STATE OF NEBRASKA

Child Abuse Prevention and Treatment Act State Plan

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2011

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Nebraska is committed to improving the child protective services system. Families Matter is a multi-year initiative to reform and strengthen Nebraska's child welfare and juvenile services and is driven by the federal outcomes of safety, permanency, and well-being. Last fall, the Department of Health and Human Services (DHHS) decided to move forward with a name that better reflected the intent of child welfare/juvenile services reform: "Families Matter." Families matter to a child whether a child is with their family, a foster family, an adoptive family or a guardianship family. "Families Matter" evokes our belief that kids grow best in their own homes; if they have to be out of the home, they should be placed with family or someone who knows them; children should be reunified or moved to permanency through adoption or guardianship in a timely manner; and that safety for all children is one of our top priorities. Nebraska continues to evaluate the PIP action steps in collaboration with the Administration for Children and Families. There have been a number of requests for revisions to the PIP action steps and time frames to better align with the continued fruition of Families Matter.

In accordance with section 106(b)(1)(A) of CAPTA, Nebraska's State plan will address the following 5 program areas described in section 106(a) with grant funds, in order to improve the child protective service system of the State. The 5 program areas are shown below:

1. Improve the intake, assessment, screening, and investigation of reports of abuse and neglect:

Nebraska's primary program area selected is the improvement of the agency's ability to provide an effective and immediate response from the Division of Children and Family Services (CFS) for children and families who are engaged in the child welfare system. Last year, a systematic analysis of the present intake process was conducted with Emily Hutchinson from the National Resource Center for Child Protective Services. The analysis resulted in changes in DHHS protocols and procedures in addition to the development of a Proficiency Model to be delivered to case managers and supervisors.

The systematic analysis identified the strengths and weakness of the present intake system. The service area field staff identified there was a need to clarify the screening definitions and incorporate those enhanced definitions into Intake policy, updating the Intake desk book to further reconcile language with Nebraska Safety Intervention System concepts and training of staff. This past year, Nebraska issued an Administrative Memorandum to revise the Adult and Child Abuse and Neglect Screening Definitions.

In addition to staff receiving training on the new Intake definitions, they have been provided with specialized training in customer service to further enhance telephone interviewing skills. Reports not accepted for assessment continue to be reviewed by a CFS Intake Supervisor within three work days to assure that concerns of abuse or neglect are not screened out inappropriately. Four Intake supervisors provide close oversight to the staff. Better communication and consultation is possible resulting in more uniform and equitable screening decision making. We are making better use of available data, and supervisors have begun to listen to intake calls received on a random basis by all specialists. We are also exploring the feasibility of recording all intake calls for complaint resolution. We will develop protocols for retention of tape recordings of Hotline calls in instances of death and/or serious physical injury for possible use in future criminal

prosecutions. The Hotline located to a new facility in early in 2011. We have developed a QA case review process of written intakes to address concerns about quality of information gathered and accuracy of priority setting. In June 2011, CFS Supervisors and Administrator received training on the QA tool and will conduct QA reviews on Intake reports beginning in June 2011 for the period October, November and December 2010. This review will provide baseline data for future improvements. CPS and APS Program Specialists are meeting with Intake supervisors and the administrator at least monthly to resolve case specific issues that arise. We also have monthly Intake Advisory Team phone calls to allow all service areas input and discussion about what is working well and not so well with the centralized process.

Additional quality assurance information will soon be provided by one of Nebraska's three Citizen Review Panels. The panel has decided to review intakes concerning families who have had 4 or more intakes screened out, to determine if the screening decisions were correct, or if there is a need for CPS intervention. The actual intake reviews are being completed by Child Advocacy Center staff. An initial report of findings will be provided to the Department the end of June.

We are working on developing a protocol to identify appropriate referrals to the new Nebraska Family Helpline to ensure that appropriate referrals are made for services when the concerns relate to mental health/substance abuse issues of the child, rather than involve the Child Welfare system through child abuse and neglect allegations. Hotline staff is expected to inform each caller about whether or not his/her report will be forwarded for initial safety assessment.

In 2007-2008 Nebraska implemented the Nebraska Safety Intervention System (NSIS). The NSIS was developed with the assistance of the National Resource Center for Child Protective Services to improve our safety interventions with children and families throughout the state. The model is a research based model that provides workers the tools needed to better assess safety for children and families throughout their involvement with DHHS. More specifically, the NSIS:

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

We believe the NSIS has many benefits. Through quality assurance activities we know that the NSIS is not being implemented as well as we would like. Accurate application of the NSIS process requires both substantive knowledge of the principles of the model, and the ability to apply those principles to individual families with each safety assessment. To improve staff knowledge and application of the model, we requested approval to work with the National Resource Center for Child Protective Services (NRC-CPS) consultant to develop a proficiency improvement process in which CFS Administrators, Supervisors, front line CFS Specialists, Trainers, and QA staff will demonstrate that they have adequate proficiency of the NSIS material.

