, CFSR placement counts do not include detention episodes, runaways, certain hospitalizations, etc.

	By Age Group				
Number of Placements	**Age 3-5**	**Age 6-10**	**Age 11-15**	**16-18**	**Total children**
1-3 placements	17	43	18	10	88
4-9 placements	17	41	41	34	133
10-19 placements	0	1	15	51	67
20-29 placements	0	0	2	13	15
30+ placements	0	0	0	1	1
Totals	**34**	**85**	**76**	**109**	**304**

Please feel free to contact us at the address below if there is a specific topic on which you would like more information, or check our website for past annual and quarterly reports and other topics of interest.

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