March 2025 Quarterly Report

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NEBRASKA

FOSTER CARE REVIEW OFFICE

Good Life, Great Outcomes

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EXECUTIVE SUMMARY

The Foster Care Review Office (FCRO) issues this Quarterly Report to inform the Nebraska Legislature, child welfare system partners, juvenile justice system partners, other policymakers, the press, and the public on identified conditions and outcomes for Nebraska's children in out-of-home care (foster care) as defined by statute, as well as to share recommendations for needed changes made per our mandate.[1]

The FCRO is the independent state agency responsible for overseeing the safety, permanency, and well-being of children in out-of-home care in Nebraska.

Through a process that includes case reviews, data collection and analysis, and accountability, we are the authoritative voice for all children and youth in out-of-home care.

This report begins with a special study in collaboration with members from the Nebraska Resource Project for Vulnerable Young Children (NRPVYC) at the University of Nebraska Lincoln's Center on Children, Families, and the Law, which includes findings on service needs, access and progress on early childhood mental health for children in out-of-home care who were involved with DHHS Children and Family Services (CFS). The report continues with the most recent data available on conditions and outcomes for children in out-of-home care through the child welfare and juvenile justice systems. Some key findings for those children include:

- 4,116 Nebraska children were in out-of-home or trial home visit placements under DHHS/CFS, DHHS/OJS, and/or the Administrative Office of the Courts and Probation – Juvenile Services Division (hereafter referred to as Probation) on 12/31/24, representing a 0.4% increase from 12/31/23. (page 25)
- Of the 4,116 total children, 3,397 (82.5%) children were DHHS/CFS wards in out-of-home care or trial home visits with no simultaneous involvement with Probation, effectively no change compared to children on 12/31/23. (page 27)
- Most DHHS/CFS wards in out-of-home placements or trial home visits (97.1%) were placed in a family-like, least restrictive setting. (page 31)
- Over half of the children in a least-restrictive foster home, excluding those in trial home visits, were placed with relatives or kin (55.1%). (page 31)
- There was a 33.3% increase in the number of DHHS/CFS wards placed in congregate care facilities from the previous year to 12/31/24 (60 and 80, respectively). Of the 80 DHHS/CFS wards in congregate care, a majority were in Nebraska (83.8%); that is slightly more than the 80.0% in congregate care placed in Nebraska on 12/31/23. (page 33)
- Depending on the geographic area, between 8.9% and 33.3% of the children have had five or more CFS caseworkers since most recently entering the child welfare system. Furthermore, 108 children statewide had 10 or more workers in that timeframe, most of whom (105) were from the Eastern Service Area. This resulted in a decrease in the Eastern Service Area since 12/31/23 when 123 children had experienced 10 or more workers. While there has been recent progress, the Eastern Service Area has been disproportionately impacted by caseworker changes for several years. (page 35)
- 141 (3.4%) youths in out-of-home care were involved with DHHS/CFS and Probation simultaneously, representing a 2.2% increase compared to youths on 12/31/23. (page 36)

1 Data cited in this report are from the FCRO's independent data tracking system which include FCRO completed case file reviews unless otherwise noted. Some of the most requested data is also available through the FCRO's data dashboards (accessed via fcro.nebraska.gov/data_dashboards). Data presented includes numbers of children impacted, the agencies and courts responsible, demographics, and key indicators, all of which can be sorted in the most useful ways.

