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Julie L. Rogers

Office of Inspector General of Nebraska Child Welfare

September 15, 2014

The Honorable Dave Heineman
State of Nebraska
State Capitol
Lincoln, NE 68509

Health and Human Services Committee
Nebraska Legislature
State Capitol
Lincoln, NE 68509

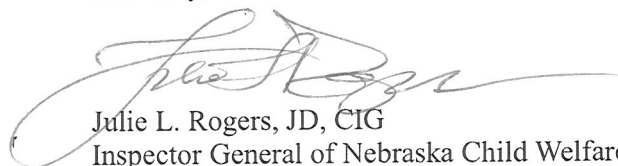
Dear Governor Heineman, Chairperson Campbell, and Senators of the Health & Human Services Committee:

In accordance with Neb. Rev. Stat. §43-4331, I submit the Office of Inspector General of Nebraska Child Welfare Annual Report for 2013-2014.

The Office of Inspector General of Nebraska Child Welfare was established to provide increased accountability and oversight of the Nebraska child welfare system through a full-time investigation and performance review program. It has been my privilege and honor to serve in this capacity.

Should you have any questions, please do not hesitate to contact me at 402-471-4211 or jrogers@leg.ne.gov.

Sincerely,



Julie L. Rogers, JD, CIG
Inspector General of Nebraska Child Welfare



Annual Report
2013-2014

September 15, 2014

OFFICE OF
**Inspector General of
Nebraska
Child Welfare**

As set forth by the Office of Inspector General of Nebraska Child Welfare Act (Neb. Rev. Stat. §§43-4301 – 43-4331), the Office is established to provide increased accountability and oversight of the Nebraska child welfare system through a full-time investigation and performance review program. This includes assisting in improving operations of the Department of Health and Human Services relating to the Nebraska child welfare system, providing an independent form of inquiry (an official effort to collect and examine information) for concerns regarding the actions of individuals and agencies responsible for the care and protection of children in the Nebraska system, and provide a process for review and investigation to determine if individual complaints and issues of investigation and inquiry reveal a problem in the child welfare system, not just individual cases, that necessitates legislative action for improved policies and restructuring of the child welfare system. Additionally, the Office of Inspector General of Nebraska Child Welfare is required to complete an annual report by September 15 of each year. Consistent with these duties, the following report highlights the activities and efforts of the OIG from July 1, 2013 through June 30, 2014.

The Office of Inspector General of Nebraska Child Welfare thanks and acknowledges the Nebraska Legislature and legislative staff for continuing to provide help and advice, the Health and Human Services Committee in particular. The Ombudsman's Office goes above and beyond in assisting the office in countless ways—operatively and substantively. The most sincere and heartfelt appreciation for all of the time, talent, and counsel that has been offered.

Finally, please note that the Department of Health and Human Services continues to be very responsive and timely in any request that has been made of them from the Office of Inspector General of Nebraska Child Welfare during the preceding year, as has Nebraska Families Collaborative, any other child and family serving agency, as well as any law enforcement agency that was asked for information from or for a meeting with the office.

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September 15, 2014

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EXECUTIVE SUMMARY

The Office of Inspector General of Nebraska Child Welfare (OIG) was created to provide increased accountability and oversight of Nebraska's child welfare system. The OIG investigates complaints, child deaths, and other critical incidents involving Nebraska's state wards, and in every instance, looks for system-wide implications.

Provided in this report is a detailed review of many issues Nebraska's child welfare system currently faces as it goes from crisis to stability. Child welfare outcomes are improving in many areas, but goals such as timeliness of permanency, rates of contact with parents, and involving families in decision making still need improvement. Families have too many caseworkers and are spending far too much time in the system prior to permanency. No service area has yet met the caseload targets set forth in statute in any given month.

Key in implementing quality models require improvements in several areas:

- Reaching a coordinated system that is trauma informed is essential. Understanding the effects of trauma will enable lawmakers, administrators, providers, and other leaders to design rehabilitative systems and behavioral health treatment models that are much more efficient and effective than in the past.
- The expectation must be that the trauma inflicted by state intervention is, in each instance, less than the trauma that would have resulted from doing nothing and that any care provided is targeted, timely, and effective.
- Decreasing worker turnover and caseworker caseload size are central to further advances to the system. Understanding system-involved families' needs, knowing what the best practices are to address those needs, and engaging the families in those practices is a difficult and stressful job. Management structure changes can only accomplish so much. Ultimately, excellent caseworker performance is the key to a great child welfare system.

Also included in this report is an overview of the Youth Rehabilitation and Treatment Centers (YRTC)—the placement of last resort for children in our juvenile justice system. They are thought of as the most restrictive placements for juveniles, meant to house and provide treatment to only those violent or dangerous youth who cannot be safely placed within their community or in any less restrictive setting. Several measures are outlined to improve the functioning of YRTCs.

Many of problems that remain within child welfare and juvenile justice require complicated and nuanced solutions and involve coordinated action among different agencies and branches of government. As we look forward to focusing on quality, the OIG remains cautiously optimistic that child-serving entities in Nebraska are continuing to progress to better and more appropriate services for our children and families.

OVERVIEW – THE OFFICE OF INSPECTOR GENERAL OF NEBRASKA CHILD WELFARE

The Office of Inspector General of Nebraska Child Welfare (OIG) was created to provide increased accountability and oversight of Nebraska's child welfare system, including any public or private individual or agency serving children in the state's care. The “child welfare system” generally refers to any child-serving government or government supported entity in Nebraska.¹

The OIG investigates (1) death or serious injury of a child which occurs in foster homes, private agencies, child care facilities, and others under contract with or receiving services through the Department of Health and Human Services; and (2) complaints of wrongdoing to children and families being served by or through the Department of Health and Human Services or private entities. (Neb. Rev. Stat. §43-4318). The OIG provides accountability and oversight of Nebraska's child welfare system by tracking issues and themes. System improvement recommendations are made both informally and formally to the Legislature's Health and Human Services Committee, the Department of Health and Human Services, Division of Children and Family Services, and the Governor.

Legislative History & Authority

In 2011, the Nebraska Legislature adopted Legislative Resolution 37, which directed the Health and Human Services Committee to review, investigate and assess the effects of child welfare reform which began its implementation by the Department of Health and Human Services in July 2009. One of the 18 significant recommendations by the Health and Human Services Committee was to create the position of Inspector General of Nebraska Child Welfare to enhance accountability and facilitate reform in the child welfare system, by being given jurisdiction to investigate state and private entities that serve children.

Office of Inspector General of Nebraska Child Welfare Act.² The Office of Inspector General of Nebraska Child Welfare Act (Act) was enacted by Legislative Bill 821 during the 2012 Legislative Session. The Act, Neb. Rev. Stat. §§43-4301 to 43-4331, sets forth that the Office of Inspector General of Nebraska Child Welfare (Office) is to:

- Provide increased accountability and legislative oversight of the Nebraska child welfare system;
- Assist in improving operations of the Department of Health and Human Services;
- Offer an independent form of inquiry for concerns—specifically regarding the actions of individuals and agencies responsible for the care and protection of children in the Nebraska child welfare system;
- Provide a process for investigation and review to determine whether individual complaints and issues inquiries reveal a system problem, which then necessitates legislative action; and
- Conduct investigations, audits, inspections, and other reviews of the system.

¹This includes what is traditionally known as juvenile justice. Substantive changes made to the Office of Inspector General of Nebraska Child Welfare Act during the 2013 Legislative Session included adding to the jurisdiction of the OIG—secure juvenile detention, staff secure juvenile detention, and private entities serving youth under contract with the Office of Probation Administration. Legislative Bill 561, 2013. Neb. Rev. Stat. §43-4318 et. al.

²The text of the Office of Inspector General of Nebraska Child Welfare Act appears in the Appendix of this report.

Julie L. Rogers was appointed to serve as the first Inspector General of Nebraska Child Welfare (IG). She is a certified inspector general through the Association of Inspectors General. The Office of Inspector General of Nebraska Child Welfare (OIG) was deemed “opened” when the appointed IG began her duties at the end of July 2012.

Office of an Inspector General. The OIG is the first established inspector general's office within Nebraska state government as provided for in state statute.³ As such, it is important to understand the concept for inspectors general offices. The core values of an office of inspector general are honesty, integrity, and trustworthiness. This is accomplished through inspector general standards of independence and confidentiality. The fundamental objective of inspectors general offices is to promote accountability, transparency, good government, and high performance. The OIG's objective is to promote these as it specifically relates to child welfare—any child-serving government or government-supported entity—in Nebraska.

“...The public expects OIGs to hold government official accountable...and to prevent, detect, identify, expose and eliminate fraud, ...illegal acts and abuse. This public expectation is best served by inspectors general when they follow the basic principles of integrity, objectivity, independence, confidentiality, professionalism, competence, courage, trust, honesty, fairness, forthrightness, public accountability and respect...”

Statement of Principles for Offices of Inspector General, Association of Inspectors General

Operation within the Ombudsman's Office. The OIG was established within the Division of Public Council (Ombudsman's Office) within the Nebraska Legislature. The Ombudsman's Office handles individual complaints about the actions of administrative agencies of state government, including those state agencies serving children and state wards. The Ombudsman's Office investigates and resolves complaints informally by working with parties involved, all the while promoting accountability in public administration. It makes sense, then, that the OIG's establishment be within the Ombudsman's Office in order to most efficiently work towards a shared goal: promoting the accountability of Nebraska's child welfare system.

Specifically, the OIG relies on the Ombudsman's Office for operations—physical space, equipment, office supplies, travel, and the like. Moreover, the OIG relies on the Ombudsman's Office for staffing cases to pinpoint and recognize systems issues within the child welfare system based on their complaint handling; mediating complaints made to the OIG, but that do not rise to the level of a full investigation and are then referred to the Ombudsman's side; and giving input on recommendations to improve the child welfare system based on their experience in working child welfare, mental health, and developmental disability-related individual cases.

Activities. In addition to investigations, reviews, and evaluations, the OIG participates in several initiatives created to elevate the workings of various areas in serving children in the state's care. Most notably, these included the Nebraska Supreme Court Commission on Children in the Courts, the Workforce Development Workgroup and the Juvenile Services Committee of the Nebraska Children's Commission, the Statewide Juvenile Detention Alternatives Initiative, the Director's Alternative Response Team, and the Barriers to Permanency Project. The position of the Inspector

³Other Offices of Inspectors General may exist in Nebraska, but they are more closely associated with the federal government and internal military operations.

General of Nebraska Child Welfare is a statutory member to the Nebraska Children's Commission⁴ and the Child and Maternal Death Review Team.⁵ Experiences and information gleaned from these activities bear substantial weight on the development of special projects and initiatives.

Challenges. The OIG does not come without challenges. There is general confusion as to the role and expectations of the OIG, the difference between work of the Ombudsman's Office and the OIG, and what exactly the OIG can do to solve individual problems. Standards for inspector general's offices require very meticulous, patient, and thorough work. This coupled with high numbers of statutorily mandated investigations and low staffing levels has created tension concerning the timeliness of full investigations.

To deal with these challenges, the OIG will reach operational capacity as new staff⁶ are trained and their new roles are solidified. In addition, the OIG will better strive toward:

- Completing full investigations with meaningful findings and recommendations.
- Focusing on recommendations for policy improvement.
- Associating with other Offices of Inspectors General to learn from others with more established and experienced offices.
- Ascertaining and utilizing a comprehensive OIG case management system for tracking cases, complaints, and issues.
- Making the OIG most efficient and effective by continually seeking out better ways to complete the work.
- Being responsive to individual complainants, thoroughly reviewing critical incident reports for full investigations, and clarifying needed improvements in the child welfare system.
- Improving timeliness through established protocols.
- Serving as an active member of initiatives to improve child welfare and juvenile justice in Nebraska.
- Conducting outreach to counties, child-serving professionals, and policy makers across the state, with a focus on reaching families and youth through leading special projects.
- Continuing frequent informal and formal communication with the Chairperson of the Health and Human Services Committee and the committee itself.

⁴Legislative Bill 269, 2013. Neb. Rev. Stat. §43-4202.

⁵Legislative Bill 361, 2013. Neb. Rev. Stat. §71-3406.

⁶Funds were appropriated to hire 2 new positions under the OIG beginning July 1, 2014. Those positions are an assistant inspector general for investigations and an executive intake assistant.

CONTACT TO THE OFFICE OF INSPECTOR GENERAL: INQUIRIES, REVIEWS, INVESTIGATIONS

The OIG investigates complaints of child welfare violations that arise from a variety of sources, including complaints from the public, information developed during the course of other reviews and activities, and requests for review and assistance by various parties. Overall, from July 1, 2013 to June 30, 2014, the OIG:

- Received approximately 120 specific complaints from the public.
- Reviewed 225 CFS critical incident reports. 12 of these reports rose to a level of further or full investigation.
- Received around 80 inquiries for information from various sources about certain situations occurring in or around state government relating to children.

In some instances, these inquiries or reviews lead the OIG to conduct comprehensive investigations, while in other instances the OIG forwarded the complaint to the appropriate oversight, regulatory, or appropriate agency. In some situations, whether or not they call for a full investigation, reviews lead to realization of issues that need to be addressed or areas that need to be improved. The OIG forwards complaints to other agencies if a preliminary investigation reveals that the complaints are outside of the office's jurisdiction or would be more appropriately handled elsewhere. The OIG also tracks child welfare system issues to most appropriately make system improvement recommendations.

Individual Inquiries & Complainants—Reviews. By conducting thorough reviews of the public's inquiries and complaints, as well as CFS critical incident reports, much is gleaned. Often such cases reveal a problem in the child welfare system that calls for improved policies and/or restructuring of the systems dealing with children in Nebraska. Understanding what has gone wrong, and specifically for the OIG, what has resulted in something negative happening to a child and/or family, is crucial in making recommendations for improvement.

In terms of investigations, the Act specifies when a complaint is warranted and when a full investigation shall be completed. Generally, a full investigation will be undertaken when, after a review and a determination is made that the allegations can be independently verified through investigation, there are incidents of misconduct, misfeasance, malfeasance, violation of statute, or violation of rules and regulations. The OIG shall investigate when there is a death or serious injury in a foster home, private agency, detention, child care facility, or other program under contract with the Department of Health and Human Services or Office of Probation Administration; or when the case involves an investigation under the Child Protection Act open one year or less.

Nature of Inquiries, Reviews, Investigations

The two significant ways the OIG receives information that leads to reviews and investigations are, through the CFS critical incident reporting procedures and through public complaints and inquiries.

Critical Incident Reports. The Nebraska Department of Health and Human Services is required to report all cases of death or serious injury of a child to the OIG.⁷ CFS does this through their Critical Incident Reporting process as set forth by CFS Administrative Memo #6-2014. The memo sets forth

⁷Neb. Rev. Stat. §43-4318 (1)(b).

what kinds of critical incidents require reporting. These include but are not limited to:

1. Death of a child resulting from abuse or neglect, where abuse or neglect is a possible cause or contributing factor of child death, or in any case of unexpected child death where there is not a clearly identified medical cause such as an illness, a trauma event such as a motor vehicle accident, or something similar;
2. Near fatality, life threatening condition or serious injury of a child resulting from abuse or neglect;
3. Suicide or attempted suicide of a state ward or a child with whom the Department of Health and Human Services is involved;
4. Elopement of a youth from a state run facility;
5. Law Enforcement: Legal allegations or arrests of youth for serious illegal/criminal activity (i.e. homicide, manslaughter; near fatality of another person, sexual assault, 1st or 2nd degree assault, aggravated or armed robbery; etc.);
6. High Profile: Any other event that is highly concerning, poses potential liability, or is of emerging public interest, such as contacts involving the media; and
7. Any other incident designated by the Director.