A workgroup consisting of 20 CFS administrators and supervisors from all five service areas, representatives of the training unit, and central office staff met throughout 2010 to develop the proficiency process. Almost all of the participants were former NSIS service area trainers. A Supervisor Survey was completed to identify application issues across the state. Supervisors and administrators reported being strongly supportive of the NSIS model, believing that it offered a good framework for decision making, enabled staff to clearly articulate family conditions, and functioned well to identify unsafe children.

Issues identified were similar to issues identified by DHHS QA reviews:

1. Staff need enhanced skills in critical thinking and analysis. Although they may have gathered necessary information, some staff didn't understand what the information means, or how to use it to drive decision making.
2. Insufficient information in domains to reliably determine safety. Unsafe cases are usually clearly unsafe, but cases determined safe may not be, due to insufficient information.
3. Missed safety threats. Although one safety threat is sufficient to determine a child unsafe, it is important to recognize all existing threats so that the safety plan is adequate and the case plan can be targeted to all diminished protective capacities.
4. Some safety plans are inadequate or still promissory, or services not adequate to assure safety when threats emerge.
5. Some assessments are still incident based. The Maltreatment and the Nature of Maltreatment domains are sometimes completed with the most detail, while Child Functioning, Discipline, Parenting, and Adult Functioning domains have insufficient information.
6. Protective Capacity Assessments were not done in depth, often relied only on information gathered during initial safety assessment, without additional information
7. Ongoing safety assessments are required at specific points in the case; when there is a change in circumstances, new baby, new boyfriend moves in; change in visitation from supervised to monitored or unsupervised, at reviews, prior to case closure. These were not done, or were not done adequately.
8. Measurement of progress was still compliance based, for example, did the family attend treatment or parenting classes, without consideration of whether or not they demonstrate behavioral changes that would indicate what they learned.

The workgroup then developed nine modules of topic specific material to address these concerns. Each module consists of a review of core concepts, exercises and activities applying the concepts to real cases and will require 8 to 10 hours of reading and practical application of the concepts. There will be a mini knowledge test and application evaluation at the end of three module units. The workgroup determined that they would not move staff to the next unit of material until staff did well enough on the mini test. At the end of all modules there will be a comprehensive test covering all modules, similar to the three part test taken by workgroup members.

Workgroup members determined the necessary level of demonstrated proficiency. "Mastery" level requires scores of 92-100% on each of the three parts of the test. "Proficient" requires a

score of 83-91%. A level of "Proficient" is required for staff that will facilitate the modules. Remedial activities and opportunities will be developed for those needing additional assistance. Actual content will be determined after the testing begins and areas of deficiency are identified.

A three part test of proficiency was developed by the NRC-CPS consultant. The first two parts consisting of a short answer, objective style test and a detailed case application activity, has been given to 15 CFS administrators and supervisors who will serve as facilitators for the learning modules discussed previously. The third part of the test, a written summary of case supervision on an actual family situation in the field, has been completed by two supervisors. This test, or a similar version, will be used to determine level of proficiency of CFS specialists, and other supervisors and administrators after completion of the learning modules.

Benefits for workgroup members have already been demonstrated as a result of the development of the process and work on the content modules. Members report they have greater understanding of NSIS principles and believe they are more able to assist staff with accurate case application.

A plan will be developed so that new staff or staff assuming responsibility for families in which child abuse or neglect is an issue will also participate in the proficiency improvement process. It will be expected that all staff working with families in which child abuse or neglect is an issue demonstrate at least adequate mastery of the NSIS material.

It will take several years for all staff to complete the proficiency process, but we believe this approach will significantly improve our ability to better recognize and respond to issues of safety in the families we serve.

In 2010 – 2011 the following changes in DHHS protocols and procedures were issues to staff that are associated with the improvement of intakes, assessments, screening and investigation of reports of child abuse and neglect:

- Administrative Memo #3-2010 – CAN Intakes on Children Under Age Three. All intakes concerning a report of abuse, neglect or circumstances that may constitute a safety concern involving a child two years of age or younger must be accepted for safety assessment when the reporter is a hospital staff member; a doctor; or a doctor's staff member who is calling at the request of a doctor. This directive can be overridden only by a CFS administrator.
- Administrative Memo #9-2010 – Mandatory Collateral Calls at Intake. Formalizes Intake practices which requires that collateral calls be made prior to not accepting (screening out) a report for initial safety assessment in specific situations.
- Administrative Memo #11-2010 – CFS Child Abuse and Neglect Intakes, Cross Jurisdiction Situations. Clarify for staff how they will respond in situations crossing state lines and service area jurisdictions.
- Administrative Memo #1-2011 – Revised Adult and Child Abuse and Neglect Screening Definitions. Adult and child abuse and neglect screening definitions have been revised to more clearly identify when it is appropriate for DHHS to investigate and assess vulnerable adult and child safety.

