Statewide Assessment

Name of State Agency
Nebraska Department of Health and Human Services, Division of Children and Family Services Policy Section Child Welfare Unit and Office of Juvenile Services
Period Under Review
Onsite Review Sample Period: 04/01/07 – 11/30/07 Period of AFCARS Data: 04/01/06 – 03/31/07 Period of NCANDS Data (or other approved source; please specify if alternative data source is used): 04/01/06 – 03/31/07

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Section I – General Information

A. Agency Description

The Nebraska Department of Health and Human Services (DHHS) is a multiservice agency that applies 'system of care' principles in its service delivery and advocacy for Nebraska's children and families. DHHS is led by a Chief Executive Officer (CEO), appointed by the Governor. The CEO leads six Divisions: the Division of Children and Family Services; the Division of Behavioral Health; the Division of Developmental Disabilities; the Division of Medicaid and Long-Term Care; the Division of Public Health; and the Division of Veterans' Homes. These Divisions are supported by Operations. The Director of each Division reports directly to the CEO.

The Division of Medicaid and Long-Term Care (DMLTC) and the Division of Behavioral Health (DBH) offer an array of services to address mental health and substance abuse issues of children and adults. The DMLTC purchases mental health and substance abuse services through an Administrative Service Organization (ASO) contract with Magellan Behavioral Health Services. Magellan is the designated ASO vendor referenced throughout this report. The DBH provides funding, oversight, and technical assistance to the local mental health regions to provide community-based mental health and substance abuse programs.

The Division of Children and Family Services (DCFS) consists of one Policy Section and five service areas. The Policy Section includes the Child Welfare Unit (CWU), the Office of Juvenile Services (OJS), the Economic Assistance and Child Support Enforcement Unit (EA/CSEU) and the Comprehensive Quality Improvement/Operations Unit (CQI/OU). The section coordinates the administrative supports to facilitate efficient operation of its programs, policies, and service offering. The CWU and OJS specifically develop policy and provide technical assistance in the areas of child abuse and neglect and juvenile services to service area staff, other division staff, and community partners. The CQI/OU is responsible for monitoring the quality of DCFS service provision via case reviews, audits, federal and state compliance reviews, contract monitoring, utilization and capacity management, and other data analysis and reporting. The service areas provide direct case management services to the children and families involved with child welfare and juvenile services. OJS also operates two secure-care facilities for the detention and rehabilitation of serious youth offenders: the Youth Rehabilitation and Treatment Center in Kearney (YRTC-K) for boys, and the Youth Rehabilitation and Treatment Center in Geneva (YRTC-G) for girls.

The CWU and OJS serve almost 12,000 children placed in state custody each year. At any point in time, Nebraska averages approximately 7,000 youth in state custody. The CWU serves about 5,500 youth and OJS serves about 1,500 youth. This does not include families being assessed for safety, non-court involved cases, or youth in the process of obtaining an OJS evaluation.

DHHS contracts with five of the state's six Behavioral Health Authorities to provide ongoing case management services for high needs families whose children are state wards. These services are provided through the Integrated Care Coordination Units (ICCU). The contract integrates state and contract staff within the unit. ICCU workers, both state and contract staff, are held to a higher level of case practice standards than workers who do not work in the ICCU

and, for that reason, have a cap of no more than 10 – 12 ongoing families. ICCUs from across the state receive funding to serve up to 1,255 "identified" youth (i.e., youth identified to receive ICCU services) and their families. This number represents approximately 18% of state wards at any given time. As of December 31, 2007, the ICCUs were serving 1,090 identified youth and their families, or 15.7% of the state wards at that time. The ICCUs were also providing services to 624 siblings of the identified youth, who were also state wards themselves.

It should be noted that the agency refers to direct case management staff as Protection and Safety Trainees (PSTs), Protection and Safety Workers (PSWs), Protection and Safety Supervisors (PSSs), and Protection and Safety Administrators (PSAs). The term Care Coordinator is used in reference to the ICCU workers. 'Protection and Safety' is a general term used in both the CWU and OJS.

B. Mission Statement

The Department of Health and Human Services' mission is to help people live better lives.

The Division of Children and Family Services' mission is to provide the least disruptive services when needed, for only as long as needed to:

- Give children the opportunity to succeed as adults;
- Help the elderly and disabled live with dignity and respect; and
- Help families care for themselves,

resulting in healthier families and safer, more prosperous communities.

C. Systemic Initiatives

Nebraska has instituted several initiatives to promote systemic change which are referenced throughout this report. These initiatives are introduced in this section of the report, with more specific detail on the way in which the initiatives may have impacted a particular outcome or item included in subsequent sections.

Family Centered Practice: DHHS implemented Family Centered Practice (FCP) in 2004. FCP principles are incorporated into DHHS policy and procedure, and DHHS staff members (including YRTC staff) have been trained in the practice. DHHS' training activities also included building internal capacity among staff to provide continued training on FCP to other workers. There are now over 38 trainers in the local areas.

Policy states that DHHS will provide family centered services to protect children from abuse and neglect, to improve conditions in families who place children in danger, and to assist youth in being productive and law-abiding citizens. These services should be:

- based on the assessed needs of the family and child;
- mindful of the safety of the child and the community;
- child focused and family centered;
- provided in the family home when appropriate;
- community and neighborhood based;
- founded on community responsibility; and
- delivered in a competent, professional manner by a staff that respects cultural diversity, and as close in proximity to the family as possible.

At the very foundation of FCP is the expectation that all individuals involved with DHHS are treated with respect and dignity, and are empowered at every level of their interaction within the system. When individuals feel empowered, they accept responsibility; recognize their strengths; and develop an ability to make choices. To facilitate that empowerment, we must offer opportunities for individuals to fulfill their roles and responsibility and assist them in gaining access to services and resources necessary to meet their needs.

Thus, FCP begins with a collaborative team planning process that involves workers, children, families, and the appropriate informal (e.g., the non-custodial parent, aunt/uncle, grandparents, family friends, etc.) and formal supports. Through the case planning process, plans are built to reflect the families' unique strengths and values, and to address each person's needs. Services and supports are delivered to help families and individuals meet their particular outcomes and goals, solutions are cooperatively sought with the input of the individual, and decisions are made collectively as a team. Child and community safety, however, is never compromised and remains the primary focus of all efforts and actions.

Nebraska Safety Intervention System: The Nebraska Safety Intervention System (NSIS) was developed with the assistance of the National Resource Center for Child Protective Services to improve our safety interventions with children and families throughout the state. Nebraska has been working with the Center since 2005 to review models used by other states, to select the model Nebraska would use, and to develop Nebraska specific materials. The model is a valid and reliable model that provides workers the tools to better assess safety for children and families throughout their involvement with DHHS. More specifically, the NSIS:

- Improves safety decisions;
- Involves supervisors to a greater degree in all aspects of decision-making;
- Provides clarity of purpose for initial and continuing safety assessment;
- Provides clarity of purpose for ongoing work with families;
- Improves the ability to assess and professionally support decisions;
- Increases the equity and fairness for all families; and
- Improves case planning and focus for safety related interventions.

It is important to note that the model is applied to cases involving child abuse and neglect only. The NSIS is not used in cases involving youth who are committed to state custody by the juvenile justice system, unless the Youth Level of Service/Case Management Inventory (detailed on the following page) indicates a safety concern in a youth's family.

NSIS implementation began in April 2007 in the Western Service Area and continued throughout the state in the spring of 2008. Service areas were asked to begin NSIS implementation as soon as they completed training. Under this implementation plan, all new child abuse and neglect reports are assessed using NSIS. Each service area was also asked to develop and implement a transition plan to ensure that all current cases were evaluated using NSIS by October 2008.

The first step in the model is to complete a safety assessment on all accepted child abuse and neglect reports to determine if the children involved are safe. If a child is determined to be safe, the family may be referred to community services but the case will be closed. If a child is determined to be unsafe, a safety plan is implemented and workers proceed with evaluating parents' protective capacities.

The Protective Capacity Assessment (PCA) is completed with families to determine enhanced and diminished parental protective capacities related to the safety threats identified in the safety assessment. Diminished parental protective capacities must be addressed in order to enhance those capacities and reduce identified safety threats. The PCA replaces what was previously referred to as a family assessment. It is formally reviewed at least every six months to coincide with any court actions, and it is reviewed each time the safety of the child is assessed.

NSIS policy and procedures (formally issued in March 2008) require an ongoing assessment of child safety and monitoring of safety plans. There are mandatory 'events' for which a formal re-evaluation of safety must occur on every active child abuse and neglect case. These are: 1) at initial contact with the child and family as a result of an accepted child abuse and neglect referral; 2) at any time during the case when a new child abuse and neglect report is received; 3) when there is any change that may result in new safety threats, (for example, a new person in the home); 4) when considering reunification of children removed from the parental home; 5) when unsupervised visitation is being considered; 6) at the time of case plan evaluation and progress report; 7) prior to case closure; 8) at transfer to ongoing services; and 9) when the Youth Level of Service/Case Management Inventory (detailed below) or other information indicates a possible safety threat for an OJS or status offending youth in his or her home. A minimum weekly review of safety plans must occur while cases are undergoing the safety assessment process and a minimum monthly review is required for ongoing cases.

There are many benefits to implementing the NSIS. Staff receive increased guidance and clarification on how to identify parental needs based on diminished parental protective capacities. Workers can then focus on why a child is unsafe and specifically address the diminished parental protective capacities which, when strengthened, will enhance the protective capacities and reduce safety threats.

NSIS also increases the level of supervisory approval and oversight. Supervisors are required to approve every safety plan, including decisions around removing children from home due to existing safety threats. Supervisors ultimately approve workers' decisions as to whether or not the child is safe. Supervisors also verify practices and protocols, such as who is interviewed in the case, the order of interviews, and whether information on relatives and cultural backgrounds are gathered.

The implementation of NSIS should begin to show benefits not only related to case planning, but also to family involvement. Since the PCA requires parental involvement, a case plan cannot be written to reflect the correct needs of the family if there is no family involvement. For that reason, staff training includes sections specific to self-determination and the importance of self-determination in the development of case plans.

Youth Level of Service/Case Management Inventory: DHHS collaborated with the State Probation Administration to implement the Youth Level of Service/Case Management Inventory (YLS/CMI), a unified assessment tool for juvenile delinquents and status offenders. Statewide implementation of this tool occurred in March 2006. The YLS/CMI is a dynamic, comprehensive, and research-based risk and needs assessment that can help identify risk, need, and responsivity factors that are important for the rehabilitation of a particular juvenile offender or status offender (e.g., family/parenting, education/employment, substance abuse, etc.). It also aids in developing case plans and determining the level of intervention needed. In other words,

the YLS/CMI provides concise information for staff regarding what issues the youth and family need to work on most, and it drives case planning and resource allocation for that youth.

The YLS/CMI compliments the NSIS system in that the YLS/CMI interview may reveal the need for a safety assessment. If a potential safety concern is identified with a juvenile or status offender, a safety assessment will be conducted to determine if the juvenile is safe or unsafe in their home. If the juvenile is unsafe, the worker will work with the family to address the safety issues, as well as the issues related to the juvenile delinquent activity and community safety.

Performance Accountability Plan: Nebraska implemented a new Performance Accountability Plan in July 2004. Measures, goals, and expectations for all staff were generated and included in the plan to improve work performance related to child and community safety, permanency, and well-being. Part of the plan includes monthly progress reports on measures related to response times, documentation, and other items (discussed throughout this document). These reports are used by supervisors and administrators to measure progress, to inform and discuss at monthly meetings between workers and their supervisors, and to make any individual staff or system improvements necessary. Additionally, supervisors must review every case managed by the individual workers they supervise at least once every 60 days. All progress reports rise to the next level of supervisory responsibility so that everyone, up to each Service Area Administrator, is held accountable for performance in these measures.

In 2007, administrators from across the state met and discussed the current performance measures and their value to monitor and evaluate employee performance related to the provision of case management services, as well as how these measures fit with NSIS. Based on these discussions, revisions to the performance standards have been proposed and should be implemented in summer 2008. These changes include eliminating some existing measures, adding some new measures, changing required time frames, and increasing goal percentages.

Children's Outcomes Measured in Protection and Safety Statistics: The Children's Outcomes Measured in Protection and Safety Statistics (COMPASS) was introduced in July 2007. COMPASS is a web-based program that houses "rolling year" data pertaining to federal and state data measurements for the child welfare and juvenile services system. The program displays data in a clear and user-friendly format. It is interactive, so that high-level data may be broken down into more specific units (e.g., state, service area, judicial district, city, and county level data) as dictated by the user. The data is available to anyone with Internet access.

Nebraska Child and Family Services Review: As part of the quality assurance process Nebraska developed its own Child and Family Services Review (NE-CFSR) that mirrors the federal CFSR. In 2005, reviews were completed in Omaha, Gering and Kearney, and in 2006 reviews were completed in Omaha, Fremont, and Lincoln. Omaha (Nebraska's largest metropolitan area) was the only common site reviewed both years. For each review a total of 50 in-home and out-of-home cases were selected (20 cases in Omaha and 15 cases in each of the other sites). Interviews were held with case participants to obtain verification and validation of case record information. The results of items referenced throughout this report are based on the 50 collective cases reviewed each year. Please consider that performance from one site to another may vary. It should also be noted that the data reflects the number of cases in which items were rated as a strength or an area needing improvement. However, there were some cases that were not applicable for every item reviewed.

D. Caseload Levels and Staff Turnover

Nebraska developed caseload standards in 1992, the same year in which the Child Welfare League of America (CWLA) developed national caseload standards. In 2003, CWLA revised national caseload standards. State standards, however, remain at the levels established in 1992. Table 1 displays the maximum number of children or families one worker should serve by the different types of services provided, as suggested by state and national standards. For reference, if workers are responsible for providing the services within each category to more families or children than suggested, their caseload qualifies as being above caseload standards.

Table 1. State and National Caseload Standards by Service Category

Caseload Category	Nebraska Standards (1992)	CWLA Standards (1992)	CWLA Standards (2003)
CAN Intake Reports	97 families	85 families	85 families
Initial Safety Assessments	10 families	12 families	12 families
In-Home Services	14 families	17 families	17 families
Out-of-Home Placement With Reunification Plan	15 families	15 families	12 families
Out-of-Home Placement Long-Term or Independent Living	18 children	20 children	12-15 children

Data from our Statewide Automated Child Welfare Information System (SACWIS) was analyzed to explore caseload levels throughout the state. As of December 2007, the state was operating at 97% of state standards and 103% of national standards. Caseloads vary from service area to service area, with all service areas falling within or at both state and national standards except for the Eastern Service Area. The Eastern Service Area is functioning at 112% of state standards and 121% of national standards. The lowest caseload levels were in the Northern Service Area (at 72% per state standards and 75% per national standards).

Courts and service providers continue to report that DHHS staff is overworked. The courts are concerned that the caseload report does not support what some staff members are reporting or what the external stakeholders believe to be the case. However, we caution the use of the caseload data with direct correlation to job performance in the field. The caseload standards do not take into account coverage for staff on approved leave such as medical, vacation, or military leave. Vacant PSW positions (due to staff turnover) and staff in new worker training are also not factored into caseload size. Thus, the total full time equivalent count will always appear higher than the actual number of workers who are performing case management duties on any given day. Nonetheless, further evaluation of caseloads is needed given stakeholders' concern with the issue.

Some areas of the state do appear to have an appropriate worker to caseload ratio and other areas are suffering due to worker turnover. DCFS Protection and Safety calculates turnover by dividing the number of workers or supervisors who leave a position by the average number of workers or supervisors who have held that particular position throughout the year. In addition to capturing the number of workers or supervisors who terminate DHHS employment, this equation also allows us to capture instances in which workers move from one service area to another within the Protection and Safety System, when workers are promoted to supervisory positions

within the system, or when workers or supervisors exit the system altogether and move onto other divisions within DHHS. All scenarios result in a vacant position within the Protection and Safety System.

According to Protection and Safety calculations, worker turnover across the state was at 34.3% in CY2007. It should also be noted that Protection and Safety measures PSW turnover separately from that of turnover among PSTs to more accurately analyze the impact of turnover among workers who are actively managing cases on our performance in case-related outcomes. Although any turnover impacts service delivery to children and families as well as worker morale, we would prefer that potential staff exit our system prior to beginning work and establishing relationships with children and families. The state experienced a 39.5% turnover rate among PSTs alone in CY2007.

According to other state and federal reports, national turnover rates range anywhere from 20% to 67%.[1] It is possible that agencies calculate turnover rates differently from state to state and apply equations that best capture the way in which their organization is structured and how worker movement or turnover occurs (that is , employee termination, transfers among positions, etc.). One report that cited national average turnover rates of 22.10% for workers and 11.80% for supervisors divided the number of vacant positions in each agency by the number authorized FTEs for that particular position.

This is similar to how turnover rates are calculated by DHHS' Human Resources and Development (HRD). HRD calculates turnover rates among workers (including PSTs) and supervisors based on the number of workers or supervisors who leave employment with DHHS, divided by the number of allocated FTEs for that particular position. Using this equation, the turnover rate for workers (including workers in training status) was 21.8% and the turnover rate for supervisors was 10.6% in CY2007.

These numbers fall below those calculated within Protection and Safety for the same year. The difference between these numbers supports the premise that there are instances in which employees do not terminate from DHHS but rather move from one position to another or from one program or division to another within DHHS.

Table 2 displays turnover rates for Nebraska since CY2001 per Protection and Safety and HRD calculation (however, turnover rates for CY2001 and CY2002 using HRD calculations are not available). Overall, there has been a gradual increase in turnover since CY2004. The major concern is the impact of worker turnover in delayed outcomes for children and families.

Table 2. State Turnover Rates by CY

	2001	2002	2003	2004	2005	2006	2007
PSWs	18.0%	19.0%	13.3%	13.0%	15.0%	20.7%	34.4%
PSSs	8.0%	13.0%	11.1%	7.7%	8.1%	9.4%	26.7%
PSW/PSTs (HRD calculations)	N/A	N/A	13.3	13.0	15.0	19.3%	21.8%
PSSs (HRD calculations)	N/A	N/A	11.1	7.7	8.1	9.4%	10.6%

[1] American Public Human Services Association. (2005). *Report from the 2004 Child Welfare Workforce Survey*. Washington, D.C.: Author.; Cornerstones for Kids. (2006). *Toward a High Quality Child Welfare Workforce: Six Doable Steps*. Houston, TX: Author.; Riggs, D. "Workforce Issues Continue to Plague Child Welfare." *Adoptalk* Summer 2007. St. Paul, MN: North American Council on Adoptable Children. 01 February 2008 http://www.nacac.org/adoptalk/WorkforceIssues.html.

Combined worker and supervisor turnover rates for CY2007 for each service area (displayed in the Table 3) reveals that the Eastern and Southeast service areas have the highest turnover rate (based on Protection and Safety calculations).

Table 3. Turnover by Service Area (CY2006)	
Central	25.1%
Eastern	35.1%
Northern	19.4%
Southeast	47.4%
Western	23.3%

DHHS also maintains length of employment data by date of employment with the state and in staff's current position, as of December 31, 2007 (displayed in Table 4).

Table 4. Length of Employment in Years			
		DHHS	Position
PSWs	Median	3.5	3.0
	Average	6.7	5.5
PSSs	Median	12.2	4.7
	Average	9.9	2.5
ICCU staff	Average	N/A	2.6

Based on the ongoing review of turnover data, DHHS chose to identify the possible causes of staff turnover and to explore how we can reduce turnover and retain qualified staff. One project currently underway is the Protection and Safety Staff Retention Study. The goal of this project is to inform the development of system interventions to enhance employee retention and reduce the incidence of preventable employee turnover. Data collection began with a survey of all workers and supervisors in May 2007, and will continue with the collection of performance, leave, and turnover data through May 2008. The survey measured a number of factors that previous research suggests may differentiate those who stay in child welfare and juvenile service agencies and those who leave, including: satisfaction with a variety of aspects of the job; commitment to the organization; involvement in the job; burnout and other psychological response to the job; perceptions of supervision; perceptions of alternative employment opportunities; intentions to search for a new job; and intentions to leave. Demographic variables include staff educational background, age, gender, and length of tenure with the agency. Of the 504 workers and supervisors employed in Protection and Safety, a total of 434 (86%) completed the survey. A final report will be available in the fall of 2008.

DHHS is also collaborating with the University of Nebraska to apply for a National Child Welfare Workforce Initiatives Grant to develop, implement, monitor and evaluate interventions related to worker recruitment, retention, and training.

Section II – Safety and Permanency Data

Child Safety Profile	Fiscal Year 2005ab						Fiscal Year 2006ab						12-Month Period Ending 03/31/2007					
	Reports	**%**	**Duplic. Childn.[2]**	%	**Unique Childn.[2]**	**%**	**Reports**	**%**	**Duplic. Childn.[2]**	%	**Unique Childn.[2]**	**%**	**Reports**	**%**	**Duplic. Childn.[2]**	%	**Unique Childn.[2]**	**%**
I. Total CA/N Reports Disposed[1]	15,501[A]		35,621		26,479		13,109[A]		30,500		23,425		11,853[A]		27,879		21,523	
II. Disposition of CA/N Reports[3]																		
Substantiated & Indicated	4,039	26.1	6,630	18.6	5,823	22.0	3,620	27.6	6,160	20.2	5,441	23.2	2,764	23.3	4,654	16.7	4,173	19.4
Unsubstantiated	11,070	71.4	19,430	54.5	14,432	54.5	9,208	70.2	16,436	53.9	12,604	53.8	8,858	74.7	15,842	56.8	12,311	57.2
Other	392	2.5	9,561	26.8	6,224	23.5	281	2.1	7,904	25.9	5,380	23.0	231	1.9	7,383	26.5	5,039	23.4
III. Child Victim Cases Opened for Post-Investigation Services[4]			3,927	59.2	3,319	57.0			3,782	61.4	3,216	59.1			2,554	54.9	2,203	52.8
IV. Child Victims Entering Care Based on CA/N Report[5]			2,387	36	2,087	35.8			2,414	39.2	2,119	38.9			1,515	32.6	1,353	32.4
V. Child Fatalities Resulting from Maltreatment[6]					4[B]	0.1					3[B]	0.1					2	0.0
Statewide Aggregate Data Used to Determine Substantial Conformity																		
VI. Absence of Maltreatment Recurrence[7] [Standard: 94.6% or more]					2,260 of						2,151 of						1,953 of	
					2,509	90.1					2,370	90.8					2,138	91.3
VII. Absence of Child Abuse and/or Neglect in Foster Care[8] (12 months) [Standard: 99.68% or more]					9,592 of	99.57					9,803 of	99.52					9,701 of	99.43
					9,633						9,850						9,757	

Additional Safety Measures for Information Only (Not Associated Standards):																		
	Fiscal Year 2005ab						**Fiscal Year 2006ab**						**12-Month Period Ending 03/31/2007**					
	Hours				**Unique Childn.[2]**	**%**	**Hours**				**Unique Childn.[2]**	**%**	**Hours**				**Unique Childn.[2]**	**%**
VIII. Median Time to Investigation in Hours (Child File)[9]	>24 but <48						>48 but <72						>48 but <72					
IX . Mean Time to Investigation in Hours (Child File)[10]	207						172						129					
X. Mean Time to Investigation in Hours (Agency File)[11]	413						312						N/A					
XI. Children Maltreated by Parents While in Foster Care.[12]					169 of 9,633	1.75					137 of 9,850	1.39					110 of 9,757	1.13
CFSR Round One Safety Measures to Determine Substantial Conformity																		
	Reports	**%**	**Duplic. Childn.[2]**	%	**Unique Childn.[2]**	**%**	**Reports**	**%**	**Duplic. Childn.[2]**	%	**Unique Childn.[2]**	**%**	**Reports**	**%**	**Duplic. Childn.[2]**	%	**Unique Childn.[2]**	**%**
XII. Recurrence of Maltreatment[13] [Standard: 6.1% or less)					249 of						219 of						185 of	
					2,509	9.9					2,370	9.2					2,138	8.7
XIII. Incidence of Child Abuse and/or Neglect in Foster Care[14] (9 months) [Standard: 0.57% or less]					30 of	0.34					33 of	0.37					46 of	0.52
					8,839						9,004						8,815	

NCANDS Data Completeness Information for the CFSR	Fiscal Year 2005ab	Fiscal Year 2006ab	12-Month Period Ending 03/31/2007
Percent of duplicate victims in the submission [At least 1% of victims should be associated with multiple reports (same CHID). If not, the state would appear to have frequently entered different IDs for the same victim. This affects maltreatment recurrence]	11.40	10.95	9.60
Percent of victims with perpetrator reported [File must have at least 75% to reasonably calculate maltreatment in foster care]*	99.60	99.69	99.60
Percent of perpetrators with relationship to victim reported [File must have at least 75%]*	95.10	98.05	99.50
Percent of records with investigation start date reported [Needed to compute mean and median time to investigation]	78.90	82.36	85.20
Average time to investigation in the Agency file [PART measure]	Reported	Reported	N/A
Percent of records with AFCARS ID reported in the child file [Needed to calculate maltreatment in foster care by the parents. All child file records should now have an AFCARS ID to allow ACF to link the NCANDS data with AFCARS. This is now an all-purpose unique child identifier and a child does not have to be in foster care to have this ID.]	100	100	100

*****States should strive to reach 100% in order to have confidence in the absence of maltreatment in foster care measure.

Child Safety Profile Footnotes

1. Each maltreatment allegation reported to NCANDS is associated with a disposition or finding that is used to derive the counts provided in this safety profile. The safety profile uses three categories.

Category	Disposition	NCANDS Maltreatment Level Codes
A	Substantiated or Indicated (Maltreatment Victim)	"Substantiated," "Indicated," and "Alternative Response Disposition Victim"
B	Unsubstantiated	"Unsubstantiated" and "Unsubstantiated Due to Intentionally False Reporting"
C	Other	"Closed/No Finding," "Alternative Response Disposition Not a Victim," "Other," "No Alleged Maltreatment," "Unknown/ Missing"

   "Alternative Response" was added in 2000. The two "Unsubstantiated" categories were added in 2000 (in prior years there was only one "Unsubstantiated" category). "No Alleged Maltreatment" was added in FYY2003 and refers to: children who receive an investigation or assessment due to an allegation concerning a sibling or other child in the household, but not themselves, AND whom are not found to be a victim of maltreatment. It applies as a Maltreatment Disposition Level but not as a Report Disposition code because the Report Disposition Code cannot have this value (there must have been a child who was found to be one of the other values).
2. Starting with FFY2003, the data year is the fiscal year.
3. Starting with FFY2004, the maltreatment levels for each child are used consistently to categorize children. While report dispositions are based on the field of report disposition in NCANDS, the dispositions for duplicate children and unique children are based on the maltreatment levels associated with each child. A child victim has at least one maltreatment level that is coded "Substantiated," "Indicated," or "Alternative Response Disposition Victim." A child classified as unsubstantiated has no maltreatment levels that are considered to be victim levels and at least one maltreatment level that is coded "Unsubstantiated" or "Unsubstantiated Due to Intentionally False Reporting." A child classified as "Other" has no maltreatment levels that are considered to be victim levels and none that are considered to be unsubstantiated levels. If a child has no maltreatments in the record, and report has a victim disposition, the child is assigned to "Other" disposition. If a child has no maltreatments in the record and the report has either an unsubstantiated disposition or an "Other" disposition, the child is counted as having the same disposition as the report disposition.
4. The data element, "Total CA/N Reports Disposed," is based on the reports received in the state that received a disposition in the reporting period under review. The number shown may include reports received during a previous year that received a disposition in the reporting year. Counts based on "reports," "duplicated counts of children," and "unique counts of children" are provided.
5. The duplicated count of children (report-child pairs) counts a child each time that (s)he was reported. The unique count of children counts a child only once during the reporting period, regardless of how many times the child was reported.
6. For the column labeled "Reports," the data element, "Disposition of CA/N Reports," is based on upon the highest disposition of any child who was the subject of an investigation in a particular report. For example, if a report investigated two children, and one child is found to be neglected and the other child found not to be maltreated, the report disposition will be substantiated (Group A). The disposition for each child is based on the specific finding related to the maltreatment(s). In other words, of the two children above, one is a victim and is counted under "Substantiated" (Group A) and the other is not a victim and is counted under "Unsubstantiated" (Group B). In determining the unique counts of children, the

highest finding is given priority. If a child is found to be a victim in one report (Group A), but not a victim in a second report (Group B), the unique count of children includes the child only as a victim (Group A). The category of "Other" (Group C) includes children whose report may have been closed without a finding ("Closed/No Finding"), children for whom the allegation disposition is "Unknown," and other dispositions that a state is unable to code as substantiated, indicated, alternative response victim, or unsubstantiated.

7. The data element, "Child Cases Opened for Services," is based on the number of victims (Group A) during the reporting period under review. "Opened for Services" refers to post-investigative services. The duplicated number counts each time a victim's report is linked to ongoing services; the unique number counts a victim only once regardless of the number of times services are linked to reports of substantiated maltreatment.
8. The data element, "Children Entering Care Based on CA/N Report," is based on the number of victims (Group A) during the reporting period under review. The duplicated number counts each time a victim's report is linked to a foster care removal date. The unique number counts a victim only once regardless of the number of removals that may be reported.
9. The data element "Child Fatalities" counts the number of children reported to NCANDS as having died as a result of child abuse and/or neglect. Depending upon state practice, this number may count only those children for whom a case record has been opened either prior to or after the death, or may include a number of children whose deaths have been investigated as possibly related to child maltreatment. For example, some States include neglected-related deaths such as those caused by motor vehicle or boating accidents, house fires or access to firearms, under certain circumstances. The percentage is based on a count of unique victims of maltreatment for the reporting period.
10. The data element "Absence of Recurrence of Maltreatment" is defined as follows: of all children who were victims of substantiated or indicated maltreatment allegation during the first six months of the reporting period, what percent were not victims of another substantiated or indicated maltreatment allegation within a six-month period? This data element is used to determine the state's substantial conformity with CFSR Safety Outcome 1 ("Children are, first and foremost, protected from abuse and neglect").
11. The data element "Absence of Child Abuse/or Neglect in Foster Care" is defined as follows: of all children in foster care during the reporting period, what percent were not victims of substantiated or indicated maltreatment by foster parent of facility staff member? This data element is used to determine the state's substantial conformity with CFSR Safety Outcome 1 ("Children are, first and foremost, protected from abuse and neglect"). A child is counted as not having been maltreated in foster care if the perpetrator of the maltreatment was not identified as a foster parent or residential facility staff. Counts of children not maltreated in foster care are derived by subtracting NCANDS count of children maltreated by foster care providers from AFCARS count of children placed in foster care. The observation period for this measure is 12 months. The number of children not found to be maltreated in foster care and the percentage of all children in foster care are provided.
12. "Median Time to Investigation" in hours is computed from the child file records using the report date and the investigation start date (currently reported in the child file in mmddyyyy format). The result is converted to hours by multiplying by 24.
13. "Mean Time to Investigation" in hours is computed from the child file records using the report date and the investigation start date (currently reported in the child file in mmddyyyy format). The result is converted to hours by multiplying by 24. Zero days difference (both dates are on the same day) is reported as "under 24 hours", one day difference (investigation date is the next day after report date) is reported as "at least 24 hours, but less than 48 hours", two days difference is reported as "at least 48 hours, but less than 72 hours", etc.
14. Average response time in hours between maltreatment report and investigation is available through state NCANDS agency or SDC file aggregate data. "Response Time" is defined as the time from the receipt of a report to the time of the initial investigation or assessment. Note that many states calculate the initial investigation date as the first date of contact with the alleged victim, when this is appropriate, or with another person who can provide information essential to the disposition of the investigation or assessment.
15. The data element, "Children Maltreated by Parents while in Foster Care" is defined as follows: Of all children placed in foster care during the reporting period, what percent were victims of substantiated or indicated maltreatment by parent? This data element requires matching NCANDS and AFCARS records by AFCARS IDs. Only unique NCANDS children with substantiated or indicated maltreatments and perpetrator relationship "parent" are selected for this match. NCANDS report date must fall within the removal period found in the matching AFCARS record.
16. The data element, "Recurrence of Maltreatment," is defined as follows: Of all children associated with a "Substantiated" or "Indicated" finding of maltreatment during the first six months of the reporting period, what percentage had another "Substantiated" or "Indicated" finding of maltreatment within a six-month period? The number of victims during the first six-month period and the number of these victims who were recurrent victims within six months are provided. This data element was used to determine the state's substantial conformity with Safety Outcome 1 for CFSR round one.
17. The data element, "Incidence of Child Abuse and/or Neglect in Foster Care," is defined as follows: Of all children who were served in foster care during the reporting period, what percentage were found to be victims of "Substantiated" or "Indicated" maltreatment? A child is counted as having been maltreated in foster care if the perpetrator of the maltreatment was identified as a foster parent or residential facility staff. Counts of children maltreated in foster care are derived from NCANDS, while counts of children placed in foster care are derived from AFCARS. The observation period for these measures is January through September because this is the reporting period that was jointly addressed by both NCANDS and AFCARS at the time when NCANDS reporting period was a calendar year. The number of children found to be maltreated in foster care and the percentage of all children in foster care are provided. This data element was used to determine the state's substantial conformity with Safety Outcome 2 for CFSR round one.

18. Additional footnotes:
    A. Nebraska has been seeing a slight decrease in reports for the last three years.
        - In FFY2003 and FFY2004, there were increases caused by a change in practice: the introduction of a new intake screening tool and an aggressive public awareness program implemented in 2003.
        - A reporting change was approved in FFY2005. The interim report disposition of "Court Pending" is no longer included in report counts. It was determined that including this disposition in report counts caused duplicate reporting in prior years.
    B. In FFY2005, Nebraska reported two additional fatalities in the agency file. In FFY2006, 12 additional fatalities were reported in the agency file.

Point-in-Time Permanency Profile	Federal FY 2005ab		Federal FY 2006ab		12-Month Period Ending 03/31/2007	
	# of Children	% of Children	# of Children	% of Children	# of Children	% of Children
I. Foster Care Population Flow						
Children in foster care on first day of year[1]	5,719		6,050		6,173	
Admissions during year	3,914		3,800		3,584	
Discharges during year	3,379		3,657		3,919	
Children discharging from FC in 7 days or less (excluded from length of stay calculations in the composite measures)	147	4.4% of discharges	147	4.0% of discharges	119	3.0% of discharges
Children in care on last day of year	6,254		6,193		5,838	
Net change during year	535		143		-335	
II. Placement Types for Children in Care						
Pre-Adoptive Homes	143	2.3	148	2.4	100	1.7
Foster Family Homes (Relative)	1,120	17.9	1,176	19.0	1,161	19.9
Foster Family Homes (Non-Relative)	2,460	39.3	2,400	38.8	2,248	38.5
Group Homes	811	13.0	685	11.1	730	12.5
Institutions	567	9.1	555	9.0	538	9.2
Supervised Independent Living	79	1.3	78	1.3	68	1.2
Runaway	123	2.0	102	1.6	103	1.8
Trial Home Visit	951	15.2	1,049	16.9	890	15.2
Missing Placement Information	0	0.0	0	0.0	0	0.0
Not Applicable (placement in subsequent year)	0	0.0	0	0.0	0	0.0
III. Permanency Goals for Children in Care						
Reunification	4,132	66.1	4,225	68.2	3,987	68.3
Live with Other Relatives	0	0.0	0	0.0	0	0.0
Adoption	791	12.6	836	13.5	764	13.1
Long Term Foster Care	17	0.3	2	0.0	0	0.0
Emancipation	445	7.1	437	7.1	436	7.5
Guardianship	452	7.2	420	6.8	431	7.4
Case Plan Goal Not Established	229	3.7	155	2.5	126	2.2
Missing	188	3.0	118	1.9	94	1.6
IV. Number of Placement Settings in Current Episode						
One	1,940	31.0	1,986	32.1	1,941	33.2
Two	1,595	25.5	1,560	25.2	1,432	24.5
Three	906	14.5	871	14.1	806	13.8
Four	575	9.2	555	9.0	502	8.6
Five	346	5.5	327	5.3	314	5.4
Six or more	892	14.3	894	14.4	843	14.4
Missing	0	0.0	0	0.0	0	0.0

	Federal FY 2005ab		Federal FY 2006ab		12-Month Period Ending 03/31/2007	
	# of Children	**% of Children**	**# of Children**	**% of Children**	**# of Children**	**% of Children**
V. Number of Removal Episodes						
One	5,005	80.0	4,917	79.4	4,634	79.4
Two	1,029	16.5	1,052	17.0	978	16.8
Three	172	2.8	176	2.8	181	3.1
Four	38	0.6	37	0.6	37	0.6
Five	10	0.2	7	0.1	7	0.1
Six or more	0	0.0	4	0.1	1	0.0
Missing	0	0.0	0	0.0	0	0.0
VI. Number of children in care 17 of the most recent 22 months[2] (percent based on cases with sufficient information for computation)	1,519	34.8	1,477	36.0	1,370	35.7
VII. Median Length of Stay in Foster Care (of children in care on last day of FY)	12.5		12.9		13.0	
VIII. Length of Time to Achieve Perm. Goal	**# of Children Discharged**	**Median Months to Discharge**	**# of Children Discharged**	**Median Months to Discharge**	**# of Children Discharged**	**Median Months to Discharge**
Reunification	2,476	10.1	2,471	10.5	2,633	10.8
Adoption	336	35.9	414	37.8	467	37.0
Guardianship	258	22.0	262	25.7	297	25.9
Other	235	21.1	510	23.3	522	23.3
Missing Discharge Reason[3]	74	6.9	0	--	0	--
Total discharges (excluding those with problematic dates)	3,379	12.7	3,657	14.2	3,919	14.5
Dates are problematic[4]	0	N/A	0	N/A	0	N/A

Statewide Aggregate Data Used in Determining Substantial Conformity: Composites 1 through 4			
	Federal FY 2005ab	**Federal FY 2006ab**	**12-Month Period Ending 03/31/2007**
IX. Permanency Composite 1: Timeliness and Permanency of Reunification [standard: 122.6 or higher]. Scaled Scores for this composite incorporate two components	State Score = 114.3	State Score = 112.5	State Score = 110.8
National Ranking of State Composite Scores[5]	24 of 47	24 of 47	19 of 47
Component A: Timeliness of Reunification The timeliness component is composed of three timeliness individual measures.			
Measure C1 - 1: Exits to reunification in less than 12 months: Of all children discharged from foster care to reunification in the year shown, who had been in foster care for 8 days or longer, what percent was reunified in less than 12 months from the date of the latest removal from home? (Includes trial home visit adjustment) [**National Median = 69.9%, 75th Percentile = 75.2%**]	68.2%	66.3%	64.8%

	Federal FY 2005ab	Federal FY 2006ab	12-Month Period Ending 03/31/2007
Measure C1 - 2: Exits to reunification, median stay: Of all children discharged from foster care (FC) to reunification in the year shown, who had been in FC for 8 days or longer, what was the median length of stay (in months) from the date of the latest removal from home until the date of discharge to reunification? (This includes trial home visit adjustment) [**National Median = 6.5 months, 25th Percentile = 5.4 months (lower score is preferable in this measure[6])**]	Median = 7.0 months	Median = 8.0 months	Median = 8.2 months
Measure C1 - 3: Entry cohort reunification in < 12 months: Of all children entering foster care (FC) for the first time in the 6 month period just prior to the year shown, and who remained in FC for 8 days or longer, what percent was discharged from FC to reunification in less than 12 months from the date of the latest removal from home? (Includes trial home visit adjustment) [**National Median = 39.4%, 75th Percentile = 48.4%**]	42.5%	42.1%	47.1%
Component B: Permanency of Reunification The permanency component has one measure.			
Measure C1 - 4: Re-entries to foster care in less than 12 months: Of all children discharged from foster care (FC) to reunification in the 12-month period prior to the year shown, what percent re-entered FC in less than 12 months from the date of discharge? [**National Median = 15.0%, 25th Percentile = 9.9% (lower score is preferable in this measure)**]	15.3%	14.2%	14.6%
X. Permanency Composite 2: Timeliness of Adoptions [Standard: 106.4 or higher]. Scaled Scores for this composite incorporate three components.	State Score = 81.4	State Score = 81.5	State Score = 90.7
National Ranking of State Composite Scores	16 of 47	17 of 47	21 of 47
Component A: Timeliness of Adoptions of Children Discharged From Foster Care. There are two individual measures of this component. See below.			
Measure C2 - 1: Exits to adoption in less than 24 months: Of all children who were discharged from foster care to a finalized adoption in the year shown, what percent was discharged in less than 24 months from the date of the latest removal from home? [**National Median = 26.8%, 75th Percentile = 36.6%**]	22.4%	16.5%	17.7%
Measure C2 - 2: Exits to adoption, median length of stay: Of all children who were discharged from foster care (FC) to a finalized adoption in the year shown, what was the median length of stay in FC (in months) from the date of latest removal from home to the date of discharge to adoption? [**National Median = 32.4 months, 25th Percentile = 27.3 months(lower score is preferable in this measure)**]	Median = 35.4 months	Median = 37.9 months	Median = 37.2 months
Component B: Progress Toward Adoption for Children in Foster Care for 17 Months or Longer. There are two individual measures. See below.			
Measure C2 - 3: Children in care 17+ months, adopted by the end of the year: Of all children in foster care (FC) on the first day of the year shown who were in FC for 17 continuous months or longer (and who, by the last day of the year shown, were not discharged from FC with a discharge reason of live with relative, reunify, or guardianship), what percent was discharged from FC to a finalized adoption by the last day of the year shown? [**National Median = 20.2%, 75th Percentile = 22.7%**]	16.9%	21.0%	23.2%
Measure C2 - 4: Children in care 17+ months achieving legal freedom within 6 months: Of all children in foster care (FC) on the first day of the year shown who were in FC for 17 continuous months or longer, and were not legally free for adoption prior to that day, what percent became legally free for adoption during the first 6 months of the year shown? Legally free means that there was a parental rights termination date reported to AFCARS for both mother and father. This calculation excludes children who, by the end of the first 6 months of the year shown had discharged from FC to "reunification," "live with relative," or "guardianship." [**National Median = 8.8%, 75th Percentile = 10.9%**]	6.0%	9.0%	11.3%