This listing is not exhaustive and is meant to be used as a minimum guide.

The Act requires investigations of death or serious injury to children served by CFS or by entities contracted by CFS to provide care. “Serious injury” is defined as, “an injury or illness caused by suspected abuse, neglect, or maltreatment which leaves a child in critical or serious condition.”⁸ Of the 225 reports reviewed in FY 2013/2014, about 65 of the reports related to state wards who were system-involved as either status offenders or delinquents at the time of the report. This is significant as supervision of such youth have been transferred from CFS to the Office of Probation Administration as part of juvenile justice reform set forth in Legislative Bill 561, 2013, during FY 2013/2014. As such, this office has not received critical incident reports on these juvenile justice cases since July 1, 2014.⁹

Inquiry & Review Process

Whether investigating critical incident reports or individual complaints, the OIG thoroughly reviews each. This includes gathering information from N-FOCUS, the CFS digital document database, as well as JUSTICE, which contains court documents, and talking with various parties about the case, usually the caseworker and/or the supervisor. Then a determination is made about whether to exercise options of opening an investigation or formally referring the complaint to the Ombudsman's Office or other agency to resolve. Sometimes after reviews are completed, it could be determined that no jurisdiction exists for case specific action by the OIG (for example, custody issues in divorce cases, issues related to probation, or issues related to the courts). Systemic issues are always noted.

⁸Neb. Rev. Stat. §43-4318 (1)(b).

⁹ The OIG and Office of Probation Administration are currently working on a process whereby the OIG is notified when there is a significant incident regarding juveniles on probation. In order to have the ability to retrieve all relevant information in cases where the OIG must investigate related to a juvenile on probation, statutory language clarifying the OIG’s proper access to information will be needed.

ISSUES IDENTIFIED BY THE OFFICE OF THE INSPECTOR GENERAL

The Office of the Inspector General of Nebraska Child Welfare (OIG) is charged with investigating problems in Nebraska's child welfare system.¹⁰ The purpose of doing so is not only to uncover wrongdoing or serious oversight, but, in every instance, to look for system-wide implications. The OIG strives to provide a systemic perspective which can guide lawmakers, advocates, administrators, and other stakeholders in efforts to improve Nebraska's child welfare system.

Over the past two years the OIG has received hundreds of complaints and notices of serious incidents involving children in the state's care which have been examined in detail, acquainting this office with the perspectives of all the groups who interact with our Child and Family Services system from parents, youth, and school officials to judges, family attorneys, and therapists. The office deals primarily in stories: the opinions and anecdotes of individuals across the child welfare system as they relate them to us and record them in official records.

The OIG has a unique perspective. It is granted access to all relevant Department of Health and Human Services (DHHS) personnel and documentation and the documentation of all providers who work under DHHS contract. Because the office is not responsible for any aspect of service provision, it is free from the sorts of biases that affect almost all other players with access to confidential information¹¹ – every agency and service provider has a natural incentive to place their work in the best possible light. Due to the sensitive nature of its work, the OIG takes great care when investigating a case or systems issue to weigh the available evidence, solicit all relevant perspectives, and remain objective.

In addition to investigating complaints and serious incidents, the OIG actively participates in or observes a myriad of committees from all three branches of government that seek to address problems with our systems. The OIG frequently observes juvenile courts and DHHS interactions with families, attends continuing education opportunities for social workers, mental health practitioners, legal professionals, and probation officers, and meets with child welfare stakeholders from across the state to solicit their expertise and concerns.

What is presented here is an attempt to synthesize and summarize these many viewpoints into one broad look at the Nebraska child welfare system with particular attention to where improvements are needed. The OIG has witnessed a great deal of positive change throughout the system in the last two years. All aspects of service provision are continuing to stabilize in the wake of a long period of neglect followed by privatization and two rounds of legislative reform. However, a great deal of improvement is still needed across the system.

¹⁰ The “child welfare system” generally refers to any child-serving government or government supported entity in Nebraska. This includes juvenile justice.

¹¹The Foster Care Review Office is in a similar position in reviewing wards in out of home placements. The OIG and the Foster Care Review Office work closely together.

Overview¹²

Nebraska has historically had one of the highest rates of state wards and foster placement per capita in the country. In 2010, Nebraska's number of children in out-of-home care was 10.9 wards per 1000 children, which was more than double the national average of 5.2.¹³ This was an alarming statistic, especially considering that we had no data suggesting that our state wards were having better or even average outcomes compared to other states. The numbers suggest that our system has for many years disrupted the lives of more families than nearly any other state, and that the families in our system were no better off than those in states whose systems were more selective and less intrusive.

Nebraska's number of state wards peaked in 2006 at 7803 and has been declining since that time. In June 2014, the Division of Children and Family Services (CFS) reported that there were 4545 state wards which shows commendable overall progress.¹⁴ However, in the same period CFS reported 3219 out-of-home wards, which is still 25% above the national average. The Southeast service area reported 790 out-of-home placements which is 44% above the national average.

The positive trend indicated by the numbers of declining wards are somewhat mitigated by an increase in non-court cases. In the last two years, the number of non-court families with CFS involvement has increased by 140. CFS does not report how many total children this includes, so we cannot know the total number of children involved in Nebraska's child welfare system.

Also, because data systems are not fully in place, we cannot account for the overall impact of the recent transfer of jurisdiction of some juveniles who were previously state wards to the Office of Probation. This may have affected over 1000 youth, removing them from the state ward numbers even though their needs have not changed and the state is continuing to provide similar services. Most recent data measures are somewhat tainted by this transfer, as are present and future attempts to compare our data to other states, because most states include juvenile justice cases in their child welfare data. Nonetheless, the number of wards had been declining for many years before this transfer occurred and is a strong sign of an improving system.

As the Foster Care Review Office (FCRO) noted in its 2013 annual report, Nebraska appears to reunite wards with their families at a rate much higher than the national average. In 2012, our rate of reunification was 73% as opposed to 51% nationally and as the system improves and the total number of state wards decreases, the reunification rate is dropping. While reuniting families should be the primary goal of CFS, these numbers suggest that we may be removing many children who could have been safely left in the home, particularly if evidence-based in-home services were more widely employed and available. Examples of such services include Multi-Systemic Therapy, Parent-Child Psychotherapy, and Parent-Child Interaction Therapy. Such therapies currently have limited

¹²This provides a quick overview contextualizing some of the central statistics about Nebraska child welfare. There is no need here to repeat the excellent and thorough work of the Foster Care Review Office's annual and quarterly reports, <http://www.fcro.nebraska.gov/AnnualReports.html>, or the Division of Children and Family Service's monthly Continuous Quality Improvement reports and performance gauges, http://dhhs.ne.gov/children_family_services/Pages/performancegauges.aspx. Please refer to those documents for more detail.

¹³Public Consulting Group, Inc. *Nebraska Cross Systems Analysis: Final Report*. December 2012. p 3. http://nebraskalegislature.gov/FloorDocs/102/PDF/Agencies/Health_and_Human_Services_Department_of/358_20121214-105755.pdf

¹⁴See the Division of Children and Family Service's June 2014 Continuous Quality Improvement report. http://dhhs.ne.gov/children_family_services/COI%20Monthly%20Reports/COI%20June%202014.pdf

availability and use in Nebraska.

Nearly all CFS outcome measures have been improving in recent years. Nebraska is currently meeting five of the six primary statewide data measures, called COMPASS measures, set forth by The Children's Bureau.¹⁵ These are the key statistics by which the Federal government monitors state child welfare systems. They measure absence of maltreatment in foster care and overall, timeliness of permanency and adoption, placement stability, and the rate of permanency. In 2006, we were only meeting two of these measures. And all measures have improved significantly except for the Absence of Maltreatment in Foster Care measure which we were already successfully meeting in 2006. It is encouraging to see continuing general trends indicating that our system-involved children are increasingly safer, returning home sooner, and reuniting with their families at a faster rate.

Though they give reason for measured optimism, these improvements do not mean reform is finished. Nebraska falls far short of best practices in nearly every area of service provision and many important statistical measures have shown only slight improvement.

Further progress will require concerted effort between agencies among which there are currently high levels of distrust. Judges often report that they do not always trust caseworkers or the Department of Health and Human Services, administrators complain of judicial overreach, the Legislature distrusts reports from administrators, medical professionals complain that lawyers ignore best practices for treatment, and administrators feel that their best efforts are being tripped up by frequent changes to the state statutes. Too many stakeholders in the system seem able to articulate only the faults and none of the strengths of other stakeholders. Widespread suspicion and gotcha politics are the result of agencies failing or refusing to work together toward common goals. This is a major barrier to progress in every area because best practices in child welfare require *coordinated* efforts between all three branches of government and across systems.

Also, a point that is consistently made throughout the child welfare literature is that quality and consistently delivered voluntary public health interventions targeted to at-risk populations and located in all schools and communities are key to reducing child welfare systems involvement.¹⁶ For example, if we can successfully provide a family in duress with appropriate mental health services or financial assistance before they become dysfunctional to the point of abuse or neglect, then the court and CFS have no need to intervene. Such services are beyond the scope of the present report, but the need for them is suggestive of the sort of integrated perspective that is required to solve the problems discussed here.

No parent wants to abuse or neglect their children. The families involved in our child welfare system are typically struggling with a myriad of adverse factors including poverty, unemployment, developmental disabilities, addiction, mental health, physical health, poor education, poor life skills, poor stress management, and serious traumas that may have recurred for generations. CFS and juvenile courts do not act in a vacuum but are part of a continuum of agencies and services that impact our families' successes and failures.

¹⁵Also known as CFSRs or Child and Family Services Reviews as the Children's Bureau at the federal level reviews a state's conformity with titles IV-B and IV-E of the Social Security Act

http://dhhs.ne.gov/children_family_services/COI%20Monthly%20Reports/COI%20Aug%202014%20Report.pdf

¹⁶See particularly the December 2012 NE DHHS report entitled *Nebraska Cross-Systems Analysis: Final Report* that was prepared by the Public Consulting Group of Boston, MA.

From Crisis to Stability and Focusing on Quality

In 2009, Nebraska shifted responsibility for service coordination and management from DHHS to private providers. In 2012, Nebraska returned case management to the state in four out of five service areas. The exception to this is that Nebraska Families Collaborative (NFC) remains the lead agency, performing service coordination in Douglas and Sarpy counties under the case management lead agency model pilot project.¹⁷ 2014 saw the transfer of all youth under the jurisdiction of the Office of Juvenile Services to Probation.

These actions were responses to a system that was largely understood to be in crisis. In 2006, not only was our number of wards high and our outcome measures low, but lawmakers and administrators did not trust data reporting and so data was not being used to drive outcomes, field staff had little interaction with or trust in central office staff, it was unknown if caseworkers were interacting appropriately with the families they were supposed to be serving, caseworker training was not reflective of current practice, and there was little coordination among the five service areas so practices and outcomes varied widely across the state. Administrators were reacting to constant crises rather than leading.

Since that time there have been significant improvements in these areas. We now have data that is largely trustworthy and being used to drive outcomes. Monthly statewide Continuous Quality Improvement (CQI) meetings bring together administrators and caseworkers from across the state for substantial two-day meetings that result in public CQI reports that are consistent, honest in highlighting needed improvements, and clearly articulate goals. This process provides a mechanism that ensures needed improvements are noted and progress is tracked, that practices are uniform across the state, that changes in practice are immediately reflected in training, that front line workers understand the importance of the data and goals, and that administrators are getting continuous feedback about how their policies are affecting workers and families.

The data shows that caseworkers are increasingly and reliably in the right place at the right time doing the appropriate tasks. This is reflected in improving statistics relating to reporting requirements, frequency of meeting with children and parents, filing case plans, and conducting team meetings.

CFS Administrators have been honest in expressing the problems of the past and current challenges. One 5-year strategic planning cycle is just ending for CFS and another is beginning. The progress of the past 5 years and the goals for the next 5 have been characterized as a shift from the quantitative to the qualitative. In other words, the numbers are more reliable and trending in positive directions, functional management practices are in place to provide accurate feedback and ensure future improvements, best practice assessment and decision-making tools have been implemented,¹⁸ administrators within CFS are coordinating with one another, and workers are increasingly doing what they need to do – each month they can be counted on to be more often in the right place at the right time, documenting their activities reliably, and ordering services when services are needed.

¹⁷ Neb. Rev. Stat. §68-1212. This report will note some areas of difference between NFC and CFS, including some innovations by NFC, but will remain largely quiet on the subject of performance by NFC specifically. The Legislature has commissioned an evaluation report of the case management lead agency model pilot project by Hornby Zeller Associates, Inc. which is due prior to December 31, 2014.

¹⁸Structured Decision Making (SDM).

So now, in the current strategic planning period, there is a shift in emphasis to making sure that all the work that is being done is of the highest quality: that families are not only being met but are effectively engaged, understand the process, and feel supported; that families drive decision making so that they get the assistance they want and they feel ownership in their success or failure; that families in need are identified before they find themselves in crisis and provided appropriate services; that mental health services are not only ordered but that best practices to meet each particular need are identified and that the right people get the right services; that provider contracts reward providers for meeting specified outcomes rather than merely providing a service, and so on.¹⁹

The system still faces major challenges. We are far from meeting many important Federal and State goals, including creating initial case plans on time, involving families in decision making, ordering needed services for parents, contacting the non-custodial parent and including them in the process, and caseworker contact goals for parents and children who are in the home.²⁰ We have high rates of children entering out-of-home care for neglect.²¹ Children have too many caseworkers and are spending far too much time in the system prior to permanency.²²

Many of these problems that remain require complicated and nuanced solutions and involve coordinated action among different agencies and branches of government. For example, if best practice mental health services are to be implemented, they will need to first be identified, providers will need to be trained, caseworkers will need to be educated, Medicaid will need to understand why these services should be funded, and judges and attorneys will need to understand their value and purpose.

What the inability to meet these goals means for too many of the families the OIG hears from is that they feel lost in a system that places many demands on them but does not tell them what they need to do to succeed. Promises are too often made and not kept. Parents and children feel that no one listens to them. Plans for the family are written long into the case and goals aren't clear. As soon as a family builds trust with a worker and seems to make progress, that worker too often goes away and is replaced by someone who manages their case differently. Services provided seem unhelpful or unrelated to needs. Group meetings often seem confusing, disrespectful, and accusatory.

CFS involvement often greatly increases the stress on already over-stressed families by mandating participation in many different services, not ordering services that are well matched to the needs of the family, not scheduling these services at convenient times and locations, and not helping families to understand why these services are necessary and important. Families are often required to continue to see therapists they do not trust and with whom they have no clear goals, attend classes that are unhelpful,²³ or submit to drug tests when they have never had a drug problem. Studies show that over

¹⁹See forthcoming 2015-2019 CFS Strategic Plan.

²⁰See June 2014 CQI report pages 36, 37, 40, 39, 39 & 43, respectively.