- There was a 41.0% increase in the number of dually involved youth placed in congregate care facilities from the previous year to 12/31/24 (39 and 55, respectively). Of the 55 dually involved youth in congregate care, most were in Nebraska (80.0%); that is slightly more than the 76.9% in congregate care placed in Nebraska on 12/31/23. (page 38)
- There were 479 (11.6%) youths that were in out-of-home care while supervised by Probation but were not simultaneously involved with DHHS/CFS or at the YRTCs, a 0.8% decrease compared to youths on 12/31/23. (page 39)
- Probation most often utilizes in-state placements; 89.5% of the 362 youths with a known placement location in congregate care were placed in Nebraska. (page 42)
- 91 youths, 76 males and 15 females, from various counties across Nebraska were at a YRTC on 12/31/24 which is a 23.0% increase compared to the 74 such youths at the YRTCs at the same time last year. (page 43)
- Disproportionate rates for children of color in out-of-home care remains a critical issue to be examined and addressed, regardless of which agency or agencies are involved. No meaningful change or improvement has occurred in the last year; disproportionality rates for Black or African American youth have increased and disproportionate rates are most notable at the YRTCs. (pages 29, 37, 40, 44)
- The median age for Nebraska children in care on 12/31/24 by agency involvement: 8 years old for DHHS/CFS wards and 16 years old for dually involved youth and Probation only youth. For youth at a YRTC the median age was 16 years old for both males and females. (pages 29, 36, 40, 44)
- The average number of times in care on 12/31/24 by agency involvement: 1.3 for DHHS/CFS wards, 1.8 for dually involved youth, 2.1 for Probation only youth, and 2.7 for youth at a YRTC. (pages 30, 37, 41, 44)
- The median number of days in care on 12/31/24: 431 days for DHHS/CFS wards, 669 days for dually involved youth, 161 days for Probation only youth, and 393 days for youth placed at a YRTC. (pages 30, 37, 41, 44)
- The average number of lifetime placements as of 12/31/24 by agency involvement: 3.3 for DHHS/CFS wards, 10.2 for dually involved youth, 5.0 for Probation only youth, and 9.7 for youth at a YRTC. (pages 30, 37, 42, 44)
- Missing from care continues to be an issue. The following 41 children and youth were missing from care as of 12/31/24 by agency involvement: 17 DHHS/CFS wards, nine dually involved youth, 14 Probation only youth, and one DHHS/OJS and Probation supervised youth. (pages 32, 37, 42, 43)
- COVID-19 had an impact on youth and families, programs, and providers. It will continue to be an important factor to consider when reviewing trends over time to understand the full impact it has had on children and youth involved in child welfare and juvenile justice systems.

RECOMMENDATIONS

Current Priority Recommendations

Children's experiences in out-of-home care have life-long impacts. In its September 2024 Annual Report, the FCRO made recommendations intended to improve conditions for children in Nebraska's child welfare and juvenile justice systems. Many of those recommendations remain relevant and can be found in the report on our website at fcro.nebraska.gov. The recommendations offered in this quarterly report are based on an analysis of the data tracked by the FCRO, as well as information collected during case reviews, findings by local review boards, and publicly available data.

1. The Special Study which includes findings on service needs, access and progress on early childhood mental health for children in out-of-home care who were involved with DHHS Children and Family Services (CFS) contains recommendations based on the findings of the study. Please refer to the Special Study beginning on page 7 for additional recommendations.

2. Meaningful and active efforts across all system-involved levels need to be made to address the continued and often increasing racial disproportionality and overrepresentation of children and youth of color in the system. System partners should hold town hall meetings in communities heavily impacted by the child protection system to identify the root causes and develop solutions to address disparities. DHHS should be intentional about recruiting, retaining, and promoting case managers of color to better reflect the population served. This will continue to be a priority recommendation until more active efforts are seen to drive change in the right direction.

3. The Western Service Area (WSA) continues to have a much higher rate of children in out-of-home care per 1,000 children in the population compared to other service areas. More prevention services and drug treatment services in the WSA may be helpful in reducing the rate of children entering out-of-home care in WSA.

4. Over 20% of Probation supervised youth in out-of-home care are in detention facilities. The FCRO remains concerned about the number of youths placed in these facilities. This is a trend we believe warrants further investigation to understand this population of youth, what their needs are, and whether those needs are being met. Youth placed in detention or other juvenile justice confinement must have access to appropriate treatment services and programming, including educational programming, to ensure that time spent in detention is not lost and youth can continue to make progress toward healing and rehabilitation. More needs to be done to develop prevention, diversion, and alternatives to detention to keep youth out of detention placements.

5. The increased use of congregate care placements across all agencies is concerning. Most notable are the large increases in the use of congregate care placements for DHHS/CFS only involved wards, which increased by 33.3% over the last year, and those that were dually involved with DHHS/CFS and Probation simultaneously, which increased by 41.0%. The increased use of congregate care placements is concerning not only because they are more restrictive settings, but they likely are not in the child's home community. The state of Nebraska must invest in infrastructure and capacity to support community-based services, including treatment foster care and residential care facilities so children can receive necessary treatment and support close to home.