	Federal FY 2005ab	Federal FY 2006ab	12-Month Period Ending 03/31/2007
Component C: Progress Toward Adoption of Children Who Are Legally Free for Adoption. There is one measure for this component. See below.			
Measure C2 - 5: **Legally free children adopted in less than 12 months:** Of all children who became legally free for adoption in the 12 month period prior to the year shown (i.e., there was a parental rights termination date reported to AFCARS for both mother and father), what percent was discharged from foster care to a finalized adoption in less than 12 months of becoming legally free? [**national median = 45.8%, 75th Percentile = 53.7%**]	42.0%	40.6%	49.7%
XI. Permanency Composite 3: Permanency for Children and Youth in Foster Care for Long Periods of Time [standard: 121.7 or higher]. Scaled Scores for this composite incorporate two components	State Score = 141.8	State Score = 151.6	State Score = 154.1
National Ranking of State Composite Scores	49 of 51	51 of 51	51 of 51
Component A: Achieving permanency for Children in Foster Care for Long Periods of Time. This component has two measures.			
Measure C3 - 1: Exits to permanency prior to 18th birthday for children in care for 24 + months. Of all children in foster care for 24 months or longer on the first day of the year shown, what percent was discharged to a permanent home prior to their 18th birthday and by the end of the fiscal year? A permanent home is defined as having a discharge reason of adoption, guardianship, or reunification (including living with relative). **[National Median 25.0%, 75th Percentile = 29.1%]**	30.1%	36.4%	40.0%
Measure C3 - 2: Exits to permanency for children with TPR: Of all children who were discharged from foster care in the year shown, and who were legally free for adoption at the time of discharge (i.e., there was a parental rights termination date reported to AFCARS for both mother and father), what percent was discharged to a permanent home prior to their 18th birthday? A permanent home is defined as having a discharge reason of adoption, guardianship, or reunification (including living with relative) **[National Median 96.8%, 75th Percentile = 98.0%]**	97.8%	99.1%	98.3%
Component B: Growing up in foster care. This component has one measure.			
Measure C3 - 3: Children Emancipated Who Were in Foster Care for 3 Years or More. Of all children who, during the year shown, either (1) were discharged from foster care prior to age 18 with a discharge reason of emancipation, or (2) reached their 18th birthday while in foster care, what percent were in foster care for 3 years or longer? **[National Median 47.8%, 25th Percentile = 37.5% (lower score is preferable)]**	25.6%	22.8%	22.5%
XII. Permanency Composite 4: Placement Stability [national standard: 101.5 or higher]. Scaled scored for this composite incorporates **no components** but three individual measures (below)	State Score = 85.7	State Score = 88.2	State Score = 89.8
National Ranking of State Composite Scores	15 of 51	17 of 51	19 of 51
Measure C4 - 1) Two or fewer placement settings for children in care for less than 12 months. Of all children served in foster care (FC) during the 12 month target period who were in FC for at least 8 days but less than 12 months, what percent had two or fewer placement settings? **[National Median = 83.3%, 75th Percentile = 86.0%]**	81.6%	82.6%	84.0%
Measure C4 - 2) Two or fewer placement settings for children in care for 12 to 24 months. Of all children served in foster care (FC) during the 12 month target period who were in FC for at least 12 months but less than 24 months, what percent had two or fewer placement settings? **[National Median = 59.9%, 75th Percentile = 65.4%]**	48.4%	54.9%	54.7%
Measure C4 - 3) Two or fewer placement settings for children in care for 24+ months. Of all children served in foster care (FC) during the 12 month target period who were in FC for at least 24 months, what percent had two or fewer placement settings? **[National Median = 33.9%, 75th Percentile = 41.8%]**	29.3%	27.5%	29.0%

Permanency Profile: First-Time Entry Cohort	Federal FY 2005ab		Federal FY 2006ab		12-Month Period Ending 03/31/2007	
	# of Children	% of Children	# of Children	% of Children	# of Children	% of Children
I. Number of children entering care for the first time in cohort group (% = 1st time entry of all entering within first 6 months)	1,652	81.3	1,560	80.8	1,500	81.0
II. Most Recent Placement Types						
Pre-Adoptive Homes	2	0.1	2	0.1	6	0.4
Foster Family Homes (Relative)	260	15.7	256	16.4	239	15.9
Foster Family Homes (Non-Relative)	495	30.0	471	30.2	452	30.1
Group Homes	151	9.1	131	8.4	163	10.9
Institutions	92	5.6	84	5.4	87	5.8
Supervised Independent Living	14	0.8	9	0.6	14	0.9
Runaway	23	1.4	19	1.2	13	0.9
Trial Home Visit	615	37.2	588	37.7	525	35.0
Missing	0	0.0	0	0.0	0	0.1
Not Applicable (placement in subsequent year)	0	0.0	0	0.0	0	0.0
III. Most Recent Permanency Goal						
Reunification	1,325	80.2	1,209	77.5	1,164	77.6
Live with Other Relatives	0	0.0	0	0.0	0	0.0
Adoption	28	1.7	48	3.1	34	2.3
Long-Term Foster Care	0	0.0	0	0.0	0	0.0
Emancipation	48	2.9	36	2.3	46	3.1
Guardianship	34	2.1	24	1.5	37	2.5
Case Plan Goal Not Established	25	1.5	33	2.1	17	1.1
Missing	192	11.6	210	13.5	202	13.5
IV. Number of Placement Settings in Current Episode						
One	795	48.1	788	50.5	756	50.4
Two	483	29.2	441	28.3	423	28.2
Three	202	12.2	200	12.8	198	13.2
Four	100	6.1	78	5.0	78	5.2
Five	42	2.5	26	1.7	23	1.5
Six or more	30	1.8	27	1.7	22	1.5
Missing placement settings	0	0.0	0	0.0	0	0.0
V. Reason for Discharge						
Reunification/Relative Placement	486	88.8	498	93.3	489	91.6
Adoption	3	0.5	1	0.2	0	0.0
Guardianship	13	2.4	10	1.9	17	3.2
Other	30	5.5	25	4.7	28	5.2
Unknown (missing or N/A)	15	2.7	0	0.0	0	0.0

Permanency Profile: First-Time Entry Cohort	**Federal FY 2005ab**	**Federal FY 2006ab**	**12-Month Period Ending 03/31/2007**
	# of Months	**# of Months**	**# Months**
VI. Median Length of Stay in Foster Care	14.5[7]	8.8[8]	8.3[9]

AFCARS Data Completeness and Quality Information (2% or more is a warning sign):						
	Federal FY 2005ab		**Federal FY 2006ab**		**12-Month Period Ending 03/31/2007**	
	#	**As a % of exits reported**	**#**	**As a % of exits reported**	**#**	**As a % of exits reported**
File contains children who appear to have been in care less than 24 hours	0	0.0 %	0	0.0 %	0	0.0 %
File contains children who appear to have exited before they entered	0	0.0 %	0	0.0 %	0	0.0 %
Missing dates of latest removal	0	0.0 %	0	0.0 %	0	0.0 %
File contains "Dropped Cases" between report periods with no indication as to discharge	3	0.1 %	5	0.1%	0	0.3 %
Missing discharge reasons	74	2.2 %	0	0.0 %	0	0.0 %
	#	**As a % of adoption exits**	**#**	**As a % of adoption exits**	**#**	**As a % of adoption exits**
File submitted lacks data on Termination of Parental Rights for finalized adoptions	42	12.5 %	6	1.4 %	2	8.4 %
Foster Care file has different count than Adoption File of (public agency) adoptions (#= adoption count disparity).	17	4.8% fewer in the foster care file.	3	0.7% fewer in the foster care file.[10]	8	1.7% more in unofficial adoption file.[10]
	#	**% of cases in file**	**#**	**% of cases in file**	**#**	**% of cases in file**
File submitted lacks count of number of placement settings in episode for each child	0	0.0 %	0	0.0 %	0	0.0 %

	Federal FY 2005ab		**Federal FY 2006ab**		**12-Month Period Ending 03/31/2007**	
	# of Children	**% of Children**	**# of Children**	**% of Children**	**# of Children**	**% of Children**
IX. Of all children who were reunified with their parents or caretakers at the time of discharge from foster care, what percentage was reunified in less than 12 months from the time of the latest removal for home? (4.1) **[Standard: 76.2% or more]**[11]	1,431	57.8	1,405	56.9	1,461	55.5
X. Of all children who exited care to a finalized adoption, what percentage exited care in less than 24 months from the time of the latest removal from home? (5.1) **[Standard: 32.0% or more]**[11]	75	22.3	71	17.1	85	18.2
XI. Of all children served who have been in foster care less than 12 months from the time of the latest removal from home, what percentage have had no more than two placement settings? (6.1) **[Standard: 86.7% or more]**[11]	3,845	82.3	3,765	83.2	3,729	84.4
XII. Of all children who entered care during the year, what percentage re-entered foster care within 12 months of a prior foster care episode? (4.2) **[Standard: 8.6% or less]**[11]	363	9.3 (80.9% new entry)	340	8.9 (80.9% new entry)	324	9.0 (80.7% new entry)

Permanency Profile footnotes

1. The FFY05, FFY06 , and FFY07 counts of children in care at the start of the year 139 , 130 , and 110 children, respectively. They were excluded to avoid exclude counting them twice. That is, although they were actually in care on the first day, they also qualify as new entries because they left and re-entered again at some point during the same reporting period. To avoid counting them as both "in care on the first day" and "entries," the Children's Bureau selects only the most recent record. That means they get counted as "entries," not "in care on the first day."
2. We designated the indicator, *17 of the most recent 22 months*, rather than the statutory time frame for initiating termination of parental rights proceedings at *15 of the most 22 months*, since the AFCARS system cannot determine the *date the child is considered to have entered foster care* as defined in the regulation. We used the outside date for determining the *date the child is considered to have entered foster care*, which is 60 days from the actual removal date.
3. This count only includes case records missing a discharge reason, but which have calculable lengths of stay. Records missing a discharge reason and with non-calculable lengths of stay are included in the cell "Dates are Problematic".
4. The dates of removal and exit needed to calculate length of stay are problematic. Such problems include: 1) missing data, 2) faulty data (chronologically impossible), 3) a child was in care less than 1 day (length of stay = 0) so the child should not have been reported in foster care file, or 4) child's length of stay would equal 21 years or more. These cases are marked N/A = Not Applicable because no length of stay can legitimately be calculated.
5. These National Rankings show your State's performance on the Composites compared to the performance of all the other States that were included in the 2004 data. The 2004 data were used for establishing the rankings because that is the year used in calculating the National Standards.
6. In most cases, a high score is preferable on the individual measures. In these cases, you will see the 75th percentile listed to indicate that this would be considered a good score. However, in a few instances, a low score is good (shows desirable performance), such as re-entry to foster care. In these cases, the 25th percentile is displayed because that is the target direction for which States will want to strive. Of course, in actual calculation of the total composite scores, these "lower are preferable" scores on the individual measures are reversed so that they can be combined with all the individual scores that are scored in a positive direction, where higher scores are preferable.
7. This First-Time Entry Cohort median length of stay was 14.5 in FFY05. This includes 0 children who entered and exited on the same day (who had a zero length of stay). Therefore, the median length of stay was unaffected by any 'same day' children.
8. This First-Time Entry Cohort median length of stay was 8.3 in FFY06. This includes 0 children who entered and exited on the same day (who had a zero length of stay). Therefore, the median length of stay was unaffected by any 'same day' children.
9. This First-Time Entry Cohort median length of stay is 8.3 in 06b07a.. This includes 0 children who entered and exited on the same day (they had a zero length of stay).
10. The adoption data comparison was made using the discharge reason of "adoption" from the AFCARS foster care file and an *unofficial* count of adoptions finalized during the period of interest that were "placed by public agency" reported in the AFCARS Adoption files. This *unofficial* count of adoptions is only used for CFSR data quality purposes because adoption counts used for other purposes (e.g. Adoption Incentives awards, Outcomes Report) only cover the federal fiscal year, and include a broader definition of adoption and a different de-duplication methodology.
11. These are CFSR Round One permanency measures. They are intended to be used primarily by States completing Round One Program Improvement Plans, but could also be useful to States in CFSR Round Two in comparing their current performance to that of prior years.

Section III – Narrative Assessment of Child and Family Outcomes

The narrative assessment for each child and family outcome is divided into three sections. A data summary presents data from federal and state sources for each outcome, composite, and item, when available. The Stakeholder Assessment section summarizes information gathered from: the stakeholder assessment team; online stakeholder and youth surveys; Tribal, court, foster and biological parent, and youth focus group discussions; and other information generated by participants who attended statewide assessment team meetings. Last, an item-by-item evaluation includes detailed information for each item, including policy and procedure, item-level data, a comparison of current to past performance as documented in the state's first CFSR, and any changes that have been implemented since CFSR round one.

As noted, the Stakeholder Assessment section includes comments from stakeholder assessment team members, focus group participant, and survey respondents. Stakeholder assessment team members included: service providers; court and legal community representatives; Tribal leaders; legislators and legislative staff; child advocates; and DHHS workers, supervisors, and administrators. Members met for three non-consecutive days to provide input and feedback to include in the statewide assessment, and then provided additional feedback on assessment drafts via subsequent emails. Regional focus groups were conducted with: 51 youth in five locations throughout the state; 80 biological family members in each of the five service areas; 66 adoptive and foster parents from seven locations across the state; and stakeholders from the child welfare and juvenile justice court systems in all 12 judicial districts. A focus group was conducted with seven Tribal representatives from across the state as well (with invitations extended to 45 representatives). Additionally, online surveys were conducted with a total of 480 internal and external stakeholders, and 17 current or former foster care youth. We recognize that the small number of youth who completed the foster care youth survey limits the conclusions we can draw from the survey responses.

A. Safety

Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect.

1. Data Summary

Safety Outcome 1 is comprised of two items. The first item is timely response to maltreatment. Counts of maltreatment reports, time to investigation, substantiation rates, the number of cases opened to receive services, and the number of children entering care are used to inform this item. Additional data from the Nebraska Family Online Client User System (N-FOCUS) were drawn to examine agency response times by case priority.

The second item pertains to absence of recurring maltreatment. Rates of children who do not experience repeat maltreatment or maltreatment by parents while in foster care are used to inform this item, and demographic data on children who experienced repeat maltreatment are compared.

Findings on these items from the federal CFSR conducted in 2002, and the subsequent NE-CFSRs (refer to Section I) conducted in 2005 and 2006 are displayed in Table 5. Performance

on Item 1 consistently increased from 2002. Performance on Item 2 decreased from 2002 to 2005, but then increased from 2005 to 2006.

Table 5. CFSR and NE-CFSR Findings by Item

	2002 Federal CFSR			2005 NE-CFSR			2006 NE-CFSR		
	Strength	ANI	%	Strength	ANI	%	Strength	ANI	%
Item 1. Timely Response	5	7	42%	16	14	53%	17	9	65%
Item 2. Repeat Maltreatment	12	0	100%	30	5	86%	41	2	95%

Note. ANI indicates an "Area Needing Improvement."

The state data profile provided by the Administration for Children and Families (ACF) indicates that while the state has not met the national standard pertaining to this measure it has made improvements. In 2003, the state implemented a new intake tool and process. At the time the new intake tool was implemented, DHHS also began to centralize the Child Abuse and Neglect (CAN) Hotline to operate under one toll-free number and then route incoming calls to the designated area of the state from which the calls originate. Each service area has a designated hotline location that accepts calls Monday through Friday from 8:00 a.m. to 5:00 p.m. Calls received after 5:00 p.m. and on weekends and holidays are routed to the Omaha site, which is the only site staffed 24 hours a day, seven days a week. Staff members were specially selected and trained as Intake Workers to staff the hotline and utilize the new intake tool to make response decisions based on the information received. Intake Workers send on reports for immediate assessment if allegations indicate that a child may be in a life threatening situation. The report is also sent to a supervisor for second level review. The process has improved decision-making at the time maltreatment reports are received and screened. We believe this intake process has led to improvements in the timeliness of our response to maltreatment reports (Item 1) as it provides clear screening and response time criteria. Additionally, it improved our ability to clarify what constitutes a new or recurring report of maltreatment (Item 2), which may explain the shifts that have occurred in the rates of recurring maltreatment.

We also anticipate that NSIS (refer to Section I) will further contribute to improved outcomes related to recurrent maltreatment as it moves our safety interventions from an incident-based safety response to a comprehensive assessment of safety. In theory, a comprehensive assessment of child safety should reduce repeat maltreatment by focusing interventions on the underlying cause of maltreatment rather than just on the incident of maltreatment itself.

2. Stakeholder Assessment

Stakeholders, particularly workers and court personnel, believe that data pertaining to this measure are generally positive, particularly in regard to appropriately screening and accepting reports and responding to reports in a timely manner.

Stakeholders noted an overall lack of services and placement options in the community, especially in rural areas where the closest service provider is not in the same town. Workers reported that they are unfamiliar with the community services and resources available for children and families and would like additional information on these services. Identified barriers specifically pertaining to timeliness include Child Advocacy Center (CAC) service delays and law enforcement delays. At the CACs, these delays usually relate to the necessary staff not

being available (for example, the interview specialist) and other scheduling issues. Law enforcement delays often relate to other criminal acts of the family being monitored or trained personnel not available. Additionally, there are service area factors such as DHHS staff turnover, high caseloads, and lengthy travel distances.

Stakeholder surveys indicate a general perception among stakeholders that DHHS is only somewhat effective in investigating reports of child maltreatment. Stakeholders recommended in a group discussion that the state's priority response system be reevaluated. The thought is that there is not much difference between reports rated as priority 2 and those rated as priority 3. It has been recommended that the time frames for priority 3 responses be shortened to emphasize the urgency to respond.

3. Item-by-Item Evaluation

Item 1. Timeliness of initiating investigations of reports of child maltreatment. *How effective is the agency in responding to incoming reports of child maltreatment in a timely manner?*

a. What do policy and procedure require?

Maltreatment reports are received on the CAN Hotline, which operates 24 hours per day and seven days per week. DHHS' response to maltreatment reports are based on both statutory requirements and perceived danger to a child. Intake Workers are responsible for screening child abuse and neglect reports for maltreatment using an intake assessment tool that examines several factors, including parental substance abuse, domestic violence, mental health issues, and other factors impacting child safety. Once the worker has made a decision to screen in a maltreatment report they must consult with a supervisor. Each accepted case is then categorized into one of three priorities, and receives the corresponding response below. The response time begins the date and time the intake call is received, regardless of any collateral calls or additional information that needs to be gathered.

Priority 1:
- Face-to-face contact with a child within 24 hours (goal = 100%); and
- Completed documentation and service provision within 10 workdays (goal = 95%).

Priority 2:
- Face-to-face contact with a child within 5 calendar days (goal = 90%); and
- Completed documentation and service provision within 20 workdays (goal = 90%).

Priority 3:
- Face-to-face contact with a child within 10 calendar days (goal = 90%); and
- Completed documentation and service provision within 30 workdays (goal = 90%).

The contact measurements are in calendar days and the service provision measurements are in workdays. If it is determined that danger is present at the time of intake, the report is designated as a priority 1 report and immediate action is taken either by DHHS and/or law enforcement.

b. What do the data show?

The total number of hotline calls and the number of calls alleging child abuse and/or neglect has continued to increase over time, as indicated in the ACF data profile. However, the number of reports investigated or assessed and the number of children involved in those reports has steadily decreased since Federal Fiscal Year (FFY) 2005. One reason for this decrease is that there can be a number of investigated reports that have not yet been assigned a case status determination or finding as of the date the data is compiled. While the initial assessment may have been conducted and service provision occurred, the initial assessments documentation itself cannot be completed by workers or approved by supervisors without including these pieces of information. For that reason, workers are allowed up to 30 working days to complete assessment documentation. If the data included in the ACF data profile is run within that timeframe and prior to initial assessment documentation being complete, the assessment is not captured in the counts.

Substantiation rates for reports increased from FFY2005 to FFY2006 and decreased from FFY2006 to the current reporting period (4/1/2006–3/31/2007).[2] Complete documentation of initial assessments (mentioned in the above paragraph) may be impacting this decrease as well. It is likely that many initial assessments that were complete with findings at the time the data was compiled were those reports classified as unfounded, or were otherwise disposed of more easily than substantiated reports. Whereas the substantiation rate in relation to the duplicate count of children was lower than that of the unique count of children in FFY2005, it was higher in FFY2006 and the current reporting period (4/1/2006–3/31/2007). It has become clear that there are individual service area practices concerning decisions about whether or not to substantiate maltreatment. Offices are not always closely following the statutory definitions for case status determinations. This issue is addressed in new policy issued in March 2008 that provided further direction and clarification for workers. The intent of the memo was to ensure case status determinations were made consistently across the state, and to facilitate more accurate substantiation rates. Follow-up case reviews will be conducted to ensure accurate case status determinations by CQI/OU staff.

The number of cases opened to receive services after an assessment have declined since FFY2005. These types of cases have traditionally been those that are voluntary (meaning a parent voluntarily requests services and that services have not been ordered by the court) and, thus, with no court involvement. Some areas of the state previously offered services through voluntary cases but then stopped serving non-court involved families because of the staff resources being needed for the court involved cases. We expect these numbers to increase once again with the NSIS implementation. Under the NSIS, non-court involved cases will have the same access to services and those services will be provided with the same level of effort as in court involved cases throughout the state.

In Nebraska there are three different response times for three different priority designations. N-FOCUS data on response times to maltreatment reports based on the state's established priority system from the last three State Fiscal Years (SFYs) is described on the following page.

[2] Please note that FFY2006 data and the current reporting period data (4/01/06– 3/31/07) overlaps for the time period of 4/01/06 to 09/30/06.

The state has three performance measures related to correct and timely decision-making related to hotline reports of child abuse and neglect:

Child Abuse/Neglect Intakes Screened In or Screened Out within 3 Days. This measure ensures that screening decisions on all child abuse and neglect intakes are made promptly. Staff is allowed up to three days from receiving an intake to make a screening decision. In SFY2007, the state screened 94.9% intakes within three days of receiving the intakes (the goal being 97.0%). This is a 26.9% relative improvement from SFY2005. Each service area screening office experienced a statistically significant improvement in this measure as well. Over the last three years, the Central and Western service areas improved their performance by 5.6%, the Eastern Service Area by 18.6%, the Northern Service Area by 19.3%, and the Southeast Service Area by 58.8%. In fact, the Northern Service Area met the goal at 97.8%.

Child Abuse/Neglect Intakes Screened Out and Reviewed within 3 Days. To ensure that the decision to screen out an intake is being determined appropriately, a secondary supervisory review of all intakes that workers screen out is required within three days of being screened out. The state increased the percent of intakes reviewed within three days of being screened out from 81.7% in SFY2005 to 84.5% in SFY2007. The goal for this measure is 97.0%. In SFY2006, the state reviewed 69.9% of screened out intakes within three days. This may have been affected by the low percent of intakes (50.0%) in the Eastern Service Area. Regardless, the state improved its performance in the measure by 3.3% from SFY2005 to SFY2007. All service areas except the Southeast Service Area experienced statistically significant changes in this measure. In the last three years, performance in the Eastern, Northern, and Western service areas increased by 6.9%, 9.2%, and 32.3% respectively, while performance in the Central Service Area decreased by 10.1%. The Western Service Area met this goal at 97.3%.

Appropriately Accepted Priority 1 Intakes. This measure ensures that any intake reports involving immediate and potentially life-threatening danger are not screened out, and that these reports are appropriately established as priority 1 intakes. From SFY2005 to SFY2007, the state's performance decreased in appropriately accepting priority 1 intakes, but not at a statistically significant level. Changes at the service area level were also not statistically significant. Overall, the state was 0.3% below meeting the 100.0% goal in this measure, but the Northern, Southeast, and Western service areas met the 100.0% goal. It should be noted that the new intake tool (refer to data summary), which drives this decision-making, is also continuously assessed for consistent decision-making and integrity of the tool.

The state also established nine additional measures related to workers' timely contact with children, documentation of assessment, and provision of necessary services by intake priority level. '*First Contact*' timeframes were designed to monitor whether staff are beginning initial assessments within the identified timeframes. '*Completed Initial Assessment*' time frames were designed to monitor if the associated computer work is completed in a timely manner. '*Service Provision*' timeframes were developed in response to a national news article in 2004 stating that Nebraska took over 200 days to provide a service to a family. DHHS knew that these National Child Abuse and Neglect Data System (NCANDS) measures were misleading based on the logic behind the federal measures, so the state developed its own version of that measure to better reflect actual case practice. It should be noted that all of the measures described on the following page are measured using the date the intake was received and comparing that date to a date on which information was entered into N-FOCUS.

First Contact. Although the state is not currently meeting the goals in any of these measures, we continue to improve every year. Improvement in response times to cases designated as priority 2 have been more gradual than those designated as priority 1 and 3.

- *Priority 1 – First Contact within One Day.* The percent of priority 1 cases in which workers made first contact within 24 hours increased from 67.2% in SFY2005 to 86.1% in SFY2007, an improvement (i.e., relative percent increase) of 28.2%. Nonetheless, the state did not meet the 100.0% goal in this measure. It should be noted that some law enforcement requests that workers not respond to maltreatment reports without the law enforcement accompaniment. Unfortunately, there are instances in which assigned law enforcement officers are unable to accompany workers to the home within the specified timeframe. There are also occasions where law enforcement requests that we not respond immediately because of other criminal activities they may be monitoring in the home. Anecdotally speaking, these situations may be impacting our ability to meet this particular measure.
- *Priority 2 – First Contact in 5 Calendar Days.* Workers increased the percent of priority 2 cases in which they made first contact within five days from 66.5% in SFY2005 to 71.9% in SFY2007, an improvement of 8.1%. The goal for this measure is 90.0%.
- *Priority 3 – First Contact within 10 Calendar Days.* From SFY2005 to SFY2007, the percent of priority 3 cases in which workers made first contact within ten calendar days increased from 64.5% to 75.0%. The goal for this measure is 90.0%. Anecdotal information indicates that some intakes initially determined as priority 3 reports may involve additional reports of maltreatment prior to the time in which workers make contact with the child and family. Thus, stakeholders recommended that DHHS evaluate the use and/or the ten day time period for priority 3 reports.

Also of note, N-FOCUS data indicates the mean number of days to worker contact with the alleged child victim was 4.4 calendar days in SFY2007. This data does not directly correlate to the above standards but serves as additional information.

Completed Initial Assessments. The data below is reflective of high workload and prevalent beliefs from the workforce that completed documentation is a less important priority than responding to situations with children and families. Supervisors and other administrators continue to talk about the importance of documentation, but there are competing priorities. The focus is on making contact with children and families to assure safety, rather than documentation. We look forward to seeing if the implementation of NSIS (refer to Section I) and its new safety assessment will have an impact on these measures once data is available. It has been proposed that workers be granted a full 30 days to complete their assessments regardless of the case priority. The goal for this measure is 90.0% of all cases.

- *Priority 1 – IA Completed within 10 Workdays.* The percent of initial assessments in priority 1 cases completed within 10 workdays increased from 32.8% in SFY2005 to 41.9% in SFY2007, a 27.6% improvement.
- *Priority 2 – IA Completed within 20 Workdays.* In SFY2007, workers completed initial assessments within 20 workdays in 43.1% of priority 2 cases. This is a statistically significant decrease of 1.3 percentage points from that of SFY2006. However, from SFY2005 to SFY2007 workers increased the number of priority 2 cases in which initial assessments were completed within 20 workdays by 10.8 percentage points. This equates to a 33.4% improvement in performance at a statistically significant level. Nonetheless, the state did not reach the goal in this measure.

- *Priority 3 – IA Completed within 30 Workdays.* The number of initial assessments completed within 30 workdays increased from 37.8% of priority 3 cases in SFY2005 to 48.8% of cases in SFY2007, an improvement of 29.2%.

Service Provision. The data below indicates that the state is improving performance in these measures. Discussion with administrators from across the state revealed that many believe that these measures are not helpful to staff or administration in evaluating and monitoring the work process. The data is based on purchased service authorizations, yet many services are not obtained through the formal purchase agreements. Thus, while we will continue to capture this data, it will not be analyzed as part of the performance evaluations in 2008.

- *Priority 1 – Service Provision within 10 Workdays.* From SFY2005 to SFY2007, workers increased the number of priority 1 cases in which they provided services within 10 workdays from 54.4% to 85.1%, a 56.5% improvement. The goal for this measure is 95.0%.
- *Priority 2 – Service Provision within 15 Workdays.* From SFY2005 to SFY2007, workers increased the percent of cases in which they provided services within 15 workdays from 42.0% to 74.2%, an improvement of 76.4%. The goal for this measure is 90.0%.
- *Priority 3 – Service Provision within 20 Workdays.* From SFY2005 to SFY2007, workers increased the number of priority 3 cases in which they provided services within 20 workdays from 38.5% to 74.0%, a 92.4% improvement. The goal for this measure is 90.0%.

Also of note, N-FOCUS data indicates the mean number of days to service provision was 4.4 workdays for all cases opened to receive services in SFY2007.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

Timeliness of investigations was rated as an area needing improvement in round one of the CFSR. Reviewers found that the agency had initiated investigations of maltreatment reports in a timely manner in only 42% of cases. Stakeholders noted delays in assigning low priority cases to assessment staff; whereas the onsite review revealed delays in both low and high priority cases.

The renegotiated goal included in the agency's Program Improvement Plan (PIP) was to achieve timeliness in 58% of cases at the end of SFY2005. Nebraska achieved this goal in the second quarter of that year, at which time investigations were initiated within required timeframes for 74.4% of priority 1 cases, 71.3% of priority 2 cases, and 69.9% of priority 3 cases.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

Since round one of the CFSR, the agency has developed written policies governing the time frames for responding to maltreatment reports based on priority (as outlined above). As stated above, Nebraska met the renegotiated goal in our PIP in the second quarter of SFY2005. At the end of that year, investigations were initiated statewide in 78.6% of priority 1 cases; 64.2% of priority 2 cases, and 69.5% of priority 3 cases within the prescribed timeframes. At the end of SFY2007,

investigations were initiated within the prescribed timeframes in 86.1% of priority 1 cases; 71.9% of priority 2 cases; and 75.0% of priority 3 cases. These rates suggest that higher priority (priority 1) cases are receiving a more timely response than lower priority cases, although responses to the lowest priority (priority 3) cases are currently above those to priority 2 cases. While these rates demonstrate overall continued improvement, they fall short of our state-established goals on all three priority levels. Nebraska continues to evaluate ways to improve response time. Each area of the state and local office analyzes their performance and develops local protocols and community relationships that will lead to improved response to child abuse and neglect cases.

The new intake tool and new staffing structure that allowed for specialized intake staff (refer to data summary) has resulted in more accurate screening of maltreatment reports and more clearly identified life-threatening situations requiring immediate response. N-FOCUS was updated to support the new intake policies and workers are now required to enter into the system the actual dates intakes were received (rather than allowing the date to default). Methods for measuring compliance with the new intake policy and goals for improvement were developed as part of the Performance Accountability Plan as well (refer to Section I).

Item 2. Repeat maltreatment. *How effective is the agency in reducing the recurrence of maltreatment of children?*

a. What do policy and procedure require?

Policy and procedures outlined in Item 1 also impact the recurrence of maltreatment. If new allegations of abuse or neglect are identified at any time during a case, workers report those allegations through the hotline. The allegations are screened like any other report, and may be added to the current intake as additional information or entered into the system as a new intake if a new incident of maltreatment has occurred.

Additionally, when initial reports of maltreatment are received, workers check the N-FOCUS system for prior reports. Current reports are to be considered in context with any prior reports. Specific attention is paid to a prior case status of "unable to locate" as it indicates that previous allegations have not been addressed and may warrant attention as part of the current intervention. Other factors that may warrant attention include: the length of time between the interventions; the severity of the past and present allegations; and/or the degree of similarity between the situations.

b. What do the data show?

Nebraska has not met the national standard of 94.6% absence of maltreatment recurrence, but is improving. According to the ACF data profile, the state has increased the percent of cases in which there was an absence of recurrent maltreatment from 90.1% in FFY2005 to 91.3% in the current reporting period (4/1/2006–3/31/2007). Data collected by the state using the ACF data profile indicates an additional increase to 93.7%, as of January 2008. The collective rate for absence of recurrent maltreatment in the NE-CFSRs was 86% in 2005 and 95% in 2006.

Additional N-FOCUS data reveals the characteristics of children experiencing recurrent maltreatment. In FFY2006, there were 219 unduplicated children who experienced repeat

maltreatment within six months of the first report. The slight majority (52.5%) of these children was male with a median age of five years. The majority (63.9%) of children who experienced recurrent maltreatment was white, 13.7% were black, and 11.9% were Native American. Race was undetermined for 9.6% of children and missing for 0.9%. Additionally, 8.7% of children were Hispanic or Latino.

According to 2006 Census estimates for Nebraska's population of youth 19 years of age or younger, the majority (51.2%) of youth are male, the median age is eight years, 88.6% are white, 5.9% are black, and 1.4% are Native American. (1.6% of youth are Asian, 0.06% Native Hawaiian/Pacific Islander, and 2.6% are two or more races). Also, 7.4% of Nebraska children are of Hispanic or Latino origin. Thus, there is an overrepresentation of black, Native American, and Hispanic youth in the population of children identified to have experienced recurrent maltreatment and these youth are generally younger than the state population of children.

The initial maltreatment reports received on the children who experienced recurrent maltreatment included a total of 276 allegations, the majority being neglect (76.5%) followed by emotional abuse (9.8%), physical abuse and sexual abuse (both 6.9%). Subsequent maltreatment reports included a total of 277 allegations, the majority again being neglect with (76.2%) followed by emotional abuse (10.8%), physical abuse (7.9%), and sexual abuse (5.1%). The majority (64%) of allegations reported in initial reports matched those reported in the subsequent report. Of these, 28.4% were reported within 30 days of the first report.

It should also be noted that the relationship between perpetrators and victims in the second report were similar to those in the initial report. In initial maltreatment reports, perpetrators included parents (202), other relatives (23), unmarried partners (25), or an unknown or other person who was not a relative or caregiver (11). In subsequent maltreatment reports, two foster parents and two daycare providers (a total of 3.6% of the subsequent reports) were also identified as perpetrators.

Surveys conducted with stakeholders indicate that the majority (55.0%) of stakeholders perceive the state as being somewhat effective in reducing instances of repeat maltreatment. One of the stakeholders' concerns was that supervisors are inappropriately approving more than one maltreatment report on the same incident. A comparison of the perpetrators from the first report to the second report reveals that 175 (80%) of the cases contained at least one of the same perpetrators in both reports. This supports the possibility that there are multiple reports for the same incident, which would impact the recurrence percentage by reporting a higher rate than actual.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

Reducing the recurrence of maltreatment was noted as an area needing improvement in round one of the CFSR. The rate of recurrent maltreatment for the state in CY2000 was 7.6%; the national standard was 6.1%. There was no recurrence of maltreatment in 100% of the cases reviewed onsite. However, there were multiple maltreatment reports over the life of the case in the majority of cases reviewed (although not all reports were substantiated or indicated). It was also discovered during the onsite review that not all new maltreatment reports were entered into N-FOCUS.

The goal stated in our PIP was to reduce the recurrence of maltreatment to 6% of cases or less. As of the end of CY2002, we met this goal at 4.7%.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

The changes from round one CFSR outlined in Item 1 have affected this item as well. Particularly, the new intake policy (refer to data summary) clarified what constitutes a new or existing report of maltreatment, further eliminating the risk of underreporting recurring maltreatment. This may explain changes in the NCANDS data from CY2000 to CY2003, the year in which the new intake tool was implemented. In CY2001, we met the national standard at 5.5%. In CY2002, we met the standard at 4.7%. In CY2003, however, the rate of recurrent maltreatment increased to 7.1%.

The implementation of the NSIS (refer to Section I) should also impact this item in the future. The new system moves the state from an incident-based safety response to a comprehensive assessment of safety, which will assist in the reduction of repeat maltreatment by correctly identifying and addressing the underlying issues that impact maltreatment.

Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate.

1. Data Summary

Safety Outcome 2 is comprised of two items. The first item is provision of services to families to protect children in the home and prevent removal or re-entry into foster care. Data from the state's N-FOCUS system were drawn to examine the time that lapses between the date an assessment begins in a case and the provision of services. Data indicates that the state has reduced the amount of time to service provision, but service delays continue to exist.

The second item pertains to risk assessment and safety management. The percent of cases in which there was an absence of child abuse/neglect in foster care documented in the ACF data profile is used to inform this item. Also included are N-FOCUS data from FFY2006 pertaining to recurrent maltreatment that occurred while the children were in care in a foster home setting, and case reviews from the ICCUs between the months of January and June 2007. Based on the ACF profile data for the current reporting period (4/1/2006–3/31/2007), there was an absence of child abuse/neglect in foster care in 99.43% of cases. Based on more recent state data, this increased to 99.68% (meeting the national standard), as of January 2008. In the past, stakeholders noted a need to improve definitions of risk to more adequately assess safety. Upon learning about the NSIS (refer to Section I), stakeholders have communicated their anticipation of the new system in meeting this need.

Findings on these items from the federal CFSR conducted in 2002, and the subsequent NE-CFSRs (refer to Section I) conducted in 2005 and 2006 are displayed in Table 6 on the following page. Performance on both items decreased from 2002 to 2005, but then increased from 2005 to 2006.

Table 6. CFSR and NE-CFSR Findings by Item									
	2002 Federal CFSR			2005 NE-CFSR			2006 NE-CFSR		
	Strength	ANI	%	Strength	ANI	%	Strength	ANI	%
Item 3. Services to Prevent Removal	15	2	88%	17	8	68%	20	7	74%
Item 4. Risk Assessment	32	3	91%	31	7	82%	34	5	87%

Note. ANI indicates an "Area Needing Improvement."

2. Stakeholder Assessment

Survey data indicate that most (56.6%) stakeholders believe DHHS is somewhat effective in protecting children in the home and preventing removal from home. Stakeholders from the courts, provider community, workers, supervisors, and family organizations all identified the NSIS and its emphasis on FCP (refer to Section I) as a strength in this outcome, as it allows for more opportunity to provide service intervention in the home and with the active involvement and support of the family. Thus, we anticipate that the new model will eventually reduce the number of children being removed from the home.

Stakeholders also believe that the NSIS assists workers in determining the correct safety management and case plan services children and families need, which has been a current difficulty identified by workers. However, the lack of services, particularly individualized services, and the inability to evaluate the services provided were identified as ongoing barriers to service provision as well. Stakeholders also identified barriers at the service area level, especially the inability to find services in close proximity to the family needing services.

DHHS recognizes the lack of services is an obstacle that we must address and has begun to do so with a new service array assessment project implemented in 2004 (refer to Systemic Factor E). Nebraska is also in the process of developing and implementing additional in-home safety services. A Request for Bids (RFB) was issued in March 2008.

Stakeholders also reported the public misperception that children who live in poverty are living in unsafe environments and should be removed from home. They also noted a lack of understanding among external stakeholders around DHHS' role in maintaining child and community safety. State statute places the authority for removing children from their home with the courts and law enforcement. DHHS is responsible to identify a safe temporary home in which they child can reside until he/she can be safely returned home. Public information on these issues may be lacking.

3. Item-by-Item Evaluation

Item 3: Services to families to protect children in the home and prevent removal or re-entry into foster care. *How effective is the agency in providing services, when appropriate, to prevent removal of children from their homes?*

a. What do policy and procedure require?

At the time of the 2002 CFSR, our procedures were incident-based and it was a common belief that removing children from home was needed to secure their safety. However, the new NSIS

(refer to Section I) offers a more comprehensive child safety assessment to determine whether the child is safe or unsafe. The system also requires every reasonable effort to be made to provide any necessary services in the least intrusive and least restrictive method possible with in-home safety plans being preferred. However, if workers determine based on specific criteria that a child needs to be removed from the home to ensure their safety, the worker must consult with a supervisor and case team members and explain why an in-home safety plan cannot be implemented.

Families whose children have been determined to be unsafe will be offered ongoing services to promote family self-sufficiency and continuity for their family and children. In cases in which children are removed from home, services are designed to address the circumstances or behaviors that resulted in removal so that the threats can be managed with an in-home safety plan and the child can safely return home.

We expect that a change of this significance will have a lengthy learning curve for workers, supervisors, and external partners. It is a systemic change in regards to the types of services that will need to be available for children and families. It is a philosophical change, for some, in regards to the belief that child safety can be managed in the home.

b. What do the data show?

NE-CFSR data indicates that the agency made diligent efforts to maintain children safely in their homes in 68% of cases reviewed in 2005 and 74% of cases reviewed in 2006. This indicates a decrease in performance from the 2002 federal CFSR (88%). One reason may be that some service areas that previously offered voluntary or non-court involved services stopped doing so due to the amount of staff resources needed to process court involved cases.