²¹FCRO 2013 Annual Report, page 19.

²²See June 2014 CQI report pages 46, 47, 49, and 50.

²³ And they may be right. Much of Nebraska's service array is not evidence based, meaning that many of the programs used, while seemingly sensible, have not been shown to improve outcomes for families. For example, parenting classes which teach parenting skills in a classroom setting are often cited as one of the least effective interventions in child welfare. Attendance of such classes is frequently required of parents by our juvenile courts. However, to be effective, research shows that such interventions need to coach parents while in the act of parenting, to address the underlying relational dysfunction, and to prepare parents for future developmental changes. See Johnson, Michelle A., et al. *Assessing Parent Education Programs for Families Involved with Child Welfare*

servicing families or requiring the wrong service can actually be harmful. Best practices in all these areas have been identified nationally and need to be implemented.²⁴

Decreasing worker turnover and caseload size within CFS are central to further improvements. Understanding system-involved families' needs, knowing what the best practices are to address those needs, and engaging the families in those practices is a difficult and stressful job. Management structure changes can only accomplish so much. Ultimately, excellent caseworker performance is the key to a great CFS system. In order to continue to improve, CFS will need to attract stronger candidates, retain caseworkers longer, train them better, and lower their caseloads. This almost invariably means salaries will need to increase, educational standards will need to rise, and more caseworkers will need to be hired (see more at Caseworker Retention below). This years' CQI reports show us on target to have 33% caseworker turnover in 2014 by the end of the year.

Social work is a highly professional endeavor similar to fields such as medicine or law, built on extensive research into practices to engage families and help them succeed. CFS caseworkers get little time for continuing education and have little incentive to pursue relevant higher degrees. While there are excellent and dedicated caseworkers who have been in their position for many years, many caseworkers are new and inexperienced, and often appear overwhelmed.

As CFS shifts its focus from major structural overhauls to the more nuanced, qualitative aspects of excellent social work and service provision, further improvements depend increasingly on the performance and professionalism of our front line workers. Any further efforts to reform the system need to focus on attracting, training, supporting, and retaining an excellent workforce.

Child Welfare Outcomes

The overall effect of the child welfare system on the children it serves is notoriously difficult to study. Statistics regarding safety and key child welfare outcomes such as rates of abuse in foster care, rates of re-entry, placement stability, and family reunification are important and relatively easy to quantify. However, it is much more difficult to discern the overall impact of child welfare systems on the families they serve and whether past wards go on to become successful adults.

There is debate as to what indicators best measure successful outcomes for the child welfare system. Typical signs of success include such things as educational performance, high school graduation rates, rates of teen pregnancy, employment, and future criminal activity. Studying any of these outcomes requires accurate data management and data sharing across systems. For any such indicator, it is difficult to separate the effects of the child welfare system from all the other factors in children's lives that might contribute to a given outcome.

There are two studies which are most frequently referred to regarding the overall effect of foster care on children's lives. These studies, the largest of their kind, were conducted by MIT researcher Joseph J. Doyle, Jr. and published in 2007²⁵ and 2008.²⁶ The first looked at 15,000 children and their

Services: Evidence and Implications. Bay Area Social Services Consortium and the Zellerbach Family Foundation. March 2006.

²⁴ The US Department of Health and Human Services maintains a list of evidence based, best-practice registries of child welfare interventions here: https://www.childwelfare.gov/preventing/evidence/ebp_registries.cfm

²⁵ Doyle, Joseph J., Jr. *Child Protection and Child Outcomes: Measuring the Effects of Foster Care.* The American Economic Review. December 2007.

outcomes in adolescence. The second studied over 23,000 children and examined how they became involved in the justice system.

These studies were conducted on data from Illinois where child protection investigations are randomly assigned to investigators who then have a demonstrable impact on the rates of removal. It could be seen that some investigators were more likely to encourage the court to remove children in certain borderline or 'marginal' cases of abuse and neglect, others to leave the family intact. This allowed researchers to identify tens of thousands of marginal cases where similar levels of abuse and neglect had occurred, but where the system removed some children and left others in the home.

What these studies both found was that outcomes for children in these marginal cases were significantly improved when the children were left in the home. The first study found that children left in their own homes were less likely to become pregnant as teenagers, less likely to be involved in the juvenile justice system, less likely to abuse drugs, and more likely to have held a job for at least three months. The report noted that in Illinois nearly 20 percent of young prison inmates and 28 percent of homeless individuals spent some time in foster care as a youth. The second study found that “among children on the margin of placement, children placed in foster care have arrest, conviction, and imprisonment rates as adults that are **three times higher** than those of children who remained at home.”²⁷

This does not mean that foster care is not often appropriate. Out-of-home placement is clearly less harmful than leaving children in homes where they are experiencing serious abuse or neglect. However, these studies do strongly suggest that foster care has significant negative effects which child welfare systems would do well to acknowledge – using foster placement only when all other options have been exhausted. Nebraska's higher-than-average rates of out-of-home placement suggest that we frequently remove children in marginal cases who could be safely left in the home and that we are over reliant on an intervention that unnecessarily creates significant negative outcomes for children.

Statistics on states such as Arkansas, Florida, and Illinois, which are frequently cited as having some of the best child welfare systems in the country, suggest that they not only remove children at some of the lowest rates in the country, but also that their children are safer than in most other states.²⁸ This suggests that policies aimed at keeping more families together, when supported by a successful service delivery system targeted to families in need before they become system-involved, keep kids safer and help them to become successful adults.

Studies such as the ones above have not been conducted in Nebraska, so we do not know much about how Nebraska wards are faring after they achieve permanency or age out of the system. One study did look at the educational performance of Nebraska state wards compared to other students. This 2012 report by the Department of Education presented some troubling statistics.²⁹ For instance, it

http://www.mit.edu/~jjdoyle/fostercare_aer.pdf

²⁶Doyle, Joseph J., Jr. *Child Protection and Adult Crime: Using Investigator Assignment to Estimate Causal Effects of Foster Care*. Massachusetts Institute of Technology and the National Bureau of Economic Research. *Journal of Political Economy*. 2008. V 116, no 4. http://www.mit.edu/~jjdoyle/doyle_jpe_aug08.pdf

²⁷ Emphasis ours.

²⁸National Coalition for Child Protection Reform. *Doing Child Welfare Right: Successful Alternatives To Taking Children From Their Families*. <http://www.nccpr.org/reports/twelveways>

²⁹Baumfalk, Benjamin and Eva Shepherd. *State Ward Statistical Snapshot Project*. Nebraska Department of

showed that Nebraska wards were eight times more likely to drop out than non-wards, absent twice as many days from school, and that 25% were enrolled in two or more schools during the academic year. To better understand how the system is affecting the families it serves, research of this nature is encouraged.

Nebraska Data & Analysis

In order to study past outcomes and plan effectively for the future, a system must be able trust that the data it collects is accurate, must properly analyze the data and draw valid conclusions, and must clearly present these conclusions. Only if all these pieces are in place can data be used accurately to drive decision making. Too much data can be as ineffective as too little data. This is sometimes referred to as “paralysis by analysis” or being “data rich and information poor.” Reliable, well analyzed and presented data is useful to policymakers to inform decisions but also to front line staff to better inform their work. Below we will examine the quality and use of Nebraska’s child welfare data with reference to these three properties of effective data.³⁰

The DHHS data management system is called N-FOCUS. Data in the N-FOCUS, is thought by most stakeholders to be much more reliable at the present time than it has been in the past. In order to prove that this is true, DHHS presented a plan in the fall of 2012 to address strategies to examine and improve its information system.³¹ That plan commissioned a report from a consulting firm called the UmmelGroup.

This report found that N-FOCUS provides a basis for reliable data collection and reporting, but that there appeared to be practices in how N-FOCUS is used that undermine its reliability to some degree. For example, various service areas have established local definitions and/or practices for using or entering data into certain fields. This lack of statewide uniformity can create problems for data integrity.³² These problems persist, to some degree, today. For instance, narrative accounts about child welfare cases can be located in dozens of places in the N-FOCUS system depending on who entered the data.

The CQI reports³³ that CFS presents monthly are the only consistent, public example of the analysis and presentation of N-FOCUS data. These reports are lengthy and many stakeholders have complained that they are difficult to read, that they lack certain important measures, or that certain measures are presented misleadingly. These reports highlight both the strength and weakness of the N-FOCUS system, because the data, while accurate, is difficult to extract and manipulate. However, UmmelGroup's report found that limitations with N-FOCUS kept administrators and workers from getting more timely reports which could be beneficial and used to drive day-to-day practice.

“Although we find the N-FOCUS system to be an information-rich environment for

Education. June 29, 2012. http://dhhs.ne.gov/children_family_services/Documents/StateWardEdSnapshot.pdf

³⁰ Presentation “Data, Data, Everywhere: ‘If We Have All This Data, Why Don’t I Know Anything?’” T. Hank Robinson, Ph.D., J.D.

³¹ State of Nebraska Child Welfare Information System Strategic Plan, Addressing the Requirements of LB 1160 on November 30, 2012, Nebraska Department of Health and Human Services. Professional Consulting and Advisory Services Provided by UmmelGroup International, Inc. Herein referred to as the UmmelGroup Report.

³² *Id.* at page 29.

³³ Division of Children and Family Service's monthly Continuous Quality Improvement reports and performance gauges, http://dhhs.ne.gov/children_family_services/Pages/performancegauges.aspx

*Child Welfare-related case information, we find the reporting and analysis environment to be cumbersome and out-of-date, which obstructs the timely and accurate reporting of Child Welfare programmatic data. These reporting and analysis barriers hinder management's ability to effectively, and in near-real-time, manage Child Welfare program outcomes and identify strategies which lead to desired program outcomes."*³⁴

Our data would be more useful if stakeholders and employees could get all the data measures they need in a timely fashion. Other systems around the country are using more nuanced and complex analysis than a single statistical reports can show. Sophisticated data systems can be used to set daily goals and adjust them in real time, to determine past performance and set outcome measures for specific providers which can facilitate better performance-based contract oversight, and to tell workers where a child is located at any given time. Our system lacks the ability to change and share data in real time and to facilitate these sorts of deeper analysis.

Many individuals and groups in and around Nebraska's child welfare system are trying to improve these data systems. CFS has dedicated research, planning, and evaluation staff involved in programmatic discussions, focused on data improvement and reliability, and continues to be open to improvements. NFC is very knowledgeable and interested in improving ways to gather data to analyze and make decisions. The Children's Commission is interested in analysis of child welfare and juvenile justice data points to inform their work. The IT Workgroup of the Children's Commission is starting to tackle this issue.

The UmmelGroup's report recommended that Nebraska spend \$17 - 40 million to modernize the N-FOCUS system and bring it up to date with best practices nationwide.³⁵ Currently this has not been done. What exactly needs to be done to improve Nebraska's data system is beyond the scope of this report. However, continued stakeholder concern and the UmmelGroup's report suggest that changes need to be made.

Recommendations:

- CFS should continue its openness to problem-solving issues with N-FOCUS data integrity. Many groups are interested in this area and give feedback to CFS: the Foster Care Review Office, Through the Eyes of the Child Initiative, NFC, the IT Workgroup of the Nebraska Children's Commission, and others.
- NFC and CFS staff should coordinate for the purposes of data system and data analysis improvement to better the data system as a whole.
- Statistical reports are good to use when looking at specific measures. It becomes overwhelming if there are an abundance of statistical reports presented. There is a need for further child welfare and juvenile justice data analytics to inform policy and decision makers.

Trauma Informed Care

³⁴ UmmelGroup Report at page 7.

³⁵ *Id.* at page 9. Note: The most expensive option in the UmmelGroup Report was to build a new custom data system on a modern architecture which would cost between \$202 – 255 million.

“Trauma informed care” is one of the most often heard catchphrases in child welfare. Administrators and providers in Nebraska and across the country are striving to become trauma informed. What exactly makes care trauma informed is the topic of some debate, though experts tend to agree on most key principals of such a system. Trauma informed care can be generally defined as care that is guided by current understandings of how the brain works and how it is affected by severe and chronic stress.

For decades psychologists have known that traumatic stress can affect the long-term functioning and health of war veterans and disaster survivors, leading to long-term mental and physical health problems. This is commonly termed Post Traumatic Stress Disorder (PTSD). Only in recent years have scientists come to understand how PTSD affects the brain and why similar problems frequently afflict children who have experienced abuse or neglect.³⁶

Research shows a remarkable prevalence of trauma in our systems-involved children. A national study of adult foster care alumni found that 25.2% had PTSD, nearly double the rate of US war veterans.³⁷ Other research offers evidence that the number for juvenile offenders could be nearly twice as high.³⁸ These dramatic numbers and recent breakthroughs in understanding and treating trauma indicate that trauma informed care is much more than the buzzword of the moment.

Understanding the effects of trauma can enable lawmakers, administrators, providers, and other leaders to design rehabilitative systems and behavioral health treatment models that are much more efficient and effective than in the past.

Previously, young children were thought to be resilient and able to 'bounce back' from the effects of abuse and neglect. We now know this to be untrue, an assumption based on the fact that young children simply are not able to articulate the lingering effects of these events on their minds. In fact, early traumas occurring in the rapidly developing brains of young children tend to have more severe and longer-lasting effects than traumas occurring later in life. Unfortunately, our public health policies, schools, and child welfare systems still largely reflect the old assumption and very little money is spent on mental health services for children younger than 5 years old, though this is the population that benefits most from effective intervention and where research suggests public health dollars have the greatest return.^{39, 40}

When a child is exposed to severe or prolonged abuse or neglect, a part of their brain's stress-response system can become heightened. Once this happens, the child may come to perceive everyday events as threatening, to generate an outsized stress response to any small stimulus. They can also come to attach inappropriate emotional responses to common occurrences. For example, a

³⁶National Child Traumatic Stress Network. *Understanding Child Traumatic Stress*. www.NCTSN.com is an excellent source of information on childhood trauma.

³⁷Pecora, Peter J., et al. *Mental Health Services for Children Placed in Foster Care: An Overview of Current Challenges*. Child Welfare. 2009; 88(1): 5–26. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3061347/>

³⁸Wolpaw, J. & Ford, J. (2004). *Assessing exposure to psychological and post-traumatic stress in the juvenile justice population*. Washington, DC: Juvenile Justice Working Group of the National Child Traumatic Stress Network.

³⁹Heckman, James J. *Policies to Foster Human Capital*. Research in Economics, 2000, 54(1), pp. 3-56.

⁴⁰For example, the Syracuse Family Development Research Program provided family development support for disadvantaged children from prenatal care through age five. Reductions in problems with probation and criminal offenses ten years later were as large as 70%.

<http://www.promisingpractices.net/program.asp?programid=133#findings>

child may respond with panic or aggression when confronted with household implements that were used to abuse them or when certain music is played that reminds them of past traumas. They may have a seemingly exaggerated reaction to reasonable punishment or normal emotional discord in the home. These reactions can confuse and discourage parents, foster parents, service providers, and even caseworkers who have not been trained in trauma and do not know the child's trauma history.

The damage to brain functioning from these traumas can be accurately predicted based on the child's history and observed with the use of brain-imaging technology.⁴¹ And this damage can have severe and lifelong effects.