6. Relatives are the preferred placement and help children achieve better outcomes when a child is removed from the home and placed in out-of-home care. The FCRO has been tracking and reporting on the licensing of relative and kinship homes, finding both have consistently decreased each

quarter over the last year and DHHS has not been maximizing the ability to pull down Title IV-E reimbursement. The FCRO recognizes DHHS obtained approval from the Administration for Children and Families (ACF) for Nebraska's plan to utilize a separate relative and kinship approval process. The new process allows Nebraska to draw additional federal dollars for child welfare services. While this is a promising development, DHHS is encouraged to ensure compliance with the approved plan, including timely home studies and adequate training, in-home supports, and resources for foster parents, especially relatives/kin, whether licensed or not.

7. The FCRO recognizes the progress DHHS has continued to make over the last year in decreasing the number of children in the Eastern Service Area who have had 10 or more caseworkers in their most recent episode in out-of-home care (from 123 to 105). Children with 10 or more caseworkers are minimal across the rest of the state. There remains an issue with children having five or more caseworkers across the state, but particularly in the Eastern Service Area where it is disproportionately an issue given 33.3% of the children have had five or more caseworkers. DHHS must continue to make progress in workforce stability to prevent the unnecessary transfer of cases between caseworkers.

8. To address turnover and staffing challenges, DHHS is encouraged to create and implement a long-term plan to develop a recruitment pipeline for individuals who might consider pursuing a career in social work, psychology, mental health practice, and related professions. This includes partnering with post-secondary education institutions to develop academic programs in human services disciplines, offering job-shadowing, volunteer, and internship opportunities, and other efforts designed to elevate human services career choices.

9. The FCRO is concerned with the increasing number of youths committed to Youth Rehabilitation and Treatment Centers (YRTCs). Over the last year, the number of youths committed to the YRTCs has increased by 23.0%. YRTCs also tend to have the highest rates of disproportionality for youth of color, particularly Black or African American and American Indian or Alaska Native youth, who had the highest rates of overrepresentation amongst this group. The FCRO encourages the development of youth gang violence prevention programs and other community-based programs that engage families and youth to improve outcomes, increase public safety, and strengthen communities, as well as reentry programming focused on youth and family well-being.[2]

10. Youth dually involved with DHHS/CFS and Probation simultaneously have consistently had the longest median length of stay (669 days) as compared to youth involved with DHHS/CFS only (431 days) and Probation only (161 days). The FCRO supports the development of prevention services for youth and families in crisis to reduce the number of youths entering either system. The FCRO also supports the development of strengths-based and evidence-informed interventions focused on meeting the complex needs of these vulnerable youth. [3]

The FCRO will continue to work with all system partners to pursue the recommended changes.

[2] See ojjdp.ojp.gov/about/ojjdp-priorities
[3] The Children's Bureau, Dear Colleague Letter Addressing the Complex Needs of Dually Involved Youth, May 29, 2024, Joint Letter on Dually Involved Youth

SPECIAL STUDY

Mental Health Needs & Service Access Among Young Children in Nebraska Foster Care

Introduction

Early childhood is a foundational period for cognitive, emotional, and social development.[4],[5],[6] For children in foster care, this period is often marked by disruptions in caregiving relationships, exposure to trauma, and significant instability.[7] These experiences place young children at heightened risk for mental health challenges that, if unaddressed, can have lifelong consequences.[8]

Despite the well-documented importance of early intervention,[9],[10] children in out-of-home care often face significant barriers to accessing these essential services.[11],[12],[13],[14],[15] In fact, emerging data from Nebraska indicate that infants and young children in out-of-home care are not consistently receiving the mental health services they need. This special study, conducted by the Nebraska Resource Project for Vulnerable Young Children (NRPVYC) at the University of Nebraska Lincoln's Center on Children, Families, and the Law, in collaboration with the Nebraska Foster Care Review Office (FCRO), seeks to illuminate the scope of this issue, identify service gaps, and highlight opportunities for system-level improvements. The report focuses specifically on children ages 0–5, a population often overlooked in mental health service delivery despite their vulnerability.