2A. Creating **and improving the use of multidisciplinary teams and interagency protocols to enhance investigations:**

Multi-disciplinary Teams

Multi-disciplinary teams are well established in almost all Nebraska counties. Teams are now regularly meeting in Brown, Cherry, Rock and Keya Paha Counties, an area previously reluctant to participate. There is an improved relationship with the Child Advocacy Center located in Norfolk, Nebraska that assumed responsibility for this previously underserved area. December 31, 2010 there is a total of 95 1184 teams that are meeting across the state. Some counties have investigative teams only, some have separate investigative and treatment teams, and some have combined them into one. Many teams are now meeting 4 times a year. Some counties meet together in sparsely populated areas where the County Attorney has responsibility for multiple counties.

Policy now reflects that teams are to be used in situations involving child death from abuse or neglect. With increased emphasis on use of the Child Advocacy Centers for situations involving serious physical injury, domestic violence and child death, it is believed that DHHS is making better use of available expertise, and that multi-disciplinary teams are involved to discuss complex cases to a greater degree.

Court Appointed Special Advocates

CAPTA funding will be used to support the development of Court Appointed Special Advocates programs. The Nebraska Department of Health and Human Services contracts with the Nebraska Children and Families Foundation for a variety of services. Nebraska Children and Families Foundation works with the Nebraska CASA Association to provide services to children and families. The Nebraska CASA Association works with the National CASA Association to support the development, growth, and continuation of local CASA programs which recruit and train CASA volunteers who speak in court for the best interests of abused and neglected children. CASA stands for Court Appointed Special Advocates - trained volunteers from the community who are appointed by a judge to advocate on a one-to-one basis for a child who has been a victim of abuse or neglect. Nineteen local CASA programs are currently serving 34 counties in Nebraska. As of December 2010 the Nebraska CASA Association reports that 615 CASA volunteers were advocating for 760 of Nebraska's abused and neglected children. Children represented by a CASA advocate generally had more services ordered and provided. Children with CASA support tended to have slightly fewer foster home placements. Children with CASA support appear to be less likely to reenter the foster-care system once their cases are dismissed. Fewer than 10% of children with a CASA volunteer re-enter the foster care system.

Interagency Protocols

In the fall of 2010, administrative staff from the Division of Children and Family Services (CFS), the Division of Medicaid and Long Term Care, and the Division of Public Health began meeting to develop a better understanding of each division's role during a child and adult abuse and

neglect investigations. Staff have presented information and had frank discussions about what has not worked well, the expectations of one another, what information can be shared across divisions and possible strategies that could be put in place to more effectively work together. In collaboration, this coming year the team will develop a protocol to be used in investigations that cross divisions.

***4. Enhancing* the general child protective system by improving risk and safety assessment tools and protocols, automation systems that support the program and track reports of child abuse and neglect from intake through final disposition and information referral systems:**

Child Advocacy Centers

CAPTA funding will continue to be used to support the Nebraska Alliance of Child Advocacy Centers (Nebraska Alliance). The centers are part of the Nebraska Alliance of Child Advocacy Centers. All centers are accredited. The Nebraska Department of Health and human Services (DHHS) has contracted with the Nebraska Alliance to provide training across the state in child abuse and neglect issues. During calendar year 2010, a total of 6,396 people received training in child abuse and neglect issues.

Child Advocacy Centers serve abused children through a comprehensive approach to services for victims and their families. Child Advocacy Centers stress coordination of investigation and intervention services by bringing together professionals and agencies as a multidisciplinary team to create a child focused approach to child abuse cases. Key components of a child advocacy center include forensic interviewing, medical evaluations, advocacy and support, therapeutic intervention, case review and tracking. The goal is to ensure that children are not re-victimized by the very system designed to protect them.

There are Seven (7) such centers in the State of Nebraska. All of the centers in Nebraska are fully accredited and offer services across all counties in the state. The Centers are:

- Bridge of Hope in North Platte
- Capstone in Scottsbluff
- Central NE Child Advocacy Center in Grand Island
- Child Advocacy Center in Lincoln
- Family Advocacy Network Kearney
- Northeast NE Child Advocacy Center in Norfolk
- Project Harmony in Omaha

The child advocacy centers have been utilized in most child sexual assault cases over the last five years, but have been used less often in situations of serious physical injury, domestic violence and child death situations. One focus is to encourage that DHHS assessment staff involve the advocacy centers in serious injury, domestic violence and child death cases. Adjustments have been made to N-FOCUS, and Intake Specialists identify when involvement of the advocacy center is necessary. This process will remind the assessment specialist to access the expertise available at the centers. CAPTA funding will continue to be used to support the continuation and further development of Child Advocacy Centers across the state. Staff will provide services to

support the development and ongoing operation of investigation and treatment teams (referred to as "LB 1184 teams"). Multi-disciplinary teams are well established in many Nebraska counties. Efforts will continue to involve those counties not currently participating. Policy now reflects that teams are to be used in situations involving child death from abuse or neglect. With increased emphasis on use of the child advocacy centers for situations involving serious physical injury, domestic violence and child death, it is anticipated that DHHS will make better use of available expertise.

CAPTA referrals to Early Development Network

Nebraska had not been adequately referring eligible maltreated children to the Early Development Network. On January 3, 2011 the system was automated to generate a referral to the Network within a week of the CFS Specialist identifying an eligible child is a victim of child abuse and neglect. Since automating the system, Nebraska has been referring at a rate of 100%.