Childhood trauma has been shown to lead to virtually all the common mental health diagnoses associated with children in our child welfare system. These include depression, dissociative disorder, oppositional defiant disorder, conduct disorder, substance abuse, attention deficit and hyperactivity disorder, and many others.⁴²

Traumatized children often have problems forming relationships (attachments) and engaging in normal social interactions. They can also have trouble self-regulating, meaning they are not as good as other children at controlling their impulses and directing their attention to a task. This can have significant detrimental effects on their ability to learn and engage successfully in mental health services.

Experiences that are common to child welfare populations such as poverty, discrimination, frequent moves, removal from parents, school problems and changing schools, grief and loss, and immigrant/refugee experiences can all aggravate trauma. Many common experiences of children in our detention facilities can also re-traumatize children such as seclusion, strip-searches, pat downs, the use of restraints, separation from family and community, witnessing physical altercations, and fear of other youth. For these reasons, a trauma history should be part of any decision to place a child in a group home, detention, or treatment center that does not specifically provide trauma-informed care.

Early, targeted intervention is key to the treatment of trauma. If children do not receive successful treatment, they can often struggle with these problems for their entire lives and problems can worsen over time. A child who seems to have minor learning problems in early grade school may display more serious behavior problems in their teenage years and could escalate to criminal behavior by the time they reach adulthood.

Children from violent or neglectful homes are often traumatized long before the higher thinking, organizing, and language processing parts of the brain have reached maturity. Even adult trauma often primarily impacts "lower" brain functions which are below conscious awareness such as hormone regulation, self-regulation, and immediate emotional reactions. Traditional talk therapy is sometimes ineffective at treating certain traumas because the lower parts of the brain are not easily accessible to the "higher" conscious, language-forming parts of the brain that are engaged by most

⁴¹ Perry, Bruce, MD, PhD. *Maltreatment and the Developing Child: How Early Childhood Experience Shapes Child and Culture*. Margaret McCain Lecture for the Center for Children and Families in the Justice System. 2005. https://childtrauma.org/wp-content/uploads/2013/11/McCainLecture_Perry.pdf

⁴²Gaskill, Richard L. & Perry, Bruce D. *Child Sexual Abuse, Traumatic Experiences, and Their Impact on the Developing Brain*. Handbook of Child Sexual Abuse: Identification, Assessment and Treatment. Ed by Paris Goodyear-Brown. 2012. John Wiley & Sons, Inc.

talk therapy. For this reason, evidence-based targeted therapies and interventions need to be made available and correctly used in order to adequately address trauma.

Because rates of trauma are very high among child welfare families, the two most common interventions, seen in nearly every child welfare case in Nebraska, are not very effective with this population. These are non-specific talk therapy and parenting classes which both require a great deal of ability to pay prolonged attention and apply higher thinking functions. If unconscious trauma reactions are the core of a family's problems, then it may be highly difficult for them to apply new ideas gained in therapy or classes. Families could be much better served and money for services much more effectively spent on treatments proven to address the specific traumas that families have experienced.

Children with trauma who do not respond well to talk therapy may be most positively affected by a calm environment, a predictable routine, and consistent adult modeling of appropriate stress-response behaviors. Because their stress-response system is over-reactive, traumatized children may be repeatedly re-traumatized by the inevitable stresses of life such as taking a test, getting teased, or showering in locker rooms. Therefore, trauma recovery work often requires many more hours and repetitions than are feasible in a therapeutic setting and must extend into nearly all the child's daily interactions. Effective care of traumatized children ideally includes training nearly every influential person they encounter, including parents, foster parents, and teachers.⁴³ Effective therapy models often include parents and caregivers.

A trauma-informed system needs to quickly screen individuals for trauma, and then refer suspected cases of trauma to a qualified mental health professional for assessment and referral for services. Targeted treatments designed to affect the various parts of the brain that are damaged by trauma have to be readily available. This means new therapies and even things not traditionally associated with behavioral health therapy may have to be employed. For example, if the lowest self-regulatory parts of the brain are damaged, then nonverbal, sensory, movement-oriented therapies may be recommended. These may include such non-traditional forms of therapy as drumming, dance, yoga, massage, and other forms of bodywork⁴⁴. In our system, because we do not often use trauma screens and assessments, children with these traumas may be medicated and may not receive any further therapeutic program. Medication may alleviate some of the symptoms of trauma, but trauma itself cannot be treated with medications.⁴⁵

Child Welfare administrators in Nebraska have acknowledged the goal of making our Children and Family Services system trauma-informed. Last fall, CFS in conjunction with the Division of Behavioral Health brought in Dr. Bruce Perry, one of the nation's foremost experts on childhood trauma, for two days of introductory training. Implementing something like Dr. Perry's recommendations will require system-wide strategic planning. This is planned but not yet underway.

Our system interventions are often unnecessarily traumatizing to children. Foster children are often removed from one home and taken to another on short notice, given little or no explanation as to why it is occurring, transported by someone who does not take the time to introduce and explain themselves, and may arrive at their new home carrying the few clothes and personal belongings they

⁴³Perry, Bruce D. and Hambrick, Erin P. *The Neurosequential Model of Therapeutics*. Reclaiming Children and Youth. Fall 2008. v17, n3. 38-43.

⁴⁴Interlandi, Jeneen. *A Revolutionary Approach to Treating PTSD*. The New York Times Magazine. May 22, 2014.

⁴⁵ National Child Traumatic Stress Network. *Effective Treatments for Youth Trauma*. www.nctsn.org

own in a plastic garbage bag. Uniformed police officers often pick children up in their schools or CFS investigators may indiscreetly remove them from class to interview them, signaling to their peers that they are system-involved. Juvenile offenders, including those guilty of nothing more serious than truancy, may be brought to court in shackles creating the perception that they are violent and dangerous. A truly trauma-informed system would work to identify and mitigate these often unnecessary and damaging events in our children's lives. A trauma informed system takes care to see itself through the child's eyes.

A trauma informed system bases its decision making on the specific trauma histories of the children and adults they serve so that, for example, an individual's stress triggers are avoided and disciplinary practices are not further traumatizing. Our child welfare and juvenile justice systems need to become aware of the myriad ways in which it can re-traumatize children. As discussed above, nearly all child welfare interventions cause harm. Anytime a child is removed from their family damage is done. Our expectation must be that the trauma inflicted by state intervention is, in each instance, less than the trauma that would have resulted from doing nothing and that any care provided is targeted, timely, and effective.

Initial positive steps are underway, though a great deal more needs to be done. A trauma screening tool has been selected and is available to caseworkers for Nebraska Families Collaborative (NFC) in Douglas and Sarpy counties. Many NFC workers have received 2-day trauma trainings put on by Project Harmony. These trainings are available to legal professionals and others in those communities. Project Harmony in Omaha also has a new program call Connections designed to encourage practitioners to receive training in best practice trauma therapies by coordinating trainings and maintaining a database of certified professionals. CFS will soon be initiating a trauma-informed strategic planning process. To be effective these efforts will need to substantially include law enforcement, courts, private providers, and schools. If we truly want to treat children and families and give them the best chance to rehabilitate and heal, then every point of system contact needs to be trauma informed.

Recommendations:⁴⁶

- Creating a trauma-informed system will require long-term strategic planning and input from a wide range of experts and stakeholders. The process must be designed to generate buy-in from all players in the child welfare, education, law enforcement, court, and juvenile justice systems.
- The first step to creating a trauma informed system will be to identify a trauma screening tool that will be used on all children and families when they enter the system. This assessment would then be used to guide service provision. A simple-to-use tool created by The National Child Traumatic Stress Network and available free online has been chosen to be used in Douglas and Sarpy counties. This questionnaire can be quickly filled out by nearly anyone familiar with the child's history and includes a decision-tree to guide subsequent decision making. The completed questionnaire can be given to providers, courts, and caregivers to help them understand the child's history and challenges.
- Best practice therapies targeting various types and effects of trauma need to be identified. Therapists need to be encouraged to receive training in these trauma-informed modalities and

⁴⁶More detail about some of these recommendations can be found in *Implementing Trauma-Informed Practices in Child Welfare*, published by the American Bar Association's Center on Children and the Law in November, 2013, written by Eva J. Klain and Amanda R. White.

legal professionals need to understand why certain practices are useful. Judges, not trusting the service provision system, will often order specific mental health services. These are decisions that should be made by an appropriate mental health professional trained in trauma and knowledgeable of the trauma specific services available in the area.

- Organizing and coordinating trainings in best practices takes time, as does maintaining a database of certified professionals. Encouraging best practices requires educating professionals about the availability and value of specific programs. Staff need to be assigned to these tasks, perhaps requiring new positions.
- Contracts should be written so as to encourage the use of best practices.
- Training of all foster parents and workers who interact with Nebraska's foster children should include a trauma component. Parents and other caregivers should be educated on trauma and their children's particular trauma histories. Adoptive parents should receive information on the effects of trauma.
- It is often difficult to get Medicaid to pay for certain best practice trauma services. Providers may need help applying for trauma-specific treatments and alternate sources of funding need to be identified.

The Importance of Extended Family Involvement

Both the OIG and the Legislative Ombudsman's office frequently receive complaints from family members who seek custody of state wards and feel they are not being given a fair opportunity to do so. These cases often involve the competing priorities of placement stability (keeping the child in their current placement) versus family placement. In cases we typically see, children are already in a stable foster placement when family members are located or choose to pursue placement. The department has no clear policy to guide workers in such cases and judges tend to value stability over family placement.⁴⁷

These two often competing priorities appear side-by-side in our state laws. Nebraska Revised Statute §43-533 states: "When children are removed from their home, permanency planning shall be the guiding philosophy. It shall be the policy of the state... (b) when a child cannot remain with parents, to give preference to relatives as a placement resource, and (c) to minimize the number of placement changes for children in out-of-home care so long as the needs, health, safety, and best interests of the child in care are considered."

Research shows that family member caregivers tend to be older and economically poorer than typical foster parents – many of them are grandparents – and that the level of care they provide is largely similar.⁴⁸ However, long-term outcomes for children placed with family show significant improvement compared to foster placements. One national study found that three years after initial placement, children placed in kinship care (with a family member or some other adult previously known to them) were 50% more likely to have achieved long-term placement stability and were 30% less likely to display significant behavior problems.⁴⁹

⁴⁷ Family Finding as a core strategy has been implemented in the Southeast service area as a pilot. Other service areas do focus on finding family, but the OIG has not seen any formal guide from CFS on Family Finding. Family Finding is part of the National Institute for Permanent Family Connectedness.

⁴⁸Office of Planning, Research and Evaluation. *NCAW, No. 15: Kinship Caregivers in the Child Welfare System*. January 15, 2007

⁴⁹Science Daily. *Kinship Care More Beneficial Than Foster Care, Study Finds*. June 2008

This would suggest that there are cases where the best interests of the child are served by prioritizing family placement over stability and that such considerations should be cautiously weighed. Often family placements can offer a child connection to their heritage and extended family, church and other community resources, friends, and other adults with whom the child was previously acquainted. Family placements often have some knowledge of the child's history, traumas, challenges, and strengths. Such positive aspects of family placements, which can be of central importance in the biography of a child, are seldom mentioned in official reports or court materials and therefore seldom influence decision making.

CFS has done an increasingly good job in recent years of locating and notifying family members when placement options are sought for wards. The FCRO reports that in December 2001 only about 12% of state wards in out-of-home care were placed with family members. That number grew to 24% by 2012. According to its June CQI report, CFS is reporting rates of kinship care (a different measure⁵⁰) that vary from 33.5% to 57.9% across the five service areas.

When families are previously known to the child, located close to the parents of a state ward, and willing to provide care for a ward immediately upon removal from the home, CFS tends to do an increasingly good job at locating and prioritizing placement with them. Difficulties arise when family members live far away or out-of-state, or when family members only express interest once the permanency objective has been changed to adoption. In these instances, the child or children are likely to already be in a stable foster placement. It is then up to courts to decide if it is a good idea to remove the children from a stable placement in order to try out an untested family placement. This is further complicated if the children have little or no previous relationship to the family. In these cases, visits must be set up so that the child and their relatives can establish a relationship. This takes time and is often a low priority.

Several cases have been brought to our attention where an appropriate relative placement was available and placement with a non-family foster home had only been stable for 1-3 months. Because there had been relatively little stability at this point, these would seem to be test cases for deciding whether to prioritize stability or family placement. In each instance we have observed, CFS did not act quickly and the court retained placement with the non-relative foster family. This shows that, though they are given equal measure in statute, placement stability tends largely to trump family placement in practice, even if the children have been in placement for a short period of time.

Such scenarios could often be avoided by locating and contacting potential family placements sooner and by approaching them in a more engaging way. The initial contact with families is usually made by letter and merely informs the family members that someone in their family has been made a state ward. Families often have very little context for this information and so do not take action they might take if more was explained to them. They often have very little knowledge of the child welfare system and are often not aware, for example, that child welfare cases sometimes end in termination of parental rights and adoption. They may know very little about the present circumstances of the ward and the extent of abuse or neglect in the home.

When Dr. Bruce Perry, one of the world's foremost experts on childhood trauma, spoke in Nebraska last year, he said that the most important thing the child welfare system could do to improve the lives of the children it serves was to immediately identify someone in that child's life, besides the parent,

⁵⁰The FCRB and CQI numbers are calculated very differently and are not comparable.

who is likely to be in that child's life for a long time and get that person involved and informed. He said, "Ask yourself, 'Who is someone that child can have thanksgiving dinner with when they are 25 years old?'"

His reason for saying this is that having one solid, stable, supportive relationship can make an enormous difference in the life of a state ward. Wards may move from placement to placement, they may get a new caseworker or provider every few months, ultimately they may be forever separated from their parents, their families, their neighborhoods, their school, and their friends. These children greatly benefit from having someone know them and support them through it all. Having a stable adult friendship or mentor has been shown to greatly increase resilience to stress and trauma.⁵¹

The famous Harvard Grant Study that began in 1938 and followed 268 men throughout the course of their lives, attempted to determine what the most important factors are to happiness and success. It found the quality of one's early relationships to caregivers to be the primary determinant, more important than any other socioeconomic factor, of all forms of success – from mental and physical health to lifetime income to reported happiness to the stability of one's adult relationships. In the absence of warm, reliable, and supportive parents and siblings, an adult mentor or more distant relative was the next best thing, even if contact with that person was only sporadic.⁵²

There is a program called Friends of the Children based entirely on this premise.⁵³ The program pays adults to actively mentor highly at-risk youth from kindergarten or first grade through graduation in 7 major American cities. A recent Harvard Business Association study of the program found that it had startlingly positive outcomes.⁵⁴ The study found that for every 100 children who participated, society gained 24 more high school graduates, 59 fewer teen parents, and 30 fewer future inmates. And the social return on investment for the program – the money saved in health spending and prison costs and gained in tax revenues, etc. – was calculated to be 26.8 times greater than the money invested, a total savings to society of \$3.4 million per child. This program is currently being studied by the National Institutes of Health.

These studies suggest that Nebraska has a great deal to gain by increasing engagement of our wards' extended families and other influential adults in their lives. They need to be identified early, educated about the importance of their involvement, and contact between them and the ward needs to be facilitated. By doing so, not only will families be more successfully positioned to potentially parent our wards if the need arises, but by encouraging these relationships, our wards can be positioned for greater success in life long after state interventions have ceased.