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[5] Nelson, C. A., & Bosquet, M. (2000). Neurobiology of fetal and infant development: Implications for infant mental health. In Handbook of infant mental health, 2nd ed (pp. 37–59). The Guilford Press.
[6] Zeanah, C. H., Stafford, B., Boris, N. W., & Scheeringa, M. (2008). Infant Development: The First 3 Years of Life. In Psychiatry (pp. 109–134). John Wiley & Sons, Ltd. https://doi.org/10.1002/9780470515167.ch8
[7] Pears, K., & Fisher, P. A. (2005). Developmental, Cognitive, and Neuropsychological Functioning in Preschool-aged Foster Children: Associations with Prior Maltreatment and Placement History. Journal of Developmental & Behavioral Pediatrics, 26(2), 112.
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[9] Dishion, T. J., Shaw, D., Connell, A., Gardner, F., Weaver, C., & Wilson, M. (2008). The Family Check-Up With High-Risk Indigent Families: Preventing Problem Behavior by Increasing Parents' Positive Behavior Support in Early Childhood. Child Development, 79(5), 1395–1414. https://doi.org/10.1111/j.1467-8624.2008.01195.x
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[13] Leslie, L. K., Gordon, J. N., Lambros, K., Premji, K., Peoples, J., & Gist, K. (2005). Addressing the Developmental and Mental Health Needs of Young Children in Foster Care: Journal of Developmental & Behavioral Pediatrics, 26(2), 140–151. https://doi.org/10.1097/00004703-200504000-00011
[14] Pecora, P. J., Jensen, P. S., Romanelli, L. H., Jackson, L. J., & Ortiz, A. (2009). Mental health services for children placed in foster care: An overview of current challenges. Child Welfare, 88(1), 5–26.
[15] Xu, Y., Soto-Ramírez, N., & Babalola, O. (2024). Facilitators and barriers of using mental health services among children in foster care: Insights from foster parents in a Southeastern state. Journal of Public Child Welfare, 1–21. https://doi.org/10.1080/15548732.2024.2381112

Why Mental Health in Early Childhood Matters

Children in foster care are disproportionately exposed to adverse childhood experiences (ACEs), including abuse, neglect, domestic violence, and parental challenges, such as mental illness, substance use, or incarceration. These experiences can profoundly affect a child's brain architecture, stress regulation, and social-emotional development, with lasting effects on a child's well-being.[16] Early adversity also shapes *internal working models of attachment*—mental frameworks that influence how children form expectations about relationships and navigate social interactions throughout their lives. When attachment is disrupted, children may struggle with trust, empathy, and self-regulation, which can undermine their ability to build healthy relationships in childhood and beyond. However, research in child development consistently shows that early intervention can buffer the impact of trauma and promote resilience, particularly when mental health needs are identified and addressed during critical developmental windows.[17]

In practice, young children's mental health needs are frequently underrecognized.[18],[19] Symptoms may manifest differently than in older children—through disruptions in attachment, sleep disturbances, feeding issues, or developmental regressions—making them harder to detect without specialized training.[20] Furthermore, service systems are often not designed to meet the unique needs of infants and toddlers, creating barriers to access even when concerns are identified.[21]

This study asks three critical questions:

1. **Are mental health needs being identified in young children placed in out-of-home care?**
2. **Are children with identified needs receiving appropriate services?**
3. **Do services make a measurable difference in children's mental health outcomes?**

The study analyzes administrative case review data from the Nebraska Foster Care Review Office (FCRO) to examine mental health needs and service access among children in Nebraska's foster care system. The dataset includes records for children ages 0-18, but in this study, we focus specifically on young children (ages 0-5) to assess gaps in early childhood mental health services. The findings presented in this report are descriptive and highlight trends in service access and mental health progress based on available documentation.

Identifying Mental Health Needs

For the purposes of this study, a **mental health need** is defined as any documented diagnosis by a clinical professional of a mental health condition or related disability, including but not limited to attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, posttraumatic stress disorder (PTSD), developmental delays, and adjustment disorders. Physical and learning disabilities were excluded from this analysis to maintain focus on mental health-specific concerns.