In regard to service provision delays, N-FOCUS data indicates that at the end of SFY2007 service provision occurred within ten workdays in 85.1% of priority 1 cases; within 15 workdays in 74.2% of priority 2 cases; and within 20 workdays in 74.0% of priority 3 cases. Although these rates are below state goals, they are an improvement from SFY2005 and indicate that delays in service provision are decreasing.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

Item 3 was rated an area of strength for the state in round one of the CFSR. In 88% of the cases, reviewers determined that the agency had made diligent efforts to maintain children safely in their homes. Nonetheless, it was noted that several stakeholders believed children were often removed from their homes unnecessarily and there were sometimes delays in service provision. Stakeholders also listed barriers such as lack of funds for preventative services, lack of services in particular regions, and long waiting lists.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

In 2003, a Governor's Task Force consisting of multiple stakeholders from a number of fields (e.g., child protective services, law enforcement, medicine, education, the legislature and courts)

was charged with examining the strengths and weaknesses in the child welfare system and developing recommendations for improvements aimed at preventing future violent child deaths. As a result of their work, the task force discovered that 1184 teams were not functioning throughout the state. 1184 teams are multidisciplinary investigation and treatment teams consisting of DHHS workers, local law enforcement, county attorneys, school, medical personnel, and others. These teams were legislatively mandated in 1992 to ensure that a collaborative approach was being followed in child abuse/neglect cases throughout the state. As a result of the task force findings, the Governor legislated funding for an 1184 team coordinator position within each of the state's CACs. Since then, actions to strengthen 1184 teams, including securing training for team members, have been taken. With the implementation of the NSIS (refer to Section I) and the renewed efforts of 1184 teams, it is expected that the number of children in out-of-home care will be reduced in the future, although child welfare professionals caution the teams to be prepared for an initial spike before the numbers begin to decrease.

Since round one of the CFSR, DHHS has also developed in N-FOCUS a way to track and report the time that lapses between the dates an assessment begins and the provision of services. A baseline and target for improvement were established in 2004, and workers who do not meet this goal must meet monthly with their supervisor to discuss barriers to their doing so. Corrective action plans that include steps to overcome those barriers are developed.

Policy has also been strengthened to mandate monthly worker visits with children and parents at a minimum, or more frequently based on the children and families' needs, to continue to monitor child and community safety and assess needed services. This data is also collected through N-FOCUS and reviewed by supervisors through the Performance Accountability Plan (refer to Section I). These requirements are outlined in more detail under Items 19 and 20. Additional data pertaining to the quality of visits is collected through quarterly case reviews conducted by internal quality assurance staff.

Last, it is anticipated that a new service array assessment project (refer to Systemic Factor E) will lead to the development of services and improved access to and availability of these services. Stakeholders have consistently identified a need for accessible services, particularly individualized and preventative services. As detailed in Systemic Factor E, the tool used in the service array assessment project addressed these same issues: community/neighborhood prevention and early intervention services, home-based interventions and services, out-of-home interventions and services, etc.

Item 4: Risk assessment and safety management. *How effective is the agency in reducing the risk of harm to children, including those in foster care and those who receive services in their own homes?*

a. What do policy and procedure require?

NSIS policy and procedures (refer to Section I) require an ongoing assessment of child safety and monitoring of safety plans. There are mandatory 'events' for which a formal re-evaluation of safety must occur on every active child abuse and neglect case, including at any time during a case when a new child abuse and neglect report is accepted and/or when there is any change that may result in new safety threats. A minimum weekly review of safety plans must occur while

cases are undergoing the safety assessment process and a minimum of monthly review is required for ongoing cases.

Reports of maltreatment perpetrated by providers in foster homes or child caring facilities against children in care are assessed by DHHS in collaboration with local law enforcement. Law enforcement focuses on conducting a criminal investigation while DHHS focuses on assessing child safety. In cases involving licensed child care homes or facilities, a licensing review also occurs. The decision to remove a ward from a foster home, group home, or residential facility should be based on specific factors. Workers should: 1) consider immediate removal if there are allegations or findings which indicate sexual abuse, physical signs of maltreatment, or the maltreatment is or could be life threatening; 2) consider removal if the youth wants to move or the facility or home requests removal; and 3) consider removal of other wards who are not the subjects of maltreatment based upon the allegations and circumstances. Following assessment, staff must make four decisions: 1) Did maltreatment occur? 2) What action should occur in regard to the license? 3) What changes should be made in the placement of the child in care? 4) What changes should be made in the conditions or the type of future placements made into the home/facility (e.g., less children, do not place children with behavioral problems, etc.)?

b. What do the data show?

According to the data profile, the percent of cases in which there was an absence of child abuse/neglect in foster care decreased from 99.52% in FFY2005 to 99.43% in the current reporting period (4/1/2006–3/31-2007). Based on more recent state data, this increased to 99.68% (meeting the national standard), as of January 2008.

To provide more context, N-FOCUS data reveals that there were 68 children reported as being abused during the time in which they were placed in a foster care setting in FFY2006: 12.9% occurred while the child was placed in a relative home; 51.4% in a foster home; 35.7% in a residential facility. Of the 219 children who experienced repeat maltreatment that same year (refer to Item 2), 8 (3.7%) were abused by a foster parent.

Also of note, the number of children maltreated by parents while in foster care has decreased from 1.75% in FFY2005 to 1.13% in the current reporting period (4/1/2006–3/31/2007), according to the ACF data profile. Although there are no standards in this area, the state has made improvement.

As part of our quality assurance system, DHHS developed performance outcomes for the ICCUs and began monitoring those outcomes via case reviews in March 2004. Each month and in each ICCU, approximately 22 cases involving youth who have received services for at least six months are randomly selected for review. A "three legged stool" approach is used to review selected cases, with representatives from family organizations, ICCUs, and DHHS serving as reviewers for each case. From January 2007 through June 2007, 5 (1%) of the 584 youth whose cases were reviewed experienced abuse or neglect during the review period. This is a much smaller percent of youth than that documented in N-FOCUS for FFY2006 and mentioned above.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

Risk assessment and safety management was rated an area of strength for the state. Reviewers determined the agency made sufficient efforts to reduce risk of harm to children in 91% of cases.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

At the time of the 2002 CFSR, there was a formalized risk and safety process and tool in place for initial safety determinations, but there was no formal process to assess child safety on an ongoing basis. The NSIS (refer to Section I) now provides a formal process to assess child safety, beginning at the point of initial assessment and continuing at other key points throughout the life of the case. The focus of the case plan is narrowed to include intervention services that target the safety threats identified in the assessment and enhance parental skills to manage and control those threats. Ongoing assessment of child safety and monitoring of safety plans is conducted, with specific events in which re-evaluation of child safety is mandatory. It is anticipated that the NSIS will serve as a tremendous strength in reducing risk of harm to children in care.

B. Permanency

Permanency Outcome 1: Children have permanency and stability in their living situations.

1. Data Summary

Permanency Outcome 1 is comprised of six items. Item 5 examines the percent of children who re-enter foster care using data from the ACF data profile. Item 6 pertains to the stability of foster care placements and includes data on the percent of children with two or fewer placement settings by length of time in care (Permanency Composite 4 in the ACF data profile). Also considered were point-in-time data on the number of placements for children in care and their current placements by type, from both the ACF data profile and supplemental N-FOCUS data. Item 7 addresses appropriate and timely permanency goals. The ACF data profile provided data on the percent of children within each permanency goal category and median months in care, and N-FOCUS data provided the percent of children with concurrent goals. Item 8 examines reunification, guardianship, or permanent placements with relatives using data from Permanency Composite 1 and Permanency Composite 3 in the ACF data profile. Item 9 examines timely adoptions and includes data from Permanency Composite 2 and N-FOCUS data on permanency hearings. Item 10 addresses permanency goals of other planned permanent living arrangements and includes data from Permanency Composite 3 and other ACF data. Additional case review data from NE-CFSRs (refer to Section I) was used to inform the above items as well.

Nebraska is currently meeting one of the four permanency composites included in the ACF data profile. Specifically, Nebraska is meeting each of the measures included in the overall composite pertaining to permanency for children and youth in foster care for long periods of time. Specific to the items in this section of the assessment is a decline in the percent of youth in foster care for more than three years and emancipated from foster care. However, this percent still represents a significant number of youth (22.5%). Additionally, the data profile reveals that the median months in care for these youth in the current reporting period (4/1/2006–3/31/2007) is 23.3.

The median months to discharge has steadily increased from FFY2005 across most all permanency goals, particularly for wards who are discharged to guardianship, independent living, or self-sufficiency. Nebraska is struggling with long periods of time in care, although less so for children first entering the system. Three issues that may be impacting timely discharge from care are: permanency hearings for children in care 15 of the last 22 months may not consistently be conducted in a timely manner; just under half of all cases do not involve concurrent planning; and there are often delays in obtaining rehabilitative services to parents that address the safety threats that brought the children into care. One notable improvement is that Nebraska has increased the percent of children in care 17 months or longer who were discharged to adoption by the end of the year. As of the current reporting period (4/1/2006–3/31/2007), we are now above the 75th percentile in this measure.

Nebraska does not fall within the national 25th percentile in the measure related to foster care re-entries of youth discharged to reunification. The percent of children who are discharged from care to reunification and who then re-enter the system within 12 months of discharge, however, has decreased slightly from FFY2005.

Slight improvements in placement stability have also been made, although we still fall below national standards in this area. Placement stability continues to be an issue for youth in care for longer periods of time and for older youth, in particular. Promising trends that have been credited by stakeholders as improving placement stability include an increase in the number of relative placements and a decrease in the percent of youth placed in emergency shelters. Data in both the ACF data profile and from N-FOCUS indicate an increase in relative foster home placements (refer to Item 15). N-FOCUS data also indicates a decrease in wards placed in emergency shelter centers, from 3.2% in FFY2005 to 1.7% as of March 31, 2007.

2. Stakeholder Assessment

Stakeholders anticipate that the NSIS and its emphasis on FCP philosophy (refer to Section I) will positively impact a number of the items included in Permanency Outcome 1. Although FCP has been a tenet in DHHS since 2004, stakeholders believe that it is interpreted and applied inconsistently by workers. The NSIS may remedy this problem as it does offer additional guidance and clarity for workers when making safety decisions, identifying parental protective capacities, and reducing safety threats, in a family centered approach.

Stakeholder discussion revealed that some of the tools and services geared towards improving performance in some items are either not being used as often as desired (in the case of family group conferencing) or are rendered inefficient by other coexisting obstacles (in the case of attempts to "match" children with appropriate placements when there are a lack of placement resources). Stakeholders also discussed barriers to establishing appropriate and timely permanency goals, some of which fell within the legal system [e.g., filing Terminations of Parental Rights (TPRs) petitions or considering DHHS' permanency goal recommendations made to the court] and others of which fell within DHHS (e.g., scheduling permanency hearings or developing concurrent plans). Court focus group participants, however, reported that the majority of permanency goals established and documented by DHHS are appropriate. Court focus group participants reported that timely service provision to parents is an ongoing problem in many parts of the state.

Stakeholders acknowledged that DHHS has implemented various strategies to support, inform, and/or train parents, relatives, guardians, and foster and adoptive parents. However, representatives from family and parent organizations relayed that many of these relatives, guardians, and parents report that they need additional preparations, services, and support, particularly after case closure.

External stakeholders reported that DHHS is not adequately preparing youth for independent living. While independent living services have been expanded in the last few years, more services are needed. Clarification for workers of the services that are actually available to youth are needed as well, and this information needs to be relayed to eligible youth.

A common question among stakeholders was whether or not data was being entered into N-FOCUS and if that data was being monitored by supervisors (for example, the documentation of independent living plans or permanency hearings). Internal stakeholders indicated that supervisors in some service areas may be reviewing cases, N-FOCUS data and reports, and individual performance with workers, while supervisors in some areas may not.

Stakeholders also speculated that caseload size may be limiting the time in which workers have to enter data into N-FOCUS. For example, some workers reported that they are unable to document visits with children and families or other efforts until days after the action has occurred. Additionally, supervisors believe that worker turnover and changes in case management may prevent data from being entered into case files. Worker turnover was also discussed as negatively impacting some of the outcomes we are trying to achieve for children, such as placement stability and timely permanency.

3. Item-by-Item Evaluation

Item 5: Foster care re-entries. *How effective is the agency in preventing multiple entries of children into foster care?*

a. What do policy and procedure require?

Many of the new policy and procedures implemented under the NSIS (refer to Section I) work to prevent multiple entries into foster care. These policies shift the system from offering an incident-based response to allegations of abuse to a more comprehensive assessment of safety, which will ultimately reduce instances of repeat maltreatment and result in a decrease in foster care re-entries. In all child abuse and neglect cases, families will receive ongoing formal and informal services from DHHS throughout the life of the case to promote family self-sufficiency. Services will be designed to address the circumstances or behaviors (i.e., diminished parental protective capacities) that were identified as compromising child safety so that the child and family can live safely in their home. Child safety is the key criterion in determining case closure. Additionally, the consideration of reunification of children removed from the parental home due to existing safety threats or case closure require a mandatory re-evaluation of safety and represent two instances in which workers must consult with their supervisors around these decisions.

b. What do the data show?

The ACF data profile indicates that Nebraska has decreased the percent of children who were discharged from foster care to reunification and re-entered foster care within 12 months of discharge from 15.3% in FFY2005 to 14.2% in FFY2006. Data from the current reporting period (4/1/2006–3/31/2007) indicates a slight increase from 14.2% in FFY2006 to 14.6%. This slight increase may be correlated with the decrease in the percent of state wards who exit to reunification in less than 12 months of entry (68.2% in FFY2005 to 64.8% in the 4/1/2006–3/31/2007 reporting period) and the increase in median length of stay for wards who exit to reunification (7.0 months in FFY2005 to 8.2 months in the 4/1/2006–3/31/2007 reporting period). In other words, the data may be suggesting that the longer children who exit to reunification remain in care, the less likely they may be to reenter the system. It should also be noted that although we have improved in decreasing the percent of children who are discharged from foster care and who then re-enter care within 12 months, we are not meeting the national 25th percentile of 9.9% or lower.

NE-CFSRs indicate a decline in performance from that noted in the federal CFSR in 2002 (85%) to 67% in 2005. However, applicable cases were reviewed in only two of the three sites, with one site scoring 100% and the other 50%. Stakeholders noted an insufficient monitoring of

cases, re-entries for reasons other than those documented at initial entry, and recurring themes of drug and alcohol use in families. Nebraska improved performance in the 2006 review, with zero instances of foster care re-entry found in applicable cases.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

In round one of the CFSR, reviewers rated Nebraska's performance in this area as a general strength. In 85% of cases reviewed, children did not re-enter the foster care system within the 12 months following discharge. There were mixed opinions among stakeholders on whether DHHS rushes reunification efforts. Some stakeholders reported that DHHS does not rush reunification while others reported that children are returned home too soon and consequently, re-enter foster care. Stakeholders agreed that DHHS provides post-reunification services to support families.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

The new intake process implemented in 2003 (refer to Safety Outcome 1), allows for the collection of more thorough information on the child, family (including non-custodial parents), and safety situation at intake. Workers and supervisors reported that by gaining this information early in the process, they are better able to respond and plan appropriately in each case, which ultimately leads to more positive and successful outcomes and theoretically would decrease foster care re-entries.

It is anticipated that the NSIS combined with our FCP philosophy (refer to Section I) will serve to further reduce the number of foster care re-entries. The NSIS process was developed to help create a home environment in which the child and family can live safely, allow the family to develop self-sufficiency to maintain this safe family environment, and subsequently decrease instances of repeat maltreatment and foster care re-entries.

FCP, in theory, reduces foster care re-entries since families are more involved in identifying and addressing their needs, and informal supports are available to families to help create and maintain change throughout the case and after case closure. However, workers have reported that the way in which FCP is defined or perceived is sometimes not clear and that the philosophy is not always applied. Also, because the philosophy is somewhat elusive, it is difficult to measure whether or not we are applying the philosophy consistently and if we are being successful in our efforts. Another barrier to providing FCP and identified by providers was that the timeframes in which workers and providers are expected to carry out the practice are perceived as unrealistic.

Systematic and contractual issues were noted as barriers to providing a number of services, including transitional services, follow-up, or aftercare services, that would potentially reduce foster care re-entry. Providers in particular noted that what they describe as a dated system is slowly evolving to better match our philosophical changes, but that limited timeframes and perceived lack of funding continue to be obstacles to providing quality service. Additionally, there is a lack of preventative services, early intervention services, in-home services, and services to address parents' needs. Recently, DHHS has been working towards developing and offering early intervention and in-home services in a new service array assessment project (refer

to Systemic Factor E). There is currently no data available on the project since it is new, but stakeholders report that anecdotally, results look positive. Another area that stakeholders believe needs to be addressed is securing services for parents' needs, particularly substance abuse issues. Both providers and workers agreed that this was a strong factor in foster care re-entry. In January 2008, stakeholders from the behavioral health, substance abuse, child welfare and juvenile services systems collaboratively developed a plan to create a balanced array of behavioral health and substance abuse services for children, adolescents, and their families, under LB542 (refer to Systemic Factor E). This plan will alleviate some of the barriers to receiving substance abuse and mental health services that parents of foster children may currently be experiencing.

Item 6: Stability of foster care placement. *How effective is the agency in providing placement stability for children in foster care (that is, minimizing placement changes for children in foster care)?*

a. What do policy and procedure require?

DHHS policy and procedure outline a variety of requirements that workers must meet when placing a child in out-of-home care to ensure that the placement is stable and a good fit for all involved parties (e.g., the child, family, and foster care provider). When placing children in foster care, workers are required to consider placements that are:

- In the least restrictive, most family-like settings;
- Closest to the family, to meet the children's best interests and special needs; and
- In settings that provide continuity for the children in school, church, or other community relationships whenever possible while also considering the safety of the community.

Placement decisions must be individualized, with consideration given to both the child and the family. Placements are made with non-custodial parents, other family members, or someone known to the child who is able to safely care for the child if possible, prior to considering other out-of-home placement options.

DHHS will assess all persons who are interested in becoming foster or adoptive parents via a process that includes home and self-studies, interviews, reference checks, background checks, criminal record checks, and medical summaries. This information is maintained in DHHS records. DHHS will provide information (e.g., the child's behavior, history, needs, etc.), payment, and support services to foster care providers. Support services include pre-service and ongoing training as required by licensure, support groups, and respite care.

The out-of-home placement planning and preparation processes must involve the parents, children, and foster care providers. Workers are required to continue to involve these entities in the case planning process and regular contact between the child, their parents, and family will occur throughout the time in which children reside outside of the home. In addition, placements are evaluated on an ongoing basis to ensure that they continue to meet the needs of all who are involved in the case and that the placement is a "good fit." However, it is the intent that the procedures described above will increase placement stability and reduce the chances of children experiencing unstable or multiple placements.

b. What do the data show?

ACF data in Permanency Composite 4 indicates a gradual improvement in this area (85.7 in FFY2005; 88.2 in FFY2006; and 89.8 for the 4/1/2006–3/31/2007 reporting period). The percent of children with two or fewer placement settings is logically higher for those in care for less than 12 months and gradually declines for those in care 12 to 24 months or 24 months or longer. The greatest improvement, however, occurred in the cohort of children in care 12 to 24 months. From FFY2005 to the current reporting period (4/1/2006–3/31/2007), there was a 6.6 % increase in the percent of children with two or fewer placement settings in this group. There was a slight improvement (2.4%) in the percent of children in care for less than 12 months, with a slight decrease (0.3%) in the percent of children in care for longer than 24 months.

Point-in-time data displaying the number of placement settings for the current foster care episode show minimal changes in the number of placements from FFY2005 to the current reporting period (4/1/2006–3/31/2007) as well. Overall, children in the first entry cohort fare better than the general population. Over half (50.4%) of the children in the first entry cohort experienced two or fewer placement settings in the current reporting period (4/1/2006–3/31/2007), compared to 33.2% of the general population. Both numbers indicate a need for improvement.

For further analysis we examined N-FOCUS data providing the number of placements for children in care during the current reporting period (4/1/2006–3/31/2007) by length of time in care and age. As already indicated by the data profile, the likelihood of a child experiencing two or fewer placement settings decreases the longer they are in care, but this decrease is much more significant for older youth. The decrease in the percent of children ages 0 through 5 with two or fewer placements shifts from 89.6% of the children in care for less than 12 months to 59.3% of the children in care for more than 24 months. The decrease in the percent of children ages 16 through 19 with two or fewer placements shifts from 77.6% of the children in care for less than 12 months to 8.8% of the children in care for more than 24 months. In fact, of children ages 16 through 19 who have been in care for longer than 24 months, 55.6% have experienced seven or more placements. Overall, we need to improve placement stability for all wards under state care. However, the groups most affected are those who are in care for longer periods of time, and particularly older youth.

The 2005 NE-CFSR indicates a decrease in performance (63%) compared to the 2002 federal review (77%). However, in 2006 performance returned to 76%. Stakeholders in both reviews identified a lack of resources, little matching of children to placements, and inadequate foster parent supports to be barriers to maintaining placement stability. Stakeholders perceive promising practices to include a decrease in the use of emergency shelter and an increase in relative placements.

Data supports both an increase in relative placements (refer to Item 15) and a decrease in emergency shelter placements. According to N-FOCUS, the percent of wards placed in emergency shelter centers decreased from 3.2% in FFY2005 to 1.7% in the current reporting period (4/1/2006–3/31/2007). One provider serving as a stakeholder in the 2008 federal CFSR process reported that they have made efforts to decrease placements in emergency shelter centers by using emergency shelter foster homes. Thus, we examined changes in the percent of wards placed in emergency shelter foster homes over the same time period to see if this might account for the decrease in emergency shelter center placements. In FFY2005, 3.1% of out-of-home placements were made in emergency foster homes, compared to 3.3% in the current reporting

period (4/1/2006–3/31/2007). The decrease in emergency shelter placements does not appear to be related to an increased use in emergency shelter foster homes as alternative placement options.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

This area was rated an area needing improvement in round one of the CFSR. Reviewers determined that children did not experience changes in placement or that any changes in placement were necessary to meet the child's need or promote the attainment of their permanency goal in 77% of cases. Stakeholders expressed the opinion that children in foster care generally did not experience stability in their placements due to extended stays in emergency shelters, a scarcity of foster family homes, and lack of support for foster parents.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

A number of changes have been made since round one of the CFSR, some of which are outlined in the policy sections pertaining to each individual outcome item. Examples include the requirement of workers to identify and include non-custodial parents in the case planning process (referenced above) and conducting monthly visits with children (detailed in Item 19).

In 2003, DHHS implemented family group conferencing to assist in locating family members, increase placement with relatives, and identify family members who may be potential foster or adoptive parents (among other goals). Unfortunately, this service is not being used as often as desired throughout the state, as detailed in Item 15.

In April 2005, DHHS issued a memorandum to staff reiterating the policy requiring them to make immediate diligent efforts to locate, contact, and involve non-custodial parents (legal and alleged) when DHHS becomes aware that a child is in danger of being removed from the home or has been removed. This policy is detailed further in Item 15. The new intake policy implemented in 2003 (refer to Safety Outcome 1) emphasized the identification of non-custodial parents early at the time of intake, and the NSIS (refer to Section 1) explicitly requires this. DHHS uses the Federal Parent Locator Service to locate non-custodial parents when there is little information available regarding their whereabouts. The Federal Parent Locator Services is a national repository of information that is used by the Economic Assistance and Child Support Enforcement Unit. The Adoption and Safe Families Act (AFSA) allows child welfare and juvenile services systems to use this service to locate absent parents.

Another recent development implemented in 2007 is the use of pre-hearing conferences for families experiencing intervention due to child abuse and neglect. More and more courts are facilitating pre-hearing conferences throughout the state (refer to Systemic Factor F). It is believed that these conferences will improve placement stability as they aid in identifying absent parents and relative placement options, but there are no formal results of this initiative at this time. As mentioned above, however, N-FOCUS data indicates an increase in relative placements (refer to Item 15), although it cannot be tied directly to this initiative.

DHHS has also developed various reports in N-FOCUS to measure the number of placement changes and disruptions for wards and reasons for those changes or disruptions. Some contracted providers have begun to collect and analyze data on this as well. DHHS has incorporated an element of supervisor oversight with placement stability data via the Performance Accountability Plan (refer to Section I) in an effort to ensure that any placement changes made by DHHS workers are based solely on children's needs. Stakeholders contend that this is currently not the case and that placement changes have occurred due to disputes between workers and providers, and sometimes changes are made simply because a placement may be licensed as an agency-based foster home but a child may no longer qualify as "agency-based." Additionally, stakeholders suggest that workers may over rely on particular placements if they have had positive experiences with them in the past, regardless if they may meet a child's particular needs.

Focus group youth suggested that DHHS conduct more thorough assessments or evaluations of youth and foster parents to ensure that placements are the best match. In an effort to improve the matching of youth and foster care providers, DHHS now requires staff to document in N-FOCUS child characteristics and foster parent preferences. An administrative memorandum to staff mandated this information to be entered for all foster cases by December 2005. Some providers are developing similar databases as well. However, as mentioned in reference to the previous item, providers find that the limited timeframes given to carry out this function prevent workers from truly getting to know the child and place them in the ideal setting. Placement decisions are sometimes rushed. Another barrier to matching children with the appropriate placement is a lack of available foster care homes. Matching efforts have coincided with extensive foster parent recruitment efforts (detailed in Systemic Factor G), but stakeholders believe that more homes are needed. There are inconsistent resources across the state (rural versus metropolitan areas) and stakeholders maintain that as a result, placements are not always reflective of the child's needs, background, or culture.

One issue of which there is considerable debate on its impact on placement stability is the use of emergency shelter centers. Some providers say that because we are rushed to place children, placements are disrupted and the child may end up at an emergency shelter center as a last resort. However, if an emergency shelter center was used early in the process, workers would have more time to identify and move children into a more permanent placement that better meets their needs. Yet other providers maintain that some of the basic characteristics of emergency shelter centers (for example, multiple staff and changing shifts) can have a negative impact on children.

Nonetheless, the issue of extended placements in emergency shelters was mentioned by stakeholders in previous reviews. This is an issue that has garnered intense discussion among Central Office and Service Area Administrators in the past and that has led to continued monitoring of all emergency shelter placements. A program memorandum was issued in August 2001, mandating all placements in emergency shelters that extended beyond 30 days be approved by administrators at DHHS central office. At the time, more than 41% of children placed in emergency shelters remained in that placement for 31 days or more. By May 2002, this percent was reduced to 8% and the requirement for approval was rescinded. Once the requirement for approval was rescinded, however, the number of extended emergency shelter placements gradually increased once again. By December 2005 (within three years), 37% of children in emergency shelters remained for 31 days or longer. Since the requirement for approval of extended emergency shelter stays was successful in decreasing the length of time children spent in emergency shelter the first time around, this requirement was reinstated. A second memo was

issued, stating that no child would remain in emergency shelter for longer than five days without supervisor review, and no child would remain in emergency shelter for longer than 15 days without written authorization from the PSA. Approval from the Service Area Administrator must be received for emergency shelter care extending beyond 30 days and approval will be granted only when an alternative placement has been located and will be available within ten days or a treatment placement has been authorized by Magellan but no placement has yet been located. One year later (as of December 2006), the percent of children placed in emergency shelter care for longer than 30 days decreased to 31%, with a further decline to 28% for the current reporting period (4/1/2006–3/31/2007). It is anticipated that these approval requirements will result in further declines in extended emergency shelter care in the near future.

Despite recent efforts, survey data reveals that the majority of stakeholders still rate DHHS as being only somewhat effective in maintaining safe (55.5%) and stable (55.8%) placements for children in care. In combination with the minimal improvements in this area per the various data included above, this data supports the need for further improvement.

Item 7: Permanency goal for child. *How effective is the agency in determining the appropriate permanency goals for children on a timely basis when they enter foster care?*

a. What do policy and procedure require?

The primary factor that is considered when determining permanency goals for children is the best interests of the child. Beyond that, first consideration is given to family preservation. If family preservation is not a viable option due to safety concerns and a child is removed from home, the next permanency goal considered is family reunification. When family preservation and reunification are not possible, DHHS will strive to arrange another permanency placement for the child. Other permanency goals (outside of family preservation and reunification) are adoption, legal guardianship, independent living, or self-sufficiency with supports for those with a disability (listed in order of DHHS preference).

The permanency goal is identified during the case planning process and clearly outlined in the case plan itself. Policy requires case plans to be developed and documented in N-FOCUS within 60 calendar days of initial custody or 60 days from the begin date of the initial safety assessment. The case planning process must involve the child, parents, family members, informal supports, care providers, and courts, and the case plan collaboratively developed by these participating entities. In court involved cases, the court ultimately approves or modifies the permanency goal and case plan as it sees fit. If the case plan is modified by the court, workers must update the plan to reflect the court's modifications within seven workdays. Cases are reviewed at least every six months to ensure progress towards the planned permanency goal. For more detail on the case planning process and relevant policy see Item 17.

Federal law and Nebraska statute allow workers to use concurrent planning. Concurrent planning can occur at any time in a case, including at the time children enter care. Workers are required to consider, in consultation with their supervisors, the possibility of using concurrent planning at specific points in a case: at initial assessment, during the PCA, and each time cases are reviewed. Whenever it is likely that the permanency objective stated in the case plan will not be obtained within a reasonable length of time (in general, within approximately 12 months of a child's entry into foster care), then concurrent planning should occur. There may, however, be

circumstances when concurrent planning is not appropriate. The most common example is cases in which reunification is likely to occur within 12 months or less.

b. What do the data show?

According to the ACF data profile, over two-thirds of wards have permanency goals of reunification, followed by adoption, independent living (labeled as emancipation in the data profile), and then guardianship. A case plan goal was not established for 2.2% of wards and goal information was missing for 1.6% of wards in the current reporting period (4/1/2006–3/31/2007). Case plan goals may not be established for all wards as policy allows workers 60 days to document into N-FOCUS initial case plans with permanency goals. Missing goal information on N-FOCUS, however, indicates that permanency goals should be in case plan files. The percent of wards with missing goal information has decreased from 3.0 % in FFY2005 to 1.6% in the current reporting period (4/1/2006–3/31/2007). This decrease may be tied to workers documenting initial case plans in N-FOCUS within 60 days and keeping case plans up-to-date thereafter. Although we are not meeting state goals in either of these particular areas, worker performance has improved, from documenting initial case plans within 60 days in 78.1% of cases in SFY2005 to 82.0% of cases in SFY2007, and keeping current case plans in 58.7% of cases in SFY2005 to 81.4% in SFY2007.

The data profile indicates that the median months to discharge has steadily increased since FFY2005. This increase exists in all permanency goal categories, although to a larger degree in discharges to guardianship and "other" permanency goals (e.g., independent living or self-sufficiency). The delay in discharges to guardianship may be due to delays in TPRs, as reported by various stakeholders who participated in the NE-CFSRs.

NE-CFSR data reveals that permanency goals were timely and appropriate in only 47% of cases in 2005 and 68% of cases in 2006. Data from 2005 was skewed by one site (14%) that was not in compliance with ASFA. Other barriers to this item were related to delays in TPRs due to workers not identifying absent parents early in the case, county attorneys not filing TPRs, or a lengthy appeals process and court delays.

Some stakeholders who participated in the 2005 and 2006 NE-CFSRs believed that concurrent planning was occurring; however, N-FOCUS data indicates that concurrent goals were documented in only 55.2% of all cases as of October 31, 2007. In fact, 10.8% of cases had no permanency goal documented. Again, some portion of these cases may involve wards who have not yet been in care for 60 days, which is the period of time workers are given to document initial case plans and permanency goals. Also, in cases in which no concurrent goals were documented, concurrent planning may not have been appropriate (i.e., cases in which reunification is likely to occur within 12 months or less).

c. Where was the child welfare and juvenile services system in round one of the CFSR?

Round one of the CFSR revealed that Nebraska needed to improve in this particular area. Permanency goals were deemed appropriate and timely in just 54% of cases. Stakeholders noted that it is rare for DHHS to seek TPR for a child, although parents will sometimes voluntarily relinquish their parental rights. Stakeholders also reported that the goal of adoption is rarely established for a child and that DHHS tends to establish guardianship rather than adoption as a case goal when children cannot be returned to their parents. Some stakeholders reported that

concurrent planning is being implemented and has been effective in expediting permanency. Others said that workers do not understand concurrent planning and implement it too late in the case.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

Stakeholder comments in round one of the CFSR indicated specific concern that workers did not understand or were not implementing in a timely manner concurrent planning. In 2003, DHHS updated the Protection and Safety Guidebook to include detail on concurrent planning and distributed the guidebook to the field. This information was also provided to workers throughout the state via training and has been incorporated into the training provided to all new workers. Supervisors provide oversight of concurrent planning via the Performance Accountability Plan (refer to Section I) as well. Findings from the NE-CFSRs (refer to Section I) suggest that concurrent planning is occurring. However, recent N-FOCUS data suggests otherwise, and stakeholders who participated in the 2008 federal CFSR statewide assessment process agree with earlier perceptions that workers do not understand concurrent planning and further suggest that while a concurrent plan may be documented it is not always pursued. Workers are reporting that county attorneys believe that concurrent planning does not support the ultimate goal of reunification and defense attorneys use any instances of concurrent planning as evidence against the state, making it difficult for workers to justify the use of concurrent plans. Court focus group participants reported that most courts do use concurrent planning but that some courts do hold varying opinions on the practice. Workers also report that families also do not understand the purpose of concurrent plans.

DHHS may need to improve its efforts in clarifying for workers, partners, and families the importance and use of concurrent planning. In fact, workers and providers both described frequent and unclear policy changes and the overall bureaucracy of DHHS as being problematic in permanency planning, and that it is difficult to contact and communicate with the organization for clarification on some of these issues. Stakeholders identified system barriers such as limited timeframes and a lack of resources as leading to inappropriate permanency goals, unrealistic permanency plans, and the closing cases before families are adequately prepared to leave the system.

Stakeholders also pointed out that while DHHS has changed the language that pertains to permanency goals in the case plan and have improved at communicating with parents these permanency goals more clearly, they neglect to communicate with the children on these goals. Many focus group youth reported that they did not know their permanency goal. However, survey data from youth indicates that eight of nine (88.9%) youth knew their permanency goal. One-third of surveyed youth reported that they were "very well" informed of their permanency options, yet another third reported that they were informed "very little." (It should be noted that 51 youth participated in five focus groups conducted throughout the state while only 17 youth began and ten youth actually completed the online survey.) Stakeholders also noted that the timeframes which families have to meet the permanency goal, however, remains unclear to many families. Thus, clearer communication with all partners, youth, parents, and family on permanency planning and goals is needed.

In June 2004, DHHS issued a program memorandum to staff reminding them of existing guidelines on identifying guardianship as a permanency goal (refer to Item 8), and to inform staff that the age of consideration for guardianship as a permanency goal would increase from at least 12 to at least 14 years. Any exceptions to these rules must be approved by the Service Area Administrator. Service areas were also required to develop and submit to the PSA an improvement plan to assure that by September 2005 guardianship as a goal would be used appropriately. Workers have recently reported that the clarification provided in this memo was helpful. Point-in-time data in the ACF data profile indicates that any practice of identifying guardianship as a permanency goal over that of adoption has since reversed, with the percent of wards with the goal of adoption (13.1% in the current reporting period of 4/1/2006–3/31/2007) just under twice that of wards with the goal of guardianship (7.4% for the same period).

TPRs were also a big concern in both federal and state reviews. In August 2005, DHHS issued a memorandum to staff to clarify the DHHS' role in permanency hearings and the resulting court findings, and to clarify when DHHS will recommend or request the filing of a TPR. DHHS has also been recording in N-FOCUS the number of children in out-of-home care who have had a permanency hearing in the last twelve months and the issue of timely TPRs is being monitored through NE-CFSRs (refer to Section I). As of September 30, 2007, 30.1% of children in out-of-home care for 15 of the last 22 months had a permanency hearing within the last twelve months at the close of FFY2007. This may be an example of data not being entered into N-FOCUS in a timely manner (as mentioned earlier) or other documentation issues, or it may be that these hearings are truly not occurring. DHHS needs to assess whether or not workers are requesting these hearings to be scheduled.

In April 2005, DHHS issued a memorandum to staff reiterating the policy requiring them to make immediate diligent efforts to locate, contact, and involve non-custodial parents (legal and alleged) when DHHS becomes aware that a child is in danger of being removed from the home or has been removed. This policy is detailed further in Item 15. The policy was developed for multiple purposes, but one particular advantage of this policy relates to the filing of TPRs. By locating non-custodial parents early in the case, workers are facilitating and speeding up the process of filing TPRs, should that be necessary. Stakeholders have since noted an improvement in workers locating non-custodial parents, and judicial stakeholders in particular reported that courts are getting more specific on requesting this information.

Occasionally, DHHS may believe it to be in the best interest of the child if the court was to change the permanency goal from reunification to adoption or some other goal prior to the child's 15th month in out-of-home care. Workers report that courts are reluctant to agree with this recommendation out of concern for the parent's legal rights and that this often delays permanency for that child. However, judicial stakeholders question whether or not the parents have received the services they needed to be reunified with their child prior to those 15 months in out-of-home care. This sentiment echoes stakeholder comments made in reference to Items 5 and 6.

Item 8: Reunification, guardianship, or permanent placement with relatives. *How effective is the agency in helping children in foster care return safely to their families when appropriate?*

a. What do policy and procedure require?

As mentioned earlier, all reasonable efforts on behalf of DHHS are made to prevent the removal of children from home if it is safe for the child. However, if family preservation is not a viable option and a child is removed from home, the next permanency goal considered is family reunification. Again, any decisions in determining a permanency goal for a child must reflect the best interests of that child. There may be cases in which the permanency goal of reunification does not match the best interests of the child and some other permanency goal should be established.

Case plans must be developed collaboratively by the worker, child, parents, family members, informal supports, care providers, court, etc. The case plan must address the circumstances or behaviors (i.e., diminished parental protective capacities) that were identified as compromising child safety and services must be designed to enhance these diminished parental protective capacities so that the child can return to live safely in their home. As mentioned previously, the consideration of reunification of children removed from the parental home due to existing safety threats require a mandatory re-evaluation of safety and workers must consult with their supervisors around these decisions.

Nebraska policy does not identify permanent placement with relatives as a permanency option. However, a relative placement is preferred when seeking short-term foster care for a child removed from their home, and in more permanent placement decisions such as adoption or legal guardianship. Workers must notify court and all interested parties, including Tribal authorities if appropriate, of significant decisions pertaining to the child's discharge from care. Ultimate approval is granted by the court.

DHHS considers legal guardianship as a permanency objective when all reunification efforts have been exhausted, the child is unable to return home, reasonable efforts to secure adoption have been unsuccessful, or it is determined that adoption is not in the best interest of the child. In these cases, children must be either 14 years of age or older, part of a sibling group, or attached to the proposed guardian. This prevents younger children from being placed in less permanent placements than that of legal adoption, the separation of siblings in cases in which legal guardianship could facilitate sibling placements, or the severing of close relationships that children may have already established with prospective guardians. In selecting potential guardians, preference is given to relatives, foster parents, or others with whom the child has an existing relationship, or new foster parents who are committed to the guardianship plan. The child's wishes are also taken into consideration in these decisions.

It should be noted that Tribal focus group participants reported that TPRs are not conducive in Tribal cases and that relative guardianship is a more beneficial arrangement for Native children. Often, terminating parental rights leads to a permanent disconnection of children from extended families and Tribes. A guardianship arrangement that would leave parental rights intact, and allow for children to be connected with their biological families and return home when it is safe to do so, would be a more appropriate goal per Tribal focus group participants.

b. What do the data show?

According to the ACF data profile, Nebraska was not meeting the national standard in achieving timely and permanent reunification in the current reporting period (4/1/2006–3/31/2006). Our performance in Permanency Composite 1 declined from 114.3 in FFY2005 to 110.8 in the current reporting period (4/1/2006–3/31/2007). The percent of all wards discharged from foster care to reunification within 12 months of entry has actually decreased and the median months in care have increased. However, we have increased the percent of wards entering care for the first time that were discharged from foster care to reunification within 12 months (after a slight decrease in FFY2006). Also, Nebraska is meeting the national goal in Permanency Composite 3, which measures performance in establishing permanency for children in foster care for long periods of time.

The percent of all wards discharged from state care that re-enter care in less than 12 months from discharge increased slightly from 14.2% in FFY2006 to 14.6% in FFY2007, but remains below the 15.3% in FFY2005. As speculated in Item 5, the longer length of time in care and the reduction in the percent of wards reentering care may have some correlation, although there is currently no data that directly supports this premise.

It should be noted that data as of January 2008 indicates that the state is now at 112.5 in Permanency Composite 1. Nonetheless, we are increasingly struggling with long periods of time in care (although less so for first entry cohorts) and we still need to decrease the percent of children re-entering care soon after discharge.

Appropriate and timely reunification, guardianship, and placement with relatives was rated a strength in 39% of cases reviewed in the 2005 NE-CFSR and 50% of cases in the 2006 NE-CFSR. The 2005 data was skewed by one site where there were zero cases in which timely reunification was rated a strength. Stakeholders in this site reported that, despite workers efforts, the county attorney was not assisting in moving permanency ahead within 12 months.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

This area was rated as an area needing improvement in round one of the CFSR. Reviewers determined that DHHS made, or was making, diligent efforts to attain the goals of reunification, guardianship, or permanent placement with relatives in 57% of cases. Stakeholders reported that some reunifications may be delayed because workers wait until the next scheduled court hearing before reunifying families or because non-custodial parents are not being considered as potential placements.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

Some of the changes that have occurred since round one of the CFSR that affect this item have already been described in previous items. These include policy requiring workers to assess and maintain current case plans and permanency goals, supervisor review of all cases assigned to workers every 60 days to identify with the worker any potential barriers to permanency, court

case reviews every six months to ensure progress towards the planned permanency goal, and of course the early identification and involvement of non-custodial parents and relatives (particularly as it relates to legal guardianship and relative placements). Again, these efforts will only enhance the appropriateness and timeliness of permanency for wards.