Recommendations

- CFS and NFC should continue to improve efforts to locate all potential family placements

⁵¹National Scientific Council on the Developing Child. *The Science of Early Childhood Development: Closing the Gap Between What We Know and What We Do*. January 2007.

⁵²The Atlantic. *What Makes Us Happy?* June 2009.

http://www.theatlantic.com/magazine/archive/2009/06/what-makes-us-happy/307439/?single_page=true

⁵³<http://www.encore.org/duncan-campbell-purpose>

⁵⁴Harvard Business School Association of Oregon. *Breaking the Cycle of Poverty: Social Return on Investment*. 2012

<http://www.friendschildren.org/wp-content/uploads/2009/10/SROI-of-Breaking-COP-2-pager-REV-2-2013.pdf>

- and make meaningful contact with them sooner.
- The art of engaging families should be improved by all players in the system. We should provide more information to families about the process and possible outcomes and encourage workers to make meaningful personal contact. Families need to be educated about the importance of placement stability and why it is not healthy or effective to wait until the permanency objective is changed to adoption before seeking placement. Visits could be set up and background checks initiated long before placement change is imminent. This would have the added benefit of building family ties and introducing foster parents, who may become adoptive parents, to positive family connections.
- CFS should include training for caseworkers on the improved long-term outcomes of family placements and providers should be required to train foster families on the importance of maintaining the child's past positive adult relationships.
- Caseworkers should work with potential family placements to articulate a list of strengths such as connection to ethnic heritage, annual family events, extended family connections, etc., and make these strengths known to the court when family placements are being considered.
- Even if the child's past positive adult relationships do not end up being a placement for a child, those adults should be engaged and encouraged to stay as an active part of that child's life both while a state ward and after.

Attorneys in Juvenile Court

There is often a disturbing absence of zealous representation in family and juvenile courtrooms. General agreement between legal parties are frequently reached informally outside the courthouse or in pretrial meetings. While this can help to lessen the trauma of the courtroom experience, it is often done hastily and with very little input from the families involved.

Families are often given only cursory explanations for the decisions arrived at in these meetings or the essentially summary court proceedings that follow. This can leave children, families, and other stakeholders feeling as though they are not being properly represented and confused about the process and the court's decision. This perception of lax representation, even when not true in fact, leads to family disengagement from services, as they feel disempowered by a system they do not well understand and that doesn't seem to forcefully represent their interests.

In 2009, the Nebraska Legislature commissioned the National Association of Counsel for Children to evaluate Nebraska's Guardian ad Litem (GAL) system.⁵⁵ Their report's findings and recommendations are straightforward, clearly written, and still relevant. The NACC concluded that:

“Nebraska’s current structure for providing GAL services results in uneven performance and lack of accountability. A child’s fate... should not hinge upon the luck of the draw as to who is her GAL. Because children cannot be expected to routinely complain about the services adults provide them – and because they do not have sufficient political power to be listened to even when they do complain – appropriate structures must be put in place to ensure excellence in services provided and accountability in those instances where quality is poor...”

⁵⁵ National Association of Counsel for Children. *Evaluation of the Guardian AD Litem System in Nebraska*, December 2009.

http://c.ymcdn.com/sites/www.naccchildlaw.org/resource/resmgr/nebraska/final_nebraska_gal_report_12.pdf

[O]ur findings show that, overall, GALs are not visiting their clients; they are not zealously advocating for appropriate permanency for their clients; they are not making their clients' position known to the court; they are not using independent experts to assist them in understanding their clients and in presenting alternative service plans to the court; they are not actively investigating their clients' education needs; and they are not receiving sufficient training or supervision. As one judge told us, 'They just sit there.'"

While there has not been a recent study of the practice of Nebraska family attorneys, in 2009 the National Juvenile Defender Center found similar results when it examined the quality of Nebraska's juvenile defenders.⁵⁶

"Nebraska's juvenile justice system has deep-rooted systemic and practice deficiencies that impede the delivery of fair and balanced outcomes to system-involved youth. Many of Nebraska's own judges, defense attorneys, county attorneys, probation officers, policy makers, detention center staff, and others expressed concerns about the quality of defense representation that Nebraska's youth receive."

The report particularly noted a lack of zealous advocacy, excessive guilty pleas, and a lack of resources, stating,

"Most juvenile defense attorneys do not have investigators, social workers, mental health experts, and other experts at their disposal to help prepare their cases for trial or for disposition. There is a paucity of juvenile-specific training opportunities. Some large offices provided training on juvenile defense, but most small and mid-sized offices lacked the capacity to do so. These resources, unavailable to most of Nebraska's juvenile defense attorneys, are indispensable for the provision of holistic and effective defense advocacy."

Some attorney offices in Nebraska—whether it is county attorney or public defender or other—assign their most inexperienced attorneys to juvenile court, essentially using juvenile court as a proving ground for future trial attorneys, who hope to “move up” to be criminal prosecutors or defenders. This, especially when it occurs in county attorney’s offices, creates a prosecutorial atmosphere that undermines the very intent of juvenile court in Nebraska and diminishes the status of juvenile court practice.

In many instances, juvenile court proceedings are reliant on, and insufficiently questioning of, the content of the court report and testimony of the caseworker. While the quality of service coordination and reporting by Case Management seems to be rising, many caseworkers struggle with presenting clear, balanced evidence to the court.

The caseworker’s court report is a document that contains roughly 5-30 pages of narrative regarding the history of the case and recommendations to the court. Caseworkers are often relied upon to build and articulate the case against the family. Some county attorney offices will not go forward with

⁵⁶ National Juvenile Defender Center. *Juvenile Legal Defense: A Report on Access to Counsel and Quality of Representation for Children in Nebraska*, Fall 2009. http://www.njdc.info/pdf/nebraska_assessment.pdf

petitions unless a compelling case is presented to them by the caseworker. This puts the caseworker in the difficult position of having to craft the basis of a legal case against the family they are supposed to be serving which can undermine their rapport with the family and bias their reporting. The recommendations themselves are often decided in coordination with the county attorney's office which works to align the caseworker with the county attorney and against the wishes of the family.

If the caseworker is trying to make the case for an outcome against the family's wishes such as removal, regression in visitation, or changing the permanency plan to guardianship or adoption, their reporting will often fail to note any positive steps whatsoever made by the family – evidence such as positive visitation notes or supportive letters from therapists will be downplayed or go unmentioned and may be altogether absent. When questioned in court, they will often strain to shade all their answers toward the recommended outcome and freely include hearsay to which objections are seldom made. Such is the pressure on these workers to present a forceful case that on multiple occasions workers have been witnessed repeatedly refusing to answer simple, unqualified yes-or-no questions about the existence and contents of documents reflecting positively on the family.

Juvenile attorneys and GALs do not always aggressively question the caseworker or call their summary reporting or the overall gist of their narrative into question. Seldom does anyone offer a counter-interpretation based on a thorough, independent review of the documentation. Seldom are witnesses called who could call the caseworker's version of events into question. Often the caseworker is the only witness asked to testify. As a result, too often the recommendations in the court report coincide with the court's final decision as that is the only side that has been presented.

The result is that frequently the caseworker in a room full of legal professionals appears to dictate the selection and contextualization of evidence and the recommendations considered. This too often leaves families feeling betrayed and underrepresented.

Recommendations:

- The GAL Sub-Committee of the Supreme Court Commission on Children in the Courts should continue to do their thoughtful work and make recommendations for improvement. Parties should take heed of their recommendations, even if not formally adopted.
- Lawyers should not be so defensive when stakeholders want to improve the practice of law in juvenile court. Many excuses are offered and little problem-solving is presented.
- Juvenile prosecution should be viewed as a specialty requiring experience and excellence in relevant statutory and procedural law, as well as basic principles of social work and family psychology.
- Nebraska's law schools should offer specializations in juvenile court practice.
- The Nebraska Bar Association should offer a certification in juvenile court work and all GALs and juvenile court attorneys should be certified.
- County Attorneys should be expected to take the best interests of families into consideration in their recommendations to the extent that those interests do not conflict with the state's interests.
- If caseworkers are to be successful in the very difficult task of engaging the family in services and helping them to make the often demanding life changes that the court insists on, they need to be viewed by the family as an ally. Court reports and caseworker courtroom testimony, while they need to contain recommendations, should contain a straightforward and unbiased view of all the facts whether or not those facts support the recommendations.

- Caseworkers should be trained in court decorum and the balanced presentation of evidence. Court reports should be audited to make sure they fairly represent *all* of the available evidence in a case.
- Attorneys need to take the time to solicit the family's point of view, particularly regarding key incidents in their case. Many documents provided to the court are currently made by an inexperienced, transient workforce. Examples include workers who oversee visitation or who do unannounced drop-ins at the parental residence to confirm compliance with the court order. These workers frequently jump to invalid conclusions which are presented as fact. Their reports often reflect their own biases about parenting, cleanliness, social norms, etc., and are often seemingly hastily written. There is often good reason to call these reports into question, but this is too seldom done. Often families who call the Ombudsman's office will say they have not been listened to and that the judge has never been told their side of the story.

Worker Retention

One of the central factors of service provision that determines the success of families in the child welfare system is the number of caseworkers assigned to a family over the life of their case. One often-cited study found that successful outcomes in child welfare correlate highly with the number of caseworkers. It found that timely permanency occurred in 75% of cases with only one caseworker, 17% of cases with two caseworkers, 2.2% of those with four caseworkers, and only .1% of cases with six or more workers.⁵⁷ The FCRO in its most recent annual report, showed that the average numbers of caseworkers Nebraska wards experienced in their lifetime varied between 4 and 5 depending on service area and age group.⁵⁸

In practice, the detrimental effects of caseworker turnover are apparent. In order to make progress, families must develop mutual trust with their caseworker. This takes time. For families with interpersonal communication problems, it can take many months. In order to make positive recommendations in court, the caseworkers must know the family well enough to feel confident that they are making progress. Case files can be thousands of pages long, too long to read in full, and workers are inconsistent in the quality of their case narration, so many details of the case are lost when cases are transferred from worker to worker. Often the effect of case transfer is that all the unique details of a family's situation are temporarily forgotten and replaced with simple stereotypes. With CFS family visitation goals calling for workers to visit children and parents only once per month, it can take a long time to establish good communication and mutual understanding.

Often, cases that seem to be heading toward positive outcomes will lose momentum or begin to regress when a new caseworker is assigned. Misunderstandings and forgotten promises are common as are delays in service and continuations of subsequent hearings. Judges who cannot get complete and confident answers to questions from newly assigned caseworkers are often reticent to allow progress toward reunification. Families become discouraged by having to repeatedly tell all the intimate details of their case to yet another stranger.

Multiple studies have repeatedly found that high caseloads are a primary cause of caseworker

⁵⁷Flower, Connie, et al. *Review of Turnover in Milwaukee County Private Agency Child Welfare Ongoing Case Management Staff*.

⁵⁸FCRO 2013 Annual Report. P 52. The reader is referred to this report for further discussion of caseworker turnover in Nebraska.

turnover. A California study showed that counties which paid caseworkers higher salaries and followed best practice standards (which include lowered caseloads) had lower incidences of abuse and neglect. Illinois conducted a study which determined that the ideal caseload is 15 families and found that money invested in lowering caseloads was offset by savings associated with reduced rates of removal, placement, and length of stay.⁵⁹

In 2012 the Legislature passed LB 961 which mandated maximum caseload sizes for CFS caseworkers.⁶⁰ No service area has yet met the caseload targets in any given month. CFS and NFC seem to treat the statutory caseload maximums as mere suggestions or unobtainable goals rather than mandates. Administrators at CFS and NFC seem to treat the statutory caseload maximums as mere suggestions or unobtainable goals rather than mandates. It is likely that administrators know what steps need to be taken to meet these goals but are being constrained from requesting the needed funding. However, the meaning and intent of the law is clear.

CFS's difficulties in recruiting and retaining caseworkers may be partially explained by the fact that Nebraska pays caseworkers some of the lowest hiring rates in the region. Our office conducted an informal survey of current open caseworker positions in states bordering Nebraska. The low end of Nebraska's starting salary range for currently open Children and Family Services Specialist (CFSS) (caseworker) positions is \$30,721. Bordering states' bottom salary figures for similar positions varied from \$34,923 in South Dakota to \$41,448 in Wyoming. The top of Nebraska's starting salary range is \$35,505, only slightly higher than any other state's lowest figure. Top salaries in other states ranged from \$37,980 in Kansas to \$59,841 in Iowa. If Nebraska is to attract and retain excellent caseworkers, it will likely have to pay salaries that are competitive for the region.

It should also be mentioned that starting salaries for probation officers are significantly higher than for caseworkers. Currently listed positions for Juvenile Probation Officers offer a salary range of \$33,204-\$40,461 and have similar education requirements to CFS caseworkers. This pay disparity along with recent increases in the numbers of probation officers after the passage of LB 561 have meant that significant numbers of experienced caseworkers have left CFS for better paying jobs as Probation officers.

In many states, caseworkers are required to have a master's degree in social work. Nebraska does not require any level of social work education for its caseworkers or the administrators who supervise them. Caseworkers are required only to have a four-year degree in any social services field. Neighboring states have similar requirements. Only Kansas requires caseworkers to have bachelor's degrees in social work and to be licensed to practice social work. Nebraska does not require or provide incentives for caseworkers or administrators to pursue any formal education in social work.

Recommendations:

- CFS administrators need to request enough money in this years' supplemental budget and all future budgets to increase their workforce to levels that will achieve a 100% compliance with statutory caseload mandates in all service areas. If they cannot determine how to accomplish this, a consultant should be hired to assist them.
- Current strategic planning should include specific targets for significantly improved caseworker retention and specific means of attaining those targets. Budget requests should

⁵⁹Social Work Policy Institute. *High Caseloads: How Do They Impact Delivery of Health and Human Services*. January 2010.

⁶⁰Neb. Rev. Stat. §68-1207.

clearly reflect these goals.

- The average number of caseworkers assigned to families during the duration of their present case for all open CFS cases should be included in monthly CQI reports – statewide and by service area.
- The average number of caseworkers assigned to a given child over the course of their lifetime for all current state wards should be included in monthly CQI reports – statewide and by service area.
- Excellent social work, no less than other professions, cannot be reduced to a set of policies and protocols enforced from the top down. Professional excellence is built from the bottom up. A quality professional workforce in any field is encouraged by high educational requirements for entry, mandated continuing education, and support from professional organizations. Therefore, the best way to assure that best practices in social work are being correctly employed throughout our system is to have a workforce that has high levels of social work education, robust continuing education requirements, and high degrees of involvement in professional organizations. To that end, Nebraska should encourage supervisors and higher level administrators to pursue degrees and licenses in social work. Continuing education requirements and opportunities for all workers should be increased. Long-term strategic planning should include strong incentives for administrators to seek additional education and should contain goals for increased education and licensing requirements to phase in over time.