***8. Developing* and facilitating training protocols for individuals mandated to report child abuse or neglect:**

Mandatory Reporter Training

The Nebraska Alliance offers training titled Child Abuse and Neglect 101: Reporting and Responding to Child Abuse and Neglect. The purpose of this course is to prepare mandatory reporters with the knowledge and skill needed to recognize and report child abuse and neglect. Participants discuss challenges associated with reporting abuse and neglect, practice asking minimal facts questions, and receive resources that will help them with knowing how and when to report. This training is offered monthly. Participants are eligible to receive three hours of Continuing Educational Units (CEU) for completion of abuse and neglect reporting modules.

We will continue to focus on education of the public by developing and providing training modules for licensed professionals regarding abuse and neglect reporting statutes and regulations. We will improve the understanding of the child abuse and neglect system by all mandated reporters by improving the quality and quantity of detailed information easily available to potential reporters. We will develop public communications and presentations to increase efforts to explain what a person can expect when they contact the Hotline. We will continue to expect that CFS Specialists located at the hotline unit tell mandated reporters what action can be expected based on the information provided Policy staff and field staff continue to offer presentations to individual groups on the reporting law, specific information needed by the Intake Specialist at the time of a report to the Hotline, and providing an overview of how DHHS responds to these reports of alleged abuse/neglect.

11. Developing and enhancing the capacity of community-based programs to integrate shared leadership strategies between parents and professionals to prevent and treat child abuse and neglect at the neighborhood level.

Domestic Violence Collaboration

Nebraska will also place greater emphasis on appropriate responses to cases that involve domestic violence. Policy staff continue to meet with members of the Nebraska Domestic

Violence Coalition to improve collaboration, enhance understanding of each other's roles and legal responsibilities, and share concerns. DHHS staff also meet with representatives from multiple agencies on a monthly basis to address identified issues, explore conflicting views on the concept of "failure to protect", and propose necessary legislative changes. DHHS field staff report improved communication with local domestic violence programs as a result of these efforts. Determining appropriate intervention criteria has been identified as an important part of the Intake improvement process currently underway. Joint training with both the local office and policy staff using trainers from both disciplines has been beneficial.

CAPTA referrals to Early Development Network

In 2010, 1,956 infants and toddlers were eligible for referral to the Network under CAPTA guidelines. Of those children eligible, 680 were referred to the Network, for a rate of 34.76%. Of the children referred, 83 children were verified as eligible for special education services. This past year, the system was automated to generate a referral to the Network within a week of the CFS Specialist identifying an eligible child is a victim of child abuse and neglect. Since automating the system on January 3, 2011, as of June 20, 2011, 1,174 infants and toddlers were eligible for referral to the Network under CAPTA guidelines.

Nebraska Automated System Described:

- This automated process is initiated through NFOCUS. The referral is created by the Protection and Safety staff doing the initial safety assessment.
- A weekly report is requested and obtains all of the information used to create an Early Development Network (EDN) referral on N-FOCUS
- The report looks for all substantiated findings (Court Substantiated, Court Pending and Agency Substantiated) entered in the previous week for a victim that is 3 years old or less on the date the intake was received
- The CONNECT computer program compares the NFOCUS record information to what CONNECT has in the data base system for END referrals
- If a qualifying referral already exists then they capture this new referral and automatically code it as a good referral; no further action is needed.
- If there is no qualifying referral or no match is found then the child is added to a que for the EDN Office to review
- The EDN Office conducts a more in depth review to see if maybe there was just a small mismatch or to determine if action is required.
- The EDN Worker may contact our worker for additional information but basically to create the referral they push a button on their side and the referral is created.
- The EDN Worker makes the decision to contact the family or provide services based upon the information they have gathered.

Nebraska has been referring at a rate of 100%. Of the children referred from January 1, 2011 to April 30, 2011, 39 children were verified as eligible for special education services. The Network continues to provide training to the community including: Special Care, IFSPWeb, Parent Training and Information (PT) Nebraska, and Helping Babies from the Bench.

The plan submission must highlight any significant changes from the State's previously approved CAPTA plan in how the State proposes to use funds to support the 14 program areas (section 106(b)(1)(C)(ii)).

Nebraska does not have any significant changes from the State's previously approved IV-B State's plan which included the CAPTA plan.