In January 2003, DHHS also implemented the utilization of family group conferencing to assist in locating family members, to include them in the case planning process, to increase placement with relatives, to identify family members who may be potential foster or adoptive parents, and to maintain family connections. Unfortunately, this service is not always utilized per stakeholder and field reports. The service is provided on a contractual basis so perhaps the service is seen as too costly by some offices. Both external and internal stakeholders were unable to provide any insight on this issue.

Stakeholders identified legal guardians as a population needing additional support. State custody for youth is terminated once legal guardianship is granted and services (other than financial subsidies) are no longer provided. Tribal focus group participants reported that even subsidies are problematic due to a lengthy process in getting them established; up to six months in some cases. Stakeholders representing parent associations say there is a need for post-guardianship supports and that DHHS should work with partners in developing these supports.

In June 2003, DHHS contracted with family organizations in each of the five service areas to provide mentoring and supports to biological families involved in the child welfare and juvenile services system. In an effort to receive feedback from biological parents and to provide further support to biological parents, DHHS began conducting quarterly surveys with a random selection of 350 parents of youth in state care (i.e., the biological parents, caregivers, or legal guardians who were legally responsible for the children at the time they entered care) in March 2005. More detail on these surveys is provided in Item 18. Handbooks were also developed for parents whose children are in the child welfare and juvenile services system to assure that parents understand the system, their rights and responsibilities within the system, and the supports that are available to them. Workers have been distributing these books to parents at the local service area level since August 2005. We have received positive feedback on the material via word-of-mouth from parents and other stakeholders.

The courts play a prominent role in expediting and establishing permanency for wards in care as well. DHHS has recently increased collaboration with judges, attorneys, and other court representatives to identify legal barriers to achieving permanency for children in care and strategies that DHHS and the courts can collaboratively pursue to overcome these barriers. More detail on DHHS collaboration with the courts is provided under System Factor F. A few concrete example outcomes of this collaboration include the development of policy around the case-related information workers are to include in court reports and expedited preliminary protective custody hearings (held within one week of removal) in Douglas and Lancaster counties. In regard to information workers include in court reports, court focus group participants stated that in general reports include the necessary information.

Recognizing that the state continues to struggle with establishing permanency for children involved in DHHS in a safe and timely manner, Nebraska Governor Dave Heineman announced new initiatives aimed to strengthen these efforts in June 2006. One of the six initiatives specifically directed DHHS to place a priority on achieving permanent placements for children ages zero through five who have spent 15 or more of the last 22 months in state care. In May

2006, there were 566 children who fit within this category. In April 2007, DHHS expanded this priority to include children ages six through ten. In sum, from June 2006 through December 2007, an additional 1,169 children ages zero through ten fell into the 15/22 priority category. Of all 1,735 children who fit this category, permanency has been established for 738 (42.5%) as of December 31, 2007. The remaining 997 (57.6%) children were still in state care at that time.

Other priority populations outlined in the Governor's initiatives include children who were never removed from home, and those who have been living safely at home for six months or more but have not yet been released from state custody. In May 2006 there were 618 children who fit into this category. An additional 1,731 children fit into this category from June through December 2007. Of the total 2,349 children never removed from home or living safely at home for seven or more months, 1,485 (63.2%) have been safely discharged from state care. We continue to document and monitor these particular groups of children as defined in the Governor's initiatives through statistical reports generated in N-FOCUS. These reports are provided to supervisors in the field for their review.

Item 9: Adoption. *How effective is the agency in achieving timely adoption when that is appropriate for a child?*

a. What do policy and procedure require?

When children cannot be reunited with their family, adoption is the preferred alternative to guardianship. Nebraska's state plan for adoption services is based on federal requirements in Title IV-B of the Social Security Act (SSA). Once parental rights have been terminated a child becomes legally free for adoption, staff make every effort to place the child in an adoptive home within nine months. If placement cannot occur within that time frame, a review and assessment of the placement process will be made until a placement is made or there is a change in the permanency goal.

DHHS will consider first and foremost the child's best interest and needs when selecting an adoptive family. Preference is given to adult relatives who are able to meet the child's needs and all efforts are made to place siblings together unless such a placement would be detrimental to any involved child. Other considerations include: biological parent requests regarding religion or openness of the adoption; accessibility of services; the prospective family's ability to parent and meet the needs of the child; the family's ability to accept and share with the child his or her family background; the family's acceptance of the openness of the adoption; the child's attachment to the prospective family; or if the child has been living with the family and the family requests the adoption. In cases involving Native American children, preference is given to a member of the child's extended family, other members of the child's Tribe, and other Native American families. Openness of the adoption is always based on the child's best interest.

Adoptive home studies conducted by DHHS or a child placing agency licensed by DHHS are required prior to placement except in situations where the child may already be living with the prospective family, the adoptive parent is a stepparent (although courts can order a study in these cases), or if the placement is voluntary. Post-placement studies are conducted in all situations, prior to the finalization of adoption.

Services are provided to adoptive parents prior to placement, post-placement, and post-finalization. Initial services include arranging and coordinating the sharing of information with the adoptive family, planning the transition for the child to the pre-adoptive family, completing necessary forms, etc. Post-placement services include payment services based on special needs, if applicable, six month post-placement supervision, assistance with integrating the child into the family, and preparing the family for finalization. Finalization services include an informative adoptive packet (including the child's birth certificate, documentation on the termination or relinquishment of parental rights, information on the child and family's medical history, etc.) for the adoptive family and the completion of any forms indicating subsidized adoption.

b. What do the data show?

According to the ACF data profile, Nebraska is not meeting the national goal in the permanency composite relating to timely adoptions. The percent of children discharged to a finalized adoption in less than 24 months actually decreased from FFY2005 to FFY2006 and has remained steady through FFY2007 at 17.7%. Median months in care increased from FFY2005 to FFY2006 and have remained steady at 37.2 months through FFY2007. We have made progress in achieving legal freedom within six months for children in care 17 months or longer (the percent nearly doubling from FFY2005 to 10.0% in FFY2007), and we have also increased the percent of children in care for 17 months or longer discharged to finalized adoption by the end of the year (falling within the national 75th percentile as of FFY2007). We have also steadily increased the percent of children legally free for adoption who were adopted within 12 month of becoming legally free from FFY2005 to FFY2007 and are gradually approaching the national 75th percentile in this measure.

The NE-CFSRs indicated improvement in the timeliness of adoptions from 13% in 2005 to 23% in 2006. Many barriers to achieving this item related to TPRs, such as a reluctance of attorneys to file TPRs, lengthy periods of time between TPRs and finalizations, and TPRs not being filed on both parents (workers failing to identify non-custodial parents early in cases).

Another issue noted by reviewers was that workers are not utilizing concurrent planning. As mentioned in Item 7, data supports this assertion. Concurrent goals were documented into N-FOCUS in only 55.2% of all cases as of October 31, 2007. The majority of cases in which concurrent goals were documented involved children with the permanency goal of reunification and a concurrent goal of adoption. In contrast, the cases in which concurrent goals were not documented may include those in which concurrent planning was not appropriate.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

In round one of the CFSR, timeliness of adoption was rated as an area needing improvement in all applicable cases. Reviewers identified unnecessary delays in attaining finalized adoptions and were concerned that these delays were due to ineffective casework practice rather than external factors. Reviewers and stakeholders identified delays in (1) filing for TPR, (2) transferring cases to adoption workers, (3) conducting home studies, and (4) obtaining adoption finalizations. In addition, children were not being registered on state or national adoption exchanges when parental rights had been terminated.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

In January 2005, the Supreme Court formed the Supreme Court Commission on Children in the Courts. The initial goal of the Commission was to examine appropriate steps for the judicial system to undertake to ensure the courts are as responsive as possible for children who interact with or are directly affected by the courts. One issue that was addressed by the Commission's Subcommittee on Expedited Appeals was the lengthy amount of time that lapses between TPR trial court orders and the resolution of subsequent appeals. As a result, significant changes have been made in order to expedite appeals for TPR cases. The Clerk of the Court now places all child abuse and neglect cases on the court schedule for oral argument earlier in the process, in comparison to other non-expedited cases. According to Chief Judge of the Nebraska Court of Appeals, it is now not unusual for oral arguments to be heard in the same month that the last brief was filed and for the opinion to be issued within 30 days. The Court is also no longer allowing continuances in TPR appeals except under extraordinary circumstances. Court focus group participants provided examples of those circumstances, reporting that continuances are sometimes due to not receiving mental health or court reports on time or the failure of parents to attend hearings. According to the Nebraska Supreme Court's Office of Public Information, these changes have resulted in an average reduction of three months (from eleven to eight) of the time it takes an appeal to work its way through the system.

DHHS has been collaborating with judges, county attorneys, and other stakeholders to address and improve barriers around locating and assessing relatives as potential placements, filing TPRs according to ASFA guidelines, and obtaining adoption finalizations in a timely manner. One example is that DHHS now contracts with private attorneys to assist in filing for TPRs. This collaboration stemmed from an analysis of the data collected under the Governor's initiatives announced in June 2006, which revealed that the state needed additional resources to move forward with TPRs.

Another collaborative project is the celebration of National Adoption Day in November in courts and communities throughout the state. Douglas County Juvenile Court began holding these celebrations in 2000 and Lancaster and Adams counties joined in the celebration in the following years. Not only do these events increase the number of adoptions finalized that particular month and in the last few years, but they have also boosted public support.

DHHS has also contracted with two organizations to assist in the completion of adoption exchange referrals on children legally free for adoption using grant monies awarded by the National Adoption Exchange. DHHS developed policy and guidebook material on listing children who are free for adoption on adoption exchanges, requiring all children free for adoption with a plan of adoption and not yet in an adoptive home to be placed on the appropriate adoption exchanges. Any exceptions must be signed by the assigned worker's supervisor and the Service Area Administrator. Data indicates, however, that this is an area needing continuing improvement. In December 2007, there were 224 children legally free for adoption: 46 (20.5%) with an exception to being listed on the adoption exchange. Of those 178 children who should have been listed on the exchange, only 52 (29.2%) were actually listed on the exchange.

A new contract with the Adoption Partnership may affect and hopefully improve this and potentially other adoption-related barriers. The Partnership is a collaborative project between three licensed child placing agencies in the Eastern Service Area. DHHS has contracted with the Partnership since May 1999 to provide a variety of adoption-related services for children in the Omaha area. Under a contract that began March 1, 2008, the Partnership will provide a modified grouping of services statewide. These services include: registration of all children who are DHHS wards, free for adoption, and not yet in an adoptive placement, on the state and national adoption exchanges and the Heart Gallery, and keeping registrations current; maintaining a list of these children for tracking purposes and use by DHHS staff with waiting families; responding to families who inquire about these children, and performing an initial screening to determine if a family might be appropriate for a specific child; reviewing children's files to locate potential placement resources, and contacting the potential resources identified to determine interest in adoptive placement for follow-up by the child's caseworker; reviewing children's files to prepare social and medical summaries for use with adoptive families; preparing adoption finalization packets; and recruiting potential adoptive families.

DHHS has also strengthened policy and practice on involving adoption workers early in cases and transferring these cases in a timely manner. The Performance Accountability Plan (refer to Section I) builds into this policy an element of supervisor oversight. Stakeholders viewed the addition of adoption specialty workers positively and reported that these specialists have quickened the adoption process, but that they are often overwhelmed by a large number of cases.

Additionally, administrative memos were sent to all staff with the purpose of clarifying home study requirements, explaining the usage of a standardized home study format, and emphasizing the requirement to conduct the studies as outlined in AFSA. However, stakeholders report that finger printing and other requirements take a considerable amount of time on behalf of the parent and worker, and that the adoption is delayed because of this.

Other policy changes mentioned in the previous sections that also affect the adoption process include policy requiring workers to develop case plans and establish permanency goals within 60 days and to continually reassess those plans and goals on a regular basis with supervisor oversight, the early identification and involvement of non-custodial parents and relatives, the documentation of child characteristics and placement preferences into N-FOCUS to match the two, and clarification on workers' roles in filing TPRs. Also, guidance on concurrent planning has been provided to staff via guidebook material and training with an element of supervisor oversight provided via the Performance Accountability Plan (refer to Section I), although data indicates that this may be an area needing additional focus.

One last barrier mentioned by stakeholders, particularly those representing adoptive families, is that adoptive parents are often ill prepared for what occurs after adoptions are finalized and there is a lack of post-adoption services to support them through this transition. DHHS does offer post-adoption casework and social services upon request for families who adopted children who were DHHS wards at the time of finalization. Workers are expected to prepare each family for adoption prior to finalization. Thus, an assessment of whether policy is leading to practice in these areas may be warranted.

Item 10: Other planned permanent living arrangement. *How effective is the agency in establishing planned permanent living arrangements for children in foster care, who do not have the goal of reunification, adoption, guardianship, or permanency placement with relatives, and providing services consistent with the goal?*

a. What do policy and procedure require?

In Nebraska, "other planned permanency living arrangements" include independent living and self sufficiency.

Policy allows for independent living as a permanency goal for a 16-year-old youth whose best interest is served by being self-sufficient. The permanency goal must be reasonably achieved within 18 months of selection, the ward must be capable of caring for him- or herself, and it is preferred that the ward be engaged in full-time academic or vocational training or employment. In situations in which the ward is not attending an educational or training program or working at least 30 hours per week, the ward will develop and sign a plan for achieving self-support. Independent living is also an option for youth who are close to the age of majority and who have received the necessary services, but for whom the move towards other permanency options (e.g., reunification, guardianship, or adoption) has been unsuccessful or is no longer a viable option.

For each youth with an independent living permanency goal, policy requires the development of a team consisting of a caseworker, Preparation for Adult Living Services (PALS) Specialist, and parent, in some cases. Foster parents or caregivers serve as mentors to the ward. Together, this team develops the PALS case plan and works toward achieving the goals of the plan. Once a plan has been developed and the date for an independent living arrangement established, workers must send notification to the parent (if rights remain intact), the legal guardian, the court and county attorney, the guardian ad litem, and the parent's attorney. Conditions for an independent living arrangement are defined in writing with a written service agreement signed by the ward and the worker. Before approving an independent living arrangement, the worker must make a home visit to assess the appropriateness of the residence, living arrangements, and persons residing in the home (including any necessary background checks). This assessment is to be included in the case file. Wards will continue to receive services during a six-month stabilization period. The state may provide support services and aftercare services for youth up to age 21 if they were a state ward after the age of 16.

Wards with mental illness, retardation, autism, a developmental disability, or a significant physical disability will be linked to specialized services to make the transition to independent living. If a disability impairs the wards' ability to care for themselves, the goal of self-sufficiency is considered.

b. What do the data show?

According to the ACF data profile, 7.5% of youth in state care had a permanency goal of independent living or self-sufficiency (labeled as "emancipation" in the data profile) in the current reporting period (4/1/2006–3/31/2007). The median months of youth in care with the permanency goal of independent living or self-sufficiency (labeled as "other" in this particular area of the data profile) is 23.3 for the current reporting period (4/1/2006–3/31/2007). Data in

Permanency Composite 3 indicates that we are decreasing the percent of youth discharged to independent living or self-sufficiency who were in care for three or more years, and fall within the 25th national percentile.

The NE-CFSRs indicate a significant improvement in this item from 2005 (50%) to 2006 (100%). However, in both years stakeholders reported a need for additional independent living services and an increased knowledge among workers on the available services and service eligibility so they can make the appropriate referrals.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

This item was rated as an area needing improvement in round one of the CFSR. Diligent efforts were not made to support a permanency goal of independent living in 50% of applicable cases. Stakeholders expressed concern that children are not being adequately prepared for emancipation and that service providers and foster parents are not provided with sufficient resources to help children make a successful transition from foster care to independent living.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

DHHS has worked to inform workers about the different types of services offered to wards who fall into this particular category in an effort to increase service utilization and referrals. A memo was distributed to all staff outlining the responsibilities of independent living contractors and describing the differences in the programs and services offered to youth with a permanency goal of independent living. The Independent Living Guidebook was updated to provide more current information on the services as well, and the guidebook was distributed to staff in July 2005. Stakeholder comments on the impact of these efforts are mixed. Some stakeholders say that there has been an increase in the knowledge around independent living services, while others (both internal and external stakeholders) report that confusion on these services still exists.

The general consensus among stakeholders is that additional funding is needed to maintain existing independent living services and establish new services. Since round one of the CFSR, DHHS has worked to develop new services to prepare youth for emancipation, especially in regard to educational attainment. Listed below are some of these service developments:

Educational Training Vouchers Program: In January 2004, DHHS received a grant from the ACF to administer the Educational Training Vouchers (ETV) Program to provide monetary assistance to current and former foster care youth to help with post secondary expenses. In SFY2007, the following developments were made in the ETV Program statewide:

- Ongoing program staff visits to colleges throughout the state to identify contacts within each school with whom they could work to coordinate educational services for wards;
- The hiring of an additional staff member to serve as an education mentor to Omaha youth and assist them in registering for classes, applying for financial aid, problem solving around barriers concerning transportation, jobs, daycare, or study habits;
- The implementation of a structured contact and support process in which staff make monthly contact with each participating youth to check in on the youth's progress and provide any needed support;

- The development of an ETV database that captures all identifying information of each youth, contacts to youth, case updates, etc.;
- The sponsoring of ETV "celebrations" or gatherings for youth to connect with one another, celebrate their academic accomplishments, and receive additional support and information on the program;
- The development of an ETV brochure, complete with quotes, graphics, and design provided by ETV Program participants; and
- The distribution of orientation packets to all new ETV applicants, which include a welcome letter, staff contact information, calling cards, and other educational resource materials.

In addition to these developments, the agency with which DHHS contracts to administer the ETV Program (Central Plains Center for Services) has been working with Nebraska's Coordinating Commission for Postsecondary Education to outline how they can best assist youth in pursuing and succeeding in postsecondary education. Central Plains' staff has also networked and collaborated with EduationQuest, a Nebraska nonprofit organization with a mission to improve access to higher education in Nebraska. In June 2007, EducationQuest hosted five college access trainings throughout the state with attendees including representatives from Vocational Rehabilitation, DHHS staff, personnel from public schools and postsecondary institutions, and General Education Development (GED) coordinators. Central Plains' staff was invited to present information on the programs they offer to wards at this event.

As a result of these efforts, Central Plains has established a working relationship with all Nebraska colleges, universities, and specialized schools. There has also been a significant increase in youth seeking additional educational funding. All participating youth have applied to receive federal Pell Grants and any scholarships for which they may be eligible. Other sources of funding for which staff assist participants in applying include the federal Supplemental Education Opportunity Grant, the Nebraska State Education Grant, and the Tuition Assistance Program offered through the University of Nebraska.

Central Plains is now able to measure, monitor, and evaluate the ETV Program using the newly developed ETV database. Staff members assess participants' educational needs, program of studies, and retention rates to inform their efforts in assisting program participants. Central Plains has seen a gradual increase in program retention rates, particularly in the Omaha area with their newly hired education mentor. The number of youth who were awarded ETVs has increased from 215 youth in FFY2006 to 311 youth in FFY2007. The retention rate of youth participating in the ETV Program was 77% in FFY2007, a gradual increase from prior years. Since the inception of this program, 515 youth have participated with an overall retention rate of 46%.

Preparation for Adult Living Services Program: Additional educational services and supports are provided to wards via the PALS Program. The PALS Program is designed to provide support and guidance for youth who are transitioning to independent living. One unique aspect in the PALS Program is the provision of monetary incentives for youth to use in their efforts towards meeting their identified program goals. The program allocated a total of $20,000 per year for youth incentives. Incentives are most commonly used to secure one-on-one mentoring with PALS Specialists, often to include elements of education planning.

In SFY2007, the following developments were made in the PALS Program:

- The use of the Chaffee Assessment to assess the needs of youth, including educational needs;
- The distribution of the "Preparing to Move On" curriculum for foster and adoptive parents, designed to assist parents and providers in learning how to incorporate independent living assessments, education, planning, and practice into their everyday lives with the children in their home;
- The distribution of the "Making It on Your Own" curriculum, a basic core self-sufficiency skills manual designed for caretakers of youth who are maturing in care; and
- The Nebraska Independent Living Conference for youth, parents, and providers, with sessions addressing financial self-sufficiency, educational attainment, positive connections with adults and peers, reduced homelessness, high-risk behaviors, and gaining access to health insurance.

In FFY2005, 521 youth participated in the PALS Program. This increased to 566 youth in FFY2006 and 590 youth in FFY2007. To gauge client satisfaction with the program, three wards from across the state who recently participated in the program are selected each month and invited to complete a PALS Program survey. Feedback from youth, caregivers, families, and workers is collected in each selected case. The questions on the surveys differ according to the intended respondent (youth versus some other respondent). All survey responses are based on a five point Likert Scale (with a rating of 1 being poor and a rating of 5 indicating excellence). From October 2006 through March 2007, surveys were completed by 33 youth and 36 caregivers, family members, and workers.

Over 70% of youth rated as excellent the assistance they received through the program in dealing more effectively with their situation, establishing a good working relationship with a PALS Specialist, and identifying realistic and achievable goals. Only 52% of youth rated their own involvement in the planning process as excellent, although 30% rated their involvement as falling between good and excellent (4). When asked how the PALS Program was most helpful to them, youth reported that the program was "good with help for college and scholarships," "helped get back into school and will now graduate, I would not have done this without PALS help," "helped me get into GED and went to orientation with me," "they were there to talk to, helped setup with school, helped getting an apartment, and making sure I pay my bills."

The majority of caregivers, family members, and workers also rated as excellent the achievability of the goals established in the youths' plans, the ability of the PALS Specialist to help the youth deal with their situations more effectively, in addition to the open communication between the respondent and the PALS Specialist, and the information provided to the respondent on the youth's progress. This group of respondents also identified educational assistance as one of the areas in which the PALS Program was most helpful, reporting that the program "helped with college, budgeting, and makes the youth feel comfortable," "benefits include college help, also with follow up," and the program was "very helpful in finding employment, registering for school, and helping caseworkers." Overall, 89% of caregivers, family members, and workers felt that without the PALS Program the youths' situations would have become worse. Just over three-fourths (76%) of youth reported the same.

Former Ward Program: DHHS also offers the Former Ward Program (FWP). The FWP is designed to assist former wards in continuing their education through financial board and room assistance. There have not been any significant changes to this program since round one of the CFSR.

In an effort to increase the development of independent living plans (a common barrier identified by internal and external stakeholders), DHHS worked with the Nebraska Foster and Adoptive Parent Association (NFAPA) in writing an article to include in the NFAPA newsletter on the expectations of foster parents to help in assessing and developing these plans. To support the assessment and development of independent living plans specifically for Tribal youth, DHHS developed a contract with Central Plains Center for Services through which Tribes began receiving funds to provide services to Tribal youth age 16 years and older. In 2004, DHHS contracted with Nebraska Children and Families Foundation (NCFF) to sponsor an Annual Tribal Youth Counsel Conference using funds from the Positive Youth Development State and Local Collaboration Demonstration Project Grant, awarded to the state by the ACF's Family and Youth Services Bureau in 2003.

Unfortunately, the documentation of independent living plans continues to be a struggle in the state. In June 2005, a memo was sent to all staff to remind them that a plan for independent living must be included in case plans for wards age 16 and older per state law and policy. Reports on the number of eligible youth without independent living plans are generated monthly and shared with supervisors, who are then expected to take appropriate actions as outlined in the Performance Accountability Plan (refer to Section I). However, according to N-FOCUS data, the percent of youth age 16 years and older who have a written independent living plan was only 48.8% for the twelve month period ending March 31, 2007. There was not one service area that was performing particularly well in this area. The percent of youth with plans ranged from 37.9% in the Eastern Service Area and 66.3% in the Northern Service Area.

Recent stakeholder comments suggest that there may not be enough PALS Specialists to work with youth one-on-one in developing independent living plans. Workers have also reported that they are not receiving independent living plans from the Central Plains Center for Services, the agency with which DHHS contracts to provide services to youth involved in the PALS Program. Stakeholders reported that the way in which independent services are provided vary from among different areas of the state and that there is an overall lack of documentation on the actual provision of these services.

Another change that has occurred in this area since round one of the CFSR is that DHHS issued contracts with residential providers that contain specific service requirements in July 2006. Per contract, all residential providers must administer on an annual basis the Ansell Casey Life Skills Assessment on any youth in care who is 16 years of age and older, and ensure that all youth in care who are 18 years of age take the online Chafee Assessment. Providers must also develop a written plan for each youth and provide age-appropriate adult living preparation and life skills training utilizing online curricula or other life skill curricula. It should be noted that workers report that they do not always receive assessment and plans from providers to include a case files. As mentioned in Item 5, providers report that DHHS contracts are not structured in a way that allows them to truly support the transition of youth to living independently.

Last, DHHS began collaborations with NCFF, the Sherwood Foundation, and the Scott Foundation in early 2007 to develop a Youth Independent Living Program in Omaha (refer to

Systemic Factor F). The program will address personal and community engagement, education, employment, and other issues for youth

Permanency Outcome 2: The continuity of family relationships and connections is preserved for children.

1. Data Summary

Permanency Outcome 2 is comprised of six items. Item 11 examines the proximity of children's foster care placement to their family and community. Item 12 addresses the placement of children with siblings in foster care. Item 13 deals with visitation between children in care, their parents, and other siblings in care. Item 14 looks at preserving important connections for children in care (e.g., neighborhood, community, faith, family, Tribe, school, and friends). Item 15 examines the identification and use of relative placements for children in foster care, and Item 16 addresses the relationship of children in care with their parents. Data from the NE-CFSRs (refer to Section I) are used to inform all items. Additionally, Item 15 includes point-in-time data from the ACF data profile and N-FOCUS data.

The data indicates a decline in performance in all of these items from 2005 to 2006. The most significant decline was seen in promoting visitation between children, parents, and siblings. The 2005 review revealed that the state had improved in this area by 14% since round one of the CFSR (an increase from 71% to 85%), but performance dropped by 32% in 2006 (to a score of 53%). The comments stakeholders made during the review were critical of the quality of supervised visitation services provided by contracted agencies.

According to the 2005 and 2006 state reviews, performance has also declined in regard to placement proximity, child and parent relationships, and the preservation of connections, although to a lesser degree (15%, 14%, and 14% respectively). In terms of placement proximity, stakeholders deemed a lack of resources to be of issue. Issues discussed in regard to preserving family and community connections seemed to arise for Native American or Tribal children. Child and parent relationships were most often lacking in regards to fathers or absent parents, and issues associated with contracted visitation services was brought up under this item as well.

The two items in which the state's performance decreased the least was locating and securing relative placements (from 66% to 59%) and placing children with siblings (88% to 82%). Stakeholders reported that the state is still doing well in efforts to place children with siblings, but that we need to make more diligent and thorough efforts to identify and secure relative placements. It should be noted that both data included in the ACF data profile and N-FOCUS data indicate a slight increase in the percent of children placed in relative homes from 2005 to 2006 (refer to Item 15).

2. Stakeholder Assessment

Stakeholders reported that DHHS is doing well in securing out-of-home placements for children that are in close proximity to their family and community, and in keeping siblings together. However, in some cases there may be a lack of placement options, particularly in smaller communities or in cases in which children require treatment, which prevent placing children in the same community. Also, stakeholders reported that they experience difficulties with some schools not allowing children to remain in the school if they move outside the district.

DHHS has increased efforts to ensure visitation between children, parents, and siblings, but stakeholders questioned the quality and way in which visitation was carried out (via contracted visitation services). Some stakeholders contend that visitation is used as an incentive with families by many child welfare and juvenile services system professionals, including DHHS staff and the courts. A few providers view visitation requirements as an "unfunded mandate" and report that they pay for mileage and transportation out of pocket. It should be noted, however, that mileage and transportation costs are included in the rates included in all DHHS contracts.

Stakeholders were able to identify several promising practices in regard to preserving youths' connections to family, community, and culture. Stakeholders from a variety of professions commended the use of family team meetings as a tool to preserve connections. Workers were able to identify additional tools that they find helpful in this area, particularly eco-maps and genograms, and they viewed the increased use of informal supports as a promising practice. In terms of cultural connections, stakeholders believe that DHHS is doing well, particularly with Native American children. However, they stated that they adhere to the adage that there is always room for improvement.

Stakeholders had fewer comments to offer in regard to relative placements. Workers and supervisors reported that the process to secure relative placements has become more streamlined. External stakeholders, particularly those representing foster families, mentioned that ongoing training of relative providers should be mandated and additional support offered to these providers since their situation is unique from those of non-relative providers. The dynamics of the relationship between birth parents and relative providers may be tenuous at times due to the circumstances involved. The situation may also present additional safety concerns for the child or the relative provider.

According to stakeholder comments, DHHS is still struggling with identifying and locating non-custodial parents early in the case planning process. To truly involve parents in meetings, appointments, and other case planning activities, professionals who work in the child welfare and juvenile services system (including DHHS, the courts, placement providers, etc.) need to maintain more accommodating schedules. The most promising trends in this area were reported by stakeholders representing foster parent organizations. Foster parents are increasingly encouraging parents to be actively involved in their child's life and are providing support to the birth parents so they are more able to do so.

3. Item-by-Item Evaluation

Item 11: Proximity of foster care placement. *How effective is the agency in placing foster children close to their birth parents or their own communities or counties?*

a. What do policy and procedure require?

When placing children in foster care, workers are required to consider placements that are:

- In the least restrictive, most family-like settings;
- Closest to the family, to meet the children's best interests and special needs; and
- In settings that provide continuity for the children in school, church, or other community relationships whenever possible while also considering the safety of the community.

Placement with non-custodial parents and relatives can typically offer such a setting for children placed in out-of-home care and, for that reason, is preferred over placement with non-relative providers (refer to item 15).

b. What do the data show?

NE-CFSRs indicate a decline in the percent of cases in which placement proximity was a strength from 96% in 2005 to 81% in 2006. Barriers to achieving placement proximity were most often related to a lack of placement resources.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

In round one of the CFSR, reviewers rated proximity of foster care placement a strength in 97% of the cases. Stakeholders reported that out-of-state placements are due to lack of resources for children with special service needs and that a number of children are placed out of state in order to place them with relatives or adoptive families.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

The state did well in round one of the CFSR and continues to focus on keeping youth in close proximity to parents and community. Since round one, DHHS has begun evaluating this issue through quality assurance initiatives in the ICCU and the NE-CFSRs (refer to Section I). In the ICCU case reads, reviewers determine whether a change was made in a child's placement, if that change was in the best interest of the child, and if the change was in optimal proximity to the child's family, school, and community. The NE-CFSR examines the same factors and includes cases in traditional care units.

One method to assure early-on in the case that workers are considering the least restrictive placements for children that best meet children's needs and are closest to their family, school, and community is through supervisor oversight provided via the Performance Accountability Plan (refer to Section I). The appropriateness of placements, including placement proximity, is one area that supervisors evaluate when reviewing the cases their staff manage.

Although every attempt is made to place children within close proximity to their family and friends, workers and providers identified barriers to being able to do so in some cases. Those from smaller or more rural areas indicated that there were cases in which a placement could not be found in the same community due to a lack of placement resources. Those from larger or more urban areas indicated that the definition of community is a critical factor. While workers may be able to locate a placement for a child within a mile or two from their home, that placement may still place the child in a new school district. Stakeholders said that this is of particular issue with the schools they perceive as not working to keep the child enrolled in the same school.

Stakeholders reported that children's treatment needs can add another obstacle to placing children in the same community in which they resided prior to entering care. First, many communities do not have placements that offer a full continuum of treatment services so children must be moved to other communities and attend a different school to receive needed treatment. Other communities are more fortunate and have treatment placements, some of which offer educational services as well. However, in one particular facility that offers both treatment and educational services, the provider still makes every attempt to keep children in the school they attended prior to entering care if possible. Another issue pertaining to treatment is that there are some cases in which an out-of-state treatment placement is closest to the child's community and school, yet Medicaid case rates and other payment logistics make the placement difficult.

DHHS and stakeholders have acknowledged and made efforts to ease some of these barriers. For example, the Nebraska Department of Education's (NDE) Ad Hoc Committee on the Education of Children and Youth in Out-of-Home Placements (detailed in Item 21) was formed to provide guidance and direction to policymakers and stakeholders in the development and implementation of educational opportunities for children in out-of-home placements and to promote effective communication, coordination, and collaboration between the key systems (e.g., child welfare, juvenile services, and education) involved in doing so. Also, it is anticipated that the implementation of NSIS (refer to Section I) will decrease in the number of youth needing out-of-home care and increase in the number of youth placed within their communities as we increase the utilization of relatives and informal supports to help keep children safe in their homes.

Item 12: Placement with siblings. *How effective is the agency in keeping brothers and sisters together in foster care?*

a. What do policy and procedure require?

Whether or not wards can be safely placed with siblings is considered in all placement decisions. All efforts are made to place siblings in the same home in both temporary and more permanent placements. When selecting adoptive placements for wards with siblings who are also in out-of-home care, preference is given to the families with whom the ward's siblings are placed, if they are interested in adopting. In fact, it is these cases in which legal guardianship becomes a more acceptable permanency option if the family were not necessarily willing to adopt, but were willing to become the legal guardian of the ward needing permanent placement.

b. What do the data show?

NE-CFSRs indicate a slight decrease in performance in placing children with siblings from 88% in 2005 to 82% in 2006. Stakeholders who participated in both reviews believed DHHS made all efforts in keeping siblings placed in the same home.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

In round one of the CFSR, reviewers rated placements with siblings a strength in 87% of cases. Stakeholders said that DHHS makes concerted efforts to place siblings together and that siblings are separated only when necessary.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

The state did well in round one of the CFSR and continues to focus on keeping youth placed with their siblings. Stakeholders agree that DHHS efforts in this area have been positive and they commend the agency in focusing on securing placements that can cater to the special needs of a child and also accept siblings.

Nonetheless, it is still a struggle to place siblings together when one sibling may have treatment needs and the other does not. One agency provider expressed a concern that DHHS sometimes prioritizes placing siblings together over placing the one sibling who has treatment needs in a placement setting that can meet that child's need. The decision becomes even more difficult in areas with limited placement options.

Item 13: Visiting with parents and siblings in foster care. *How effective is the agency in planning and facilitating visitation between children in foster care and their parents and siblings placed separately in foster care?*

a. What do policy and procedure require?

Policy requires workers to ensure that visitation is provided between parents and children in foster care at least once per month, and between siblings who are in foster care but placed in different settings at least once per month. A visitation plan is required in every child's case plan with visitation to occur within three calendar days from the child's removal from home. The frequency of visitation between parents and their child, and between siblings in foster care must correlate with the children's age and development and be consistent with the identified permanency goal. Efforts must be made to include both children's mothers and fathers in visitation planning, although in some cases this may involve separate visitation plans. Visits should be supervised only when supervision is necessary to ensure child safety.

Exceptions to the above requirements are made when:

- The court has ordered that no visits occur, due to safety concerns for the child;
- Parental rights are no longer intact; or
- Other exceptional circumstances exist and an exception is approved by DHHS administrators or the court.

b. What do the data show?

The 2005 NE-CFSR conducted indicates improvement since the federal 2002 CFSR (from 71% to 85%), but the state experienced a decrease to 53% in the 2006 NE-CFSR. Recurring barriers identified by stakeholders in both reviews were inadequate contracted visitation services (in that services were not being provided as need or contracted), and a lack of providers to offer transportation to visits and to supervise visits.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

Visitation with parents and siblings was found to be a strength in 71% of the cases reviewed in round one of the CFSR. Stakeholders reported that for most cases, visitation plans with parents and siblings are in place and appropriate. However, stakeholders also noted that workers frequently do not observe children and parents during visitation. Consequently they have no direct knowledge of the quality of that relationship.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

As detailed in Item 7, DHHS has recently strengthened policy and practice regarding diligent efforts to locate and assess non-custodial parents. This policy can support a number of efforts, including that of promoting visitation between a child and a non-custodial parent. Additionally, background checks are being processed locally rather than through the central office, and stakeholders report that this has made the visitation process much smoother and quicker. Last, a program memo was sent to all staff in June 2005, to emphasize the importance of visitation between children, siblings, and parents, and to clarify for staff the expectations regarding the frequency of these visits. Stakeholders now say that efforts are typically made towards setting up parent and sibling visitation, but that these efforts are not always documented adequately in the case file. Focus group youth, however, stated that they would like more visits with parents and that they did not understand why workers would not allow them to visit with their parents in cases in which visitation was not occurring. Focus group feedback from biological parents echoed these sentiments.

A variety of stakeholders, particularly those from family organizations, said that visitation is not always used to assess and promote permanency goals, but rather it is sometimes used by both DHHS and the courts as an incentive. Also of issue is that sometimes judges routinely order supervised visits, even in cases in which supervision might not be necessary.

The Supreme Court's Commission on Children in the Courts is currently developing a unified statewide visitation protocol that emphasizes the use of visitation as developing and maintaining connections between parents and children, offering opportunities for parents to build parental

skills, and allowing for workers to assess parental protective capacities. Additionally, the 2008 "Through the Eyes of a Child" Initiative lecture series offers training on using visitation as a tool for and a guide to rehabilitation for parents and children to stakeholders in the child welfare and juvenile justice court system. In regard to DHHS changes, the new NSIS policy and procedures (which require an ongoing assessment of child safety and monitoring of safety plans with mandatory points of re-evaluation, as detailed in Section I) include a mandatory consultation point for workers when unsupervised visitation between parents and children is being considered in cases in which it was previously supervised. It is anticipated that these efforts will lessen the barriers mentioned above.

One of the barriers noted by stakeholders who participated in the NE-CFSRs was the quality of contracted visitation services. Internal stakeholders who are currently involved in the 2008 federal CFSR process agree, and some pointed to DHHS as carrying primary responsibility in this matter. First, stakeholders explained that DHHS visitation contracts have not been updated to reflect FCP (refer to Section I) and to require agencies providing visitation services to use family centered services. Also, the referrals DHHS made to contracted agencies are not always clear on the visitation services needed. Last, stakeholders suggested that the rates paid to receive visitation services were too low. Another downside to contracted visitation services mentioned by stakeholders who participated in the 2002 federal CFSR was that workers frequently do not observe children and parents during visitation and as a result have no direct knowledge of the quality of the parent and child relationships.

Other barriers mentioned by stakeholders include limits on visits for youth transitioning from a treatment setting to the youth's home, complicated logistics such as transportation, a lack of places to conduct visits, and an overall lack of visitation services in more rural areas. Stakeholders pointed out that expectations on visitation are unrealistic for some providers because it is often provided at providers cost (i.e., transportation and mileage). Providers labeled this as an "unfunded mandate." Stakeholders also pointed out that visits that occur in visitation centers do not offer a sense of normalcy for the children.

A RFB for in-home safety services issued in March 2008 includes a continuum of care process that may have a positive impact on the provision of visitation services. This RFB is described in more detail under Systemic Factor E.

Item 14: Preserving Connections. *How effective is the agency in preserving important connections for children in foster care, such as connections to neighborhood, community, faith, family, Tribe, school, and friends?*

a. What do policy and procedure require?

Many of the policies outlined in the above sections were established in an effort to preserve children's connections to neighborhood, community, faith, family, Tribe, school, and friends. Requiring workers to include the child, parent, family members, and care providers in the case planning process allows workers to identify and preserve those important connections by planning accordingly.

When placing children in foster care, workers are required to consider (in tandem with child and community safety and needs) placements that are closest to the family and that provide

continuity for the children in school, church, or other community relationships whenever possible.

b. What do the data show?

There was a significant decrease in the percent of cases in which preserving family and community connections was viewed as a strength from 73% of cases reviewed in the 2005 NE-CFSR to 59% of cases in the 2006 NE-CFSR. The 2006 data may have been skewed by one particular site in which reviewers found that genograms and eco-maps were not being completed with families and that informal supports were not being utilized to an ideal degree.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

In round one of the CFSR, reviewers rated the preservation of connections as a strength in 71% of cases. Several stakeholders addressed the issue of DHHS compliance with the Indian Child Welfare Act (ICWA), with some expressing the opinion that compliance is high and others noting room for improvement. Stakeholders at one site stated that the court did not pay attention to ICWA requirements and placed children in foster care and adoptive homes without notifying the Tribe. A key issue identified is that it is unclear who in DHHS or the judicial system is responsible for Tribal notification.

It should be noted that reviewers in the 2005 NE-CFSR noted room for improvement in terms of ICWA compliance and stakeholders expressing the opinion that workers just "go through the motions" in their ICWA efforts.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

Since round one of the CFSR, the state has implemented the FCP (refer to Section I) philosophy requiring the inclusion and involvement of the child, parents, and other family members in the case. DHHS has also implemented family group conferencing to locate family members to involve in cases and to maintain children's connections with those members, although few workers report that they use this service.

Additionally, connections to family and community are one of the items assessed through the comprehensive assessment process included in the new NSIS (refer to Section I). Information on connections is gathered by the worker, usually in a family team meeting at which families identify formal and informal supports. Family team meetings are one of the efforts stakeholders cited as successful in maintaining and preserving connections. Although workers are told that anyone can attend family team meetings provided that those meetings remain safe for the child and other participants, one stakeholder reported that workers do not always allow youth to invite who they would like to attend these meetings.

Many stakeholders agree that DHHS has made improvements in this particular area and is making more efforts early in cases to identify and maintain connections. Internal stakeholders were better able to provide specific examples of improved efforts, such as the implementation of the new intake process (refer to Safety Outcome 1) that allows for the collection of more

thorough information, the use of eco-maps and genograms, and the identification and use of informal supports.