Youth Rehabilitation and Treatment Centers

Nebraska has two youth rehabilitation and treatment centers (YRTCs) that serve as the placement of last resort for children in our juvenile justice system. The facility for girls is located in Geneva (YRTC-G) and the boys' facility is in Kearney (YRTC-K). The YRTCs are small, self-contained campuses with dorms, schools, gyms, cafeterias, chapels, and recreational facilities. Facilities such as these are the most restrictive placements for juveniles and are meant to house and provide treatment to only those violent or dangerous youth who cannot be safely placed within their community or in any less restrictive setting.⁶¹

In 2011, Nebraska had the third highest rate of youth incarceration in the nation.⁶² This is highly undesirable because research shows that incarcerating youth has negative outcomes compared to less restrictive treatment settings and little to no effect on future criminal activity.⁶³ Also, YRTCs are the most expensive form of placement.

Nebraska's primary challenge is that our YRTC populations are not limited to only those youth who cannot be safely housed at lower levels of restriction. In many communities across the state there are few options for treatment and placement, so judges see no alternative but to commit deviant, though

⁶¹See the testimony of Dr. Terry Lee, MD before the judiciary committee regarding LB 561 on March 1, 2013. Dr. Terry was commissioned to conduct an evaluation of Nebraska's Juvenile Justice System which was published on May 3, 2013.

⁶²This is according to the Annie E. Casey Foundation's Kids Count Data Center.

<http://datacenter.kidscount.org/data/tables/42-youth-residing-in-juvenile-detention-correctional-and-or-residential-facilities?loc=1&loct=2#ranking/2/any/true/867/any/320>

⁶³The National Juvenile Justice Network. *The Truth About Consequences: Studies Point Toward Sparing Use of Formal Juvenile Justice System Processing and Incarceration*. January 2012.

Mendel, Richard A. *No Place for Kids: The Case for Reducing Juvenile Incarceration*. Annie E. Casey Foundation. 2011.

not dangerous, youth to the YRTC. This increases the population making these institutions more difficult and expensive to run, traumatizes those youth unnecessarily, and creates a population that is too varied to effectively treat.

In order for the YRTCs to be used correctly and house appropriate populations they need to be situated within a continuum of care that includes the full range of options necessary to treat each youth at the least restrictive level. Such a continuum needs to include “outpatient services, school-based services, intensive outpatient services, day treatment programs, intensive in-home services, therapeutic foster homes, group homes, residential treatment, and long-term secure detention.”⁶⁴ These services will need to be available to all counties across the state. Without them, judges will continue to feel there are no better options and commit youth to YRTCs in Nebraska and neighboring states who would be better served in a less restrictive setting.

Placing a youth in an unnecessarily restrictive setting wastes resources, traumatizes the youth, and teaches deviant behavior by exposing them to others with more severe tendencies to violence and aggression. Placing a youth at too low a restriction can increase anti-social behaviors, disrupt the others who are appropriately placed, and wastes resources because the youth do not receive effective treatment.

Treatment programs for violent and aggressive youth are different from treatment programs for youth who display other deviant behaviors. If the YRTC populations continue to include non-violent probation violators, they will never be able to adequately treat their population. And without a full continuum of care youth will continue to be placed at too high or too low a level of restriction.

The OIG has observed a great number of youth in both YRTCs who are taking multiple medications for psychiatric problems but who do not have an individualized treatment plan beyond the usual institutional programming. There has been little research on the effect of multiple psychiatric medications on youth. There is little evidence that treatment of disruptive or aggressive behavior in youth with medications is effective. Traumatized youth, which some studies show could be as high as 70% in YRTCs, may be made worse by many common medications.⁶⁵ To effectively treat youth, best-practice for most psychiatric conditions suggests medications be coupled with an appropriate, individualized psychosocial treatment program.⁶⁶ Further research into this topic should be conducted by qualified medical professionals to make sure youth at the YRTCs are not over-medicated and are receiving appropriate behavioral health care which compliments their psychiatric treatment.

Finally, because the YRTCs house the most violent and aggressive youth, they are always going to be relatively expensive compared to other placements and more difficult to manage. Likely, no matter how well they are run, there will unfortunately always be occasional violent incidents which result in newspaper articles and political recrimination. For this reason administrators seem not to want responsibility for the YRTCs. Annually there is talk of moving responsibility for the YRTCs to a

⁶⁴Dr. Terry Lee. *Nebraska Juvenile Justice System Evaluation*. p 17.

⁶⁵Zelechowski, Amanda D., et al. *Traumatized Youth in Residential Treatment Settings: Prevalence, Clinical Presentation, Treatment, and Policy Implications*. Journal of Family Violence. Vol 28, No 6. http://www.traumacenter.org/products/pdf_files/Youth%20Trauma_Residential%20Treatment_Prevalence_Policy_Zelechowski_Spinazzola.pdf

⁶⁶We hear this repeatedly from medical professionals who complain of over-medicated youth in state care. See Dr. Lee's report, p 16 for a brief discussion.

different agency or of abolishing them altogether.

Nebraska will always need youth placements of last resort.⁶⁷ Because national standards dictate that residential treatment facilities need to be therapeutic, these facilities belong within CFS or Behavioral Health rather than Corrections or Probation. Without the Y RTCs, Nebraska would likely send more youth to out-of-state facilities, place more youth in county detention facilities, or try more youth as adults. None of these are desired outcomes.

Recommendations:

- Because population issues are central to problems at both Y RTCs, one of the primary means of improving these institutions will be accomplished elsewhere – by building a continuum of provider resources across the state.
- Improving the Y RTCs and decreasing their populations needs to be included centrally in CFS's strategic planning and should have strong support from the DHHS central office and buy-in from the judiciary. The goal should be for Y RTC populations to be as low as possible and restricted only to youth considered too dangerous for any other placement.
- Research shows that Y RTC populations are heavily affected by trauma. And for many traumatized youth, Y RTC placement is much more traumatizing than therapeutic.⁶⁸ Trauma assessments and histories should be part of any decision to place a child at a Y RTC. Y RTCs need to be included as a key feature in the statewide trauma strategic planning process. Y RTCs should employ best practices in treating trauma, which includes creating a calm, safe environment facilitated by low staff-to-resident ratios. A trauma informed placement should be available to all youth who need one, regardless of the level of restriction.
- Nebraska does not track data on recidivism at the Y RTCs. Without doing so there is little evidence as to whether these programs are successful or improving. Nebraska should track and analyze outcome data for this population, particularly how many residents return to the Y RTCs or detention facilities or are later incarcerated as adults.
- These recommendations and those below coincide with other recent reports such as Bud Potter's 2012 recommendations for Y RTC-K⁶⁹ and Dr. Terry Lee's report as well as those in the Nebraska Juvenile Facilities Master Plan Update.⁷⁰ These reports include many additional recommendations that should be implemented and which coincide with and support the recommendations here. Most notably, all three advise that staffing levels need to be increased and staff pay and benefits need to be sufficient to attract and retain a quality workforce. Presently, the administrations of these facilities struggle to keep positions filled and staff too often consider employment at the Y RTC a short-lived stepping stone to better paid employment elsewhere in the justice system. The consistency of recommendations across these reports and throughout juvenile justice literature suggest that what is needed to improve these institutions is well known and documented.
- Youth who do not arrive at the Y RTCs having had a trauma screen should have one done on admission. Those with evidence of a trauma history should be referred to a mental health professional for a trauma assessment. Their programming within the institution should reflect best practice treatment for trauma.

⁶⁷Ideally, these would be small facilities located around the state so children could be placed close to their families, but due to Nebraska's low population that may not be feasible. Further study is needed.

⁶⁸Zelechowski, Amanda D., *et al.*

⁶⁹Bud Potter. Memo to Jana Peterson, Facility Administrator, Y RTC-K. November 12, 2012.

⁷⁰Chinn Planning, Inc. Prepared for the Nebraska Juvenile Project Steering Committee. June 15, 2007.

Youth Rehabilitation and Treatment Center - Geneva

The OIG and Ombudsman's offices have visited YRTC-G many times in recent years. Often these visits are in response to specific complaints from residents or their families. Evidence of neglect or abuse has not been found in recent years. On all visits, facilities were clean and well maintained and the girls appeared well behaved, fairly treated, and to interact positively with staff. The overall environment in the living units and on campus appears orderly and calm. There are some excellent features to the campus, such as an apartment where young mothers can have visits with their children, including overnight visits, and learn better parenting skills in a comfortable, home-like setting.

However, the OIG has repeatedly received complaints about and observed what appears to be a lack of engagement of and programming opportunities for the youth. Girls appear to have many hours where they sit in dorms with no organized activity and little to do. Girls who are not enrolled in school or who do not have a job in the community can spend much of the day sitting in their dorms staring at a television or puzzle. Many girls seemed bored or disengaged, and in reviewing their schedules, long stretches of unstructured time are found. Girls often claim that the activities that are available do not hold their interest. Many of the girls at YRTC-G have no history of violence and may be needlessly enduring separation from homes, families, communities, and schools.

YRTC-G does not follow a best-practice treatment model. Its programming is an amalgamation of various programs whose effect on outcomes and recidivism has never been studied. Best practice models for YRTCs involve training all staff on an evidence-based cognitive behavioral program that affects nearly every interaction with the youth. Best practice programs for these populations coordinate the work that is done in therapeutic settings with regular group meetings and all staff interactions, including interactions with administrators, teachers, and cafeteria staff. In such programs the youth learn consistent terms and methods that helps them build coping skills, control violent impulses, build upon their strengths, set and achieve positive goals, and reduce deviant behavior. These programs require extensive training and put in place feedback mechanisms that assure consistent adherence to the model by all staff (program fidelity).

Recommendations:

- A campus-wide review of youth schedules should be done to verify the observations above and to generate a baseline for future improvements.
- YRTC-G should provide more programming opportunities for the youth in its care including more on- and off-campus employment opportunities, physical activities, outings, interest groups and clubs, college preparation activities, and social events. We suspect these things are not offered at sufficient levels because staff-to-resident ratios are too low and staff cannot be freed up to oversee and coordinate sufficient levels of activities. This needs to be assessed and improved in conjunction with a plan to structure as much of the girls' time as is in accord with best practice.
- YRTC-G should select and implement with fidelity an evidence-based cognitive behavioral treatment model. This model should be trauma informed.

Youth Rehabilitation and Treatment Center – Kearney

YRTC-K receives a great deal more attention and criticism than the Geneva facility because youth-on-youth and youth-on-staff assaults have been a perennial problem there. Violence is typically a problem that is more pervasive at residential treatment facilities for boys. Most of the OIG visits to YRTC-K have been in response to reports of violence.

The YRTC-K campus is observed to be similarly clean and the facilities orderly. The gymnasium stands out as exceptional because it is large enough to allow several groups to use it at once, enabling the youth to have healthy amounts of exercise. The boys seem engaged and active and there have been no complaints about a lack of extracurricular programming. The school has some exceptional facilities, particularly a large art room and woodworking shop which proudly display the boys' creative work.

One problematic aspect of the physical plant is the dormitory rooms where the youth sleep. These are large rooms with 30 beds side-by-side. Best practice is for each boy to have his own room. Individual rooms help boys to feel safe, allow them a small measure of privacy, cut down on fighting, allow for better sleep, and can be used as part of the disciplinary and incentive program – for example, boys would not need to be sent to solitary confinement in order to have some time alone.

One of the most apparent problems at YRTC-K is a large difference in behavior among living units. Living units are separated by lower and higher needs youth. The usually younger, lower needs youth are typically seen to be following the rules in an orderly way, staff and youth leadership appear to do a good job of modeling positive behavior, youth appear to treat staff with respect, and group therapy meetings seem organized, focused, and positive.

The older youth tend to behave very differently. Aggressive shouting, fighting, and minor physical altercations have been noted during periods of observation. The OIG and Ombudsman's office have frequently observed youth behaving in a disordered way, blatantly disregarding minor rules (such as standing on chairs, cursing, laying down on tables, throwing objects, or removing their shirts indoors), and showing little respect for the staff. Because experienced staff get to choose which living unit they work in, the least experienced staff tend to work with the most difficult youth which compounds this problem.

In 2007, YRTC-K switched from a treatment model called Positive Peer Culture (PPC) to one called Equipping Youth to Help One Another (EQUIP). The reason for this is that the way the PPC model was being implemented was overly punitive, non-therapeutic, and encouraged negative youth interaction. Under that system youth were divided into small groups and each group was responsible for the behavior of its members – youth were rewarded or punished as a group. If a youth misbehaved, the group would frequently “take-down” that member, tackling him to the floor and restraining him. Youth were often injured in such interactions.

Under EQUIP there are no take-downs of youth. Discipline is carried out by trained adults. EQUIP is an evidence-based cognitive behavioral treatment model. The shift from PPC to EQUIP can be seen as a shift from a corrections-based approach with an emphasis on control to a treatment-based model with an emphasis on rehabilitation. There have been some difficulties with the implementation of EQUIP which cause staff and youth to complain of feeling unsafe and problems with assaults and youth aggression to rise.

There is a portion of the staff at YRTC-K who actively oppose the implementation of the EQUIP

program and regularly make complaints about this matter. These include some of YRTC-K's most senior and experienced staff. They claim to feel unsafe and cite continued youth-on-staff violence statistics. They claim that certain levels of disrespect and aggressive behavior by the youth, which used to be documented and recorded, have become so common they are no longer recorded and so are disregarded in the statistics.⁷¹ They have repeatedly expressed the wish to return to the PPC program because they felt safer when it was in place.

In response to these complaints, our office has had many meetings with YRTC-K employees about this topic and will continue to do so. We have observed youth and staff interacting in the living units, group therapy rooms, cafeteria, and reviewed surveillance footage of violent incidents. We've also had a conversation with Bud Potter, an author of the EQUIP program and the consultant who helped YRTC-K implement the program, and studied his November 2012 follow-up report evaluating the implementation of the program.

Staff opposing the EQUIP program is a serious problem for the institution. Programs like EQUIP are often referred to as milieu therapies because every aspect of the social environment is supposed to be part of the therapeutic program. These programs are designed to be consistently implemented by every adult the youth encounters. They dictate specific language that is used to discuss and address problematic behaviors and specific methods for doing so. Having staff that do not believe in the program or who are taking it upon themselves to alter or ignore aspects of the program undermines the work of those who are attempting to implement the program to fidelity.

These staff members are likely not the source of this problem. Assuming they are not all being disingenuous in their claims, the only reason they are resistant to the EQUIP program is because they feel unsafe. Their wish is to return to a previous way of doing things which made them feel safe and in control. However, federal standards have changed and a return to PPC and take-downs is not in the youths' best interest. One must conclude that, because staff feel unsafe, EQUIP is either an inadequate therapeutic program for the YRTC-K population,⁷² that it is not being implemented successfully, or that disciplinary policies are ineffective.

Staff have complained that EQUIP does not allow them to effectively discipline the youth. This shows a basic misunderstanding of EQUIP, which is a therapeutic and not a disciplinary program. Disciplinary policies and training coordinate with, but are separate from, EQUIP policies and training. EQUIP trains staff to notice signs of escalating aggression early and to intervene and "de-escalate" the youth prior to aggressive actions, but there should also be an effective system of incentives and punishments in place for controlling behavior. The fact that this distinction does not seem clear to many staff is worrisome.

In footage viewed of violent incidents at YRTC-K, EQUIP protocols were often not being followed. Youth could be seen to be clearly escalating in aggressive feelings and behaviors and no staff were approaching them or communicating with them as the program prescribes. Prior to violence, youth appear visibly agitated – breathing heavily, pacing, intimidating and taunting other youth, shouting,

⁷¹We have not been able to verify this. Reviewing records and disciplinary procedures in specific incidents, including incidents where staff have claimed procedure was not followed, have always found that procedures were followed, any assaults were accurately recorded, and disciplinary measures were fairly implemented.