As required by section 106(b)(2)(D), the plan must also include a description of:

- The services to be provided under the grant to individuals, families, or communities, either directly or through referrals aimed at preventing the occurrence of child abuse and neglect;
    - Child Advocacy Centers, which coordinate a review system for identified intakes, facilitate investigation and treatment meetings, provide investigation training, and facilitate local child death reviews.
    - Court Appointed Special Advocates (CASA), which provide training for volunteers to advocate for the youth in court cases to prevent reoccurrence of abuse/neglect.
    - LB 1184 Child Abuse/Neglect Investigative and Treatment Teams provides a review of intakes to evaluate agency response and to review ongoing court families referred by court, community partners and or DHHS.
    - Child abuse prevention and identification materials. These materials are provided to families and community agencies.
    - Training to include speakers, attendance at national and state training and other child maltreatment training.
    - Citizen Review Panels, which review system responses and make recommendation for improvements.
    - Governor's Commission for the Protection of Children that services as the State's Task Force for Child Abuse Prevention and Treatment Act funds and activities. The Commission reviews data, practices and system operations and makes recommendations to the Governor
    - Nebraska Children and Families Foundation, facilitates a Citizen's Review Panel and facilitates community meetings to establish supports to assist in the prevention of abuse and neglect.

- The training to be provided under the grant to support direct line and supervisory personnel in report taking, screening, assessment, decision making, and referral for investigating suspected instances of child abuse and neglect;
    - Training to include speakers, attendance at national and state training and other child maltreatment training.
    - Intake Screening Tool
    - Proficiency Model
    - Training for CFS and Divisional partners
    - Differential Response

- The training to be provided under the grant for individuals who are required to report suspected cases of child abuse and neglect;
    - The Nebraska Alliance offers training titled Child Abuse and Neglect 101: Reporting and Responding to Child Abuse and Neglect. The purpose of this course is to prepare mandatory reporters with the knowledge and skill needed to recognize and report child abuse and neglect. Participants discuss challenges associated with reporting abuse and neglect, practice asking minimal facts questions, and receive resources that will help them with knowing how and when to report. This training is offered monthly. Participants are eligible to receive three hours of Continuing Educational Units (CEU) for completion of abuse and neglect reporting modules.

- Policies and procedures encouraging the appropriate involvement of families in decision making pertaining to children who experienced child abuse or neglect;

  Nebraska's policies encourage the involvement of families in decision making. The expectations can be located in chapter 5 of the Title 390 Nebraska's Administrative Code on the DHHS website located at http://www.sos.state.ne.us/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-390/Chapter-5.pdf

  The policies below make it known to the worker their responsibility to work in partnership with the family and that the case plan is to be developed with the family.

    - 5-001.01 PROTECTION AND SAFETY WORKER ROLE
      The worker will work in partnership with families, supervising staff and teams to ensure children and families a quality, comprehensive service delivery. The worker's role and responsibilities during ongoing are to:

        - Conduct and complete an assessment of the family and child.
        - Maintain child's, families and community's safety.
        - Develop and implement a case plan to address the identified issues and current risk of maltreatment, status offense behaviors or delinquency.
        - Provide and coordinate services to assist the child and family in resolving issues.
        - Assist in securing stability and permanency for the child.
        - Refer the family and child to community, social agencies, or legal systems that are necessary to support achievement of the identified case outcomes.
        - Evaluate family's and child's progress.
        - Coordinate service delivery to the child and family.
        - Prepare child and family for closure.
        - Close case.
        - Consult with the case consultation team at the key decision points as listed in 390 NAC 2-001.

- 5-004 GUARANTEED SERVICES
  All families and children involved with the Department will be provided with the following services:
  1. An assessment of needs that may include a diagnostic and evaluation service; and
  2. A case plan developed with the family and child to address the issues that brought the family or child to the attention of the Department, and
  3. Case management, which includes face to face contact; and
  4. Referral to community services, and
  5. A therapy service, when appropriate, or
  6. A parent-skill development service, when appropriate.

In addition, we have an administrative memo that requires a worker to use Family Team Meetings as the process for case planning, evaluating, and updating of the Case Plan and/or the Safety Plan. This administrative memo can be located on the DHHS website at http://www.dhhs.ne.gov/jus/memos/NSIS-OA.pdf

The language below is taken from Ongoing Assessment, page 6 of the administrative memo.

- Family Team Meetings
  The PSW is required to use Family Team meetings as the process for case planning, evaluating, and updating of the Case Plan and/or the Safety Plan. The PSW will assure that the plan is the result of a collaborative effort and that the case plan is developed "with", not "for" the family. The Family Team meeting must include, at a minimum, the family and the PSW. Others the family has identified may also be included, e.g. GAL, CASA, and foster parents.

- Policies and procedures that promote and enhance appropriate collaboration among child protective service agencies, domestic violence service agencies, substance abuse treatment agencies, and other agencies in investigations, interventions, and the delivery of services and treatment provided to children and families affected by child abuse or neglect, including children exposed to domestic violence, where appropriate; and

  The Department is involved in a number of collaborative initiatives to improve our response to child abuse and neglect issues.
  - Co-Occurrence of Domestic Violence and Child Abuse Workgroup: This group was developed following attendance at a national conference in June 2009 focused on co-occurrence of domestic violence and child abuse issues. Representatives from the state Domestic Violence Coalition, Lancaster County Attorney's Office, Lincoln Police Department, local domestic violence and sexual abuse program staff, Legal Services of Southeast Nebraska, DHHS service area and Central Office program staff and Lead Agency representatives meet monthly or every other month. Perspectives from each discipline are shared, problems are discussed in an effort to jointly agree on a solution, and promising and best practice strategies are considered. A subset of the workgroup recently wrote for a grant that, if awarded,

will allow a pilot project in one county. Although there is not participation by representatives statewide, it is believed that efforts, activities, and lessons learned in this local area will ultimately be able to be offered to other service areas across the state.