In 2007, DHHS collaborated with the Nebraska Supreme Court and other key stakeholders involved in the "Through the Eyes of a Child" Initiative to provide funding to mediation centers across the state. Funding was used to implement pre-hearing conferences for families experiencing intervention because of child abuse and neglect. Conference facilitators ensure that topics related to the preservation of connections, such as the identification and location of absent parents, the consideration of relatives for placement options, and parent/child visitation, are addressed. There are no formal results of this initiative at this time, but anecdotal data indicate that the court process runs much smoother since the utilization of these hearings and that placement with absent fathers and/or relatives have increased. Of course, the data on the number of relative placements (refer to Item 15) support this assumption, although increases were minimal.

Additionally, the "Better Service through Enhanced Partnering" (BSEP) grant between the Economic Assistance and Child Support Enforcement Unit, the CWU, and OJS should also lead to more absent fathers being identified and involved in child welfare cases (refer to Systemic Factor E). This is a three year grant and results of its outcomes should be available at the end of the third year of the grant in 2009.

DHHS partners have been making efforts in this area as well. In July 2005, NFAPA published an article in their summer 2005 newsletter for foster parents emphasizing the importance of FCP (refer to Section I) and maintaining connections between children in foster care and their biological parents or caregivers from which they were removed. Foster parents also receive this message in the Parent Resources for Information Development and Education (PRIDE) pre-service training. Stakeholders from foster parent organizations report that many foster care providers develop monthly reports documenting activities or events that help preserve connections, such as when biological parents attend school events.

Stakeholders identified mediation between foster, adoptive, and biological parents as effective methods used by DHHS to help preserve these connections. On another note, stakeholders also mentioned that DHHS allowing children who are 19 years of age but still in high school to remain in their foster care setting is another way in which the agency helps preserve connections.

Efforts towards ensuring culturally competent services and maintaining cultural connections have been made as well. First, in July 2003, DHHS changed the language included in contracts to require due diligence in securing culturally competent service providers when arranging services for children. Culturally competent services were still mentioned as lacking in the state; however, attempts to secure such services are made whenever possible.

In June 2004, DHHS collaborated with NFAPA to conduct a targeted foster parent/resource family recruitment campaign. The campaign included materials that reflected the ethnic and racial diversity of children in state care. More detail on this plan is included in Systemic Factor G. Despite improved efforts, the state still struggles with recruiting families from diverse backgrounds. However, workers attempt to select placements for children that best match the child's needs whenever possible using the child and provider characteristics documented in N-FOCUS.

Efforts specific to Tribal connections have been made as well. In 2005, DHHS hired a Program Specialist with a specialized knowledge of and focus on ICWA to assure DHHS is ICWA compliant in all applicable cases. The same year, DHHS strengthened policy and practice pertaining to ICWA to include the notification of Tribes when cases involve Tribal youth and efforts to maintain the youth's cultural beliefs, customs, and traditions whenever possible. The supervisor review component in the Performance Accountability Plan (refer to Section I) provides the supervisor oversight to ensure these practices are carried out in each applicable case. Tribal focus group participants, however, reported that they do not always receive notification from DHHS on Tribal cases. Although notification has improved, Tribes are still learning of cases from family members themselves. Tribal stakeholders also stated that DHHS does not realize that family relationships extend beyond biological family relations to bands or clans, and that these relationships must be maintained and that whether or not Tribal connections are maintained is ultimately based on the efforts of foster parents or guardians to preserve these connections. Often, they do not.

Foster parents and providers, however, report that they are making an effort in preserving connections for children in general. Many providers acknowledge that the preservation of connections is a necessity and that they use many informal, community-based programs to help them in doing so. Some providers are also developing "matching" databases to use when finding out-of-home placements for children. Foster parents report that they often provide transportation for the children in their care to basketball games, religious activities, and other social or community functions.

Stakeholders speculated that ICCUs may be able to make more efforts to preserve connections when compared to DHHS traditional care units since they carry smaller caseloads. However, they generally believe that DHHS is doing well in preserving cultural connections, particularly for Native American youth. Stakeholders also acknowledged that there is always room for improvement. Focus group discussion among youth supports this premise, with a strong theme being that the youth would like more contact and connection to family members, friends, and other support systems.

Item 15: Relative placement. *How effective is the agency in identifying relatives who could care for children entering foster care, and using them as placement resources when appropriate?*

a. What do policy and procedure require?

It is expected that diligent efforts be made to locate, contact, and involve non-custodial parents and other relatives in the case planning process. These efforts must be started as soon as DHHS becomes aware that a child is in danger of being removed from home or has been removed, and continue until all relevant parties have been explored.

For these purposes, the term non-custodial parent refers to not only legal parents, but also alleged fathers. Workers must obtain the name, address, and phone number of the non-custodial parent, information about the frequency of the non-custodial parent's contact and relationship with the child, and any concerns the custodial parent may have about involving the non-custodial parent in the situation.

Families are to be consulted about persons they would consider to be relatives. When the child is Native American, the Tribe's definition of "relative" must be followed. At a minimum, efforts must be made to locate and involve maternal and paternal grandparents, adult siblings, aunts and uncles, and cousins. Workers must obtain the names, addresses, and phone numbers of relatives.

Diligent efforts include, at a minimum, asking the parent or guardian and the child, when appropriate, for information; following up on "leads" provided by collateral contacts or family members; and, if a parent's whereabouts are unknown, making a referral to the Federal Parent Locator Service. When the child falls under ICWA, diligent efforts must include providing notification to the Tribe.

When non-custodial parents or relatives are located, workers must explore whether they are potential placement resources or may know of other appropriate potential placement resources who will enhance continuity for the child. Placing children with non-custodial parents is preferred over placement with other relatives. If the non-custodial parent lives out of state or an extended distance from the custodial parent with whom reunification is planned, the following factors should be considered:

- The ongoing relationship the child has had with the non-custodial parent;
- The child's school situation and whether a change of school would be beneficial or detrimental to the child's education;
- The potential for and benefits of continued visitation with the custodial parent and siblings;
- The impact that placement with the non-custodial parent is likely to have on reunification with the custodial parent; and
- The anticipated length of time that separation from the custodial parent may be necessary.

If the home of the non-custodial parent is not selected as the living arrangement for the child, it must be documented why the decision was made to place the child elsewhere. This decision is a mandatory consultation point with the supervisor. In instances in which non-custodial parents are identified, a concurrent permanency goal of family preservation with the non-custodial parent will be noted, should reunification efforts with the custodial parent fail.

b. What do the data show?

NE-CFSRs reveal that since round one of the federal CFSR, the cases in which relative placements was a strength decreased to 66% in 2005 and 59% in 2006. A common barrier identified by stakeholders in both reviews was that workers were not locating relatives for potential placement options and that the tools and services to do so (e.g., genograms, eco-maps, or family group conferencing) were not always utilized.

Although the NE-CFSRs indicate a decline in the percent of cases in which family placements was viewed as a strength from 2005 to 2006, both data included in the ACF data profile and N-FOCUS data indicate a slight increase in the percent of children placed in relative homes from 2005 to 2006 (as well as in the current reporting period of 4/1/2006–3/31/2007). According to point-in-time data from the ACF data profile, over one third of wards in out-of-home care are placed in non-relative foster family homes with the second most common placement (just under one fifth) being a relative foster family home. Non-relative foster family home placements have just barely decreased from FFY2005 and relative foster family home placements have increased minimally.

N-FOCUS data supports the shifts in placement as indicated in the ACF data profile. The percent of wards placed in non-relative foster homes decreased from 47.1% in FFY2005 to 45.0% as of March 31, 2007 (non-relative foster homes include traditional, child-specific, agency-based, treatment, and emergency shelter foster homes). Relative foster home placements increased from 19.8% in FFY2005 to 21.2% at the end of the current reporting period (4/1/2006–3/31/2007).

The data included in these three sources (e.g., the NE-CFSR, the ACF data profile, and N-FOCUS) may seem contradictory, but reviewer and stakeholder comments might suggest otherwise. Many stakeholders noted that relative placements were occurring, but in some cases efforts to secure these placements were not sufficiently documented or stakeholders felt they fell short in locating absent parents or were occasionally rushed. Thus, we are achieving a positive outcome but our means to achieving that outcome could improve. We need to ensure that our efforts in locating and securing relative placements are diligent and thorough, including the documentation of those efforts.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

Relative placements were seen as a strength in 67% of cases reviewed in round one of the CFSR. Most stakeholders commented that there is support for relative placement in DHHS and it is being used, while some stakeholders reported that DHHS does not sufficiently search for non-custodial fathers and their relatives.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

Under the new NSIS (refer to Section I), if a child is removed from their home and if the child is not being placed with a noncustodial parent, they must then be placed with another relative, or then be placed with a family known to the child. Relative placement is always preferred when seeking short-term foster care for a child removed from their home, as well as in more permanent placement decisions such as adoption or legal guardianship.

In 2004, legislation was passed to allow a waiver of training for relative placements on a case-by-case basis in an effort to secure relative placements in a timelier manner. However, while the number of training waivers granted for relative providers has steadily increased from 19 in SFY2005 to 40 in SFY2007, the number of licensed relative foster homes has gradually decreased from 92 in SFY2005 to 52 in SFY2007. Stakeholders from foster parent associations pointed out that relative foster parents sometimes struggle with unique issues such as maintaining boundaries with the parents from which children were removed yet they do not receive the training or support needed to deal with these issues. Perhaps that is one reason why DHHS has seen a reduction in the number of licensed relative foster homes. Stakeholders believe that while training waivers may expedite relative placements, additional supports should be implemented to maintain these placements.

Some of the other changes that have occurred since round one of the CFSR that affect this item were mentioned in previous items and include: the early identification and involvement of non-custodial parents and relatives in cases; the utilization of pre-hearing conferences to discuss

relative placement options; and the utilization of family group conferencing to assist in locating family members, to include them in the case planning process, to increase placement with relatives, and to identify family members who are potential foster or adoptive parents.

Stakeholders were able to provide feedback on how some of these changes have impacted relative placements. First, they report that the process has been "streamlined" considerably. DHHS is locating relatives earlier in the case and placements are arranged much quicker. However, stakeholders from the foster parent associations noted that there were some unique and sometimes difficult aspects to these cases, particularly for the relative placement provider. Biological parents may disagree with the values or parenting techniques of the relative provider and there may be boundary or safety issues. Thus, stakeholders believe that relative placement providers need additional supports. Also, while stakeholders agreed that training waivers streamlined or quickened the placement process, there may be topics on which relative providers would benefit from training, such as information on the child welfare and juvenile services system or the supports available to them through the system and partner organizations. It was agreed that while training is not necessarily required, it should definitely be encouraged. Stakeholders commended the use of mediation as a tool to address family conflict, but they said that it should be used more often. Last, they reported that while the general relative placement process has been streamlined, DHHS now needs to work towards making the Interstate Compact on the Placement of Children (ICPC) and the Interstate Compact on Juveniles (ICJ) processes easier and faster.

Item 16: Relationship of child in care with parents. *How effective is the agency in promoting of helping to maintain the parent-child relationship for children in foster care, when it is appropriate to do so?*

a. What do policy and procedure require?

One of the roles of workers is to create opportunities for family involvement and contact throughout the case. Workers are instructed to encourage parents to attend medical appointments, school events, and other functions, and to participate in other activities with their children. Ultimately, it is the parents' responsibility to maintain contact with their child and to work with the child, the worker, and others towards meeting the child's needs and achieving permanency for the child.

b. What do the data show?

There is a lack of data on the state's efforts to support parent-child relationships of children in foster care. In our attempts to examine our efforts in this area (via the NE-CFSRs detailed in Section I), we incorrectly focused on parent-child visitation, which is already addressed in Item 13. However, some insight can be gleaned from stakeholder comments to other items in this outcome. For example, in reference to Item 15, stakeholders commented that workers were not always making diligent efforts to locate non-custodial parents. This would, of course, negatively impact the parent-child relationships of children in care.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

This area was viewed a strength in 55% of cases reviewed in round one of the CFSR. Case review findings varied, with clear indication of DHHS efforts to support the parent-child relationships of children in foster care in some cases and lack of effort in others. Lack of effort was particularly problematic regarding promoting visitation and bonding between children and their fathers.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

In 2002, DHHS began working with the NCFF on the Fatherhood Initiative. The initiative is a statewide collaborative effort with a mission to actively encourage and promote the involvement of fathers in the lives of their children and families. DHHS sent communication on the initiative to all fathers of state wards and to inform the fathers of the available resources and supports.

DHHS' partners, particularly foster parents, are making efforts as well. Stakeholders representing foster parent associations report that foster parents are increasingly reaching out to birth parents to involve them in their foster child's life and inform them of the child's activities and progress. Some foster parents are even serving as mentors for birth parents in terms of being involved.

The majority (70.0%) of youth who completed an online survey reported that their worker also encouraged them to maintain connections with their parents and involve their parents in their lives. However, most youth reported that they never saw or spoke to their biological parent. Unfortunately, the survey did not inquire about the reasons why youth did not see or speak to their biological parents or if the youth previously had contact with their parents prior to entering care. Workers report that there are difficulties in some cases to involve parents in some cases, particularly in regards to non-custodial parents and fathers who were not involved and/or choose not to be involved in the children's lives.

One area in which clarification or agreement is needed is around supervised or unsupervised activities. Stakeholders from a variety of professions could not agree on whether a parent who has supervised visitation with their child should be allowed to attend a child's school play or other public school activity unsupervised. DHHS does not currently have a written policy on this issue. If it is acceptable, stakeholders report that this is not currently being communicated to parents.

C. Child and Family Well-Being

Well-Being Outcome 1: Families have enhanced capacity to provide for their children's needs.

1. Data Summary

Well-Being Outcome 1 is comprised of four items. Item 17 addresses the effectiveness of assessments of the needs of children, parents, and foster parents and the provision of services. Data on the percent of cases with initial and current case plan documentation in N-FOCUS were used to inform this item. Also included are data on family team meetings obtained from six month case reviews and item scores from the NE-CFSRs (refer to Section I) conducted in 2005 and 2006. Item 18 examines the involvement of children and family in the case planning process. Again, scores from the NE-CFSRs and the case review data pertaining to family team meetings were used to inform this item, in addition to data collected from customer satisfaction surveys. Item 19 focuses on worker visits with children, and Item 20 examines worker visits with parents. N-FOCUS and case review data on the number of visits conducted with children and parents, findings from customer satisfaction surveys, and scores from the NE-CFSRs are used to inform these items. Also included in Item 19 are data collected from a quality assurance review of randomly selected cases on workers' visits with children in residence.

The state is not currently meeting its goal of documenting case plans in N-FOCUS. Workers identified caseloads as a barrier to meeting the outcome. Caseload data, however, do not support this assertion (refer to Section I). Additionally, family team meetings are not generally being conducted as required. Of particular issue is the lack of involvement of non-custodial parents in family team meetings and other case planning activities, as revealed by multiple sources of data. Worker visits with children fall just below our state goal of 80%, and just over half of youth are visited by their worker in their current residence. Parents' responses to customer satisfaction surveys, however, reveal that workers visit children on a monthly basis in less than half of their cases. The rate in which workers visit parents has increased according to N-FOCUS data and the state has met its compliance goal of 50%. Again, customer satisfaction surveys reveal slightly lower rates, although the survey question inquires about worker visits with the "family" rather than individual parents.

Recent policy and procedural changes have been made pertaining to these items (for example, updated requirements around monthly visitation with children in their residence). However, a recurring theme throughout stakeholder discussion on these items was that the *quality* of visits and family involvement in case plans was equally important to the quantity of these efforts. Thus, we have recently developed methods to monitor the quality of family involvement and visits, and we are in the initial phases of using these tools to gather and analyze such data. The most significant change is the recent implementation of the NSIS. The NSIS places a renewed focus on FCP (refer to Section I) and youth and family involvement in assessment and case planning activities.

2. Stakeholder Assessment

DHHS stakeholders anticipate the NSIS (refer to Section I) will allow for more objective and comprehensive safety assessments since it requires workers to locate and include non-custodial

parents and other family members in the assessment and case planning process, along with the children, parents, foster parents, and other informal supports in assessment and case planning activities. Workers, however, expressed difficulty in doing so when non-custodial parents do not want to be involved.

DHHS, court, and service provider stakeholders identified increased supervisor oversight in the Performance Accountability Plan (refer to Section I) and the statewide comprehensive quality assurance system (refer to Systemic Factor C) as additional strengths in this area. However, stakeholders wanted better well-being quality assurance measures that capture *quality* (in addition to quantity) information of child and family involvement and visits.

Service providers reported that DHHS needs to be much clearer with providers on the services they would like developed and include providers in developing services prior to the Request for Proposals (RFP) process. Service provider and DHHS stakeholders also said that contracts are too restrictive and do not allow for providers to address children's specific needs, leading workers to move children from one placement to another to receive needed services. Additionally, providers said that agency-based foster care and treatment foster care are not utilized, even though these services provide additional resources to the worker in assessing and meeting the needs of foster parents. Internal staff, however, believe the latter issue may vary by service area. Some workers stated there is a lack of agency-based foster care and treatment foster care services in their particular area. Overall, it was agreed that there is a strong provider base in the state and they want to be more actively involved in decisions pertaining to the child welfare and juvenile services system. Providers also need to receive a copy of the family's case plan, so they can support all the activities and assist with goal achievement.

Caseloads are mentioned as a barrier to obtaining our goals in these areas by workers and stakeholders alike, although caseload data does not always support this assertion (refer to Section I). This is more of a reflection of worker turnover (refer to Section I) and covering for staff on extended leave. Worker turnover also increases the number of workers assigned to cases, which makes it difficult for the child, family, and worker to establish a relationship. Discussion from youth focus groups support this assertion, with many youth reporting that their caseworker keeps changing, that they were confused on why this was happening so often, and that they wished they had the same worker throughout their case. Biological and foster parent focus group discussion repeated these very thoughts. Court focus group participants pointed out that worker turnover not only affects the well-being of a child, but ultimately the child's movement towards permanency. Additionally, the learning curve for new workers who are assigned cases further delays permanency.

Stakeholders pointed out that caseload does not necessarily equal workload either. That is, caseload levels do not accurately reflect that amount of time and work involved in each case. Workers noted that time constraints often interfere with case planning activities, particularly visits. Large workloads also leave workers with little time to document visits and other work in N-FOCUS. On a related issue, workers noted that N-FOCUS documentation as it is currently set-up captures only quantitative rather than qualitative data in regard to well-being. It is difficult to document whether or not parents and children provided input into case plans and to what extent without reading the entire case narrative. Overall, workers would like available more tools for use to ensure a child and family's well-being, a better understanding of how current policy and procedure requirements enhance a child's well-being, and more skill-based training on ensuring well-being.

3. Item-by-Item Evaluation

Item 17: Needs and services of children, parents, and foster parents. *How effective is the agency in assessing the needs of children, parents, and foster parents, and in providing needed services to children in foster care, to their parents and foster parents, and to children and families receiving in-home services?*

a. What do policy and procedure require?

Assessments of the family and individual members (including all children, youth, and parents) are ongoing throughout the family's involvement with DHHS. After the completion of the initial safety assessment in cases of child abuse and neglect, a PCA (refer to Section 1) is completed through ongoing meetings with parents and others knowledgeable about the family. This assessment is used to determine the enhanced and diminished parental protective capacities related to the safety threats that were identified as causing a child to be unsafe in the initial safety assessment. Any diminished parental protective capacities identified in the assessment are incorporated into a case plan as the family's needs, as they must be addressed in order to enhance parental protective capacities and reduce safety threats.

The initial family team meeting must be conducted within 30 calendar days, and the PCA must be completed and documented in N-FOCUS within 60 calendar days. The PCA will be formally reviewed at least every six months to coincide with any court actions, but it is continuously reviewed every time workers reassess the safety of a child.

After the completion of the PCA and during the case planning process, the worker, child, and all family members will work together to identify the ongoing services needed to enhance parental protective capacities and diminish child safety threats. Services should be provided in the least intrusive manner as possible (for example, community-based services when appropriate) and on a time-limited basis. Initial case plans must be documented in N-FOCUS within 60 calendar days. Review and revision of current case plans should occur at least every six months and be documented in N-FOCUS.

Some of these policies and procedures were developed as part of the NSIS (refer to Section I) and implemented in February 2008. Others, such as the time requirements for completing assessments and case plans, have been in place and have been reinforced through various administrative and program memos. All efforts are monitored through the Performance Accountability Plan (refer to Section I) and our formal quality assurance case reads (refer to Systemic Factor C).

It should be noted that there are currently no formal statewide policy or procedures in place to assess the needs of foster parents. However, each individual service area has its own processes for assessing and meeting the needs of foster parents, and addressing any concerns raised about a foster family. When foster parents have questions or request assistance, caseworkers and/or resource development staff respond to those questions and arrange for the parents any needed training or assistance related to the issue. Foster parents can also request one-on-one mentoring through NFAPA.

Each individual service has also developed a team of individuals who examine and address any concerns regarding the suitability of a particular foster family in the area. Local teams discuss the presenting concerns regarding the foster family and examine potential ways in which the foster family can be assisted or supported by the agency or other community services. The team also evaluates whether presenting concerns may preclude a foster family from serving as a placement resource in the future.

Information gleaned from these processes carried out at the service area level are then used to identify any systemic issues around which new supports, services, or training could potentially be developed at the system level.

b. What do the data show?

In SFY2007, the state did not meet its goal of documenting initial case plans in N-FOCUS within 60 days of custody in 90% of cases. However, its performance has consistently improved from 78.1% in SFY2005 to 82.0% in SFY2007. The state also fell short of its goal of documenting a current case plan in N-FOCUS in 90% of cases. It has improved though, from 58.7% in SFY2005 to 81.4% in SFY2007.

Of all five service areas throughout the state, the Central Service Area had the highest percent of cases (84.4%) in which initial case plans were documented in N-FOCUS within 60 days of custody in SFY2007. The Central Service Area also performed the highest (88.3%) in updating case plan documentation the same year. According to the caseload data (refer to Section I), this area falls within both state and national caseload standards. This supports stakeholders' hypothesis that caseload levels are correlated with workers documenting case plans as functioning at recommended caseload levels would leave workers sufficient time to document case plans. However, the area with the lowest caseload levels in the state is the Northern Service Area. This area performed the lowest in documenting initial case plans within 60 days of custody (72.8%) and updating case plans (74.6%) in N-FOCUS in SFY2007. This does not support stakeholders' hypothesis that caseload levels are correlated with workers documenting case plans. The other three service areas of the state scored 80% or better in both measures. For comparison, two of these areas fall below or at both state and national standards and one area falls above both standards.

In March 2007, the Eastern and Southeast service areas began using a tool to monitor their performance in activities associated with child and family well-being. Data is related to workers contact with youth, parents, and caregivers; invitations to family team meetings, and the attendance of custodial and non-custodial parents and youth in these meetings; and the involvement of youth and parents in case plan activities during family team meetings. The tool was developed to capture more qualitative data on worker visits and family involvement in case planning activities.

From April 2007 through September 2007, the well-being tool was used to review 998 cases. Data indicates family team meetings were being conducted as required in 41.6% of cases in the Eastern and Southeast service areas. (The expectation is one meeting per month for ICCUs, and one meeting during the six-month review period for traditional units.) Custodial parents attended these meetings in 87.3% of cases, noncustodial parents attended in 29.7% of cases, and youth attended in 82.9% of cases. The Eastern and Southeast service areas need to improve in

conducting family team meetings as required and to increase the attendance of these meetings by parents (particularly non-custodial parents) and youth.

From January 2007 through June 2007, quality assurance staff conducted ICCU case reads throughout the state that examined factors similar to those mentioned above. According to the ICCU case reads, 58% of family team meetings were conducted monthly (as required) across the state. Most service areas fell within this 50% to 60% range, although the Northern Service Area conducted 79% of meetings as required and the Western Service Area only conducted 35% of meetings as required. Custodial parents were actively involved in 79% of these meetings, ranging from 67% in the Central Service Area to 89% in the Southeast Service Area. In comparison, non-custodial parents were actively involved in only 23% of meetings, with the Western Service Area engaging non-custodial parents in only 11% of meetings and the Eastern Service Area in 30% of cases (remaining service areas fall within this range). Last, youth were actively involved in 79% of meetings conducted throughout the state, with all service areas falling within 10 percentage points of this average.

Caseload data for CY2007 were calculated for ICCUs separately from that of traditional care units for a comparison analysis. ICCUs across the state were functioning anywhere from 44% to 89% of recommended caseload levels depending on the standard applied (i.e., state versus national standard) and the service area in question. The Northern Service Area ICCUs have the lowest caseloads at 44% per state standards and 51% per national standards. The Western Service Area ICCUs have the highest caseloads at 74% per state standards and 89% per national standards. Caseload levels in the Eastern, Southeast, and Central service areas fall between these two levels with these areas listed in order from highest to lowest. The Northern Service Area, which has the lowest caseloads, is conducting family team meetings as required at a much higher rate than other areas and, to a lesser extent, involving youth in those meetings. In comparison, the Western Service Area, which has the highest caseloads, is struggling with conducting monthly family team meetings and engaging non-custodial parents in these meetings.

NE-CFSR data indicates that this item was a strength in 52% of cases reviewed in 2005 and 67% of cases reviewed in 2006. In both reviews, stakeholders reported that the services provided to children and families did not always match the services suggested by the assessment. In some cases parents were dictating the services provided to children or the services were lacking, and in other cases reviewers found the assessment of parents' and children's needs inadequate or assessments were not conducted on an ongoing basis.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

In the first round of the CFSR, this item was rated as an area needing improvement. The needs and services of children, parents, and/or foster parents had been, or were being, adequately addressed by DHHS in only 56% of cases. Key concerns included incomplete assessments, lack of assessment of fathers or of all children in the home, and lack of service provision to meet identified child or family needs or to support foster parents.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

The implementation of FCP (refer to Section I) prompts workers to gather and incorporate information from families into comprehensive assessments of the family and child. Staff members are trained to identify the strengths and needs of the child and family, including all children, youth, and parents. NSIS (refer to Section I) training provides workers with greater guidance and clarity on identifying parental needs based on enhanced and diminished parental protective capacities noted in the assessment, and encourages workers to focus on and address these parental protective capacities to reduce child safety threats. The staff is also trained to identify, in collaboration with the family team, the services needed to improve any diminished parental protective capacities. An additional benefit is increased supervisory oversight and involvement to help staff implement the practices.

According to stakeholder comments, efforts need to be made to ensure that workers are aware of all available services and that they communicate the availability of services to children, parents, and foster parents. Youth who participated in focus groups were not aware of most of the services about which they were asked. Foster parents reported that whether or not youth and families were informed of available services varied by worker and was dependent on worker knowledge of services. Biological parents reported that they would like more information from workers about available services and supports for parents.

Another recognized barrier to providing necessary services is the lack of services available, particularly community-based services. Multiple sources (e.g., discussion among various focus groups and stakeholder feedback) support this. To address this issue, DHHS conducted a service array assessment (refer to Systemic Factor E) to identify service needs, gaps, and necessary improvements to address timely initiation of services in two areas of the state. The process has been expanded to other areas of the state as well. Additionally, initiatives in the recently approved Legislative Bill (LB) 542 (refer to Systemic Factor E) will lead to the development of a more balanced array of accessible services.

Item 18: Child and family involvement in case planning. *How effective is the agency in involving parents and children in the case planning process?*

a. What do policy and procedure require?

Policy presents case planning as a team effort in which workers, children, parents, family members, and other resources or supports participate. For that reason, all workers are required to work with each family to complete a genogram and eco-map in an effort to identify family members and potential supports. Workers are then expected to make diligent efforts to locate, contact, and involve non-custodial parents and other relatives in the case. These efforts and their result must be documented in N-FOCUS.

Family team meetings (which can include foster parents and other formal/informal resources) are the primary avenue used to create, implement, update, and evaluate case plans and the family's progress towards achieving identified outcomes. Workers must conduct a family team meeting

within 30 calendar days of receiving the case assignment, and at least two times per year before each case plan review. Additionally, all family team meeting documentation must include information on the child and family involvement.

b. What do the data show?

In March 2005, DHHS began conducting quarterly customer satisfaction surveys with 350 randomly selected caregivers of children in care (i.e., the biological parents, caregivers, or legal guardians who were legally responsible for the children at the time they entered care) at the time. The customer satisfaction surveys were developed to collect external, *qualitative* data pertaining to workers' performance in ensuring children's well-being. The surveys include questions on caregivers' levels of satisfaction with the extent to which workers involve them in case planning activities, how frequently workers visit children and families, etc. The responses are based on a five point Likert Scale: (1) strongly disagree, (2) disagree, (3) neutral, (4) agree, and (5) strongly agree. From March 2005 through March 2007, caregivers have participated in 2,633 customer satisfaction surveys. According to these surveys, caregivers are slightly satisfied (3.6) with how well the worker involves them in their children's case plans.

According to the NE-CFSRs, the percent of cases in which child and family involvement in case planning was rated a strength improved from 44% in 2005 to 51% in 2006. Consistent themes among stakeholders' comments include a general lack of family involvement, lack of involvement of non-custodial parents or fathers, and lack of documentation.

According to data collected from the well-being tool (refer to Item 17), family team meetings were conducted as required in 41.6% of cases reviewed in the Eastern and Southeast service areas. Attendance of family team meetings varied, with non-custodial parents being least likely to attend the meeting. Non-custodial parents attended family team meetings 29.7% of the time, custodial parents attended in 87.3% of the time, and youth attended in 82.9% of the time. That said, only 23.7% of non-custodial parents who did not participate in the family team meeting were invited by workers to attend the meeting (compared to 69.0% of custodial parents).

To better capture the *quality* of these meetings, the well-being tool examines the levels at which youth and parents are involved (for example, whether or not the participants identified strengths and needs, requested or reviewed services, or established or evaluated their case plan). Custodial parents were the most involved in these activities (ranging from 67.5% to 70.7% depending on the activity). Youth were active in these tasks anywhere from 66.5% to 67.8% of family team meetings. Non-custodial parents participated in these activities in only 28.0% to 28.9% of family team meetings.

A separate ICCU case review (refer to Item 17) indicates that, while both youth and custodial parents were actively involved in 79% of meetings and non-custodial parents were actively involved in 23% of meetings, all meeting participants signed the case plan developed in the meeting in only 51% of cases.

As stated in Item 17, DHHS needs to improve in conducting team meetings. Additionally, DHHS needs to improve in extending invitations to family team meetings to parents, particularly non-custodial parents, and actively engaging youth and parents in the case planning process. The overall lack of involvement of non-custodial parents continues to surface as an issue when engaging youth and parents in the case planning process, as well as in when working towards

many of the other goals workers strive to achieve when working with youth (e.g., promoting visitation, preserving family connections, etc.) Workers first need to improve in identifying non-custodial parents. However, effective strategies to overcome non-custodial parents' reluctance towards being involved in their children's lives are also needed. While the fact that parents are not necessarily dissatisfied with how well workers involve them in their children's case plans is positive, we would like to improve in this measure so that parents are satisfied with workers' performance in this area and involved and supported in regards to the case plan.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

In round one of the CFSR, the state was rated as needing improvement in this area. DHHS appropriately involved parents or children in the case planning process in only 25% of cases reviewed. Stakeholders agreed that DHHS was not effective in involving parents in the case planning process.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

The philosophies of FCP (refer to Section I) have been consistently ingrained into the daily work practices since 2004. This focus has led to and continues to improve DHHS' involvement of children and families in developing case plans. However, additional work needs to be done in engaging families and allowing the families to 'own' their plan. While the ICCUs utilize the Wraparound Fidelity Index (refer to Systemic Factor C for more information on the WFI) to evaluate adherence to FCP, DHHS resource allocations have not allowed for full analyses of the findings. Workers need to understand that their role in case planning is that of facilitating change. Only the individuals involved in the case plan can institute change: the worker facilitates the events to allow for change, while simultaneously controlling for child safety.

The implementation of NSIS (refer to Section I) should begin to show benefits related to case planning and the involvement of the family as well. The PCA cannot be properly completed without parental involvement and a case plan cannot be written if family involvement does not occur. Additionally, NSIS training includes sections on the importance of self-determination in the development of case plans.

Although DHHS has and continues to make improvements in involving children and families in case planning, workers struggle with obtaining information and engaging the family in discussion and decision-making. Youth, biological parent, and foster parent focus group participants all reported that they were not always asked for their opinions or thoughts on the case plan. Foster parents said that they are rarely invited to be involved in the case planning process. Biological parents and foster parents agreed that it depends largely on the worker, but that sometimes they do not feel respected or valued by the worker, and that there have been instances in which they have felt threatened.

Stakeholders participating in the statewide assessment process and representing youth and family stakeholders reported that families do not always perceive workers as applying FCP to their work. Some families view workers as acting more punitive and blaming, particularly in the family team meeting environment. Stakeholders have heard instances of parents being scared or

intimidated by workers to speak up at family team meetings because parents believe that workers will document their comments and participation as 'non-compliance.' There is a generalized fear of sharing concerns with workers. Whether this information is factual or not, it is a perception by stakeholders. DHHS needs to evaluate ways in which to change these perceptions so that families do feel empowered to speak up and make change. Individual workers need to put effort towards making families more comfortable so family members can have a voice and feel empowered.

Another more concrete method to improve the engagement of families in family team meetings is to hold the meetings at a time convenient for the family rather than the workers or other professionals involved. This was mentioned by stakeholders in reference to other items. Also, as seen through the data mentioned above, DHHS needs to continue to improve on involving non-custodial parents and other informal supports as well.

Item 19: Caseworker visits with child. *How effective are agency workers in conducting face-to-face visits as often as needed with children in foster care and those who receive services in their own homes?*

a. What do policy and procedure require?

Policy requires workers to conduct monthly in-person visits with children. Initially, visits were to occur where the child resided at that time at least every other month. However, in February 2008, updated policy and procedure relating to worker visits with child were issued to comply with IV-B requirements. Monthly visits must now take place at the child's residence. A "child's residence" is defined as the home in which the child is residing, whether in or out of state, and can include a foster home, a child care institution, or the home from which the child was removed if the child is on a trial home visit. Additional visits can take place in an alternative setting such as court, school, a parent's home, etc., but such visits do not meet the monthly in-home visit requirement. Some portion of the visit must allow for the worker and child to meet and discuss issues privately. Visits must be documented in N-FOCUS and include in the narrative the following information: date and location of visit; who was present during the visit; worker observations; issues addressed or discussed during the visit; and any actions needed as follow-up to the visit.

b. What do the data show?

In SFY2007, workers made monthly face-to-face visits with children in 79.9% of cases. This indicates a consistent improvement in this measure (up from 69.8% in SFY2005), but it is 0.1% shy of our 80% compliance goal. Nonetheless, the following service areas met this compliance goal in SFY2007 and have done so for the past three years: Central (93.3%); Southeast (85.5%); and Western (85.6%). Performance in the Eastern Service Area has improved from 50.3% in SFY2005 to 73.0% in SFY2007, and performance in the Northern Service Area decreased from 74.0% to 72.6%.

In March 2006, the agency added questions to the customer satisfaction surveys conducted with caregivers on the frequency in which workers visit their children and family. Response choices include: never; less than once per month; about once per month; or more than once per month. The majority (41.1%) of parents said that their workers visited their children about once per

month; 16.9% responded less than once per month; 15.2% more than once per month; and 8.45% never, according to data collected over the last two quarters (October 2006 through March 2007). For the most part, parent focus group discussions support the range of frequency in which workers visit their children.

An ICCU case review conducted January through June 2007 (refer to Item 17) indicates that workers made 88% of required monthly face-to-face contact with youth served by ICCUs and whose permanency objectives were reunification or family preservation, and workers addressed the youth's needs and case plans in 84% of these contacts. ICCU workers are required to make two face-to-face contacts per month with youth whose permanency objectives were adoption, guardianship, or independent living. According to case review data, workers made 91% of the first face-to-face contact with youth and discussed the needs of the youth or their case plan in 85% of these contacts. However, workers made only 58% of the second face-to-face contact with youth, and the percent of these contacts in which workers and youth discussed the youths' needs or case plan remained consistent at 83%.

To capture DHHS compliance with the new federal requirement of visits needing to occur in the child's residence, a quality assurance review of a random sample of both traditional and ICCU cases was conducted. The review revealed that approximately 58% of the youth had monthly contact in the residence of the child. The review confirmed that approximately 70% of the youth are being seen monthly by their worker and that the quality of the visits that are occurring falls in the 80% range. We need to continue to emphasize that visits need to be private and in the child's residence. Worker and supervisor stakeholders report that private visits are taking place and that if the documentation were improved or interviews with the youth and/or their family would be conducted, that percentage would increase. The more challenging issue is monthly visits with youth in their residence. Particularly when school is in session, it can be difficult to find a time to visit the youth in their home. Workers are given the flexibility to adjust their schedules in order to work evenings and weekends to try to address this issue.

NE-CFSR data indicate that the state's performance in this item has remained consistent at 51% in 2005 and 2006. Stakeholders' concerns included the lack of consistent, timely, and private visits with children, and large caseloads. Stakeholders suggest that DHHS work towards improving the quality (versus quantity) of visits with children. It should be noted that recent comments from foster parent focus groups indicate that visits are still not of the best quality because workers are rushed.

The performance accountability data indicates that workers visit monthly with youth 80% of the time. DHHS performance accountability data is reported differently in that it is a point-in-time measure, it includes children placed with parents, and it does not include children placed out of state or on run.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

It was determined in round one of the CFSR that workers need to improve their performance in conducting visits with children. The frequency of worker visits with children was sufficient to ensure adequate monitoring of children's safety or to otherwise meet their needs in only 60% of cases reviewed. A key concern was that DHHS did not have written policy pertaining to either the frequency or quality of worker visits with children.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

DHHS now has a written policy on worker visits with children and monitors worker compliance with the policy. The state's goal of compliance is 80%. Monthly performance reports are generated from N-FOCUS and provided to all staff via an Intranet document repository. If the 80% compliance goal is not met, a corrective action plan is developed to ensure that DHHS is working towards meeting that goal. Corrective action plans can be completed at any administrative level within the agency.

It should be noted that even though all of the current foster care youth who completed the online survey reported that they visited with their worker once per month (the minimum requirement for worker visits with children). Youth who participated in the focus group expressed a desire for additional contact with their worker (beyond monthly visits). Focus group youth also stated that they wished workers would answer and return phone calls.

Item 20: Worker visits with parents. *How effective are agency workers in conducting face-to-face visits as often as needed with parents of children in foster care and parents of children receiving in-home services?*

a. What do policy and procedure require?

Policy requires workers to conduct monthly in-person visits with parents when the permanency objective for the child is reunification. When reunification is not the plan but parental rights remain intact, the need for monthly contact is determined on a case-by-case basis by the worker in consultation with a supervisor, and consideration for the court-approved case plan and any legal issues is made. When parental rights are not intact there is usually no ongoing contact with the parent. At least every other visit must be conducted in the parent's home.

Visits must be documented in N-FOCUS and include in the narrative the following information: date and location of visit; who was present during the visit; worker observations; issues addressed or discussed during the visit; and any actions needed as follow-up to the visit.

b. What do the data show?

Nebraska has set a 50% compliance goal for workers to conduct monthly face-to-face contact with parents. In SFY2007 the state met this goal at 61.0%, a consistent improvement from 54.8% in SFY2006 and 44.7% in SFY2005. In SFY2007, all service areas met this goal as well. Initially this goal was purposefully set at a lower expectation in order to focus on safety while continuing to ensure that workers were making contact with parents. In summer or early fall 2008, this expectation will be increased to 70%.

The customer satisfaction surveys from the last two quarters (October 2006 through March 2007) reveal more detailed information on visits. It should be noted though, that the customer satisfaction surveys ask about worker visits with the family rather than just the parent. The majority (37.3%) of parents said workers visited about once per month, but 28.5% of parents said

workers never visited them; 18.0% of parents reported that workers visited less than once per month, 12.5% more than once per month and 8.45% never. Again, parent focus group discussion supports these ranges in worker visits.

An ICCU case review reveals ICCU worker contact with parents separate from that of traditional cases. ICCU workers are required to make two face-to-face contacts with parents per month in cases with a goal of reunification or family preservation. Phone contact will suffice in cases involving parents who live in another state or are incarcerated. From January through June 2007, workers made 75% of first face-to-face contacts with parents and 18% of first phone calls to parents. The needs of the youth were addressed in 79% of these contacts. Workers made 41% of second face-to-face contacts with parents and 34% of second phone calls to parents when required over the same time period. The youth's needs were addressed in 73% of these contacts.

According to the NE-CFSRs, DHHS performance in this item has decreased from 44% in 2005 to 35% in 2006. Stakeholders reported that visits were inconsistent and did not allow for one-on-one time with parents. Stakeholders also reported a lack of clear and understandable documentation of the contacts.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

Round one of the CFSR determined this to be an area in which Nebraska needs to improve. Reviewers determined that visits with parents were sufficiently frequent or of adequate quality to promote the safety and well-being of the child and enhance attainment of case goals in 44% of the cases reviewed. High caseloads and the absence of policy pertaining to worker visitation with parents were identified as potential reasons for the lack of contact with parents in many cases.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

Since round one of the CFSR, the state has implemented FCP, which requires parents to be involved in the case planning process. Workers have been using eco-maps and genograms to identify family members to involve in the family centered case planning process. Additionally, requirements of the NSIS should lead to improved contact with all family and kin, including non-custodial parents. Workers are now required to make efforts to identify non-custodial parents at the point of intake. Another change we have made to ensure that parents are involved in the process was to require and monitor worker visits with parents via our Performance Accountability Plan. These three changes (i.e., FCP, NSIS, and the Performance Accountability Plan) are detailed in Section I of this report.