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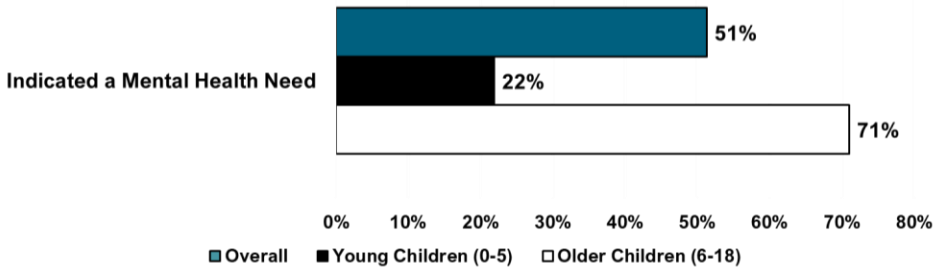
[16] Pears, K., & Fisher, P. A. (2005). Developmental, Cognitive, and Neuropsychological Functioning in Preschool-aged Foster Children: Associations with Prior Maltreatment and Placement History. Journal of Developmental & Behavioral Pediatrics, 26(2), 112.
[17] Center on the Developing Child at Harvard University. (2016, April 14). From Best Practices to Breakthrough Impacts: A Science-Based Approach to Building a More Promising Future for Young Children and Families. Center on the Developing Child at Harvard University. https://developingchild.harvard.edu/resources/report/best-practices-breakthrough-impacts/
[18] Horwitz, S. M., Gary, L. C., Briggs-Gowan, M. J., & Carter, A. S. (2003). Do Needs Drive Services Use in Young Children? Pediatrics, 112(6), 1373–1378. https://doi.org/10.1542/peds.112.6.1373
[19] Shepard, S. A., & Dickstein, S. (2009). Preventive Intervention for Early Childhood Behavioral Problems: An Ecological Perspective. Child and Adolescent Psychiatric Clinics of North America, 18(3), 687–706. https://doi.org/10.1016/j.chc.2009.03.002
[20] ZERO TO THREE. (2024, April 10). What do mental health issues in young children look like? ZERO TO THREE. https://www.zerotothree.org/resource/what-do-mental-health-issues-in-young-children-look-like/
[21] Hickey, L., Harms, L., Evans, J., Noakes, T., Lee, H., McSwan, A., Bean, H., Hope, J., Allison, L., Price, S., & Harris, N. (2024). Review: Improving access to mental health interventions for children from birth to five years: A Scoping Review. Child and Adolescent Mental Health, 29(1), 84–95. https://doi.org/10.1111/camh.12652

Key Findings:

- **22% of children ages 0–5** in out-of-home care have an identified mental health need.
- **71% of children ages 6–18** in out-of-home care have an identified mental health need.

Figure 1: Mental Health Needs for Young and Older Children



While some variation is expected due to developmental differences, the significant gap between young children and older youth in identified mental health needs raises important questions. Mental health symptoms in young children often present differently than in older youth, making early identification inherently more complex. Young children may exhibit signs through changes in behavior, developmental delays, or difficulties in attachment, which can be easily overlooked without specialized training and developmentally appropriate assessment tools.[22]

National prevalence data on diagnosed mental health disorders in children under age five are limited, making direct comparisons between our sample and the general population challenging. However, estimates from 2016 indicate that one in six U.S. children ages 2-8 years (17.4%) has a diagnosed mental, behavioral, or developmental disorder.[23] This provides a useful benchmark, though it is with a slightly older population and likely underrepresents the true prevalence of mental health concerns in high-risk populations such as children in out-of-home care. More recent data from the National Survey of Children's Health indicate that approximately 78.3% of children ages 6 months to 5 years in the general population meet all four criteria for *flourishing*—demonstrating curiosity, resilience, strong attachment, and contentment.[24] This measure reflects positive indicators of well-being, offering insight into how very young children are thriving socially and emotionally, and suggesting 21.7% of children in this age group may not be flourishing. In comparison, 39.6% of children ages 6-18 in the same survey did not meet all four flourishing criteria, highlighting a potential gap in very young children's and older children's well-being.

However, it's important to recognize that the absence of flourishing and the presence of an identified mental health need are not synonymous. The absence of mental health need identification does not necessarily equate to flourishing, just as the presence of flourishing behaviors does not rule out the existence of mental health concerns. Additionally, many young children with emerging mental health challenges may not meet the threshold for formal identification, particularly when screening and assessment practices are inconsistent.

[22] ZERO TO THREE. (2024, April 10). What do mental health issues in young children look like? ZERO TO THREE. https://www.zerotothree.org/resource/what-do-mental-health-issues-in-young-children-look-like/
[23] Cree, R. A. (2018). Health Care, Family, and Community Factors Associated with Mental, Behavioral, and Developmental Disorders and Poverty Among Children Aged 2–8 Years—United States, 2016. MMWR. Morbidity and Mortality Weekly Report, 67. https://doi.org/10.15585/mmwr.mm6750a1
[24] Child and Adolescent Health Measurement Initiative. 2022-2023 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved [02/10/2025] from [www.childhealthdata.org].