- In-Depth Technical Assistance Program (IDTA): Nebraska received a federal grant to assist in development and coordination of services for families with substance abuse issues in the child welfare system. Goals of the grant are to:
  - Develop a step-by step cross system communication and process for managing families who come into the child welfare system and substance abuse has been a factor in the maltreatment of their children;
  - Develop and implement statewide, cross divisional and court-agency training to improve outcomes of families with co-occurring substance abuse and child maltreatment problems;
  - Develop a plan to utilize and maximize various funding streams;
  - Develop capacity for data collection across systems;
  - Explore the appropriate use of consumer and peer led services to address substance abuse disorders in the child welfare, juvenile justice services system.

  The following workgroups were developed to focus on these goals.
  - Data and Funding Workgroup
  - Best Practice Workgroup
  - Training and Workforce Team
  - Screening & Assessment Workgroup

  The IDTA Screening & Assessment Workgroup has been discussing appropriate drug screening protocols and lab levels to determine use/non-use with the goal of standardizing practices across agencies and across geographic areas. The group is also considering recommending use of a short substance abuse screening tool that can be used by initial safety assessment staff and juvenile service staff who have initial contact for with OJS youth.

- Policies and procedures regarding the use of differential response, as applicable.

Nebraska is currently working to develop-a protocol to identify appropriate referrals to the new Nebraska Family Helpline to ensure that appropriate referrals are made for services when the concerns relate to mental health/substance abuse issues of the child. Referral to the Helpline will provide for support to families without needing to involve the Child Welfare system. The time line for implementation of the new protocol is October 2011.

Nebraska has not implemented a specific differential response for reports of child abuse and neglect. Nebraska does have a different priority response to intakes based upon the serious of the intake. **Nebraska utilizes three alternative response times to an accepted report of abuse and neglect are as follows:**

- For those intakes that may be life threatening and are designated as Priority 1, the expected response time to contact the alleged victim is 0 to 24 hours from the time the Intake is received.
- For those Intakes designated as a Priority 2, the required response time to make contact with the alleged child/youth victim is 0 to 5 calendar days from the date the Intake is received.
- If the Intake is designated as a Priority 3, the required response time to make contact with the alleged child/youth victim is 0 to 10 calendar days from the time the Intake is received.

Administrative Memo #3-2010 –. All intakes concerning a report of abuse, neglect or circumstances that may constitute a safety concern involving a child two years of age or younger must be accepted for safety assessment when the reporter is a hospital staff member; a doctor; or a doctor's staff member who is calling at the request of a doctor. This Memo allows for a differential response when the reporter is a doctor and or hospital staff.

The State plan submission shall also contain a notification regarding substantive changes, if any, to State law or regulations, including laws and regulations relating to the prevention of child abuse and neglect, that could affect the State's eligibility for the CAPTA State grant (section 106(b)(1)(C)(i)). The State must also include an explanation from the State Attorney General as to why the change would, or would not, affect eligibility. Note: States do not have to notify ACF of statutory changes or submit them for review if they are not substantive and would not affect eligibility.

There were no substantive changes in Nebraska State law during the 2011 102nd Legislature, First Session that would affect CAPTA eligibility.

Citizen Review Panel

CAPTA funding will support three Nebraska Citizen Review Panels. The first Nebraska Citizen Review Panel (the Panel) had been a sub-committee of the Governor's Commission for the Protection of Children (the Commission). In order to be more efficient and effective, the sub-committee has been dissolved and the Commission will assume the duties directly and, if needed, form an ad hoc committee with representatives from the community to deal with specific issues.

The Nebraska Foster Youth Council (FYC) will also serve as a Citizen Review Panel. The FYC is a group of young people, ages 14-24, who are currently in Foster Care or alumni of Foster Care. The FYC has become a family and a lifelong support to many current and former Foster Youth in Nebraska. This group is now referred to as Project Everlast. They submitted their recommendations on 06/30/11. These will be reviewed and CFS will provide a response to their recommendations which will be included in the upcoming CAPTA report.

The third Citizen Review Panel will be the Nebraska Federation of Families for Children's Mental Health. The Federation was incorporated in 2000 and is a family run network of family organizations. The Federation provides a network of family and youth voices to help create the best system of care for our children with behavioral health challenges in Nebraska. They

submitted their recommendations on 06/08/11. These will be reviewed and CFS will provide a response to their recommendations which will be included in the upcoming CAPTA report.

We believe that these three Citizen Review Panels offers a very good balance: one that includes system representatives; one that provides the youth perspective and one provides the family perspective.