NE-CFSR reviewer comments and data show that monthly worker contact with parents is not always occurring though. Stakeholders participating in the current statewide assessment process reported that the time constraints of families and workers restrict the scheduling of visits. In cases involving two parents, scheduling can become problematic and one of the parents (often the non-custodial parent) is left behind in the process. DHHS needs to find ways to overcome this obstacle.

It should also be noted the focus group discussion among biological parents revealed that workers can be difficult to reach and do not always answer calls or return calls. Youth noted this barrier as well.

Well-Being Outcome 2: Children receive appropriate services to meet their educational needs.

1. Data Summary

Well-Being Outcome 2 is comprised of one item. Item 21 addresses the educational needs of children in state care. Data from the NE-CFSRs (refer to Section I) were used to inform this item and suggests that the state's performance in this area has decreased from round one of the CFSR.

2. Stakeholder Assessment

The majority (52.9%) of stakeholder survey respondents rated DHHS as being somewhat effective in ensuring the educational and developmental needs of children in care are met. Stakeholders identified both strengths and barriers to children receiving appropriate services to meet their educational needs. Stakeholders commended DHHS for including contract language promoting the educational needs of wards and the effort DHHS makes to work with schools and to keep children in their home districts. Stakeholders also view the accredited educational programs offered in the YRTCs as a strength in meeting children's educational needs. Other programs rated effective in meeting the educational needs of wards included the Former Ward Program, the ETV Program, and the PALS Program, each of which are detailed in Item 10.

The barriers identified by stakeholders included: a general confusion among schools around parents retaining legal rights over their child's education; a reluctance from schools to work with DHHS; tight school budgets, limiting the special educational services in which they provide; lack of understanding in schools about the role and purpose of educational advocates, and failure to appoint advocates; the reluctance of schools to verify or acknowledge issues such as behavioral disorders; and the differential treatment of children with behavioral disorders in schools. Stakeholders and internal DHHS staff were unsure of whether or not the Mc-Kinney-Vento Homeless Assistance Act which requires home school districts to pay to transportation to and from school for children in shelters is being applied. Stakeholders also commented that judges sometimes order specific school placements for wards, which can sometimes limit the options or educational services for wards in care.

Stakeholders were also concerned that Individualized Education Program (IEP) plans were not being monitored to ensure that the services outlined in the plan were actually being provided. There is confusion among who holds the responsibility of monitoring this plan (i.e., workers or school personnel). Stakeholders also suggested training for parents, workers, and school personnel on IEPs and other school related issues. Efforts to provide such information and support are addressed in this section below.

Last, stakeholders also said that additional educational services are needed for older transitioning youth. Despite recent efforts of clarification, there is still confusion among workers on what independent living services are available to youth and which youth are eligible. This confusion

was noted in stakeholder discussion and supported by youth and biological parent focus group participants. Youth reported that they did not know that many of the services for which they might be eligible were available, and parents reported that workers often fail to communicate with parents about the availability of these services. As a result, stakeholders report that not all eligible youth are being referred to receive services through these educational programs.

3. Item-by-Item Evaluation

Item 21: Educational needs of the child. *How effectives is the agency in addressing the educational needs of children in foster are and those receiving services in their own home?*

a. What do policy and procedure require?

Policy requires that DHHS notify the school districts in which children reside when they become state wards. Additionally, DHHS must notify districts if any changes in placement occur, if children enter a new school district and subsequently must change schools, if parental rights are terminated or relinquished, and when children are no longer under state care (i.e., court dismisses state custody, a child is adopted, a ward turns 19 years of age, etc.). Workers are also required to inform school districts if a child has a disability and there are no parents available to participate in planning that child's education. As part of the Individual with Disabilities Education Act, the school district will then determine if an independent party needs to be appointed to represent the child and their educational needs. The role of surrogate parents is to advocate for the educational rights and educational and emotional needs of the child in their care, and help school personnel understand those needs. In cases in which a child requires unique services, workers will inform school districts of those needs and obtain any existing special education/resource room records. Educational history is often obtained by workers during a comprehensive assessment, in which the strengths and needs of the family and youth, including educational needs, are assessed. Last, wards are generally provided public education, although placements in interim program schools in detention facilities and approved or accredited private or parochial schools are considered upon parental request and cost.

b. What do the data show?

NE-CFSR data indicates that our performance in providing appropriate services to meet children's educational needs has decreased from 77% in 2005 to 64% in 2006. Reviewers cited a lack of documentation in records and a lack of education on educational programs as barriers to this item.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

This area was determined to be an area needing improvement in round one of the CFSR. Reviewers determined that DHHS was found to have substantially achieved this outcome in 86% of cases, which was 4% less than the federal goal. Although this rate indicates that DHHS was effective in meeting the educational needs of the majority of the children in the cases reviewed, there were cases in which DHHS efforts to meeting the needs were deemed inconsistent.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

Since round one of the CFSR, DHHS has collaborated on a number of initiatives aimed at improving educational services to foster care youth. Information on the purposes of these initiatives is listed below, and more detailed information on these initiatives is provided under Systemic Factor F.

Committee on the Education of Children and Youth in Out-of-Home Placements: The mission of the Committee is to provide guidance and direction to policymakers and stakeholders in the development and implementation of educational opportunities for children in out-of-home placements, and to promote the successful transition of these youth from out-of-home placements into the public school system or other education programs.

Special Education Advisory Council: The Council's purpose is to provide advice and policy guidance with respect to special education and related services for children with disabilities in Nebraska.

Special Education Services Task Force: The Task Force was developed to review the manner in which special education services were provided and financed in Nebraska and to provide legislative and policy recommendations based on their review.

Stakeholders identified barriers to youth receiving quality special education services. It was noted that workers and parents need more knowledge on NDE's Rule 51, the primary state regulation governing special education services. Workers report that parents do not always understand their involvement in obtaining special educational services for their children. Parent and family organizations have been providing information and support on these issues to parents and staff. Some stakeholders reported that more parents are asking about special education services for their children, and foster parents are collaborating with workers in securing educational services for the children in their care.

A major issue noted by stakeholders was around IEPs. There seems to be confusion around who is responsible for advocating for children's educational needs and securing IEPs for children. In July 2005, DHHS distributed a memo to all staff clarifying that workers share the responsibility with parents and, in cases in which parents are unable or unwilling to advocate for their child's needs, the school must appoint a surrogate advocate with whom DHHS workers will then share the responsibility. The memo also clarified what actions such educational advocacy might entail, including the review of school reports to monitor children's progress and assuring that children are receiving the services they need.

Recent stakeholder comments suggest, however, that this is still a confusing area for workers, parents, and schools. Stakeholders specifically reported that most parents do not realize that family organizations can assist them with issues of IEPs and that workers are unable to advocate for an IEP without parent approval. It was also noted that there is a lack of follow through on an IEP once children leave a provider's facility. Stakeholders believe schools should also be asking about special education services at enrollment.

Stakeholders also said that additional educational services are needed for older transitioning youth. In recent years, DHHS has worked to develop new services to assist older transitioning youth in their educational attainment, improve already existing educational services for this population, and enhance the utilization of these services by all eligible youth (refer to Item 10). However, internal and external stakeholders reported that there is confusion among workers on what independent living services are available to youth and which youth are eligible. As a result, not all eligible youth are being referred to receive services through these educational programs.

Supervisors in particular noted that it was difficult to keep workers informed about these services due to high worker turnover. In an effort to inform workers of the educational services available to youth and to ensure that all eligible wards receive referrals to these programs, DHHS has provided information to workers on the basics of each program, the differences between programs, and workers' roles in the programs. This information was distributed via a program memo and included in the Independent Living Guidebook in July 2005 (as these programs are geared for youth with permanency goals of independent living). Workers reported that this information was helpful to them in their work, particularly the information on the PALS Program. External stakeholders suggested that DHHS provide this type of information to foster parents as well, so that they too can advocate for the educational needs of children under their care.

Well-Being Outcome 3: Children receive adequate services to meet their physical and mental health needs.

1. Data Summary

Well-Being Outcome 3 is comprised of two items. Item 22 addresses children's physical health needs and Item 23 addresses children's mental health needs. NE-CFSRs (refer to Section I) conducted in 2005 and 2006 are used to inform both items. The data indicates a slight improvement in addressing the physical health needs of children from 2005 to 2006, although this was rated a strength in less than two-thirds of cases reviewed. There was a more significant improvement in addressing children's mental health needs, with reviewers rating this item a strength in just under three fourths of reviewed cases in 2005 to over 90% of cases in 2006. Of particular issue in regard to physical health is a lack of dental resources and services and a lack of documentation. Concerns related to mental health include a lack of follow-up services or care, little ongoing assessment, lack of knowledge among workers about the services needed and provided, and occasionally the provision of inappropriate services.

2. Stakeholder Assessment

According to stakeholder survey responses, DHHS is effective in meeting the physical health needs of children but only somewhat effective in meeting their mental health needs. Youth survey responses support this. Stakeholders commended workers for making referrals for children to receive physical and mental health care, but suggested that workers improve in documenting physical and mental health care and maintaining thorough records that can follow a child throughout the life of a case. Stakeholders reported a good working relationship between DHHS and medical providers, but they also noted a lack of coordination in sharing medical information between the two. Providers are not receiving updated information on children to

provide the appropriate follow-up services and workers do not always receive medical information from providers.

There was a lot of discussion around insurance and Medicaid. Parents using private insurance experience difficulties in coverage which results in confusion, delays, and limits to services. Some stakeholders believe that there is a wide array of services offered through Medicaid while others reported that the Medicaid services are short-term and that they would like Magellan to become more active in creating more long-term, transitional, and aftercare services. On a positive note, stakeholders report that workers are more familiar with Magellan, the process, and their role. Additionally, parents are becoming more involved in Medicaid related decisions.

Stakeholders also reported a lack of services, lack of treatment placements, and a lack of providers who are trained to work with children (particularly child psychiatrists). Stakeholders were concerned because some children have to leave the state to receive needed services. There is also a lack of providers who offer culturally competent services or who are able to communicate with non-English speaking children. Other identified treatment barriers are related to rural issues such as long travel distances to receive services and a lack of services in rural areas.

3. Item-by-Item Evaluation

Item 22: Physical health of the child. *How does the state ensure that the physical and medical needs of children are identified in assessments and case planning activities and that those needs are addressed through services?*

a. What do policy and procedure require?

Medical services are available to all state wards and to those parents or families of wards who meet eligibility requirements for other state-sponsored programs. Nebraska policy authorizes DHHS to make all decisions around medical treatment for children in state care, although this authorization may be modified by a court order. Any medical services provided to children must be based on a comprehensive assessment of the child's needs. The worker is responsible for developing a plan that reflects the needs identified in the assessment and ensuring that all necessary services are implemented. Although policy authorizes workers to make all medical treatment decisions for children in care, regulations include instructions for involvement and consultation when specific issues arise and encourage workers to involve parents in the medical decision-making process whenever possible. Additionally, policy mandates worker consent to any necessary emergency medical treatment for a child, except as restricted by court. Ultimately, workers are responsible for providing or arranging medical services when needed, and parents are responsible to the extent possible for payment of the medical services provided.

For children who remain in their home, parents and workers work together to make ongoing medical care decisions regarding the child. An initial examination is not required, but workers can request a physical examination if health concerns exist. All children receive ongoing medical care as necessary throughout the time they are committed to DHHS, and parents are responsible for scheduling and maintaining all routine, recommended, or follow-up medical appointments for children who live in the home. It should be noted that in an effort to attain continuity in medical care, if a child has a primary physician when entering care, DHHS will

attempt to use this provider whenever possible. Stakeholders noted that this is not always successful.

For children in out-of-home care, an initial physical examination is required within 14 days of placement, and at least annually thereafter. Additionally, children receive ongoing medical care outside of annual examinations as necessary. Children in out-of-home placement are also provided with dental care with exams scheduled annually. In these out-of-home situations, it is the responsibility of the temporary caregivers to secure medical care and treatment for the child in their care. It is recommended that the parent from which the child was removed be present at all medical appointments, unless the parent's presence would not be in the best interest of the child.

It should be noted that the Comprehensive Child and Adolescent Assessment that is conducted with youth receiving services through OJS (refer to Item 23) can include both physical and mental health evaluations. However, if youth have received a physical evaluation in the last 12 months that continues to reflect their current physical health, a physical exam does not have to be conducted.

Youth who are placed in YRTCs also undergo an initial state-funded medical, dental, and eye exam within seven to fourteen days of admission. At YRTC-G, any additional medical care or exams beyond the initial exam are provided on grounds. At YRTC-K, wards are provided with additional medical care and are transported to the provider's office to receive the care.

b. What do the data show?

NE-CFSRs conducted in 2005 and 2006 revealed that the state was adequately addressing children's health needs in 64% and 68% of cases respectively. In both years, reviewers noted a lack of documentation, especially dental records. Stakeholders reported a lack of dental care resources, especially in dental care providers who accepted Medicaid.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

This item was identified as an area needing improvement in round one of the CFSR. DHHS adequately addressed children's health needs in 73% of cases but did not do so in 27% of cases. Children in the cases reviewed did not receive regular preventive physical health and/or dental services and stakeholders expressed the opinion that children's health screenings were not thorough or comprehensive in nature.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

In stakeholder discussions, workers reported that information on scheduled medical exams is not entered into N-FOCUS. Also, stakeholders noted a lack of coordination when sharing children's medical information among workers, parents, and providers, and medical records and assessments are not following children throughout the life of their case.

Efforts have been made to improve the maintenance of medical records. In March 2004, a Guide for Nebraska Foster Families was developed in collaboration with NFAPA. This guide provides expectations to foster families regarding the health care of foster children and what records must be obtained and given to the DHHS worker.

In February 2005, a Resource Guide to Record Keeping was developed and contains information regarding records for medical, dental, eye, and mental health. This booklet provides the forms needed for documentation of a child's examinations along with a medical history during placement form, medication log, and a form to maintain the foster child's appointments and activities.

Also in 2005, DHHS updated policy requiring workers to enter the dates of dental, vision, and psychological evaluation for children as they occur. As the supervisor reviews cases via the Performance Accountability Plan (refer to Section I) he or she must discuss with workers the importance of children receiving regular health, vision, and mental care, and the importance of documenting these examinations in N-FOCUS. Supervisors must also ensure that workers have a plan for obtaining any care that is overdue.

As a result of these efforts, stakeholders have noted increased collaborations between workers, foster parents, and other partners around documenting children's health care issues and report that foster parents are now using medical record books to document the health services received by children in their care. Stakeholders also indicate that more attention is focused on documenting and paying attention to which and how many medications children receive. However, stakeholders also report that adequate dental records are still not maintained.

Additional clarification on requirements included in the Child Abuse Prevention and Treatment Act (CAPTA) were shared with workers as well. CAPTA requires child welfare departments to refer children under the age of three who are involved in a substantiated case of child abuse or neglect to the Early Development Network (EDN) to receive early intervention services (e.g., services coordination, special instruction, speech or language therapy, etc.) under Part C of IDEA. The law also requires states to develop procedures for responding to reports of medical neglect, including instances of withholding of medically indicated treatment from disabled infants with life-threatening conditions. Memos providing steps to meeting these requirements were shared with staff.

In FFY2007, DHHS referred 720 children to EDN. This is a slight decrease from 746 children in FFY2006. According to N-FOCUS data, a total of 978 children should have been referred to EDN per CAPTA requirements. Thus, DHHS was at 73.6% compliance with CAPTA referral requirements in FFY2007.

Item 23: Mental/behavioral health of the child. *How does the state ensure that the mental/behavioral health needs of children are identified in assessments and case planning activities and that those needs are addressed through services?*

a. What do policy and procedure require?

Policy states that for the duration of the court-ordered custody of a child, DHHS is authorized to make all decisions about psychological treatment for that child. As is the case in general medical

treatment, this authorization maybe modified through court orders. Again, regulations include instructions for involvement and consultation when certain special issues arise and policy mandates worker consent to any necessary emergency psychological or psychiatric treatment for a child.

Needs assessments may include a diagnostic and evaluation service and a therapy service, when appropriate. Referral to therapy services will be made if a family assessment indicates undue stress and severe social, emotional, or behavioral problems that threaten or negatively affect the family's structure and stability, and if the family is not yet receiving therapy services.

The ultimate responsibility for providing or arranging psychological or psychiatric services when needed lies with the worker. In out-of-home settings it is also the responsibility of the temporary caregivers to secure psychological or psychiatric care for the children in their care.

b. What do the data show?

NE-CFSR data indicates that this area was a strength in 72% of cases in 2005 and 92% of cases in 2006. Reviewers noted that assessments were not always conducted, there was a lack of ongoing assessments in some areas, that services were not always appropriate or did not necessarily match those identified in the assessment, and instances of delayed service provision.

c. Where was the child welfare and juvenile services system in round one of the CFSR?

This area was rated as an area needing improvement in round one of the CFSR. Reviewers determined that DHHS adequately addressed children's mental health needs in 66% of cases but did not do so in 34% of cases, either because the needs were not assessed or services not provided.

d. What changes in performance and practice have been made since round one? What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated? What are the casework practices, resource issues, and barriers that affect this item?

The changes listed in Item 22 and referring to medical documentation affect mental health documentation as well. An additional change that has helped DHHS better meet the mental and behavioral health needs of wards receiving services through OJS was the development and implementation of a standardized pre-treatment assessment of children's mental health needs (the Comprehensive Child and Adolescent Assessment). This assessment helps workers identify the needs of children as well as the necessary treatment for those needs, such as substance abuse, eating disorders, etc. The assessment was developed in collaboration by representatives from the CWU, OJS, and staff from the DMLTC. A training curriculum was developed, training was delivered to supervisors (with the intent that supervisors would then train their staff), and the assessment was implemented in August 2004. Workers have reported that they no longer wait a lengthy amount of time to receive evaluation results and youth are now able to receive services sooner.

The DMLTC is also in the process of implementing a comprehensive family assessment to complete with families who are involved in the child welfare and juvenile services system due to

the occurrence of child abuse or neglect, and for whom it is suspected might have a need for mental health or substance abuse treatment.

In 2004, DHHS received a Substance Abuse Mental Health Services Administration's (SAMHSA) Systems Integration Grant (SIG) to develop a statewide mental health and substance abuse service delivery system for children and youth with co-occurring disorders and substance abuse issues, and youth who are transitioning out of the system. A statewide committee was developed to oversee the work of this grant, which would focus on best practices and outcomes, early intervention and prevention services, coordinated service plans, and more (refer to Systemic Factor F).

In January 2008, LB542 created a plan to address the behavioral health needs of children, adolescents, and their families. In this plan, stakeholders from different systems (e.g., behavioral health, substance abuse, child welfare, and juvenile services) will collaboratively develop a balanced array of accessible services, including specific facilities and services for some of the state's most challenging children and adolescents. Detail on this plan is included under Systemic Factor E. It is anticipated that this plan will address multiple mental health service barriers identified by stakeholders. It will increase collaborations between behavioral health, child welfare, and juvenile services (whereas stakeholders currently describe the system as being in "silos"); it will address substance abuse issues among children, adolescents, and adults (whereas stakeholders report that parents are not currently receiving adequate substance abuse treatment and there is a lack of inpatient services for youth who need substance abuse treatment); and it will provide additional services for youth who need more intensive (or what stakeholders refer to as "high end") services.

DHHS is in the beginning phases of changing our service delivery system. In early February 2008, DHHS released a RFP for an ASO to automate, manage, and coordinate mental health and substance abuse treatment, gambling addiction services, and services for children in the child welfare and juvenile services system. The new contract was awarded April 15, 2008 to Magellan Behavioral Health Services and will be effective July 1, 2008. Under this contract, Magellan will authorize mental health and substance abuse services, register child welfare and juvenile service providers, provide utilization management and quality assurance review of all services, and provide service systems support.

DHHS also released a RFB for safety and in-home services and, in the future, will be reforming out-of-home care services. DCFS is working with the DMLTC and DBH to coordinate a comprehensive service array and service delivery system. While this system is in the early stages of implementation, it is clear that it will create a seamless, more efficient, and more effective service delivery system for children and families involved in the child welfare and juvenile services system.

Magellan is currently in the process of expanding their network. The network has recently been expanded to include an intensive outpatient program (IOP) for adolescents in South Sioux City and is in the process of establishing a highly individualized IOP for adolescents with Beneficial Behavioral Health in Omaha. They have also expanded the network to include a treatment foster care program for sexual offenders at Lutheran Family Services in Omaha.

As mentioned earlier, stakeholders reported the services Magellan will or will not allow can be a barrier to children receiving the mental health services they need. Stakeholders reported that

providers often do not receive payment for treating children in situations unless the child receives a diagnosis. The concern among stakeholders is that this results in applying a medical model to what may be a non-medical issue. Stakeholders also believe that, in general, there is an overuse of medication for wards with behavioral needs rather than the treatment of those needs.

While stakeholders noted improved collaborations between health care providers and workers, workers report that communication with therapists continues to be limited. Therapists typically do not attend team meetings because they do not receive compensation or reimbursement to do so. In some cases, workers do not receive therapists' reports, or there are significant delays in receiving reports. Court focus group participants also acknowledged delays in providers submitting assessments to workers. Workers are hopeful that with the new triage centers in Omaha (and soon in Lincoln) conducting more evaluations, they will receive reports sooner. This will not alleviate the delays in receiving reports in rural service areas though, as they continue to struggle with a lack of providers in the areas.

Another issue for workers is that, when they do receive reports, they are not sure if the children actually received the services they needed. Either the reports are not clear or the worker does not have enough knowledge to interpret the report. In other cases, workers report that the services provided may appear to match the child's identified needs but the treatment methodology is questionable. Some workers believe therapists' methods (e.g., "talk therapy") do not promote permanency goals and may actually delay permanency. DHHS has recently moved to outcome-based contracting with private providers. The results of this effort remain to be seen as the contracts have not yet been carried out. However, it is expected that therapist will use treatment methods that have been empirically validated to meet the needs and support the permanency goals of children in their care.

Section IV – Systemic Factors

A. Statewide Information System

DHHS operates a Statewide Automated Child Welfare Information System (SACWIS) called the Nebraska Family Online Client User System (N-FOCUS). N-FOCUS is utilized by workers and supervisors to readily identify the status, demographic characteristics, location, and goals for the placement of every child who is (or within the immediately preceding 12 months, has been) in foster care (Item 24).

1. Stakeholder Assessment

N-FOCUS is designed for direct data entry by a caseworker or support staff. According to DHHS administrator comments, it must be assumed that if the data is not entered into N-FOCUS, the action did not occur. Workers, however, expressed difficulty in entering data within required timeframes due to time constraints. Some workers and supervisors described the system as cumbersome and stated that it limits the time in which they could be providing direct services to children and families. Yet others reported that they find the system useful in their casework.

2. Factor Evaluation

a. What do policy and procedure require?

The state has developed and implemented various policies and procedures to ensure that data is entered into N-FOCUS timely and accurately. N-FOCUS was built and enhanced to support the implementation of the state's policies and procedures.

b. Where was the child welfare and juvenile services system in Round One of the CFSR?

Nebraska was found to be in substantial conformity with this systemic factor during round one of the CFSR as N-FOCUS meets all federal requirements. Stakeholders reported that staff members use the system regularly and that the system can identify information such as the location, permanency objectives, legal status, and demographic characteristics of all children in foster care.

c. What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated in terms of its statewide information system?

The CWU and OJS is dedicated to making data-based decisions when managing cases and is working to enhance the understanding of data at all levels. N-FOCUS offers numerous data and reports for workers, supervisors, and administrators to use in their day-to-day work. Staff across the state has access to N-FOCUS and reports generated in N-FOCUS either at their desks or via a secure website.

Most N-FOCUS reports are published as pivot charts, which allow users to "drill down" to detailed information that meets their specific purposes. Some reports, such as those related to state and federal outcomes, display data trends. Many of these reports are saved on a web-based site called

Info-view, through which users are able to view the reports based on the security access for that user. Reports are also stored on a shared Lotus Notes database for easy access.

N-FOCUS underwent a federal SACWIS/Adoption and Foster Care Analysis Reporting System (AFCARS) review in 2000. It was determined that Nebraska either complied with all applicable requirements or had proposed action plans to complete those requirements. There were no AFCARS compliance issues noted in the review and an action plan to comply with the SACWIS requirements has since been submitted. The plan will remedy the issue of concern related to external entities purchasing services for children and families under case management contracts. Once this plan is implemented, Nebraska should be federally approved as fully SACWIS compliant by July 2008.

Currently, N-FOCUS provides an array of functions that meet and in some areas exceed federal SACWIS requirements. The core objectives met by N-FOCUS include:

- Supports a consistent intake and assessment of child abuse/neglect function;
- Provides online safety risk assessment;
- Provides a structured service planning and delivery process, incorporating case review and planning requirements;
- Assists workers in assessing children's needs or resource availability immediately, providing an improved case management function;
- Supports a case tracking and control process to help in meeting case review and time requirements consistent with federal and state regulations and best practice concepts;
- Encourages a structured case review process;
- Supports provider management to reduce manual efforts required in performing such functions;
- Provides workload management support;
- Provides financial management functionality;
- Improves management reporting;
- Supports the reuse of data and reduction of work redundancy;
- Supports DHHS policy and practice; and
- Encourages uniformity across the state and across programs.

DHHS upgrades N-FOCUS on a quarterly basis with interim updates in urgent situations, such as to support an immediate implementation of new legislation. Numerous changes were made to N-FOCUS as a result of new and revised policies emerging from the implementation of our PIP during round one of the CFSR. The following highlight some of the upgrades that have been incorporated into N-FOCUS since round one of the CFSR:

- All tools and documents related to the NSIS (most if not all information collected during the NSIS process is required to be entered in N-FOCUS; refer to Section I);
- Reviews of cases included under the Governor's initiatives (wards residing with parents for six or more months and wards ages zero through ten years of age who have spent 15 of the last 22 months in out-of-home care; refer to Item 8); and
- Documentation of worker contacts with children, specifically where these contacts occur.

Additionally, data from the Foster Care Review Board (FCRB) was incorporated into N-FOCUS in March 2006 and FCRB is now using the system to document data. The FCRB is a state agency with statutory oversight related to children in out-of-home care. The mission of the FCRB 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 (refer to Systemic Factor B).

Nebraska introduced Children's Outcomes Measured in Protection and Safety Statistics (COMPASS) in July 2007 (refer to Section I). This is the first time Nebraska has been able to offer such accessibility to its performance in all of federal and state measures and outcomes.

DHHS continues to be involved in collaboration with the several organizations that have a part in shaping the Nebraska Criminal Justice Information System (NCJIS). NCJIS is a data portal maintained and supported by the Nebraska Crime Commission. It allows member agencies to display data other agencies require to complete their work effectively, efficiently, and safely. Each agency maintains ownership of their respective data and determines which of their data items, if any, other organizations or individuals within organizations can access. This year DHHS intends to share data regarding the YLS/CMI (refer to Section I) and safety plans on the NCJIS portal.

DHHS collaborated with the Fostering Court Improvement (FCI) project to include NCANDS and AFCARS data on the FCI website as well (http://fosteringcourtimprovement.org/state_websites.php). Nebraska is one of three states that have allowed their data to be accessed by the public and is one of eight states to provide data to this valuable resource for the courts.

d. What are the casework practices, resource issues, and barriers that affect the child welfare and juvenile services system's overall performance in terms of the statewide information system?

Some workers and supervisors report that the time needed to enter data on N-FOCUS is a barrier, that quarterly enhancements or fixes to the system are not timely, and that there are not enough staff resources to enhance and fix all identified issues in the system. The CWU and OJS have three full-time business analysts dedicated to working on N-FOCUS, but have to share technical resources with the 33 other programs supported by the system.

Tribal focus group participants reported that they do not receive reports generated from N-FOCUS, but that these reports would be helpful to their work. Tribes are interested in receiving reports on the number of tribal members who are participating in various DHHS programs, the number of intakes for Tribal children and families, etc.

B. Case Review System

DHHS provides a process that: ensures that each child has a written case plan to be developed jointly with the child's parent(s) that includes the required provisions (Item 25); allows for the periodic review of the status of each child, no less frequently than once every 6 months, either by a court or administrative review (Item 26); ensures that each child in foster care under the supervision of the state has a permanency hearing in a qualified court or administrative body no later than 12 months from the date the child entered foster care and no less frequently than every 12 months, thereafter (Item 27); allows for TPR proceedings in accordance with the provisions of the AFSA (Item 28); and ensures that foster parents, pre-adoptive parents, and relative caregivers of children in foster care to be notified of, and have an opportunity to be heard in any review or hearing held with respect to the child (Item 29).

1. Stakeholder Assessment

Stakeholders identified FCP (refer to Section I) as positively impacting the case planning process as more families and children become involved in their plan. Some stakeholders stated that the number of case plans may actually be higher than what was presented in the data (refer to Item 17) since the data does not account for draft plans or safety plans. Additionally, staff turnover and training could be limiting the number of case plans completed with the 60 days allotted.

Courts and the FCRB require six month case reviews that are tracked in N-FOCUS. Also, several external teams such as the 1184 teams and CACs conduct reviews. Stakeholders commented that it is great that these reviews are conducted, but it is difficult to determine the substance of the reviews. They suggest cross-training on reviews throughout the state. Tribal focus group participants pointed out the FCRB does not include Native stakeholders and that, as a result, recommendations that emerge from this group are not always culturally appropriate.

Stakeholders identified the strengths pertaining to permanency hearings are that all issues are addressed at the hearing and children placed out of state are able to participate in the hearings via phone. Others noted that hearings are not very in-depth and do not always address the permanency direction. Another identified barrier is that the documentation workers submit to the courts is not consistent, but stakeholders believe this issue could be addressed through worker training.

Stakeholders commented that one of our strengths related to TPRs included contracts with private attorneys to file TPRs. Another positive is that we do not require separate home studies to be completed for foster and adoptive placements. However, while Nebraska has a defined TPR process, stakeholders do not always believe it to be effective. Stakeholders said that TPRs can "drag out" due to a lack of up-front knowledge and planning in the case and because paternity is not established.

In 2007, Nebraska passed a state law requiring notice of hearing and reviews to be given to foster parents, pre-adoptive parents, and relative caregivers. The law also gives these caregivers the right to be heard in court. Passage of this law and the development of a reporting form for the caregiver to complete are viewed as strengths by stakeholders. Stakeholders commented that there appears to be variations in the way caregivers are notified. The law requires the court to make notification; however, sometimes the courts do not have current addresses for caregivers, they forward the notice to DHHS to send, or they require the local DHHS office to furnish the notification due to a lack of court resources. Both foster and biological parent focus group participants reported that they are notified of court hearings and reviews, but that notifications can sometimes be last minute. Another common statement made by both foster and biological parents is that workers did not encourage them to attend hearings. Court focus group participants reported that they encourage parents to attend and participate in hearings, and that many parents do. The majority of parents stated that they do attend the hearings, but that they do not always feel heard or that their input is valued.

Tribal focus group participants reported that they are not receiving non-Tribal court orders. In comparison, non-Tribal courts reported strong collaborations and working relationships with Tribal courts in areas with an increased population of Native children.

2. Factor Evaluation

a. What do policy and procedure require?

Case plans are considered written, working agreements developed between the family, worker, and other team members as appropriate. Case planning must be a collaborative, ongoing process that continues throughout the time DHHS is involved with the family and/or youth. The case plan is to be developed and documented in N-FOCUS within 60 calendar days of the initial custody date or 60 days from the begin date of the initial safety assessment, whichever is sooner. When there is insufficient time to develop a case plan within 60 days from the date the intake is accepted, the safety plan will serve as the case plan.

Nebraska Revised Statute (NRS) 43-1313 mandates that when a child is in foster care, the court having jurisdiction over the child for the purposes of foster care placement shall review the dispositional order for the child at least once every six months. The FCRB also conducts case reviews of children placed in the custody of DHHS and in out-of-home care at least once every six months by state statute. The FCRB provides the courts with written reports on the case reviews they conduct to inform decision-making in the court review process. DHHS workers also prepare and submit a written case plan and court report to the court and other team members at least every six months after the first dispositional hearing.

Policy requires a full permanency review hearing (versus a paper review): within 12 months of removal from the home and every 12 months thereafter, as long as the child remains in DHHS custody; within 30 days of a court TPR; within 30 days of a court determination that reasonable efforts to reunify the child and parent are not required; and when a child has been in out-of-home care for the most recent 15 of the past 22 months in care.

NRS43-292 establishes grounds for TPR. NRS42-292.02 and NRS43-292.03 establishes ASFA requirements when filing for TPR. NRS43-1314 and policy provide that foster parents, including pre-adoptive parents and relatives providing care for a child, are entitled to have notice of court reviews for the children in their care and to participate in those hearings.

b. Where was the child welfare and juvenile services system in Round One of the CFSR?

Nebraska was not in substantial conformity with this systemic factor in round one of the CFSR. Although Nebraska had a process to ensure that each child had a written case plan, case plans were not present for all children. In addition parents and children were not active participants in the case planning process.

Nebraska provided a process for TPR, yet DHHS practice did not always follow this process. Stakeholders commenting on this issue expressed the opinion that there is process in place for TPR, but petitions were not being filed according to ASFA guidelines. Also, exceptions and compelling reasons for not filing were not being consistently documented. Last, foster parents were not always receiving notification of court hearings regarding the child in their care.

c. What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated in terms of its Case Review System?

The Performance Accountability Plan (refer to Section I) includes measures for completion of case plans within 60 days of a child coming into DHHS' care and updating those plans every six months. The data presented in Item 17 indicates that the state has improved in completing and updating case plans within the time allotted from SFY2005 to SFY2007, but we are still not meeting the state-established goal of doing so in 90% of cases. Workers are also expected to achieve reunification within 12 months of custody for those cases in which reunification is the goal, and for achieving adoption within 12 months of the permanency objective being set to adoption. However, the ACF data addressed in Items 8 and 9 indicate that the state continues to struggle with timeliness in these areas.

As mentioned earlier in this section, legislation was passed that gives foster parents, including pre-adoptive parents and relatives providing care for a child, notice of court reviews for the children in their care and to participate in those hearings. However, according to stakeholder feedback, this has not remedied the issue of parents not receiving notification of court hearings as identified in round one of the CFSR. NRS43-1314 states that the court having jurisdiction over the child in foster care provide foster parents with this notice.

In June of 2006, Governor Heineman established initiatives to ensure continued improvements in case management and services for children and families involved with DHHS (refer to Item 8). As noted in that section, 1,485 (63.2%) of the 2,349 who fit the categories included in the Governor's initiatives have been safely discharged from state care by the end of CY2007.

d. What are the casework practices, resource issues, and barriers that affect the child welfare and juvenile services system's overall performance in terms of the Case Review System?

The stakeholder and focus group comments mentioned above identify some current practices and barriers, particularly in regard to ICWA case notification, notice of court hearings to parents and Tribes, and court review content and documentation. The lack of case plan documentation and documentation on whether or not permanency hearings are being scheduled and/or occurring are other barriers pertaining to this systemic factor (refer to Item 7). As stated above, we are not currently meeting the state-established goal of documenting and updating case plans in 90% of cases. As of September 30, 2007, 30.1% of children in out-of-home care for 15 of the last 22 months had a permanency hearing within the last twelve months at the close of FFY2007.

Caseloads were identified by stakeholders as a barrier to documenting case plans into N-FOCUS in some areas, although the data does not always support this hypothesis (refer to Section I). Last, although a process exists to notify foster and adoptive parents of case reviews and afford caregivers a right to be heard, stakeholders maintain that notification does not always occur.

C. Quality Assurance System

The state has developed and implemented standards to ensure quality services to children in foster care (Item 30). The state has implemented and is operating an identifiable quality assurance system to evaluate the quality of these services, identify the strengths and needs of the

service delivery system, provide relevant reports, and evaluate program improvement measures (Item 31).

1. Stakeholder Assessment

Stakeholders view DHHS' quality assurance system as a strength, particularly in regards to measuring outcomes related to child and family well-being. However, there is still a collective desire among internal and external stakeholders to obtain better measures of *quality* (rather than *quantity*), especially in the well-being outcomes (e.g., child and family visits and involvement in case plans). Stakeholders do report that the state is doing much better at obtaining quality measures. The quality assurance system was seen as one avenue in which to obtain this information.

Both internal and external stakeholders (including private providers) favored performance- or incentive-based contracts between DHHS and external service providers in an effort to provide quality services to children and families involved in the child welfare and juvenile services system. DHHS is currently moving towards such a system in our quality assurance efforts.

Stakeholders would also like to see more sharing of information pertaining to common goals and initiatives among workers and providers, and then monitoring performance in these outcomes as a collective group. Currently, such an exchange of information between DHHS and external providers is lacking according to both internal and external stakeholders.

Quality assurance activities involving statewide initiatives provide consistent data and feedback related to those activities. Internal stakeholders did note that quality assurance as it is being carried out on a local level by individual service areas is not always consistent. Some areas are monitoring the quality of services provided to children and family involved in the system, whereas other areas are not.

2. Factor Evaluation

a. What do policy and procedure require?

DHHS has developed and implemented various policies and procedure to ensure quality services to children in foster care (e.g., workers' monthly contact with children and parents, involvement of children and parents in case planning activities, etc.). Many of these policies are monitored via the quality assurance system.

State law provides standards and expectations that apply to most aspects of the system of care for child welfare and juvenile services. These range from narrowly focused and highly prescriptive to broad requirements. Certain standards, while nominally relating to other state agencies, are highly related to the quality of child welfare and juvenile services and thus require a collaborative approach to meeting requirements.

Specific requirements are provided in statute for the most programmatic components of the DHHS' child welfare and juvenile services system of care, including:

- licensing of foster homes, child care institutions, and child placing agencies;
- child protective investigations;
- adoption and subsidized adoption;

- guardianship and subsidized guardianship;
- former ward;
- Interstate Compact on the Placement of Children (ICPC);
- Interstate Compact on Juveniles (ICJ);
- case planning; and
- judicial reviews.

Service standards may also be set in various program guidance documents issued from the DCFS Policy Section. This guidance is often issued in formal memos to the field, and provided via an Intranet document repository. Once a formal memo is issued, it is the responsibility of supervisors to ensure that staff complies with the policy and procedure outlined in each memo via the Performance Accountability Plan (refer to Section I). In some instances, central office staff may monitor compliance of these policies across the state using N-FOCUS data. In fact, an analysis of N-FOCUS data is conducted to inform the administration of not only whether or not workers are complying with the standards outlined in the memo, but also as to whether or not new policy or an administrative memo is even necessary to begin with. An example of this can be seen in regard to the various memos that were issued on extended emergency shelter placements (refer to Item 6). It should also be noted that the DHHS Intranet includes other documents intended to support the provision of quality services, including program guidance documents, policy and procedure manuals, service guidebooks, and similar materials.

b. Where was the child welfare and juvenile services system in round one of the CFSR?

Nebraska was not in substantial conformity with this system factor in round one of the CFSR. It was determined that the state needed to improve in regards to implementing and operating a quality assurance system. Although the state had some components of a quality assurance system in place at the time, there was not a comprehensive, statewide approach to quality assurance.

Reviewers also determined that the state needed to improve in developing and implementing standards to ensure quality services to children in foster care. Although such standards had been developed, there was no policy at the time that required supervisory visits of children in foster homes. At the time, DHHS maintained that workers were not visiting children in out-of-home placements with sufficient frequency and this was confirmed in 31% of the case reviews.

c. What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated in terms of its quality assurance system?

It was recognized early in round one of the CFSR process that Nebraska needed to improve its quality assurance system. For that reason, a quality assurance implementation team was assembled prior to the completion of the CFSR to immediately begin developing a PIP. The team worked in collaboration with the National Resource Center for Organizational Improvement (NRCOI) and, using the NRCOI's framework for quality assurance, the team identified priorities towards which the state needed to direct its efforts. Existing federal, state, and department requirements drove many of the priorities and shaped the outcomes and measurements developed to monitor the state's performance.

The identified quality assurance system priorities include:

- Mandate quality assurance-related evaluation activities;
- Develop a statewide case review system similar to that of the federal CFSR (the NE-CFSR detailed in Section I);
- Identify more efficient and effective service management throughout the state;
- Move towards a performance-based contracting with service providers;
- Coordinate and analyze existing methods of review;
- Create consistent performance outcomes for ICCUs;
- Conduct surveys with youth and parents receiving services;
- Establish practice standards; and
- Develop outcomes and measurements to monitor the performance of Protection and Safety and Resource Development Administrators.

As a result of the team's work, the state developed a more comprehensive quality assurance system that is now carried out on a statewide level. There is currently seven quality assurance staff across the state, housed in CQI/Operations, and supervised by the central office. The staff is responsible for conducting quality assurance activities, audits, case reviews and consultations; monitoring contracts, utilization management, and compliance with federal and state standards; and analyzing data and writing reports. We now conduct a variety of quality assurance activities, the findings of which are shared with all staff. The following provide an overview of recent activity:

- DHHS implemented the Performance Accountability Plan in 2004 (refer to Section I).
- DHHS conducted two rounds of the NE-CFSR in 2005 and 2006 (refer to Section I).
- DHHS implemented intake and initial assessment reads, home study reviews, background checks, and ongoing case file reviews, including monthly reviews of cases in ICCU.
- DHHS hired an ICWA specialist to review cases involving Native American or Alaska Native children to ensure ICWA compliance and to work with Tribes to develop their own quality assurance process.
- DHHS conducts quarterly consumer satisfaction surveys with caregivers and foster parents, and surveys with youth released from the YRTCs.
- Local DHHS offices have conducted "mini" CFSRs, reviews of out-of-home care assessments, and visitation service contract monitoring.
- All areas of the state have active child abuse and neglect investigative and treatment teams to review investigative and treatment issues (refer to Item 3).
- Quality assurance staff members are applying a tiered review of cases processed using the NSIS (refer to Section I) to monitor adherence to the model: an initial review of 15 safety assessments from each supervisor; a second review of five assessments from each supervisor; and ongoing case reviews thereafter.