⁷²There has only been one major study of the EQUIP. Leeman, Leonard W., John C. Gibbs, and Dick Fuller. *Evaluation of a Multi-Component Group Treatment Program for Juvenile Delinquents*. Aggressive Behavior 1993. v 19. p 281–92.

picking up chairs, etc. Staff were either not present, engaged elsewhere, or not noticing their behavior until a physical altercation had begun.

The follow-up report by Mr. Potter, written two years after the initial implementation of EQUIP, noted a great deal of improvement but also observed many habits and practices that seemed to be held-over from PPC which went against EQUIP practice. A year later, Dr. Lee's report to the Legislature noted many similar practices – most notably, group punishments. Dr. Lee also seemed to see a general lack of an environment proper to any milieu therapeutic program because he recommends staff receive more training on the basic principles of these programs, that staff be observed and evaluated for adherence to the therapeutic program, and that staff visit a facility that has successfully implemented a milieu therapy program.

Recommendations:

- In order to successfully rehabilitate Nebraska's highest needs youth, YRTC-K will need to be able to implement a milieu therapy program to greater fidelity than seems to be the case presently with the EQUIP program. This therapeutic program will have to be coordinated with an effective disciplinary program. Administrators at YRTC-K are extremely dedicated, hard-working individuals who are eager to improve their program and implement any directives from the Administration or the Legislature. However, they are not behavioral health professionals, experts in milieu therapy, or organizational consultants and cannot be expected to have those skill sets. In order to succeed, they will need support from central administration in deciding if EQUIP is adequate to the institution's needs, coordinating all policies and disciplinary practices with the therapeutic model, and effecting an internal culture shift so that all employees are working together to implement the program with fidelity.
- According to Bud Potter, EQUIP training standards require 24 hours of initial EQUIP training followed by 24 hours of additional training annually. Currently, YRTC-K provides employees with only 12 hours of initial training followed by 13 hours annually. EQUIP training should be increased to at least the amounts recommended by the program.
- Providing effective treatment to Nebraska's most violent and aggressive youth is a necessary and difficult job. YRTC-K will continue to have problems if it does not pay enough to attract and retain a high-quality workforce. Salaries and benefits need to be sufficient to maintain full staffing levels and commensurate with other positions in the Nebraska Juvenile Justice System.

LOOKING FORWARD: OFFICE OF THE INSPECTOR GENERAL FOCUS IN 2014 - 2015

The OIG recognizes several areas relating to child welfare and juvenile justice in Nebraska that will be monitored for further understanding and progress. This is not an exhaustive list, but rather a recognition that development and advancement of these topics will be a focus the OIG over the coming year.

Juvenile Justice Cases - From State Wards to Probation Supervision

Fiscal year 2013-2014 brought the transfer of delinquent or juvenile justice state wards to the supervision of Probation.⁷³ Probation has had to hire and train many and various positions to accommodate this reform. Meanwhile, CFS has had to adjust as their Office of Juvenile Services budget has shrunk significantly. This reform also includes what was formerly known as juvenile parole. A youth now transitions out of the YRTCs to a re-entry process supervised by Juvenile Probation. By all accounts, so far in the reform efforts, the new re-entry process is going very well and can be looked to as a model of collaboration between two agencies in two different branches of government—the YRTCs under CFS and Juvenile Probation under the Supreme Court.

As the systems continue to adjust to this reform, the OIG will be interested in the following topics:

- Ensuring that appropriate oversight and tracking exists with any child served by or through any government agency, including Juvenile Probation.
- Clarifying roles and services provided when a child either becomes a state ward and is served by the Division of Children and Family Services, or when a juvenile is placed on probation and is supervised by Juvenile Probation. The creation of 2 parallel child-serving systems is not the intent of the reform, but rather the intent is each system is to be expert in serving their respective populations. This includes educating all stakeholders in the systems about which cases should properly belong under the jurisdiction of CFS or Probation.
- Adjusting budgets according to how filing practices by county attorneys may change. For example, if more 3(a) no fault and 3(c) cases are filed than what was usually filed under 3(b)⁷⁴, it will likely be because the legal parties believe those youth could be better served through CFS. The Department of Health and Human Services will need to be upfront with any increases in numbers and how that correlates to their budget requests.

State Ward Permanency Pilot Project

During the 2014 Legislative Session, funding was allocated through LB 905 for the State Ward Permanency Project. This is intended to help state wards who are not qualified for priority funding, but who are eligible for services through the Division of Developmental Disabilities. If this population of state wards receives the enhanced level of care necessary, permanency objectives can be met sooner. In addition, this provides a platform for various divisions within the Department of Health and Human Services to work together to find the best and most cost effective way to serve these children. The OIG is interested to see how these collaborations evolve.

It is hoped that by participating in this pilot project, administrators within the Division of

⁷³ Legislative Bill 561, 2013.

⁷⁴ Referring to Neb. Rev. Stat. §43-247 and each county's juvenile court jurisdiction.

Developmental Disabilities and Division of Children and Family Services will continue to collaborate on other issues for children who are state wards, such as how to best serve those that currently fall short of the criteria for developmental disabilities services but could clearly benefit from habilitative care. Other items such as utilizing an appropriate child-specific assessment tool for system-involved children to access appropriate and needed development disability services is an area where solutions could be presented if appropriate collaboration existed.

Statutory Follow-Up

There have been several pieces of legislation passed to statutorily involve the OIG in various issues. Follow-up on each area is ongoing.

Alternative Response

Alternative response demonstration projects through CFS are scheduled to roll out in 5 pilot sites on October 1, 2014. The OIG and CFS are developing procedures to allow the IG's review of cases subject to alternative response.⁷⁵ In addition, the IG has been included as a member of CFS Director Pristow's Alternative Response Steering Committee.

Children's Commission & Child and Maternal Death Review Team Membership

The position of the Inspector General of Nebraska Child Welfare was added as a member to the Nebraska Children's Commission⁷⁶ and the Nebraska Child and Maternal Death Review Team⁷⁷ in 2013. The IG is an active member of the Nebraska Children's Commission, serving on various committees and workgroups for the improvement of child welfare. Membership on the Nebraska Child and Maternal Death Review Team was clarified in the fall of 2013, and the first meeting the IG attended was in December 2013.

Department of Health and Human Services Formal Grievance Process

Neb. Rev. Stat. §81-603 provides:

The Department of Health and Human Services shall implement a formal grievance process for families involved in the child welfare system or juvenile justice system. Such grievance process shall ensure that families are not dissuaded from utilizing the grievance process for fear of reprisal from the department, providers, or foster parents. A report of each grievance allegation and the determination of and any action to be taken by the department shall be provided to the Inspector General for Nebraska Child Welfare within ten days after such determination is made.

The OIG understands that CFS is currently creating an internal formal grievance process. Thus far, no such reports have been provided to the OIG. NFC has a complaint process established per requirements within their contract for services with the Department of Health and Human Services. NFC is not required to forward determinations to the OIG, but will voluntarily share outcomes of certain cases.

⁷⁵ Neb. Rev. Stat. §28-712.01 (5).

⁷⁶Legislative Bill 269, 2013. Neb. Rev. Stat. §43-4202.

⁷⁷Legislative Bill 361, 2013. Neb. Rev. Stat. §71-3406.

Special Projects Being Pursued by the Office of the Inspector General

The OIG will continue to be involved in several special projects to improve Nebraska's child welfare system. This is a summary of new and ongoing reviews and activities that the OIG plans to pursue with respect to child welfare related programs and operations during the next fiscal year and beyond. These special projects are coordinated with the Ombudsman's Office.

Choosing special projects is a dynamic process and adjustments are made throughout the year to meet priorities and to anticipate and respond to emerging issues with the resources available. Identifying the areas most in need of attention and, accordingly, setting priorities for the sequence and proportion of resources to be allocated for each project is ongoing. In evaluating special projects to engage in throughout the year, a number of factors are considered, including:

- Mandatory requirements for OIG reviews, as set forth in laws, regulations, or other directives;
- Requests made or concerns raised by the Health and Human Services Committee;
- Work to be performed in collaboration with partner organizations; and
- Timeliness.

I: Develop a Nebraska Child Welfare Code of Ethics

Child welfare professionals make important decisions on behalf of the state that affect the lives of children and families. In making sound decisions, professionals should rely on incorporating the values of the child welfare profession and current knowledge about the problem with which they are dealing, while thinking critically about the decision that they must make. The OIG will lead an effort to develop a Nebraska child welfare code of ethics.

II: Improve the Engagement of Attorneys Operating in Juvenile Court—Legal Specialization in Juvenile Court

It is important that all attorneys appearing in juvenile court—prosecutors, guardians ad litem, and juvenile defense attorneys, are properly engaged and trained in the specialization that families and children appearing in juvenile court deserve. The OIG will champion the elevation of juvenile court practice.

III: Workforce Development—Audit Training of Professionals & Survey Caseworkers on Needs

In coordination with current efforts of the Nebraska Children's Commission, the OIG will audit training of caseworkers through CFS and NFC and will conduct a survey of caseworkers on what they think they need to do a quality job for their clients as well as what they need to stay in their role as caseworker in order to alleviate caseworker turnover.

IV: System-Involved Youth - Multiple Placement History

The OIG will continue to study youth who have had multiple placements (likely youth who have been characterized by the system as “high-risk, high-need”), whether in foster homes, detention

facilities, group homes, inpatient psychiatric hospitals, or YRTC's. Additionally, the study should note the frequency of use of psychotropic medications and assess whether the system possessed the proper tools to help these children become functioning members of the community as they either reach permanency or age out of the system.

V: Ascertain the Fidelity to the Structured Decision Making Model of Assessment

CFS utilizes Structured Decision Making in each point of the child welfare process. Questions have arisen as to whether the tools are being utilized with fidelity, inter rater reliability, and quality assurance, including at the hotline and the initial assessment stage. The OIG will study and understand the model and its adherence to fidelity and actions towards quality assurance.

VI: Breaking Down Silos/Encouraging Collaboration in Systems Serving Nebraska's Kids

Children and families are served by many statewide government entities: the Division of Children and Family Services, the Division of Behavioral Health, the Division of Medicaid and Long-term Care, the Division of Developmental Disabilities, the Division of Public Health, the Department of Education, and Juvenile Probation, to name some. Some efforts are coordinated but too many are not. The OIG will encourage collaboration among separate government entities to better problem solve and serve kids in Nebraska.

APPENDIX

OFFICE OF INSPECTOR GENERAL OF NEBRASKA CHILD WELFARE ACT

OFFICE OF INSPECTOR GENERAL OF NEBRASKA CHILD WELFARE ACT

43-4301. Act, how cited.

Sections 43-4301 to 43-4331 shall be known and may be cited as the Office of Inspector General of Nebraska Child Welfare Act.

43-4302. Legislative intent.

(1) It is the intent of the Legislature to:

(a) Establish a full-time program of investigation and performance review to provide increased accountability and oversight of the Nebraska child welfare system;

(b) Assist in improving operations of the department and the Nebraska child welfare system;

(c) Provide an independent form of inquiry for concerns regarding the actions of individuals and agencies responsible for the care and protection of children in the Nebraska child welfare system. Confusion of the roles, responsibilities, and accountability structures between individuals, private contractors, and agencies in the current system make it difficult to monitor and oversee the Nebraska child welfare system; and

(d) Provide a process for investigation and review to determine if individual complaints and issues of investigation and inquiry reveal a problem in the child welfare system, not just individual cases, that necessitates legislative action for improved policies and restructuring of the child welfare system.

(2) It is not the intent of the Legislature in enacting the Office of Inspector General of Nebraska Child Welfare Act to interfere with the duties of the Legislative Auditor or the Legislative Fiscal Analyst or to interfere with the statutorily defined investigative responsibilities or prerogatives of any officer, agency, board, bureau, commission, association, society, or institution of the executive branch of state government, except that the act does not preclude an inquiry on the sole basis that another agency has the same responsibility. The act shall not be construed to interfere with or supplant the responsibilities or prerogatives of the Governor to investigate, monitor, and report on the activities of the agencies, boards, bureaus, commissions, associations, societies, and institutions of the executive branch under his or her administrative direction.

43-4303. Definitions; where found.

For purposes of the Office of Inspector General of Nebraska Child Welfare Act, the definitions found in sections 43-4304 to 43-4316 apply.

43-4304. Administrator, defined.

Administrator means a person charged with administration of a program, an office, or a division of the department or administration of a private agency or licensed child care facility.

43-4305. Department, defined.

Department means the Department of Health and Human Services.

43-4306. Director, defined.

Director means the chief executive officer of the department.

43-4307. Inspector General, defined.

Inspector General means the Inspector General of Nebraska Child Welfare appointed under section

43-4317.

43-4308. Licensed child care facility, defined.

Licensed child care facility means a facility or program licensed under the Child Care Licensing Act, the Children's Residential Facilities and Placing Licensure Act, or sections 71-1901 to 71-1906.01.

43-4309. Malfeasance, defined.

Malfeasance means a wrongful act that the actor has no legal right to do or any wrongful conduct that affects, interrupts, or interferes with performance of an official duty.

43-4310. Management, defined.

Management means supervision of subordinate employees.

43-4311. Misfeasance, defined.

Misfeasance means the improper performance of some act that a person may lawfully do.

43-4312. Obstruction, defined.

Obstruction means hindering an investigation, preventing an investigation from progressing, stopping or delaying the progress of an investigation, or making the progress of an investigation difficult or slow.

43-4313. Office, defined.

Office means the office of Inspector General of Nebraska Child Welfare and includes the Inspector General and other employees of the office.

43-4314. Private agency, defined.

Private agency means a child welfare agency that contracts with the department or the Office of Probation Administration or contracts to provide services to another child welfare agency that contracts with the department or the Office of Probation Administration.

43-4315. Record, defined.

Record means any recording, in written, audio, electronic transmission, or computer storage form, including, but not limited to, a draft, memorandum, note, report, computer printout, notation, or message, and includes, but is not limited to, medical records, mental health records, case files, clinical records, financial records, and administrative records.

43-4316. Responsible individual, defined.

Responsible individual means a foster parent, a relative provider of foster care, or an employee of the department, a foster home, a private agency, a licensed child care facility, or another provider of child welfare programs and services responsible for the care or custody of records, documents, and files.

43-4317. Office of Inspector General of Nebraska Child Welfare; created; purpose; Inspector General; appointment; term; certification; employees; removal.

(1) The office of Inspector General of Nebraska Child Welfare is created within the office of Public Counsel for the purpose of conducting investigations, audits, inspections, and other reviews of the Nebraska child welfare system. The Inspector General shall be appointed by the Public Counsel with approval from the chairperson of the Executive Board of the Legislative Council and the chairperson of the Health and Human Services Committee of the Legislature.

(2) The Inspector General shall be appointed for a term of five years and may be reappointed.