In addition, Nebraska has a Child Death Review Team (CDRT) created by the Nebraska Legislature in 1993. At that time, about 300 Nebraska children were dying each year, but there was no process to understand why and how the deaths happened. The CDRT reviews the numbers and causes of deaths of children ages 0 to 17. CDRT members also try to identify cases where a person or community could reasonably have done something to prevent the death. All child deaths are reviewed, not just "suspicious" or violent ones. The goals of these reviews are to: identify patterns of preventable child death; recommend changes in health care and social services systems' responses to child deaths; refer any previously unsuspected cases of abuse, malpractice, or homicide to law enforcement; and, report to the public and state policy makers about child deaths. These reports include recommendations on changes that might prevent future deaths. After several discussions with CDRT members, the CDRT will not be identified as a Citizen Review Panel. The CDRT cannot review cases until all pending court action is resolved.

CAPTA Annual State Data Report

1. Information on Child Protective Service Workforce: For child protective service personnel responsible for intake, screening, assessment, and investigation of child abuse and neglect reports in the State, report available information or data on the following:

   - Information on the education, qualifications, and training requirements established by the State for child protective service professionals, including for entry and advancement in the profession, including advancement to supervisory positions;

     Education and Qualifications as posted in the published class specifications:

     CFSS Trainee:
     MINIMUM QUALIFICATIONS: (Applicants will be screened for possession of these qualifications. Applicants who need accommodation in the selection process should request this in advance.) A Bachelor's degree in social work, psychology, sociology, counseling, human development, mental health care, education, criminal justice or other closely related area.
     SPECIAL NOTE
     Positions in this class may require an employee to possess a valid driver's license and provide a passenger vehicle with adequate liability insurance, or the ability to provide independent authorized transportation, in order to perform work-related travel such as customer visits or customer transportation. These situations will require prior supervisory approval.

Individuals assigned in this class may be on call 24 hours a day. Some overtime will be required to complete case activities outside normal working hours including some travel outside the assigned service area.

CFSS:

MINIMUM QUALIFICATIONS: (Applicants will be screened for possession of these qualifications. Applicants who need accommodation in the selection process should request this in advance.) A Bachelor's degree in social work, psychology, sociology, counseling, human development, mental health care, education, criminal justice or other closely related area. Employees must have successfully completed all required in-service training to be eligible for this job classification.

SPECIAL NOTE

Positions in this may class require an employee to possess a valid driver's license and provide a passenger vehicle with adequate liability insurance, or the ability to provide independent authorized transportation, in order to perform work-related travel such as customer visits or customer transportation. These situations will require prior supervisory approval.

Individuals in this class may be on-call 24 hours a day. Some overtime hours will be required to complete case activities outside normal working hours including some travel outside the assigned service area.

CFS Supervisor:

MINIMUM QUALIFICATIONS: (Applicants will be screened for possession of these qualifications. Applicants who need accommodation in the selection process should request this in advance.) A Bachelors degree in social work, psychology, sociology, counseling, human development, mental health care, education, criminal justice or other closely related area AND experience performing case management activities in counseling, protective services, alcohol/drug abuse, juvenile justice probation, social services delivery.

SPECIAL NOTE

Positions in this class may require an employee to possess a valid driver's license and provide a passenger vehicle with adequate liability insurance, or the ability to provide independent authorized transportation, in order to perform work-related travel such as customer visits or customer transportation. These situations will require prior supervisory approval.

Individuals in this class may be on- call 24 hours a day and may be required to answer calls on abuse cases outside the normal working hours.

In some Service Areas, the Child and Family Services Specialist Supervisor may also supervise Social Services Workers in social service programs and Title XX caseloads.

Training Requirements:

Since the late 1980s, CFS Trainees are trained upon new hire. The model for training newly hired CFS Specialists places a strong focus on:

- adherence to the principles and procedures of the Nebraska Safety Intervention System for keeping children and families safe
- implementation of Family Centered Practice principles to ensure the inclusion of children and families in the decision-making processes that impact their lives
- achieving the key outcomes of safety, permanency, and well-being for every child and family
- helping each CFS Specialist develop the knowledge, skills, and abilities that are needed to successfully carry out his/her job

If an individual is rehired into the same position, they may have the opportunity to attend all or components of the new worker training. Human Resources and Development maintains training transcripts to assure CFS staff have adequate training.

- Data on the education, qualifications, and training of such personnel;
  Effective November 18, 2003 the Director implemented an expectation that all CFS staff have at minimal a Bachelor's degree in social work, psychology, sociology, counseling, human development, mental health care, education, criminal justice or other closely related area.

  The most current break down of this information for all staff education, qualification and training of all CFS staff is from May 2007. We requested an updated report from our Human Resources Division. However, they were not able to generate a new report. A meeting has been scheduled with Human Resource to implement a reporting process of current staff breakdown. The plan is to have a reporting process in place no later than December 2011. We are attaching information that is available regarding the education of trainees.

We have attached three reports;

1. Demographic-education -2010: This report indicates the number of staff that attended New Worker Training January – December 2010 and their education.
2. Demographic – education – 2011: This report indicates the number of staff that attended New Worker Training January – June 2011and their education.
3. PS Education Survey 2007

It is important to note the demographics of 2010 and 11 demonstrate the individuals in training have met or exceeded minimum requirements.