DHHS collaborated with its partners to expand quality assurance of system efforts outside of the agency itself. For example, we have worked with 24 judges throughout the state to review court orders and compliance with Title IV-E of SSA. An in-person or phone conference meeting was held with these judges to discuss what was being done well and where there were shortfalls in this area. Protection and Safety staff and/or income maintenance staff (IV-E eligibility workers) participated in all meetings, and other court staff persons and county attorneys participated in some of them. In December 2007, DHHS initiated a process in which local staff members send a sampling of court orders that they find questionable to central office. Central office staff members review the court orders and then provide feedback to the judges. The goals of these

efforts are to enable courts to conduct hearings, make findings, and issue orders that meet IV-E requirements.

DHHS has also partnered with the Nebraska Association of Homes and Services for Children to look at ways to move towards performance-based contracting. The plan is to start with a small group (i.e., contracted group home providers) and gradually expand our efforts to include all service providers. Our work with the contracted group home providers led to the revision of the performance measures that we initially required from the providers to data more specific to group home performance. Data collection began in July 2007 and meetings are held regularly to review the process and any barriers to the collection of this information. The goal is to use the data collected to establish a baseline for expectations to incorporate into the performance-based contracts.

Some of the agencies DHHS contracts with are already monitoring their performance, and have been doing so for some time. Family organizations from each of the Behavioral Health Regions collect and report data on the outcomes of wards served in the ICCUs using the WFI. The WFI is a set of brief, confidential phone or face-to-face interviews conducted with caregivers, youth (eleven years of age or older), wraparound care coordinators, and team members. The WFI interviews are intended to assess adherence to the principles of wraparound in service delivery as well as assess conformance to the FCP model (refer to Section I). Gaining the unique perspectives of all of these informants allows us to understand how fully FCP is being implemented and to improve adherence to the model within ICCUs based on the information obtained.

Last, NFAPA periodically includes a questionnaire in the NFAPA newsletter, asking foster parents to respond to questions dealing with frequency and timeliness of contact with workers, the information they receive from workers, and the quality of support provided by workers. NFAPA staff members have obtained a wealth of information on how effective foster parents perceive our services to be through the information gleaned from these surveys and through their other interactions with parents. Representatives from NFAPA were included on our stakeholder assessment team to ensure that this information was incorporated into our review.

d. What are the casework practices, resource issues, and barriers that affect the child welfare and juvenile services system's overall performance in terms of the quality review system?

The most difficult part of the quality assurance system is the development of the feedback loop and implementation. There has been a lot of quality assurance data gathered, but there is no formalized process of sharing the information, developing a plan of improvement, and re-assessing performance. This may explain the inconsistencies between stakeholder feedback and some of the quality assurance data included in this report. Currently, the Quality Assurance Administrator provides PSAs with quality assurance data from their particular area and asks the PSAs to develop improvement plans based on the data. The data review and improvement planning processes are completed by internal staff and at the local level only.

The new organizational structure put in place in July 2007 included the development of state level quality improvement system, housed in the CQI/Operations of DCFS. CQI/Operations was fully implemented in April 2008. DHHS believes that the development of this area will allow for or a more formal feedback loop throughout the state. This will allow for a fuller analysis of

the inconsistencies that exist between stakeholder feedback included in this report and what the quality assurance data currently indicate, and whether these inconsistencies are due to communication, philosophical, practice, or other issues.

There are some initiatives that have taken longer to fully implement than expected, such as performance-based contracting and a comprehensive review of FCP (refer to Section I). Some stakeholders have also expressed disappointment in that we do not conduct satisfaction surveys with core DHHS service providers.

While the state has made much progress in developing a more comprehensive quality assurance system, we heard from stakeholders that quality assurance efforts are not being carried out consistently throughout the state. This is because staff assignments are made based on local needs. The quality assurance staff works closely with PSAs to examine specific issues or areas of concern on both a statewide level and at the individual service area level.

D. Staff and Provider Training

DHHS operates a staff development and training program that supports the goals and objectives in the Child and Family Services Plan (CFSP), addresses services provided under IV-B and IV-E, and provides initial training for all staff who deliver these services (Item 32); provides for ongoing training for staff that addresses the skills and knowledge base needed to carry out their duties with regard to the services included in the CFSP (Item 33); and provides training for current or prospective foster parents, adoptive parents, and facility staff that care for children receiving foster care or adoption assistance under IV-E that addresses the skills and knowledge base needed to carry out their duties with regard to foster and adopted children (Item 34).

1. Stakeholder Assessment

Stakeholder surveys reveal that the majority of respondents rated DHHS' effectiveness in providing knowledgeable and well-trained staff as somewhat effective. Stakeholders identified strengths and barriers to staff and provider training. Just over half of respondents felt workers had the skills needed to help children and families.

Stakeholders identified a few specific areas in which worker training is needed. While some stakeholders say that there has been an increase in the knowledge around independent living services, others (both internal and external stakeholders) report that confusion on these services still exists. Workers in particular need training on the independent services available to youth and which youth are eligible to receive these services. Both biological parent and youth focus group participants reported that they did not receive information about services (independent living or otherwise) for which children might be eligible, and it has been concluded from stakeholder comments that workers may not have this information themselves.

Tribal focus group participants reported that workers need training on Tribal cultures to recognize that every Tribe has its own culture and language. Tribal stakeholders suggested using Tribal representatives as trainers to present this information to workers, as was done at the annual supervisors' conference in 2006.

Workers reported that they would like a better understanding of how current policy and procedure requirements enhance a child's well-being, and more skill-based training on ensuring well-being. It was also reported by workers and supervisors that workers need additional training on data entry and documentation.

A particular area in which more training is needed for workers, providers, and other stakeholders is on IEPs and other school related issues. There also seems to be confusion among stakeholders among whose role (e.g., workers, foster parents, or school personnel) it is to advocate for children in schools.

Another recurring theme among stakeholder comments made throughout the statewide assessment process is that more cross-training is needed among DHHS and external partners, particularly in regards to services array and meeting the needs of high-risk youth and families.

Stakeholders representing foster parents reported that the PRIDE training was beneficial to foster parents. However, there are long waiting lists to receive this training due to the contract between DHHS and the agencies that provide the training limiting the number of families that can receive training to no more than six families at one time. This particular group of stakeholders also noted that while the training waiver for relative placements may have streamlined the relative placement process, relatives still need training to deal with the unique issues involved when providing placement to a relative child. Last, these stakeholders believed that DHHS should encourage relative foster care parents to attend PRIDE training as well. Other stakeholders, however, believe that this is already occurring.

2. Factor Evaluation

a. What do policy and procedure require?

Staff Training: Training is provided to DHHS staff primarily through a contract with the Center on Children, Families, and the Law at the University of Nebraska-Lincoln (CCFL). CCFL staff and Field Training Specialists (FTSs), along with internal Protection and Safety staff, DHHS HRD staff, and external presenters, collaborate to provide continuous training throughout the state. Training is designed to support the cross-system coordination and consultation needed to effectively meet CFSR outcomes. Since courses are based on policy and programs, development and redevelopment of training content is an ongoing process.

All PSTs and ICCU staff who are new to the work are required to complete the Protection and Safety New Worker Employment Practicum Curriculum over a six month period. Upon completion of the curriculum and by demonstrating satisfactory performance, PSTs are promoted to PSWs. PSWs continue employment in probationary status for an additional six months, during which they will continue skills building and training under the direction and guidance of PSSs. Probationary workers must demonstrate minimum competency levels on all identified performance dimensions to be promoted to permanent status. It should be noted that while PSSs who are new to the work are not automatically required to complete the Protection and Safety New Worker Employment Practicum Curriculum, most are recommended to do so based on their prior professional experience.

All CWU and OJS staff must have a minimum of 24 hours of ongoing, supervisor-approved training annually (i.e., in-service training). The number of training hours and the training content

provided fluctuates annually based on job performance needs identified by administrators, supervisors, and staff.

Foster and Adoptive Parent Training: Foster and pre-Adoptive families are required to participate in 21 hours of DHHS-approved pre-service PRIDE training prior to being licensed as a foster or adoptive home. Licensed parents are also required to obtain 12 hours of in-service training annually, within the effective dates of the license.

Training is available through various forums and may include DHHS-sponsored training and workshops, training sponsored by professional organizations or educational institutions, DHHS-approved self-study and/or videotape materials, and college courses. DHHS also cosponsors an annual Foster and Adoptive Parent Summer Conference with NFAPA, which provides caregivers with 12 hours of in-service training.

Provider Training: Licensing approval of out-of-home care providers requires that each staff member, including direct care volunteers, obtain between 21 to 24 hours of DHHS-approved pre-service training prior to assuming his/her duties. In addition, providers must complete at least 12 to 15 hours of approved in-service training annually within the effective dates of the provider's license. Personnel in group home settings must achieve the lesser number of training hours (21 and 12 respectively), while personnel in child caring and child placing agencies must obtain the greater number (24 and 15 respectively).

b. Where was the child welfare and juvenile services system in Round One of the CFSR?

Nebraska was found to be in substantial conformity during round one. New workers, foster parents, and facility staff were required to receive a minimum number of training hours and in-service training hours annually. Reviewers identified as areas of concern the fact that the provisions for ongoing training did not address professional growth and skills development, and did not provide opportunities to learn new skills.

c. What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated in terms of its staff development and training system?

New Worker Employment Practicum: In September 2004, DHHS implemented a six month model of new worker training. In CY2007, 161 individuals were enrolled in new worker training. It should be noted that only 40.5 of these trainees were hired as PSTs in CY2007. Staff participating in training can cross over calendar years, so some PSTs hired in CY2006 continued training in CY2007 and some PSTs hired in CY2007 will continue training in CY2008. Additionally, not all trainees are DHHS employees (as mentioned above). Of the 161 individuals who participated in new worker training in CY2007, 112 were DHHS PSTs, 46 were ICCU staff, and three were employees from other DHHS programs. Occasionally, staff members who are not new to the work may attend a new worker training session as well. In CY2007, an additional 66 staff attended at least one new worker training session: 42 PSWs; 21 ICCU staff members; and three Tribal child welfare workers. In whole, a total of 7,786.50 new worker training hours were provided to new and existing staff in CY2007.

The goal of the new worker training model is: to increase workers' competency levels at the end of the training period; to better serve the children and families with which we work and to achieve more positive outcomes with them; to increase satisfaction among community partners,

to increase the stability of our workforce; to improve morale and reduce turnover through encouraging staff members' confidence and pride in their work; and to increase federal support to allow us to continue and improve our training efforts.

The new worker training model includes three components: classroom lecture and discussion; lab training and experiences facilitated by a FTS; and on-the-job field learning experiences in which trainees apply the knowledge gained in the classroom and lab settings. Upon completion of the first phase of training, trainees are assigned limited case management functions and responsibilities as a part of a formal structured learning experience. During this second phase, trainees are assigned up to four cases to process under the oversight and direction of a PSS. The trainee does not make any independent case decisions during this time.

Nebraska continues to utilize the Competency Development Tool (CDT) to assess trainee's knowledge, skills, and abilities during the training period, to provide feedback to the employee on their performance, and to determine whether the employee is to be promoted from trainee to a worker under probationary status, and then later from probationary to permanent status. If employees do not meet minimum competency in each required performance dimension, they may be directed to attend additional training and development, or their employment may be terminated.

In September 2007, CCFL provided a comparison of the current new working training model compared to the model used prior to 2004 based on CDT results. Initial findings indicate that the model used prior to 2004 may have prepared workers better than the model used today.

For additional analysis on the effectiveness of new worker training, CCFL is conducting a post-training survey to gather training perceptions from recent trainee and their supervisors. The survey was designed to supplement individual unit evaluations by assessing broader perceptions of training both at the end of training and six months after training. The survey tool includes questions related to a number of items, including training content, delivery methods, the overall training quality, and the extent to which trainees are prepared for the job upon completion of the training. Surveys were sent to staff in September 2007. As of April 1, 2008, a total of 135 surveys have been completed: 51 post-training surveys from trainees; 35 post-training surveys from supervisors; and 50 six month surveys from workers. Data is limited at this time with an initial analysis in progress**.**

In December 2007, DHHS implemented a pilot for a revised new worker training in the Eastern and Southeast service areas of the state. This pilot consists of a pre-service training period ranging from 23.5 to 54 days of classroom training, followed by an additional 10.5 days of classroom training completed as an in-service component. The pre-service phase includes core and specialized training based on new workers' casework assignments (e.g. intake, initial assessment, ongoing case management, adoption specialists, or juvenile service officers). Trainees complete the core training and are then promoted to probationary status and carry a limited caseload. Probationary workers complete the new worker training curriculum via in-service trainings occurring over the course of their first year of employment. During this time, probationary workers are closely monitored by a FTS and a PSS.

In-service Training and Professional Development:

In CY2007, 450 PSWs, PSSs, and PSAs attended in-service training. A majority of the in-service training focused on the new Nebraska Safety Intervention System (refer to Section I). Additionally, new and existing staff have received extensive training on FCP (refer to Section I) since its implementation in 2004. DHHS has built internal capacity to train on the FCP philosophy and now has over 38 trainers presenting this material in their local area.

DHHS has also held an annual supervisor's conference for administrators, supervisors, and central office staff since 2000. These conferences are designed to increase the knowledge and skill of administrators and supervisors, provide forums to discuss and improve practice, inspire and stimulate creativity, and build morale. The most recent conference held in 2007 focused on the new policies and procedures outline in the NSIS (refer to Section I).

FCP manuals, family team meeting tools, and a variety of other tools to assist workers in their work with families have been posted on DHHS' Intranet as well. The DHHS Intranet is an internal document repository containing arious program guidance documents, policy and procedure manuals, service guidebooks, administrative memos, and similar materials. All staff have access to this repository. New workers receive a brief introduction on how to use the repository and the resources it provides during new worker training. It is the responsibility of supervisors to ensure existing staff use and understand the materials posted on the DHHS Intranet thereafter.

Last, financial support for DHHS staff to attain a Bachelor of Science in Social Work degree or Master in Social Work degree is also available through DHHS' tuition assistance program. DHHS offices in individual service areas also collaborate with local colleges and universities to provide opportunities for staff to participate in internship projects. There have also been instances in which the new worker training curriculum has been approved to serve as a component to undergraduate or graduate study, although payment must be made at that institution's tuition rate.

Employees' competency, knowledge, and ability to transfer knowledge are evaluated annually through employee performance evaluations. Information related to deficiencies in knowledge, skills, or abilities are shared with training staff to ensure that those needs are addressed in training.

Foster and Adoptive Parent Training: DHHS continues to contract with NFAPA to conduct ongoing training sessions for licensed and approved foster and adoptive parents. In 2007, there were 13 training sessions offered to foster parents throughout the state on FCP and the NSIS (refer to Section I); the revised foster parent conflict resolution process; a foster parent disaster plan; and the service area emergency contacts for foster parents. In 2008, a new training titled "Roles and Responsibilities: What Happened in Court? Making a Difference for Foster Children in the Courtroom" will be available for foster and pre-adoptive parents. This in-service addresses ways in which foster and pre-adoptive parents can participate in court decisions regarding the foster children in their care. DHHS and NFAPA also cosponsor annual Resource Parent Summer Conferences designed to provide foster parents with ongoing education and training in the field of fostering children.

d. What are the casework practices, resource issues, and barriers that affect the child welfare and juvenile services system's overall performance in terms of the staff development and training system?

There is concern over the length of time new workers spend in training, particularly given the significant staff turnover in this field. As a result, DHHS has piloted a revised model of training (mentioned above) in the Eastern and Southeast service areas to compare with the current training model.

Another concern is that in some areas of the state probationary workers are immediately assigned full caseloads (rather than experiencing a gradual increase in cases from the four cases trainees are initially assigned while in training status). This appears to be related to staff turnover as this most often occurs in areas with high turnover rates (refer to Section I). In areas where staff turnover is more stable they are able to maintain a gradual growth in caseloads that allow new workers to become familiar with cases prior to receiving additional cases.

In response to concerns about worker retention, DHHS has contracted with CCFL to conduct a survey with PSWs and PSSs as part of the Protection and Safety Staff Retention Study (refer to Section I). The survey was titled "Why Staff Stay" and included questions designed to collect information on the factors that affect employees' decisions to leave or remain working in Protection and Safety. The survey was sent to staff in the spring of 2007 and there was an 86% return rate. The second component to the study includes an analysis of worker performance, leave, and turnover data through May 2008. A final report will be available in the fall of 2008.

The high turnover rates in combination with the large geographical size of the state have placed increasing demands on our training resources. A total of 227 individuals have participated in at least one new worker training session in 2007. These individuals represented 14 different training groups from five different locations across the state. An additional 1,178 staff participated in in-service training sessions conducted throughout the state that same year.

The NSIS implementation training (refer to Section I), which began in July 2006, took a tremendous amount of resources, as each session spanned over six workdays. While DHHS utilized CCFL trainers in these sessions, DHHS supervisors, administrators, and central office staff co-trained participants in these sessions. Although supervisors and administrators have participated in train-the-trainer sessions to prepare for presenting the material themselves, they have since identified additional areas in which they need additional instruction.

E. Service Array and Resource Development

The state has in place an array of services that assess the strengths and needs of children and families, that determine other service needs, that address the needs of families in addition to individual children to create a safe home environment, that enable children to remain safely with their parents when reasonable, and that help children in foster and adoptive placements achieve permanency (Item 35). The services are accessible to families and children in all political jurisdictions covered in the state's CFSP (Item 36). The services can be individualized to meet the unique needs of children and families served by the agency (Item 37).

1. Stakeholder Assessment

A common theme in stakeholder comments is that there is a lack of services in all areas of the state, and that existing services are not always accessible to families. Stakeholder surveys support these statements, with respondents rating DHHS as being only somewhat effective in providing a range of accessible services.

Service providers and agency staff are optimistic about NSIS (refer to Section I) and believe that it helps define the types of services children and families need, and allows for more opportunity to provide service intervention prior to making children in voluntary cases wards of the state. The identification of service needs and lack of early intervention services were both listed as current barriers to providing services throughout the state. Implementation of NSIS has also brought a renewed focus on FCP (refer to Section I). Stakeholders are eager to develop a more comprehensive, local system of care that can meet each family's individualized needs and reflect their culture, language, and values (again, another service need identified by stakeholders).

Other identified strengths in service array and resource development include collaborative efforts between child welfare and juvenile services, behavioral health, developmental disability groups, and other professional partners. One example of such collaboration includes the 1184 multidisciplinary child abuse and neglect investigation and treatment teams (refer to Item 3). However, stakeholders believe that not all service areas are utilizing 1184 teams, or are not referring cases to teams in a timely manner.

Despite the recent changes made to strengthen services throughout the state, many stakeholders believe that there is a lack of services in residential treatment centers and in-patient psychiatric facilities, causing children to be sent out of state to receive services. The average number of children placed in out-of-state facilities has steadily increased from 33.6 in FFY2003 to 87.6 in FFY2006. However, this number decreased to 65.8 in FFY2007. This accounts for 0.9% of state wards population at the close of FFY2007. The reason for which these children may have been sent to an out-of-state facility is not readily available or easily attainable with our current data system. In some cases, children may have resided in a border town or city where the treatment facility that was in the closest proximity to their family and community was located in a neighboring state.

In regards to lack of services, stakeholders also reported a lack of child psychiatrists throughout the state and some providers are not trained to work with children. They said that there is also a lack of transitional services for older youth and a lack of services for youth with developmental disabilities. Often, youth who are "borderline" developmentally disabled "slip through the cracks."

Stakeholders believe that the services that *are* available through child welfare and juvenile services are fragmented. Families must often visit multiple locations or agencies to receive needed services and these services are not necessarily individualized to meet each family's need. It is difficult to find providers who speak languages other than English and who are culturally competent, particularly in the more rural regions of the state. However, stakeholders identified promising practice in the Central Service Area, which has managed to provide wraparound services to families via adequate funding, strong leadership, and positive incentives (rather than negative sanctions).

The Tribal focus groups recognized that there is a lack of Native-based services, but where the services do exist, they are seldom used. They also stated that behavioral health services provided to children and families are not addressing the cultural issues.

Internal DHHS barriers also exist. Some stakeholders describe the child welfare and juvenile services system as inflexible and over reliant on Medicaid. While there is a wide array of services available through Medicaid, there are restrictions to which services are authorized and to whom. Overall, stakeholders agree that DHHS not only needs to develop more services, but that it needs to be clearer on what services they need from providers. Stakeholders called for enhanced communication, collaboration, and cross-training among DHHS and partners, and a respect for each partner's differing role in the system. Service providers, family organizations and court stakeholders identified a concern related to the purchase and provision of services for parents of youth in care. The concern ranged from statements that DHHS will not purchase any services for parents to statements suggesting that there is no funding to purchase services for parents. DHHS policies and procedures do allow for the purchase of services for parents of children involved with DHHS. In review of this issue it has been determined that each service area has developed local processes and protocols related to the expenditure of state funds as the areas hold responsibility to manage their expenditures within the allocated budgets. These protocols and processes should be re-evaluated at regular intervals to determine the continued direction to allow families to receive necessary services and to allow service areas to remain within budget. The implementation of NSIS (refer to Section I), the development of new safety services, and the new behavioral health initiative described on page 116 may affect future direction in this issue.

Workers said that they would like more information on community services available in their area, and more detail on the procedures and practices used by service agencies. Workers expressed difficulty in determining what services are needed and an inability to evaluate service effectiveness. While the services provided may match the identified needs, workers are unsure of this as the provider does not identify the level of intervention provided or the method may be questionable. Additionally, worker turnover and high caseloads affect the ability of workers to assess, arrange for, or provide needed services. Workers also describe a disconnect with courts in that judges often reject the workers' service recommendations for a variety of reasons ranging from distrust of the worker to "the judge knows best." Interestingly, court focus group participants reported that most of the recommendations workers make to the court are appropriate and include pertinent information, although this is largely dependent on the individual worker and their skills and knowledge.

In regard to regional concerns, many stakeholders noted the lack of services in particular areas of the state and the resulting travel distances to services in some areas, specifically the north central and far western areas. Transportation was identified by both biological and foster parents as being a barrier to receiving services. Biological parents identified a need for more community-based services to allow children to remain closer to home. Stakeholders reported that service area and state boundaries sometimes serve as barriers to allowing children and families to access services closer to home. Youth from smaller areas that have fewer services must move to or be placed in larger areas that offer more services, and are then distanced from family connections. There is also a stigma about mental health treatment in rural areas, which stakeholders believe could be remedied through the provision of more preventative services.

2. Factor Evaluation

a. What do policy and procedure require?

DHHS policy states that it will provide family centered services to protect children from abuse and neglect, to improve conditions in families that place children at risk, and to assist youth in being productive, law-abiding citizens. The following values and beliefs guide service delivery:

- The safety of children and communities are priorities;
- Services and supports are sensitive to community interests while providing for community safety and security;
- Children grow best in families, which are the cornerstone of our society;
- Every family and individual is unique and has basic rights and responsibilities;
- The strengths of families, children, and communities should be identified and supported, and all efforts should build on these strengths;
- In juvenile services situations, the mission is to provide necessary service to juveniles with the goal of reducing the probability of their continued delinquent behavior, while also protecting the community;
- An array of services for children and families must be provided while ensuring the safety of the child and the community;
- All people we serve are equal and are afforded respect and dignity; and
- Services are provided in a collaborative manner with individuals, families, agencies, organizations, and communities.

Services and supports to families and children should be child focused and family centered in that they are based on the assessed needs of the family and child. Providers should be mindful of the safety of the child while also being mindful of community safety. Services should be founded on community responsibility and be community- and neighborhood-based. When appropriate, services should be provided in the family home or in as close in proximity to the family as possible. Lastly, services should be delivered in a competent, professional manner by a staff that respects cultural diversity.

It is important to recognize that the CWU and OJS are only part of a broader protective, safety, and service system that stretches throughout communities across the state. DHHS will deliver services in a way that supports integrating, improving, and strengthening services in the community. Policy states that a well-defined, integrated, adequately funded system of support should be in place, which focuses on outcomes; evaluates progress toward meeting outcomes; and maintains and improves quality.

In addition, families must be involved and empowered to assume responsibility for their children as well, by having access to resources to meet their needs, the ability to make choices, and the opportunity to fulfill their parental role and accept responsibility. Ultimately, family members will gain a recognition and enhancement of their own individual and family strengths.

These overarching values and beliefs are incorporated into child abuse, neglect, and dependency situations by directing efforts at reducing current and future threats to the child and helping the family become self-sufficient. In juvenile delinquency situations, efforts are directed at holding the youth accountable for their behavior, teaching them how to become responsible citizens, addressing their risks and needs, and maintaining public safety. In all cases, reasonable efforts are essential to preserve or reunify the family. When preservation or reunification is not

possible, every effort will be made to provide the child with an appropriate permanent placement in the least restrictive setting.

b. Where was the child welfare and juvenile services system in round one of the CFSR?

Nebraska was not in substantial conformity with this systemic factor in round one of the CFSR. Service gaps in parent education, family support, substance abuse treatment, foster care placements, services for developmentally disabled children, dental care, culturally and linguistically competent providers, independent living services, residential treatment, community-based services, juvenile justice services, and services for sexual offenders and sexual abuse victims were identified by stakeholders involved in the review. Reviewers determined that services were not consistently available statewide or, if available, there were frequently long waiting lists, particularly for inpatient substance abuse treatment services and home-based services. As a result of these service gaps and service inaccessibility, children and families were not receiving services that were individualized to meet their needs.

c. What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated in terms of service array?

DHHS currently administers funding through various avenues to support community agencies and organizations in providing abuse-related services to children and families. Funding is distributed to seven CACs and 22 domestic violence/sexual assault programs throughout the state. When CACs were initially developed, the primary intent was to provide coordinated, multidisciplinary services to children and families involved in cases of child sexual abuse. However, most CACs today have broadened their target service population to include suspected child victims of serious physical abuse, child witnesses to domestic violence, and children affected by other forms of victimization.

The 22 domestic violence/sexual assault programs located throughout the state offer shelter, counseling, and support to children and families experiencing domestic violence or sexual assault. A statewide child death review team analyzing 30 child maltreatment related deaths that occurred between 1998 and 2003 revealed that domestic violence served as a direct factor or was part of the family's history in 46% of cases. Thus, supporting these community programs and the services they offer will impact our ability to keep children in safe and stable homes.

In 2004, DHHS and community stakeholders conducted a service array assessment in two pilot sites in the state to assess which services are lacking. The purpose of the assessment was to identify service needs, gaps, and necessary improvements to address timely initiation of services; assure the ability to offer the services needed; develop in-home services; and reduce service waiting lists in these two sites. The assessment utilized the Service Array in Child Welfare tool, provided by the National Child Welfare Resource Center for Family Centered Practice. The tool addresses community/ neighborhood prevention and early intervention services, investigative assessment functions, home-based interventions and services, out-of-home interventions and services, and child welfare and juvenile services system exits, and was later expanded to also assess basic needs, healthcare access and health promotion, child and youth safety and development, family development, and prevention systems.

In 2005, the project was expanded to other areas of the state. The expanded project will: decrease duplicative assessments and planning, particularly in greater Nebraska communities;

support the assessment of community capacity to develop and implement prevention systems of care; identify policies and procedures that impact the development and sustainability of community prevention systems; assess community decision points for juvenile offender cases; and further assess the DHHS child welfare and juvenile services system's service delivery structure.

To date, 28 counties have completed the service array process. From this assessment communities developed a systemic logic model for prevention and early intervention priority areas to develop and/or enhance. These priority areas include: an internal understanding of collaborations, communities, and inter-relationships; the creation of rurally competent policies; the access of data to analyze service impact and trends; and the development of a core level of services and a single planning and evaluation process. Counties are now eligible to participate in an ongoing learning community to further build their capacity to identify, implement, and sustain needed services for children and families, and to work systemically to improve access to and availability of services.

In January 2008, a plan for the behavioral health needs of children, adolescents, and their families in Nebraska was created under LB542. Among the key elements of this plan are: 1) balanced array of services 2) accessible services 3) strategic use of evidence-based approaches 4) improved service quality with existing financial resources 5) developing facilities and services to address some of the state's most challenging children and adolescents 6) strengthened behavioral health workforce 7) definition of the states role, which includes: a) facilitating private treatment where possible b) coordinating different systems to work together for a common vision c) facilitating increased interaction through common language d) supporting evidence based practices 3) securing high-risk juvenile offenders. In March 2008, DHHS issued an RFB to solicit qualified contractors to provide the entire continuum of safety and in-home services to children and families identified. Letters of Intent to Award were issued May 6, 2008.

Stakeholders commented that this plan should provide for the creation, availability, and accessibility of an array of services for children and families. It would also address stakeholder concerns about Nebraska being a "bed-based" system that relies heavily on out-of-home group home or facility care and does not offer early up front services in the home. Family organizations expressed concern though that the plan is geared toward services for children but not for parents. They believe that more substance abuse and mental health services are needed for parents of state wards since there are waiting lists for the services that are currently provided.

d. What are the casework practices, resource issues, and barriers that affect the child welfare and juvenile services system's overall performance in terms of service array?

The service array assessment project revealed advocacy and service barriers; non-existing and duplicative services; lack of education and diversity; and the need for law and policy change. Specific themes pertaining to these barriers included:

- Dwindling resources and cutbacks in state programs;
- Disparity of funding to rural communities;
- Multiple collaborations and coalitions;
- High investment of time and resources and extreme competition for limited funds;
- Sustainability requirements of grants;
- Silo funding restrictions;
- Flawed evaluations of program effectiveness;

- Lack of data and process to assess impacts of change and programs;
- Lack of training and education to work with high-risk youth and families;
- Families receiving services from multiple agencies and schools, and inability to identify these families; and
- Lack of a single, coordinated process due to multiple case coordinators, plans, and home visitors.

With Nebraska being a largely rural state, the lack of services in remote regions often leads to children being moved outside of their community to other areas to receive services, or traveling long distances to receive these services. Identifying, arranging for, and even providing transportation to services, particularly in remote areas of the state, is taxing on workers. High turnover rates and large caseloads (refer to Section I) further exacerbate these obstacles.

F. Agency Responsiveness to the Community

DHHS engages in ongoing consultation with Tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child- and family serving agencies, and includes the major concerns of these representatives in the goals and objectives of the CFSP (Item 38). DHHS develops, in consultation with these representatives, annual progress and services reports pursuant to the CFSP (Item 39). The state's services under the CFSP are coordinated with services or benefits of other federal or federally assisted programs serving the same population (Item 40).

1. Stakeholder Assessment

Stakeholders reported increased collaborations with courts and community providers. It was expressed that overall there has been better communication and more timely responsiveness on the part of upper and middle management since the restructuring of DHHS. DHHS administrators meet monthly with representatives of the Court Improvement Project (CIP), "Through the Eyes of a Child" Initiative, and State Supreme Court. Meetings with providers occur at the request of the providers or DHHS. In 2007, DHHS collaborated with the provider community in sponsoring a statewide conference on FCP (refer to Section I). DHHS also participated in an event with the Drug Endangered Children's (DEC) Committee [detailed in section 2(c)], which focuses on methamphetamine use in Nebraska.

Improvements could be made in responding to foster and biological parents and youth, based on their comments on this issue. Foster and biological parent focus group participants reported a lack of communication and responsiveness on the part of workers and, to some extent, comments made by youth focus group participants in regard to returning calls supports this statement. Participants in the court focus groups echoed the need for workers to be timelier in returning calls. It should be noted that all participants recognized that these issues were largely dependent on the individual worker though, and youth offered glowing comments about the workers with whom they had a positive experience with in terms of responsiveness and connections. Some stakeholders, particularly parents and the courts, believed that workers' delayed responsiveness is due to high caseloads and worker turnover.

Tribal stakeholders identified recent improvements in DHHS' responsiveness to Tribes. They commended DHHS for hiring a full-time ICWA Specialist, and they commended PSAs and the

ICWA Specialist for recognizing the sovereignty of the Tribes. They also reported that removing the requirement for Tribes to obtain approval from DHHS to make a child a state ward was another positive step. However, Tribal stakeholders also identified areas in which communication between the DHHS and the Tribes needed to improve, such as notification in changes of DHHS central office staff assignments and contacts. Tribes receive some communication from DHHS concerning child and family services, but often the only communication is received from the ACF. The ACF have Tribal consultation on a semiannual basis and stakeholders stated it would be nice for DHHS to do the same. Semiannual meetings between DHHS programs and parallel Tribal programs would be beneficial.

Partner agencies expressed a desire to have had more input in recent initiatives taken on by DHHS. Court partners felt the courts should have been more involved in the discussions regarding the development of the NSIS (refer to Section I), as the new emphasis on safety is perceived to contradict the courts legal obligation to examine risk. Several representatives feel agencies should have input in the development of provider contracts to gain a better understanding of contract expectations and to adjust their program accordingly, especially with performance-based contracts.

A common theme throughout the comments above and in comments pertaining to earlier sections of this report is that DHHS does not communicate well with stakeholders and partners about changes in policy and practice, even in instances such as the recent restructuring in which DHHS believed the decision-making process to be inclusive of external partners and community. There is still, however, a strong perception that such changes are made by DHHS in isolation and are not clearly communicated with others. Stakeholder survey responses support this assertion with the majority of respondents rating the agency as not effective in communicating policy and practice changes. A summary of stakeholder and survey comments indicate that DHHS is viewed as a large bureaucracy by internal and external stakeholders alike.

2. Factor Evaluation

a. What do policy and procedure require?

Administrative Code requires and provides for a public comment and hearing process as a part of the adoption of any policies, regulations, or state plan. DHHS' Office of the System Advocate responds to questions, concerns, and complaints about DHHS from consumers, providers, elected officials, citizens, and internal employees. The Office refers people to the appropriate resource within DHHS for information and problem resolution. As needed, the Office provides oversight and assistance in resolving issues.

With the exception of a few technical bills, most bills introduced into the Legislature must receive a public hearing by a committee. At hearings, citizens are allowed to express their opinions to committee members. Testimony is recorded and transcribed to become a part of the official committee record.

b. Where was the child welfare and juvenile services system in Round One of the CFSR?

Nebraska was found to be in substantial conformity with this factor during the first round of the CFSR. Extensive input was sought from Tribal representatives, consumers, service providers, and others, in the development of the Nebraska Family Portrait and in the CFSP process.

Stakeholders reported that the relationship between community providers and DHHS had improved and they felt they were more in partnership with DHHS.

c. What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated in terms of its agency responsiveness?

There is a tremendous effort, energy, and enthusiasm in all branches of Nebraska's government (e.g., Executive, Judicial, and Legislative branches), partner organizations, and the community at large to improve the child welfare and juvenile services system and outcomes for abused and neglected children and juvenile offenders. DHHS has collaborated with these bodies and organizations to improve child welfare and juvenile services outcomes, and has made internal efforts to ensure continued collaborations in this area as well. Many of these collaborations and initiatives have been included in previous sections of this report in corresponding sections. Below are a few more promising programs and practices that have not yet been mentioned in previous sections, or may have been referenced but not fully defined.

Executive: In 1993, the Governor's Youth Advisory Council (GYAC) was formed to assure youth were represented in state initiatives that impact employment and job training opportunities, rural and urban economic sustainability, and child welfare and juvenile justice services, and to collaborate with other state and local youth organizations. In January 2008, the GYAC held their annual luncheon with Senators and the Governor and shared their position on three proposed bills:

- LB1159, to decrease the truancy rate by establishing an agreement between parents, students, and the school to promote accountability among all parties;
- LB782, to give the DHHS CEO the opportunity to determine whether to publicly release information on children in care, and what information should be released; and
- LB157, outlining the Safe Haven Act.

The majority of GYAC members were in agreement with the goal of the first bill, although there were concerns regarding the placement of accountability and responsibility. GYAC members supported the second bills, believing that a specific voice needs to be in place to deal with these matters and to protect the rights of the children involved. GYAC members supported the third bill, as they believe it will provide shelter for unwanted children, decrease the number of abandonment cases that result in physical harm to the child due to easier separation of the child and parent(s).

Judicial: The Nebraska Supreme Court has led a number of recent initiatives including a statewide Children's Summit, the Nebraska Supreme Court Commission on Children in the Courts, and the "Through the Eyes of the Child" Initiative. DHHS has responded to these initiatives with considerable staff time and energy. DHHS financially supported the attendance of staff and administrators at the Children's Summit, the Director of DCFS serves on the Supreme Court Commission on Children in the Courts, and various DHHS representatives serve on a variety of subcommittees of the Commission. For example, the DHHS staff has worked on subcommittees that have made proposals to the Supreme Court on guidelines and training requirements for guardians ad litem representing children in abuse and neglect cases, guidelines and training for parents in these cases, and the development of a "Caregiver Information Form" for foster parents. DHHS staff serves as integral partners in the 25 "Through the Eyes of a Child" Initiative collaborative teams that are working on improving their local court systems. DHHS administrators meet regularly with court personnel at all levels from these local teams, to

a middle management workgroup, to meetings between DHHS top administrators, and the Nebraska Chief Justice and State Court Administrator. A number of DHHS staff members serve as team secretaries for these teams and provide considerable support to the functioning of the teams. These meetings offer an opportunity for the courts and DHHS to communicate openly about shared concerns from different perspectives.

DHHS has also worked with the courts in their efforts to establish pre-hearing conferences, a standardized court model identified as a promising practice in improving child welfare outcomes for children in court. Conferences are held within a few days of the child's removal from home to determine the immediate plan for the child and family. Pre-hearing conferences have become widely used by the courts and anecdotal evidence from judges, attorneys, caseworkers, and others suggest that these conferences have been successful in acquiring more information at the commencement of the case, providing services to the child and family at the earliest opportunity, and moving the case to permanency faster. There is currently a data study on pre-hearing conferences occurring in six sites across Nebraska. The purpose of the study is to analyze the nature and effect of pre-hearing conferences on the court process and the outcome of abuse and neglect cases. Data will be collected through case reviews and online surveys of participants. It is expected that results will be released in summer 2008.

In 2005, the Nebraska State Patrol, the Attorney General's Office, the Nebraska Crime Commission, Midwest High Intensity Drug Trafficking Areas, and DHHS collaborated in to form the Drug Endangered Children's (DEC) Committee to address methamphetamine laboratories and other substance abuse to which children could potentially be exposed. This is a big issue in the state that is often a factor in many child abuse and neglect cases. Thus, DHHS has taken an active involvement on this committee. A statewide conference and training was provided by the DEC Committee in September 2006 to DHHS staff, law enforcement, and the medical community on drug endangered children's issues and how to minimize the impact and trauma on caring for children found in clandestine laboratory situations. The DEC Committee continues to work on enhancing Nebraska's Children Exposed to Methamphetamine Labs protocol in order to define "best practice" in dealing with children who have been exposed to methamphetamine, with DHHS playing an active role in these efforts.

Schools: DHHS participates on NDE's Ad Hoc Committee on the Education of Children and Youth in Out-of-Home Placements, along with representatives from public schools, group homes, and detention facilities. The mission of the Committee is to provide guidance and direction to policymakers and stakeholders in the development and implementation of educational opportunities for children in out-of-home placements, and to promote the successful transition of these youth from out-of-home placements into the public school system or other education programs. The Committee took an active role in the development of statewide standards for interim program schools and in providing training and technical assistance to schools on the standards. The Committee also developed and implemented an evaluation process to monitor the impact of the standards and schools' compliance with the standards. Annual conferences have been sponsored by the Committee in 2006 and 2007, with a third scheduled for summer 2008. The most recent conference drew over 200 educators and professionals from the child welfare and juvenile services system from across the state to attend workshops addressing topics such as mental health, Medicaid and Magellan, vocational rehabilitation, the child welfare and juvenile services system, etc.

As per the federal Individuals with Disabilities Education Act (IDEA), NDE established a Special Education Advisory Council to provide advice and policy guidance with respect to special education and related services for children with disabilities in Nebraska. DHHS participates on this committee and brings to the table special education issues pertinent to state wards. The Council is currently in the process of identifying their committee priorities for the next two years. Past efforts have focused on improving learning for children with disabilities throughout the state, assessing special educational needs, assisting youth in transitioning into or out of school, and interim program schools.

In May 2007, the Nebraska Legislature passed LB316, which created the Special Education Services Task Force. The Task Force was developed to review the manner in which special education services were provided and financed in Nebraska and to provide legislative and policy recommendations based on their review. DHHS participated on the Task Force and contributed to the development of recommendations introduced to the Nebraska Legislature in early 2008 as LB1153. As it pertains to the child welfare and juvenile services system, LB1153 would enhance parental involvement in the IEP process and provide clarification on the requirement of home school districts to pay for the educational services provided to children in residential facilities (such as a treatment setting), upon parental request. Historically, school districts have been reticent to do so unless the child was a ward of the state, and occasionally children were made wards of the state just to receive this funding. Stakeholder comments also indicate that schools' reluctance to pay for educational services is a large barrier to obtaining services. Thus, not only would the bill assure the provision of educational services to children placed in residential facilities, but it would potentially prevent children from coming into state custody simply as a means to receive these services. Nebraska's Legislative Education Committee identified this bill as one of two priority bills.

Community: In April of 2003, DHHS partnered with and funded family organizations in each of the service area to provide one-on-one mentoring and support services to families involved with child welfare or juvenile services. The Nebraska Federation of Families and local family organizations continue to serve as members of the DCFS Partners Council and the SAMHSA SIG Steering Committee (both described in further detail on page 123).