The Inspector General shall be selected without regard to political affiliation and on the basis of integrity, capability for strong leadership, and demonstrated ability in accounting, auditing, financial analysis, law, management analysis, public administration, investigation, or criminal justice administration or other closely related fields. No former or current executive or manager of the department may be appointed Inspector General within five years after such former or current executive's or manager's period of service with the department. Not later than two years after the date of appointment, the Inspector General shall obtain certification as a Certified Inspector General by the Association of Inspectors General, its successor, or another nationally recognized organization that provides and sponsors educational programs and establishes professional qualifications, certifications, and licensing for inspectors general. During his or her employment, the Inspector General shall not be actively involved in partisan affairs.

(3) The Inspector General shall employ such investigators and support staff as he or she deems necessary to carry out the duties of the office within the amount available by appropriation through the office of Public Counsel for the office of Inspector General of Nebraska Child Welfare. The Inspector General shall be subject to the control and supervision of the Public Counsel, except that removal of the Inspector General shall require approval of the chairperson of the Executive Board of the Legislative Council and the chairperson of the Health and Human Services Committee of the Legislature.

43-4318. Office; duties; law enforcement agencies and prosecuting attorneys; cooperation; confidentiality.

(1) The office shall investigate:

(a) Allegations or incidents of possible misconduct, misfeasance, malfeasance, or violations of statutes or of rules or regulations of the department by an employee of or person under contract with the department, a private agency, a licensed child care facility, a foster parent, or any other provider of child welfare services or which may provide a basis for discipline pursuant to the Uniform Credentialing Act; and

(b) Death or serious injury in foster homes, private agencies, child care facilities, juvenile detention facilities, staff secure juvenile facilities, and other programs and facilities licensed by or under contract with the department or the Office of Probation Administration and death or serious injury in any case in which services are provided by the department to a child or his or her parents or any case involving an investigation under the Child Protection and Family Safety Act, which case has been open for one year or less. The department and the Office of Probation Administration shall report all cases of death or serious injury of a child in a foster home, private agency, child care facility or program, or other program or facility licensed by the department to the Inspector General as soon as reasonably possible after the department or the Office of Probation Administration learns of such death or serious injury. For purposes of this subdivision, serious injury means an injury or illness caused by suspected abuse, neglect, or maltreatment which leaves a child in critical or serious condition.

(2) Any investigation conducted by the Inspector General shall be independent of and separate from an investigation pursuant to the Child Protection and Family Safety Act. The Inspector General and his or her staff are subject to the reporting requirements of the Child Protection and Family Safety Act.

(3) Notwithstanding the fact that a criminal investigation, a criminal prosecution, or both are in progress, all law enforcement agencies and prosecuting attorneys shall cooperate with any investigation conducted by the Inspector General and shall, immediately upon request by the

Inspector General, provide the Inspector General with copies of all law enforcement reports which are relevant to the Inspector General's investigation. All law enforcement reports which have been provided to the Inspector General pursuant to this section are not public records for purposes of sections 84-712 to 84-712.09 and shall not be subject to discovery by any other person or entity. Except to the extent that disclosure of information is otherwise provided for in the Office of Inspector General of Nebraska Child Welfare Act, the Inspector General shall maintain the confidentiality of all law enforcement reports received pursuant to its request under this section. Law enforcement agencies and prosecuting attorneys shall, when requested by the Inspector General, collaborate with the Inspector General regarding all other information relevant to the Inspector General's investigation. If the Inspector General in conjunction with the Public Counsel determines it appropriate, the Inspector General may, when requested to do so by a law enforcement agency or prosecuting attorney, suspend an investigation by the office until a criminal investigation or prosecution is completed or has proceeded to a point that, in the judgment of the Inspector General, reinstatement of the Inspector General's investigation will not impede or infringe upon the criminal investigation or prosecution. Under no circumstance shall the Inspector General interview any minor who has already been interviewed by a law enforcement agency, personnel of the Division of Children and Family Services of the department, or staff of a child advocacy center in connection with a relevant ongoing investigation of a law enforcement agency.

43-4319. Office; access to information and personnel; investigation.

(1) The office shall have access to all information and personnel necessary to perform the duties of the office.

(2) A full investigation conducted by the office shall consist of retrieval of relevant records through subpoena, request, or voluntary production, review of all relevant records, and interviews of all relevant persons.

43-4320. Complaints to office; form; full investigation; when; notice.

(1) Complaints to the office may be made in writing. The office shall also maintain a toll-free telephone line for complaints. A complaint shall be evaluated to determine if it alleges possible misconduct, misfeasance, malfeasance, or violation of a statute or of rules and regulations of the department by an employee of or a person under contract with the department, a private agency, or a licensed child care facility, a foster parent, or any other provider of child welfare services or alleges a basis for discipline pursuant to the Uniform Credentialing Act. All complaints shall be evaluated to determine whether a full investigation is warranted.

(2) The office shall not conduct a full investigation of a complaint unless:

(a) The complaint alleges misconduct, misfeasance, malfeasance, violation of a statute or of rules and regulations of the department, or a basis for discipline pursuant to the Uniform Credentialing Act;

(b) The complaint is against a person within the jurisdiction of the office; and

(c) The allegations can be independently verified through investigation.

(3) The Inspector General shall determine within fourteen days after receipt of a complaint whether it will conduct a full investigation. A complaint alleging facts which, if verified, would provide a basis for discipline under the Uniform Credentialing Act shall be referred to the appropriate credentialing board under the act.

(4) When a full investigation is opened on a private agency that contracts with the Office of

Probation Administration, the Inspector General shall give notice of such investigation to the Office of Probation Administration.

43-4321. Cooperation with office; when required.

All employees of the department, all foster parents, and all owners, operators, managers, supervisors, and employees of private agencies, licensed child care facilities, juvenile detention facilities, staff secure juvenile facilities, and other providers of child welfare services shall cooperate with the office. Cooperation includes, but is not limited to, the following:

(1) Provision of full access to and production of records and information. Providing access to and producing records and information for the office is not a violation of confidentiality provisions under any law, statute, rule, or regulation if done in good faith for purposes of an investigation under the Office of Inspector General of Nebraska Child Welfare Act;

(2) Fair and honest disclosure of records and information reasonably requested by the office in the course of an investigation under the act;

(3) Encouraging employees to fully comply with reasonable requests of the office in the course of an investigation under the act;

(4) Prohibition of retaliation by owners, operators, or managers against employees for providing records or information or filing or otherwise making a complaint to the office;

(5) Not requiring employees to gain supervisory approval prior to filing a complaint with or providing records or information to the office;

(6) Provision of complete and truthful answers to questions posed by the office in the course of an investigation; and

(7) Not willfully interfering with or obstructing the investigation.

43-4322. Failure to cooperate; effect.

Failure to cooperate with an investigation by the office may result in discipline or other sanctions.

43-4323. Inspector General; powers; rights of person required to provide information.

The Inspector General may issue a subpoena, enforceable by action in an appropriate court, to compel any person to appear, give sworn testimony, or produce documentary or other evidence deemed relevant to a matter under his or her inquiry. A person thus required to provide information shall be paid the same fees and travel allowances and shall be accorded the same privileges and immunities as are extended to witnesses in the district courts of this state and shall also be entitled to have counsel present while being questioned.

43-4324. Office; access to records; subpoena; records; statement of record integrity and security; contents; treatment of records.

(1) In conducting investigations, the office shall access all relevant records through subpoena, compliance with a request of the office, and voluntary production. The office may request or subpoena any record necessary for the investigation from the department, a foster parent, a licensed child care facility, a juvenile detention facility, a staff secure juvenile facility, or a private agency that is pertinent to an investigation. All case files, licensing files, medical records, financial and administrative records, and records required to be maintained pursuant to applicable licensing rules shall be produced for review by the office in the course of an investigation.

(2) Compliance with a request of the office includes:

- (a) Production of all records requested;
- (b) A diligent search to ensure that all appropriate records are included; and
- (c) A continuing obligation to immediately forward to the office any relevant records received, located, or generated after the date of the request.

(3) The office shall seek access in a manner that respects the dignity and human rights of all persons involved, maintains the integrity of the investigation, and does not unnecessarily disrupt child welfare programs or services. When advance notice to a foster parent or to an administrator or his or her designee is not provided, the office investigator shall, upon arrival at the departmental office, bureau, or division, the private agency, the licensed child care facility, the juvenile detention facility, the staff secure juvenile facility, or the location of another provider of child welfare services, request that an onsite employee notify the administrator or his or her designee of the investigator's arrival.

(4) When circumstances of an investigation require, the office may make an unannounced visit to a foster home, a departmental office, bureau, or division, a licensed child care facility, a juvenile detention facility, a staff secure juvenile facility, a private agency, or another provider to request records relevant to an investigation.

(5) A responsible individual or an administrator may be asked to sign a statement of record integrity and security when a record is secured by request as the result of a visit by the office, stating:

(a) That the responsible individual or the administrator has made a diligent search of the office, bureau, division, private agency, licensed child care facility, juvenile detention facility, staff secure juvenile facility, or other provider's location to determine that all appropriate records in existence at the time of the request were produced;

(b) That the responsible individual or the administrator agrees to immediately forward to the office any relevant records received, located, or generated after the visit;

(c) The persons who have had access to the records since they were secured; and

(d) Whether, to the best of the knowledge of the responsible individual or the administrator, any records were removed from or added to the record since it was secured.

(6) The office shall permit a responsible individual, an administrator, or an employee of a departmental office, bureau, or division, a private agency, a licensed child care facility, a juvenile detention facility, a staff secure juvenile facility, or another provider to make photocopies of the original records within a reasonable time in the presence of the office for purposes of creating a working record in a manner that assures confidentiality.

(7) The office shall present to the responsible individual or the administrator or other employee of the departmental office, bureau, or division, private agency, licensed child care facility, juvenile detention facility, staff secure juvenile facility, or other service provider a copy of the request, stating the date and the titles of the records received.

(8) If an original record is provided during an investigation, the office shall return the original record as soon as practical but no later than ten working days after the date of the compliance request.

(9) All investigations conducted by the office shall be conducted in a manner designed to ensure the preservation of evidence for possible use in a criminal prosecution.

43-4325. Reports of investigations; distribution; redact confidential information; powers of

office.

(1) Reports of investigations conducted by the office shall not be distributed beyond the entity that is the subject of the report without the consent of the Inspector General.

(2) Except when a report is provided to a guardian ad litem or an attorney in the juvenile court pursuant to subsection (2) of section 43-4327, the office shall redact confidential information before distributing a report of an investigation. The office may disclose confidential information to the chairperson of the Health and Human Services Committee of the Legislature when such disclosure is, in the judgment of the Public Counsel, desirable to keep the chairperson informed of important events, issues, and developments in the Nebraska child welfare system.

(3) Records and documents, regardless of physical form, that are obtained or produced by the office in the course of an investigation are not public records for purposes of sections 84-712 to 84-712.09. Reports of investigations conducted by the office are not public records for purposes of sections 84-712 to 84-712.09.

(4) The office may withhold the identity of sources of information to protect from retaliation any person who files a complaint or provides information in good faith pursuant to the Office of Inspector General of Nebraska Child Welfare Act.

43-4326. Department; provide direct computer access.

The department shall provide the Public Counsel and the Inspector General with direct computer access to all computerized records, reports, and documents maintained by the department in connection with administration of the Nebraska child welfare system.

43-4327. Inspector General's report of investigation; contents; distribution.

(1) The Inspector General's report of an investigation shall be in writing to the Public Counsel and shall contain recommendations. The report may recommend systemic reform or case-specific action, including a recommendation for discharge or discipline of employees or for sanctions against a foster parent, private agency, licensed child care facility, or other provider of child welfare services. All recommendations to pursue discipline shall be in writing and signed by the Inspector General. A report of an investigation shall be presented to the director within fifteen days after the report is presented to the Public Counsel.

(2) Any person receiving a report under this section shall not further distribute the report or any confidential information contained in the report. The Inspector General, upon notifying the Public Counsel and the director, may distribute the report, to the extent that it is relevant to a child's welfare, to the guardian ad litem and attorneys in the juvenile court in which a case is pending involving the child or family who is the subject of the report. The report shall not be distributed beyond the parties except through the appropriate court procedures to the judge.

(3) A report that identifies misconduct, misfeasance, malfeasance, or violation of statute, rules, or regulations by an employee of the department, a private agency, a licensed child care facility, or another provider that is relevant to providing appropriate supervision of an employee may be shared with the employer of such employee. The employer may not further distribute the report or any confidential information contained in the report.

43-4328. Report; director; accept, reject, or request modification; when final; written response; corrected report; credentialing issue; how treated.

(1) Within fifteen days after a report is presented to the director under section 43-4327, he or she shall determine whether to accept, reject, or request in writing modification of the

recommendations contained in the report. The Inspector General, with input from the Public Counsel, may consider the director's request for modifications but is not obligated to accept such request. Such report shall become final upon the decision of the director to accept or reject the recommendations in the report or, if the director requests modifications, within fifteen days after such request or after the Inspector General incorporates such modifications, whichever occurs earlier.

(2) Within fifteen days after the report is presented to the director, the report shall be presented to the foster parent, private agency, licensed child care facility, or other provider of child welfare services that is the subject of the report and to persons involved in the implementation of the recommendations in the report. Within forty-five days after receipt of the report, the foster parent, private agency, licensed child care facility, or other provider may submit a written response to the office to correct any factual errors in the report. The Inspector General, with input from the Public Counsel, shall consider all materials submitted under this subsection to determine whether a corrected report shall be issued. If the Inspector General determines that a corrected report is necessary, the corrected report shall be issued within fifteen days after receipt of the written response.

(3) If the Inspector General does not issue a corrected report pursuant to subsection (2) of this section, or if the corrected report does not address all issues raised in the written response, the foster parent, private agency, licensed child care facility, or other provider may request that its written response, or portions of the response, be appended to the report or corrected report.

(4) A report which raises issues related to credentialing under the Uniform Credentialing Act shall be submitted to the appropriate credentialing board under the act.

43-4329. Report or work product; no court review.

No report or other work product of an investigation by the Inspector General shall be reviewable in any court. Neither the Inspector General nor any member of his or her staff shall be required to testify or produce evidence in any judicial or administrative proceeding concerning matters within his or her official cognizance except in a proceeding brought to enforce the Office of Inspector General of Nebraska Child Welfare Act.

43-4330. Inspector General; investigation of complaints; priority and selection.

The Office of Inspector General of Nebraska Child Welfare Act does not require the Inspector General to investigate all complaints. The Inspector General, with input from the Public Counsel, shall prioritize and select investigations and inquiries that further the intent of the act and assist in legislative oversight of the Nebraska child welfare system. If the Inspector General determines that he or she will not investigate a complaint, the Inspector General may recommend to the parties alternative means of resolution of the issues in the complaint.

43-4331. Summary of reports and investigations; contents.

On or before September 15 of each year, the Inspector General shall provide to the Health and Human Services Committee of the Legislature and the Governor a summary of reports and investigations made under the Office of Inspector General of Nebraska Child Welfare Act for the preceding year. The summary provided to the committee shall be provided electronically. The summaries shall detail recommendations and the status of implementation of recommendations and may also include recommendations to the committee regarding issues discovered through investigation, audits, inspections, and reviews by the office that will increase accountability and legislative oversight of the Nebraska child welfare system, improve operations of the department and the Nebraska child welfare system, or deter and identify fraud, abuse, and illegal acts. The summaries

shall not contain any confidential or identifying information concerning the subjects of the reports and investigations.