- Demographic information of the child protective service personnel; and

  Please review the Table below regarding demographic information of child protective service personnel.

Child/Family Specialists, Trainees and Supervisors
On June 1, 2011
By Gender, Race/Ethnicity and Age

	Child/Family Services Specialist Trainee	Child/Family Services Specialist	Child/Family Services Specialist Supervisor
Gender:			
Female	27	243	48
Male	5	44	10
Total	**32**	**287**	**58**
Race/Ethnicity:			
White, non-Hispanic	23	253	56
Black/African American	5	14	1
Hispanic or Latino	1	12	1
Asian/Pacific Islander	0	1	0
Other	0	2	0
Not Reported	3	5	0
Total	**32**	**287**	**58**
Age:			
< 25 years	5	15	0
25-29 years	12	72	6
30-34 years	2	50	13
35-39 years	3	34	10
40-44 years	4	37	7
45-49 years	3	26	8
50-54 years	0	19	5
55-59 years	1	17	5
60-64 years	0	13	4
65-69 years	0	4	0
Unknown	2	0	0
Total	**32**	**287**	**58**

- Information on caseload or workload requirements for such personnel, including requirements for average number and maximum number of cases per child protective service worker and supervisor (section 106(d)(10)).

  In 2010, the Hotline received 43,668 calls. The Hotline is responsible for answering calls related to reports of Adult and Child Abuse and Neglect for the entire state of Nebraska. For the year 2010, the average caseloads are:

  Child abuse /neglect intake reports and screening - 112.65 cases
  Assessment and investigation – 13.48 families

  Nebraska has not established a maximum number of cases per worker and supervisor.

2. Juvenile Justice Transfers: Report the number of children under the care of the State child protection system who were transferred into the custody of the State juvenile justice system in Federal FY 2010. Provide contextual information about the source of this information and how the State defines the reporting population (section 106(d)(14)).

   Both Child Welfare children/youth and Juvenile offender youth are committed to the care, custody and control of the Department; therefore there is no transfer of custody. Child Welfare provides care for child abuse and neglect populations, as well the Office of Juvenile Services (OJS) population. The OJS population consists of youth who are adjudicated by a court of competent jurisdiction as having committed a crime.

Additional Annual State Data Reports as referenced in ACYF-CB-IM-11-02

The law requires States to report additional data in the annual State data reports, to the extent practicable, including:

- the number of families that received differential response as a preventative service during the year (section 106(d)(4));

  We will need to develop a differential response and method to collect this data in Nebraska.

- the number of children referred to child protective services under policies and procedures established to address the needs of infants born with and affected by illegal substance abuse, withdrawal symptoms or a Fetal Alcohol Spectrum Disorder (section 106(d)(15));

  In 2004, Nancy Montanez, Director for Health and Human Services and JoAnn Schaefer, Deputy Chief Medical Officer provided communication to Nebraska Medical Association the requirement that health care providers involved in the deliver or care of infants born or identified as affected by illegal substance abuse, or withdrawal symptoms resulting from prenatal drug exposure, notify the children protective services of the occurrence of such condition in such infants Nebraska is currently hand collecting data specific to "Substance Exposed Newborns". Enhancements need to be made to N-FOCUS which can enable the Intake worker to collect data specific to "Illegal Substance Abuse", "Withdrawal symptoms" and "Fetal Alcohol Spectrum Disorder" electronically are targeted for release July 9, 2012.

- the number of children under the age of three involved in a substantiated case of child abuse or neglect that were eligible to be referred to agencies providing early intervention services under part C of the Individuals with Disabilities Education Act (IDEA), and the number of these children actually referred to these early intervention services (section 106(d)(16)).

  In 2010, 1,956 infants and toddlers were eligible for referral to the Network under CAPTA guidelines. Of those children eligible, 680 were referred to the Network, for a rate of

34.76%. Of the children referred, 83 children were verified as eligible for special education services. This past year, the system was automated to generate a referral to the Network within a week of the CFS Specialist identifying an eligible child is a victim of child abuse and neglect. Since automating the system on January 3, 2011, as of June 20, 2010, 1,174 infants and toddlers were eligible for referral to the Network under CAPTA guidelines. Nebraska has been referring at a rate of 100%. Of the children referred from January 1, 2011 to April 30, 2011, 39 children were verified as eligible for special education services.

Assurances:

Nebraska will submit the Governor's Assurance Statement separately, but no later than September 30, 2011.

Attachments:

1. Nebraska Children and Families Foundation Annual Report 2009
2. Nebraska Federation of Families for Children's Mental Health CRP Annual Report (Received June 8, 2011)
3. Nebraska Foster Youth Council CRP Annual Report (Received June 30 2011)
4. Demographic-education -2010: This report indicates the number of staff that attended training January – December and their education.
5. Demographic – education – 2011: This report indicates the number of staff that attended training January – December and their education.
6. PS Education Survey 2007
7. Citizen Review Panel Annual Report and Department Response
8. Power point presentation for the Citizen Review Panel

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