DCFS and DHHS' Office of Family Health collaborated with Prevent Child Abuse Nebraska (a program of NCFF) and the Nebraska Child Abuse Prevention Fund Board to develop a statewide child abuse prevention plan. This plan was implemented in 2006. The plan serves as a guide to those in the field as they make decisions, develop policies, and implement programs around the prevention of child abuse. Ideally, legislators will use the plan to guide policy and funding decisions, state agencies will use the plan to guide them in setting priorities and funding decisions, and community groups will use the plan as they design and secure resources for effective, research-based child abuse prevention programs. In 2007, the Board began using the plan to focus its annual grant making process. Funding priorities were placed on the needs and strategies identified in the plan and applicants were asked to address one or more of the needs and strategies in their proposals.

Another statewide initiative is the "Nebraska's Promise" (based on the America's Promise Alliance). Nebraska's Promise is an alliance of agencies, organizations, and individuals dedicated to ensure that Nebraska children grow up with the benefit of supportive relationships with caring adults, safe places to learn and grow, a healthy start in life, effective education for marketable skills, and opportunities to give back to their communities. The alliance has

developed statewide benchmarks for each of the five promises, communication tools for communities, and materials for an awareness campaign. These activities have complemented the work occurring in DHHS and vice versa, creating a more unified community response to issues of child abuse and neglect in the state. It should be noted that in 2008, three Nebraska communities (Boys Town, Grand Island, and Lincoln) were recognized in the 100 Best Communities for Young People Contest sponsored by America's Promise Alliance.

DHHS has also worked with the NCFF, the Sherwood Foundation, and the Scott Foundation, and over 100 stakeholders from other various community organizations, to develop an Independent Living Plan for Youth in Omaha. The plan focuses on some of the same areas as the Nebraska's Promise alliance, such as community engagement and education. The plan includes specific action steps to take in the next four years to achieve outcomes in the following areas: personal and community engagement; education; employment; daily living and housing; physical and mental health; and training and policies. Detailed work plans and budgets were developed in March 2008 and agreements with each of the funders regarding their financial commitment to the plan are being finalized.

Youth: In addition to the GYAC, Nebraska has established other programs and initiatives directly involving youth in recent years. Youth involvement is critical in ensuring that the system is responsive to youth and that programs and services provided to youth meets their needs. Nebraska's Foster Youth Council (FYC) is statewide council for current and former foster care youth, ages 14 to 24 years. FYC's mission is to help youth transition into independent living while recognizing and taking full advantage of their strengths, to create opportunities for youth in care to connect with each other, and to provide input on program and policy issues. In 2008, FYC began developing regional councils for foster youth.

The Circle of Courage program, developed with support from the ACF's Family Youth Service Bureau, targets Native American youth who reside in Box Butte, Scottsbluff, Sheridan, and Dawes counties. Program efforts are directed at maintaining safe and secure homes for the youth, education supports, community recreational activities, community leadership opportunities, the ability to give back to the community, and a cultural connection (through the Sons and Daughters of Tradition curriculum).

Another youth development program developed for Native American youth in Nebraska's four federally recognized Tribes is the Circle of Nations. In July 2007, the group sponsored the 6th Annual Circle of Nations Youth Conference. The conference addressed seven key areas identified by the youth planning committee: abstinence; gang awareness; bullying; teen pregnancy; youth suicide prevention; domestic violence; and drug and alcohol use. Through participation in this event youth have the opportunity to gather information and influence change in their community youth councils, while developing pivotal leadership skills.

DHHS: In October 2006, DHHS hired an ICWA Specialist to provide consultation to Protection and Safety staff and Tribal members in situations involving Indian children and families. The ICWA Specialist attends court hearings and family group conferences, staffs cases when requested, and reviews case files for ICWA compliance through a systemic review process. Tribal leaders and social service personnel from each of the four Nebraska Tribes have met with DHHS central office staff within the past year, and additional meetings with Tribal leaders and social service personnel are scheduled as needed. Current and ongoing meeting agendas include topics related to the sharing of information included in background checks and gleaned from

fingerprint checks, defining family relationships and roles, and streamlining Tribal court process used to make children state wards and to access services using DHHS funding. Some of these discussions have and will continue to produce results that will be incorporated into renewed agreements with three of the four Tribes that begin on July 1, 2008.

In 2006, the former Offices of Child Support Enforcement and Protection and Safety (now DCFS) received a federal grant to implement the BSEP pilot program in the Southeast Service Area. BSEP is a three-year project designed to refine protocols and procedures for child support collections and to establish best practices for improving communication and information sharing between the child support enforcement, child welfare and juvenile services, district courts, county/juvenile courts, and other entities. The approach incorporates the creation of two new multidisciplinary caseworkers, knowledgeable in child support enforcement, child welfare, and juvenile services. Case processes, procedures, and training to improve outcomes for dual-program cases have been initiated. The evaluation of this grant will guide future steps to improve this collaboration.

In 2004, DHHS received a Systems Integration Grant (SIG) from SAMHSA to develop a statewide mental health and substance abuse service delivery system for children and youth with co-occurring disorders and substance abuse issues, and youth who are transitioning out of the system. The goals of this system are to develop the following elements on the state, regional, and local levels:

- Coordination across agencies;
- Family centered approaches across systems;
- Coordinated service plans;
- A single point of accountability;
- Outcome information;
- Standard assessment;
- Best practices;
- Clear policies regulating similar services; and
- Preventative and early intervention services.

The SAMHSA SIG Steering Committee was developed to oversee the work of this grant. The statewide committee includes three smaller subcommittees: the Early Childhood Subcommittee; the Youth Subcommittee; and the Evaluation/Academic Subcommittee. In 2006, the Early Childhood and Youth subcommittees completed and submitted their recommendations to the statewide steering committee. The Evaluation/Academic Subcommittee continues to meet.

In 2007, the DCFS Director appointed a Partners Council consisting of key stakeholders in Nebraska's child welfare and juvenile services system. Members include representatives of provider and advocacy organizations with an interest in children and family services. The Council meets quarterly to monitor outcomes and improvements, and to provide input on how to improve federal outcomes. The Council has been and will continue to be involved in the CFSR process. Council members have reviewed and provided feedback on the statewide assessment, and will assist in developing our PIP and monitoring our progress in the PIP.

The largest effort for DHHS over the last year has been conducting the statewide assessment for our upcoming federal CFSR in July 2008. DHHS has invested much time, resources, and energy to conduct a fully collaborative assessment. In November 2007, DHHS held a statewide assessment kick-off event to share with stakeholders our successes, challenges, and vision for the

future, and to engage stakeholders in the statewide assessment process. Over 100 stakeholders attended, including representatives from the National Child Welfare Resource Centers for Organizational Improvement and Data and Technology; over 50 stakeholders committed to be involved in the CFSR process by the end of the day. Additional day-long meetings were conducted with stakeholders who comprised our statewide assessment team to obtain information and feedback to include in the statewide assessment report. Team members reviewed sections of the report via subsequent email communications.

The courts, Tribal representatives, youth, parents, and family have had a large involvement in the CFSR process to date. Local court teams developed under the "Through the Eyes of a Child" Initiative served as focus groups for the statewide assessment. The Director of Nebraska's CIP and staff have also provided extensive information to include in the statewide assessment and have served as reviewers of assessment material. We have already received commitment from judges to participate in the onsite review process. Representatives from partner youth and parent organizations have facilitated focus groups with foster care youth, biological family members, and foster and adoptive parents, to gain feedback to include in the assessment. These same representatives have been active participants on our statewide assessment team. The DHHS ICWA Specialist also conducted focus groups with Tribal leaders throughout the state, from which we have gained tremendous insight into Tribal cases and related issues occurring throughout the state. All of these individuals have proven a strong commitment to establishing safety, permanency, and well-being for children in the state.

DHHS has also begun using surveys in the CFSR process and in other efforts as a method to seek feedback from stakeholders on which to base program changes and improvements. In 2007, DCFS administrators surveyed stakeholders at various meetings to gather input on the outcome, needs, and strategies included in Nebraska's Annual Progress and Services Report (APSR). We also developed two online surveys for stakeholders and youth to complete to inform our CFSR statewide assessment, as referenced throughout this report.

d. What are the casework practices, resource issues, and barriers that affect the child welfare and juvenile services system's overall performance in terms of the agency responsiveness?

Stakeholder feedback indicates a barrier with the way in which courts and other stakeholders understand or perceive the NSIS (refer to Section I) and their roles and responsibility in keeping children safe. Stakeholders believe that the evaluation of risk is an essential component of the safety assessment process. The focus of DHHS, however, is on children who have been determined to be unsafe. Law enforcement, the County Attorney's Office, and the courts have different responsibilities, and all can act on behalf of children they believe to be in danger.

Additionally, although Tribes identified that the addition of an ICWA Specialist and other recent efforts made by DHHS administration are positive changes, communication barriers still exist around changes in staff contacts, programs, and services.

As noted above, DHHS needs to improve in responding to foster and biological parents and youth. Currently, many stakeholders view workers as unresponsive. The agency also needs to communicate better with both internal and external stakeholders about policy and practice changes.

G. Foster and Adoptive Home Licensing, Approval, and Recruitment

DHHS has implemented standards for foster family homes and child care institutions that are reasonably in accord with recommended national standards (Item 41). DHHS complies with federal requirements for criminal background clearances related to licensing or approving foster care and adoptive placements, and has in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children (Item 42). DHHS has in place a process for ensuring the diligent recruitment of potential foster and adoptive families that reflect the ethnic and racial diversity of children for whom foster and adoptive homes are needed in the state (Item 44). DHHS has in place a process for the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children (Item 45).

1. Stakeholder Assessment

Stakeholders identified a number of recent developments as promising practices in this area, including: a streamlined approval process for kinship placements; improved standards for relative background checks; criminal background checks that meet national requirements; and enhanced home study requirements. Stakeholders also commended the fact that Nebraska licensing standards have been revised to take into consideration Native American issues, and that Nebraska accepts the licensure of foster families by the Tribes using Tribally-recognized and approved standards. Tribal focus group participants reported, however, that Tribally-recognized and approved standards are not respected by DHHS. DHHS representatives have questioned Tribal standards and compliance and have asked in the past to review homes licensed under Tribal standards to ensure that the home also meets DHHS standards.

Delays in the home study process and background checks, however, were identified as barriers to foster and adoptive parent licensing. Stakeholders also reported delays in DHHS resolving complaint allegations in foster homes. DHHS is currently streamlining this process to resolve these issues sooner.

As stated in Systemic Factor B, the notice of hearings and reviews given to foster parents, pre-adoptive parents, and relative caregivers, and recent emphases on the right for parents to be heard in court were also recognized as positive steps in this area (although a few issues remain around notifications of court hearings). Stakeholders also felt that there has been an increase in workers engaging foster parents as team members in cases and stakeholder survey responses reveal that most stakeholders believe the agency treats caregivers respectfully throughout case processes.

Stakeholders also identified gaps within this systemic factor. They reported that most of the recruitment of foster homes occurs by word of mouth and print ads, and the majority of ads portray younger children and emphasize adoption. Stakeholders feel these ads misrepresent who the majority of foster children are (i.e., older children with behavior issues) and overemphasize the possibility for adoption. Interestingly, the numbers of calls to the inquiry line have increased recently. Stakeholders also stated that little recruitment or outreach is made to churches or targeted communities such as the Hispanic or Asian communities. Recruitment for ethnic and racial diversity is not visible, yet there is a lack of foster parents with diverse cultures and backgrounds.

The reimbursement rate to foster parents was identified by stakeholders as a possible recruitment issue, although some agency-based care providers who reported that their reimbursements rates were higher than others also reported difficulties in recruiting and retaining parents. While stakeholders were positive about the PRIDE training foster parents receive, they stated that potential foster parents often have to wait long periods of time to receive the training since DHHS' contract with contracted training agencies limits the training to be presented to no more than six families at one time. Stakeholders also believed that DHHS should encourage relative foster care parents to attend PRIDE training. Currently the relative foster care parents are not required to do so.

Nebraska does not allow placement of a foster child with unmarried adults without administrative approval. Some stakeholders believe that because of this policy we are missing a sector of individuals who may be interested in providing care. However, staff may request and have received exemptions to this policy.

2. Factor Evaluation

a. What do policy and procedure require?

Nebraska code provides standards for approval and licensing of all out-of-home placement settings. A licensing review summary is completed for both initial and renewed licenses, which includes a health information report, a fire safety inspection, a sanitation inspection report (if required based on the type of license being issued), and an evaluation and recommendation. Nebraska requires the completion of the following background checks for all prospective foster and adoptive parents and other adult relatives and non-relatives living in the home prior to placement of a child:

- Federal Bureau of Investigation's (FBI) National Criminal History System;
- Nebraska Central Register for Child Abuse;
- Nebraska Adult Central Registry; and
- Nebraska State Patrol Sex Offender Registry.

In CY2007, there was an average of 2,158 fully licensed foster care homes in the state. This is a 5.3% decreased from 2,273 homes in CY2006.

Relative caregivers, or persons who are already known to the child, may be approved as the foster care placement without having full licensed status. Authorization must be obtained from the Service Area Administrator or his/her designee, if a home is to be approved instead of licensed.

In CY2007, there was an average of 1,619 approved foster care homes. This is a 46.8% decrease from 2,376 approved homes in CY2006. Overall, the combined average number of licensed and approved foster care homes decreased 18.8% from 4,649 in CY2006 to 3,777 in CY2007.

To meet the federal requirements in the Adam Walsh Child Protection and Safety Act, DHHS developed a policy memorandum stating:

- Staff will obtain the places of residence in the past five years for any prospective foster and/or adoptive parent and any other adult(s) age 18 and over living in the home.
- If the prospective parents and any other adult in the home have resided out of state in the five years prior to the date of application for licensure or approval, staff will request a child protective services check in each state where the person resided.
- All out-of-state background checks are required prior to the final approval or licensure of the foster and/or adoptive home.

b. Where was the child welfare and juvenile services system in Round One of the CFSR?

Nebraska was not in substantial conformity with this systemic factor in round one of the CFSR. Although Nebraska has state code for licensure, the criminal background clearances for foster and adoptive parents were not consistently implemented and the requirement did not include an FBI criminal background check. Also, Nebraska had a Foster and Adoptive Parent Recruitment and Retention Marketing Plan, but it was not scheduled to be implemented until July 2003.

c. What are the strengths and promising practices that the child welfare and juvenile services system has demonstrated in terms of its Foster and Adoptive Parent Licensing, Recruitment and Retention?

DHHS and NFAPA have an ongoing partnership in an effort to recruit and retain foster and adoptive parents. NAFAP perform a variety of activities, including:

- Management of the foster and adoptive parent inquiry line;
- Provision of in-service trainings and a foster parent mentoring program with regional groups in 36 areas of the state;
- Distribution of a bimonthly foster and adoptive parent newsletter;
- Distribution of guidebooks on assessment, foster care, and adoption, and adoption life books;
- Sponsoring an annual adoption conference, foster parent conferences, and the Foster Care Awareness Day

The Foster and Adoptive Parent Recruitment and Retention Marketing Plan was collaboratively developed by DHHS and NFAPA in April 2007 with a focus on products that emphasize and improve foster and adoptive parents roles as partners in serving children and families in foster care. The outcomes of this plan include: a contract with NFAPA to conduct 13 training sessions on FCP (refer to Section I) for foster parents across the state; a briefing of NFAPA foster parent mentors on the NSIS; the revision of the foster parent conflict resolution process; the development of a foster parent disaster plan; and the identification of service area emergency contacts for foster parents.

In 2006, DHHS collaborated with NFAPA and the Nebraska Broadcasters' Association to develop and air foster and adoptive parent recruitment campaigns. The foster care recruitment campaign was titled "Why You Should Become a Foster Parent," and the adoption recruitment campaign was titled "When I Get Home." It should be noted that the adoption recruitment campaign focused on the adoption of teenagers as stakeholders were concerned that prior recruitment efforts had emphasized the adoption of younger children. The ads were aired a total of 18,371 times across the state.

DHHS has a performance-based contract with the Adoption Partnership, which will play a large role in the recruitment of adoptive families. Please refer to Item 9 for more information on this partnership. Item 9 also provides detail on other efforts that have impacted the recruitment of adoptive families, such as National Adoption Day celebrations. National Adoption Day not only celebrates the many adoptions that occur on that particular day and throughout the year, but it also boosts the community's interest in adopting due to the media attention it receives.

d. What are the casework practices, resource issues, and barriers that affect the child welfare and juvenile services system's overall performance in terms of the Foster and Adoptive Parent Licensing, Recruitment and Retention?

Stakeholders identified barriers in this particular area, as summarized above. The most notable concern is that we do not currently have a comprehensive, statewide recruitment/retention plan that focuses on specific neighborhoods or cultural groups. Although a foster parent recruitment/retention plan was developed after the first CFSR round, funding and staffing restraints impacted its full implementation.

Section V – State Assessment of Strengths and Needs

1. Determine and document which of the seven outcomes and systemic factors examined during the statewide assessment are primarily strengths, citing the basis for the determination.

Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect. The absence of recurring maltreatment is determined to be a strength for the state. It has been hypothesized that the new intake tool implemented in 2003 (refer to Safety Outcome 1) increased the number of cases in which repeat maltreatment was reported because the tool clarified for workers what constitutes a new or existing maltreatment report and, as a result, it reduced the risk of underreporting recurring maltreatment. This hypothesis appears to have been correct since the number of accepted maltreatment reports has remained relatively stable since that time. According to the ACF data profile and additional N-FOCUS data, the percent of cases in which there was an absence of recurring maltreatment has since increased from 90.1% in FFY2005 to 93.7% as of January 2008. The collective rate for absence of recurrent maltreatment in the NE-CFSRs increased from 86% in 2005 to 95% in 2006. Additionally, N-FOCUS data from SFY2005 through SFY2006 indicates that workers are responding to maltreatment reports in a timelier manner.

Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate. Based on ACF and N-FOCUS data, reducing the risk of harm to children while in care is determined to be a strength for the state. The percent of cases in which there was an absence of child abuse/neglect in foster care increased from 99.57% in FFY2005 to 99.68% (meeting the national standard) as of January 2008. The state has also decreased the number of children maltreated by parents while in foster care from 1.75% in FFY2005 to 1.13% in the current reporting period (4/1/2006–3/31/2007). The implementation of the NSIS (refer to Section I) has most likely facilitated these reductions, as it provides a formal safety assessment process that begins at the point of initial assessment and continues at other key points throughout the life of the case.

Permanency Outcome 1: Children have permanency and stability in their living situations. Nebraska is doing well in establishing permanency for children in care for long periods of time, achieving legal freedom and facilitating timelier adoptions for children in care 17 months or more, increasing the number of legally free children who are adopted within 12 months of becoming legally free, and achieving independent living for children in care for three or more years. Also, Nebraska has gradually reduced the number of foster care re-entries from 15.3% in FFY2005 to 14.6% as of March 2007. The new intake tool and NSIS (refer to Section I) has most likely had the most direct impact on the reduction of foster care re-entries; the new intake tool facilitates the collection of more thorough information at the point of intake and the NSIS helps families achieve self-sufficiency to maintain a safe home environment for their family. Nebraska has also placed much emphasis on and has made extensive efforts towards adoption, as detailed in Item 9.

Systemic Factor A. State Information System. DHHS has in place a statewide information system that is used by all workers to identify the status, demographic characteristics, location, and goals for the placement of every child who is in care. The system is continuously upgraded

to accurately reflect state policy and procedures, to facilitate easy use for staff, and to generate informative data and reports. Recently, information from the system has been made available to the public so that they too can monitor our progress towards achieving safety, permanency, and well-being for the children and families we serve.

Systemic Factor B. Case Review System. This factor is determined to be primarily a strength for the state. DHHS staff has improved in creating case plans with the input of children and families, and updating those plans within a specified time frame. The courts, the FCRB, and other external partners and agencies are working more collaboratively to conduct periodic reviews of case plans. Parents are being notified of court hearings and, according to stakeholder comments, most parents are attending these hearings.

Systemic Factor C. Quality Assurance System. This factor is viewed as a strength for the agency. DHHS has implemented numerous comprehensive quality assurance system processes since round one of the federal CFSR and continues to do so. DHHS uses the information gleaned from the quality assurance processes to inform policy and practice related decisions. Recently, a more formalized system has been established within the new organizational structure to further emphasize and enhance our quality assurance efforts.

Systemic Factor D. Staff and Provider Training. Staff and provider training is determined to be a strength by the agency. All new staff is required to participate in an extensive training program prior to assuming case management responsibilities and all existing staff is required to participate in a minimum of 24 hours of ongoing training annually to enhance their knowledge, skills, and abilities. Providers are required to participate in ongoing training as well, with foster parents receiving initial and ongoing training through the PRIDE program and other training venues.

Systemic Factor F. Agency Responsiveness to the Community. This factor is determined to be a strength by both DHHS and external stakeholders. Stakeholders participating in the CFSR statewide assessment process noted increased collaborations between DHHS, the courts, and community providers. As a result, stakeholders believe DHHS is more responsive and is communicating more effectively with external partners and agencies. Tribal stakeholders also identified improvements in DHHS' responsiveness to Tribes. DHHS has made many efforts to engage and work with the courts, schools, community, and youth, in an effort to achieve the outcomes related to child and family safety, permanency, and well-being.

2. Determine and document which of the seven outcomes and systemic factors examined during the statewide assessment are primarily areas needing improvement, citing the basis for the determination. Identify those areas needing improvement that the state would like to examine more closely during the onsite review. Priority the list of areas needing improvement under safety, permanency, and well-being outcomes.

Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect. N-FOCUS data indicates that DHHS has recently improved in responding to maltreatment reports in a timely manner but that continued improvements are needed. Also, some service areas are struggling with providing services to children and families in non-court involved cases due to a reported lack of staff and resources. This concern should improve with the implementation of the NSIS (refer to Section I). Another issue to examine is whether or not case determinations are being made consistently throughout the state, so that we can better determine the accuracy of our

substantiation rates. Last, the NSIS (refer to Section I) has replaced what was previously an incident-based assessment process with a more comprehensive safety assessment process. DHHS is interested in examining how comprehensive assessments are being conducted and the impact of these new assessments on child safety.

Permanency Outcome 1: Children have permanency and stability in their living situations.
Nebraska is struggling with achieving permanency for children with the goals of reunification, guardianship, and independent living or self-sufficiency. Median months to discharge have steadily increased across all of these categories, although to a larger degree in discharges to guardianship and "other" permanency goals (e.g., independent living or self-sufficiency). Our performance in Permanency Composite 1 (e.g., reunification) declined from FFY2005 to the current reporting period (4/1/2006–3/31/2007). It should also be noted that Nebraska is not meeting the national goal in the permanency composite relating to timely adoptions. The percent of children discharged to a finalized adoption in less than 24 months has actually decreased from FFY2005 to FFY2007. Areas to explore include:

- Whether permanency hearings for children in care 15 of the last 22 months are being conducted in a timely manner;
- Whether concurrent planning is being applied in all applicable cases;
- Issues surrounding any delays in the filing of TPRs and the TPR appeals process (and any impact the recent court initiatives have had on these delays);
- Whether or not workers are identifying non-custodial and/or absent parents early in cases;
- The use (or lack thereof) of the adoption exchange services, and reasons why the service is not utilized;
- Workers' level of knowledge on independent living services;
- Issues surrounding the documentation (or lack thereof) of independent living plans; and
- Whether the barriers to parents receiving timely and appropriate treatment services impact the timeliness of establishing permanency for children.

Permanency Outcome 2: The continuity of family relationships and connections is preserved for children. NE-CFSR data indicates a decline in all items under this particular outcome, with the most significant decline occurring in the promotion of visitation between children, parents, and siblings, and less significant declines occurring in the location and securing of relative placements and placing children with siblings. Also of note, in cases in which child and parent relationships were found to be lacking, most often it was in regards to fathers or absent parents. Comments from stakeholders participating in the current federal CFSR statewide assessment process reveal that the preservation of family and community connections for Native American or Tribal children is an issue at times. Issues that arose during the statewide assessment process and that warrant further analyses during the onsite review include:

- Whether visitation is being used to promote and build family relationships and allow for the assessment of parenting knowledge, skills, and abilities;
- The quality of contracted visitation services currently being provided;
- ICWA compliance and issues related to providing services to and preserving connections for Native and Tribal children and families;
- The identification of non-custodial and other family members early in cases; and
- The quality of parent connections.

Well-Being Outcome 1: Families have enhanced capacity to provide for their children's needs.
N-FOCUS data reveals that the state is not currently meeting its goal of documenting case plans in N-FOCUS or conducting monthly visits with children in care. Family team meetings are not

generally being conducted as required. There is a lack of involvement of non-custodial parents in family team meetings and other case planning activities, as revealed by multiple sources of data. Issues to be examined include:

- The level of involvement of non-custodial parents in children's plans and barriers to involving non-custodial parents;
- How children, parents, and families perceive the dynamics of family team meetings; and
- The quality of worker visits with children and families.

Systemic Factor E. Service Array. Stakeholders noted a lack of accessible services in all areas of the state. In a rural state, a lack of services in remote regions often leads to children being moved outside of their community to other areas to receive services, or traveling long distances to receive these services. Nebraska's child welfare and juvenile services system was also described by stakeholders as a "bed-based" system that relies heavily on out-of-home group home or facility care and does not offer early up front services in the home. Data indicates that the majority of children in care are receiving services in out-of-home care settings. Parents are also encountering long waiting lists to receive the services they need to address the issues that make their children unsafe, particularly substance abuse and mental health services. The implementation of NSIS (refer to Section I), the development of new safety services and the new behavioral health initiative (refer to Systemic Factor E) may alleviate these barriers in the near future, but currently these issues remain.

3. Recommend two additional sites for the onsite review activities.

Ten of the 93 counties throughout the state (excluding the largest metropolitan area, which is automatically selected as one of the three review sites) had a sufficient number of in-home and out-of-home cases from which to select an adequate sample of cases for review. Individual county-level data was compiled for each site, including: safety measures and permanency composites (included in Table 7), additional safety and permanency related data, county demographics, and demographics of children in care in that particular county.

Table 7. Safety Measures and Permanency Composite Scores by Counties Eligible for Review

County	Absence of Recurrent Maltreatment	Absence of Maltreatment in Care	P1: Timeliness and Permanency of Reunification	P2: Timeliness of Adoption	P3: Permanency for Children in Care for Long Periods of Time	P4: Placement Stability
Adams	100.0%	100.00%	117.0	128.7	139.8	93.4
Buffalo	100.0%	100.00%	106.8	69.8	200.3	93.9
Dawson	100.0%	100.00%	123.5	173.4	155.2	104.1
Dodge	92.9%	92.06%	135.3	106.9	143.4	89.5
Douglas	89.6%	99.97%	116.0	99.9	148.6	89.7
Hall	100.0%	99.13%	104.0	154.4	138.5	85.2
Lancaster	92.3%	99.77%	90.7	96.3	146.7	90.6
Lincoln	100.0%	99.73%	110.1	54.4	151.6	86.4
Madison	90.0%	100.00%	83.9	131.8	159.0	82.4
Sarpy	100.0%	100.00%	143.4	75.2	156.1	92.4
Scotts Bluff	100.0%	99.08%	121.6	40.3	112.7	96.1

Statewide assessment team members were also asked to identify the top two sites they would suggest for review based on their analysis of the data and their group discussions within the team. Additionally, each of the five local service areas were asked which counties they would recommend to participate in the review, based on performance, identified strengths or barriers, new or promising practices, or other unique issues.

These data and suggestions were used to narrow the ten eligible counties to four counties: Hall, Dawson, Dodge, and Scotts Bluff. Statistical and background information on all ten counties eligible for review was shared with our federal partners, along with a description of how and why we came to believe Hall, Dawson, Dodge, and Scotts Bluff counties were the ideal counties for review. Federal approval was granted for Douglas (Omaha), Hall (Grand Island), and Dawson (Lexington) counties to serve as the three sites for review. The following provides a brief synopsis of each county, with additional detail on the unique issues occurring in Hall and Dawson counties and that influenced the site selection decisions:

Douglas County. The metropolitan area of the state is Douglas County. While it is one of the geographically smallest counties in the state, it has the largest in population with 492,003 residents. The county also comprises one of the wealthiest regions in the state. Douglas County's largest city is Omaha, with a population of 446,915 residents.

Hall County. Hall County is located in the central Nebraska and has a population of 53,534 residents. It is served by the local office in Grand Island, the fourth largest city in the state. Hall County has the higher percentage of Hispanic children and children five years of age or younger in out-of-home care. The county is particularly interested in identifying any cultural or immigration issues that may be increasing the number of Hispanic youth in out-of-home care. The county is also struggling with the filing of TPRs and TPR appeals delaying permanency for children in care. They note a lack of early intervention services and adolescent substance abuse services in the county, and an increasing number of youth being sent to probation rather than OJS. Hall County is one of the areas that is participating in the service array project (refer to Systemic Factor E). Additionally, the county implemented pre-hearing conferencing approximately one year ago and they are interested in examining if this has impacted the timeliness in identifying non-custodial parents, the use of informal supports, the timeliness of reunification, or the establishment of alternative permanency goals when reunification is not possible.

Dawson County. Dawson County is a rural county with approximately 25,000 residents. It is located in the southwest region of the state and served by the local office in Lexington. Dawson County is unique in a number of ways. There is a meat packing plant in the community, which has drawn many Hispanic families to the community for employment. The community has a low tolerance of cultural differences and needs and there is a lot of bitterness in the community due to the increased minority population. The levels and quality of services minority children and families receive from some community agencies reflect these sentiments. There is also a lack of community activities and support for teens outside of school and the area has experienced an increase in gang affiliation. There is a low tolerance of the misbehavior of youth and schools and law enforcement are placing more emphasis on truant or delinquent youth. More of these youth are being placed on probation rather than in the care of OJS. Dawson County reports a good working relationship with the County Attorney's Office and the courts. The area would like to examine the significant

decrease in their substantiation rates. They are also interested in identifying the potential causes for their success in facilitating adoptions.

4. Provide comments about the state's experience with the statewide assessment instrument and process.

Nebraska's experience with the statewide assessment instrument and process was positive overall, but it was not without its challenges. It would be helpful to be granted more time between the state's receipt of the state data profile and the initiation of the statewide assessment process. This would allow for a more complete compilation and analysis of additional data that could potentially shed some light or provide further clarification on issues or questions arising from an analysis of the data profile itself.

Another challenge was trying to meet the documentation requirements within the statewide assessment instrument itself. Every attempt was made to address each item and factor with the sufficient amount of data, information, and analysis as requested, yet remain within the allotted number of pages.

5. Provide the names and affiliations of the individuals who participated in the statewide assessment process and please note their roles in the process.

The following list of people attended one or more of the statewide assessment team meetings and provided information and feedback throughout the statewide assessment project. We would like to thank these individuals for their time, commitment, and support.

Department of Health and Human Services Stakeholders	
Division of Children and Family Services Staff	
Todd Landry	Division of Children and Family Services Director
Todd Reckling	Policy Section Administrator
Margaret Bitz	Foster Care/Adoption Administrator
Chris Hanus	Child Welfare Unit Administrator
Lori Harder	Child Abuse and Neglect Administrator
Rita Krusemark	Child Welfare Unit Program Specialist
Shirley Pickens-White	Child Welfare Unit Program Specialist
Kathy Anstine	Quality Assurance Specialist
Monica Dement	Quality Assurance Specialist
Terri Farrell	Quality Assurance Administrator
Frank Fornataro	Comprehensive Quality Improvement/Operations Unit Business Analyst
Sherri Haber	Comprehensive Quality Improvement/Operations Unit Administrator
Sheila Kadoi	Quality Assurance Specialist
Lori Koenig	Comprehensive Quality Improvement/Operations Unit Business Analyst
Joe Skorupa	Comprehensive Quality Improvement/Operations Unit Business Analyst
Michaela Swigle	Quality Assurance Specialist
Rachel West	Comprehensive Quality Improvement/Operations Unit Program Specialist
Allison Wilson	Comprehensive Quality Improvement/Operations Unit Program Coordinator
Terri Nutzman	Office of Juvenile Services Administrator
Trish Bergman	Food Stamps/TANF Administrator
Betty Medinger	Child Care/NHAP/Refugee Program/CSBG Administrator
Lindy Bryceson	Protection and Safety Administrator

Division of Children and Family Services Staff (cont.)	
Kathy Carter	Protection and Safety Administrator
Jerrilyn Crankshaw	Protection and Safety Administrator
Kinsey Baker	Protection and Safety Administrator
Camas Diaz	Protection and Safety Administrator
Treva Haugaard	Protection and Safety Administrator
Maria Lavicky	Protection and Safety Administrator
Jana Peterson	Protection and Safety Administrator
Melanie Strathman	Protection and Safety Administrator
Cindy Williams	Protection and Safety Administrator
Jodi Allen	Protection and Safety Supervisor
Pat Anderson	Protection and Safety Supervisor
Kristi Dowse	Protection and Safety Supervisor
Sara Jelinek	Protection and Safety Supervisor
Benita Steffes	Protection and Safety Supervisor
Theresa Dunson	Protection and Safety Worker
Brandee Ehlers	Protection and Safety Worker
Colby Holtz	Protection and Safety Worker
Shawn La Roche	Protection and Safety Worker
Kelly Nelson	Protection and Safety Worker
Judy Pfeifer	Protection and Safety Worker
Division of Behavioral Health	
Vicki Maca	Children's Behavioral Health Sect./Community-Based Services Sect. Administrator
Division of Medicaid and Long-Term Care	
Roxie Cillessen	Behavioral Health, Pharmacy, and Ancillary Services Unit Administrator
Division of Public Health	
Pat Urzedowski	Child Care Licensing Administrator
Operations	
Mary Osborne	Human Resources and Development Section Administrator
Paulette Wathen	Human Resources and Development Section Resource Coordinator
Service Area Administrators	
Nathan Busch	Western Service Area Administrator
Barry DeJong	Eastern Service Area Administrator
Mike Puls	Northern Service Area Administrator
Yolanda Nuncio	Central Service Area Administrator
Jeff Schmidt	Southeast Service Area Administrator

Stakeholders from Partner Agencies and the Community	
Karen Authier	Nebraska Children's Home Society
Lynn Ayers	Lincoln/Lancaster County Child Advocacy Center
Marvin Binnick	Foster Youth Council
Trisha Blakely	Healthy Families Project
Cassy Blakely	Nebraska Children and Families Foundation
Eve Bleyhl	Nebraska Family Support Network
Lisa Blunt	Child Saving Institute
Denise Christensen	Family Advocacy Network
Sharon Dalrymple	Families Inspiring Families
Daniel L. Daly	Boys Town
Anderson Debra	Project Harmony Child Advocacy Center

Stakeholders from Partner Agencies and the Community (cont.)	
Dr. Mark DeKraai	University of Nebraska Public Policy Center
Kathleen Dolzzal	Governor's Policy Research Office
Renee Dozier	Region 5 Behavioral Health Services
Elizabeth Dugger	SPEAK OUT Nebraska
Sue Ellermeier	South Central Behavioral Services, Inc.
Mary Frasier Meints	Nebraska Assc. of Homes and Services for Children – Uta Hallee Girls Village
Cindy Goodin	Youth Emergency Services
Tim Guetterman	Region 6 Behavioral Health Services
Gregg Hanson	Ponca Tribe of Nebraska
Kelli Hauptman	University of Nebraska-Lincoln Center on Children, Families, and the Law
Ruth Henrichs	Lutheran Family Services
Jessica Hilderbrand	Nebraska Children and Families Foundation
John Hoffman	Visinet, Inc.
Liz Hruska	Nebraska Legislature
Rose Hughs	Nebraska Children and Families Foundation
Frann Huse	Nebraska Family Support Network
Nick Juliano	Boys Town
Candy Kennedy	Nebraska Federation of Families for Children's Mental Health
Pam Kirschman	Child Connect
Carol Knierman	Foster Care Review Board
Patrick Kreifels	Region 5 Behavioral Health Services
Gloria LaCrosse	The Salvation Army CARES
Tara Leonard	Child Connect
Regina Littlebeaver	Winnebago Tribe of Nebraska
Ann Masters	Nebraska Department of Education
Mary McKee	Administration for Children and Families
Katie McLesse-Stephenson	CEDARS
Monica McMahon	Child Connect
Amanda Miller	Fillmore County CASA
Kathy Moore	Voices for Children in Nebraska
Felicia Nelsen	Nebraska Foster and Adoptive Parent Association
Lisa Nicklas	Christian Heritage Children's Homes
Leeann Nielsen	Bridge of Hope Child Advocacy Center, Inc.
Kathy Olson	University of Nebraska-Lincoln Center on Children, Families, and the Law
Robert Pick	Boys Town
Brenda Riley	Region 4 Behavioral Health Services
Carly Runestad	Nebraska Hospital Association
Cindy Ryman Yost	Child Welfare League of America
Sabrina Schalley	Child Saving Institute
Sondra Schwehn	Central Nebraska Child Advocacy Center
Georgie Scurfield	Sarpy County CASA
Amy Sherbeck	South Central Behavioral Services, Inc.
Bob Storey	Youth Emergency Services
Mark Storetvedt	Oasis Counseling International
Lana Temple-Plotz	Lutheran Family Services
Patrick Tyler	Boys Town
Dr. Dana Wear	Child Saving Institute
Lynn Weidel	Nebraska Foster and Adoptive Parent Association
Dr. Vicky Weisz	University of Nebraska-Lincoln Center on Children, Families, and the Law

It should also be noted that many of the focus groups conducted during the statewide assessment project were facilitated by some of the same community partners and agencies listed above. These agencies include: the Nebraska Foster and Adoptive Parent Association; the Nebraska Children and Families Foundation; the University of Nebraska-Lincoln Center on Children, Families, and the Law (Court Improvement Project); and the Nebraska Federation of Families for Children of Mental Health (with partner family organizations). Additionally, DCFS ICWA Specialist Sherri Eveleth facilitated the Tribal focus group. We would like to thank these organizations and individuals as well as all focus group participants for their time and assistance.

Appendix A – List of Acronyms

A

ACF	Administration for Children and Families
AFCARS	Adoption and Foster Care Analysis Reporting System
ANI	Area Needing Improvement
APSR	Annual Progress and Services Report
ASFA	Adoption and Safe Families Act
ASO	Administrative Service Organization

B

BSEP	Better Service through Enhanced Partnering

C

CAC	Child Advocacy Center
CAN	Child Abuse and Neglect
CAPTA	Child Abuse Prevention and Treatment Act
CCFL	Center on Children, Families, and the Law
CDT	Competency Development Tool
CEO	Chief Executive Officer
CFSP	Child and Family Services Plan
CFSR	Child and Family Services Review
CIP	Court Improvement Project
COMPASS	Children's Outcomes Measured in Protection and Safety Statistics
CQI/OU	Comprehensive Quality Improvement /Operations Unit
CWLA	Child Welfare League of America
CWU	Child Welfare Unit
CY	Calendar Year

D

DBH	Division of Behavioral Health
DCFS	Division of Children and Family Services
DEC	Drug Endangered Children's Committee
DHHS	Department of Health and Human Services
DMLTC	Division of Medicaid and Long-Term Care

E

EA/CSEU	Economic Assistance/Child Support Enforcement Unit
EDN	Early Development Network
ETV	Education and Training Vouchers Program

F

FBI	Federal Bureau of Investigation (FBI)
FCI	Fostering Court Improvement (FCI)
FCP	Family Centered Practice (FCP)
FCRB	Foster Care Review Board (FCRB)
FFY	Federal Fiscal Year (FFY)
FTS	Field Training Specialist (FTS)

FWP	Former Ward Program (FWP)
FYC	Foster Youth Council (FYC)

G

GED	General Education Development
GYAC	Governor's Youth Advisory Council

H

HRD	Human Resources and Development

I

ICCU	Integrated Care Coordination Units (ICCU)
ICJ	Interstate Compact on Juveniles (ICJ)
ICPC	Interstate Compact on the Placement of Children (ICPC)
ICWA	Indian Child Welfare Act (ICWA)
IDEA	Individuals with Disabilities Education Act (IDEA)
IEP	Individualized Education Program (IEP)
IOP	Intensive Outpatient Program (IOP)

L

LB	Legislative Bill

N

N-FOCUS	Nebraska Family Online Client User System
NCANDS	National Child Abuse and Neglect Data System
NCFF	Nebraska Children and Families Foundation
NCJIS	Nebraska Criminal Justice Information System
NDE	Nebraska Department of Education
NE-CFSR	Nebraska Child and Family Services Review
NFAPA	Nebraska Foster and Adoptive Parent Association
NRCOI	National Resource Center for Organizational Improvement
NRS	Nebraska Revised Statute
NSIS	Nebraska Safety Intervention System

P

PALS	Preparation for Adult Living Services
PCA	Protective Capacity Assessment
PIP	Program Improvement Plan
PRIDE	Parent Resources for Information Development and Education
PSA	Protection and Safety Administrator
PSS	Protection and Safety Supervisor
PST	Protection and Safety Trainee
PSW	Protection and Safety Worker

R

RFB	Request for Bids
RFP	Request for Proposals

S

SACWIS	Statewide Automated Child Welfare Information System
SAMHSA	Substance Abuse Mental Health Services Administration
SFY	State Fiscal Year
SIG	Systems Integration Grant
SSA	Social Security Act

T

TPR	Termination of Parental Rights

Y

YLS/CMI	Youth Level of Service/Case Management Inventory
YRTC-G	Youth Rehabilitation and Treatment Center in Geneva
YRTC-K	Youth Rehabilitation and Treatment Center in Kearney

W

WFI	Wraparound Fidelity Index