Within this context, the finding that **22% of young children in Nebraska's foster care system have an identified mental health need** is both expected and concerning. It reflects the increased vulnerability of children in out-of-home care due to exposure to trauma, adversity, and disrupted caregiving relationships. However, given these heightened risks, one might anticipate even higher rates of identified mental health needs compared to the general population. This suggests that under-identification may still be a significant issue, likely influenced by developmental complexities and limited access to specialized early childhood mental health assessments.

Without systematic, developmentally informed approaches to mental health screening, early signs of mental health challenges can easily be missed and many young children in out-of-home care may have unmet or unrecognized mental health needs. Left unaddressed, these needs can compound over time, increasing the risk of more severe challenges in adolescence and adulthood, including academic difficulties, substance use, and involvement with the juvenile justice system.[25]

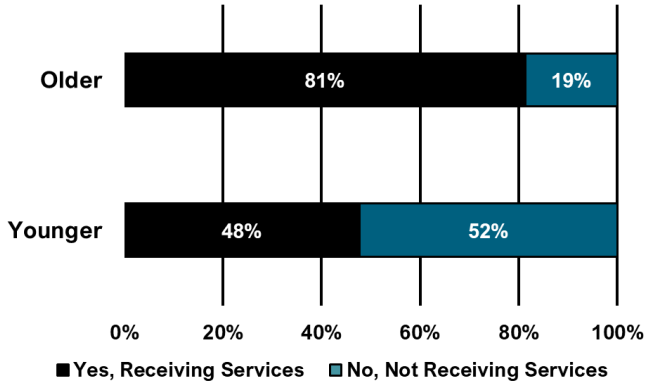
Access to Mental Health Services

While identifying mental health needs is a critical first step, access to high-quality, evidence-based mental health services is essential for addressing those needs and supporting positive developmental outcomes. Our findings indicate that many young children in Nebraska's foster care system with identified mental health concerns are not receiving the services necessary to support their well-being.

Service Access Rates:

- Only **48% of children ages 0–5** with an identified mental health need were reported as receiving services.
- In contrast, **81% of children ages 6–18** with an identified mental health need were receiving services.

Figure 2: Service Access for Children with Mental Health Needs



The disparity in service access between young children and older youth is both significant and concerning. Despite having identified mental health needs, less than half of young children in out-of-home care are connected to mental health services, compared to more than four out of five older children. This suggests that young children in out-of-home care are less likely to receive mental health support, even when their

[25] National Academies of Sciences, Engineering, and Medicine. (2019). Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth: A National Agenda. Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/25201.

needs are documented. The gap likely reflects a combination of systematic, workforce, and developmental factors that create barriers to timely and appropriate care.

Despite the clear need for mental health services in early childhood, there are no accurate national estimates of the number of children receiving Infant and Early Childhood Mental Health (IECMH) services or supports.[26],[27] Previous research has shown that 24% of 3- and 4-year-olds in low-income clinical settings screen positive for social-emotional problems, yet many of these children do not receive the mental health services that could address these concerns.[28] This underscores the challenges faced not only within child welfare systems but across early childhood programs more broadly, reflecting a national trend of under-identification and limited service access for young children with mental health needs.

Geographic Disparities in Service Access

Where a child lives in Nebraska significantly impacts their likelihood of receiving the mental health services they need. Our analysis observed substantial variability across the state's five Department of Health and Human Services (DHHS) service areas, highlighting geographic differences in service access for young children in out-of-home care with an identified mental health need.

These rates reflect the percentage of young children ages 0-5 in out-of-home care with an identified mental health need who are receiving mental health services, providing insight into how access to care varies geographically within Nebraska.

While these differences were not statistically significant when examining children ages 0-5 alone, analyses including all children in foster care with identified mental health needs (ages 0-18) revealed significant disparities in service access (p = .002). Notably, the ordinal ranking of service areas remained consistent when older children were included, with the Central Service Area consistently showing the highest access rates and the Southeast Service Area the lowest, while the other service areas fall in the same order as detailed below. This consistency suggests that service area differences in access to mental health services may be stable across age groups within Nebraska's foster care system, indicating persistent geographic patterns in service availability or utilization.

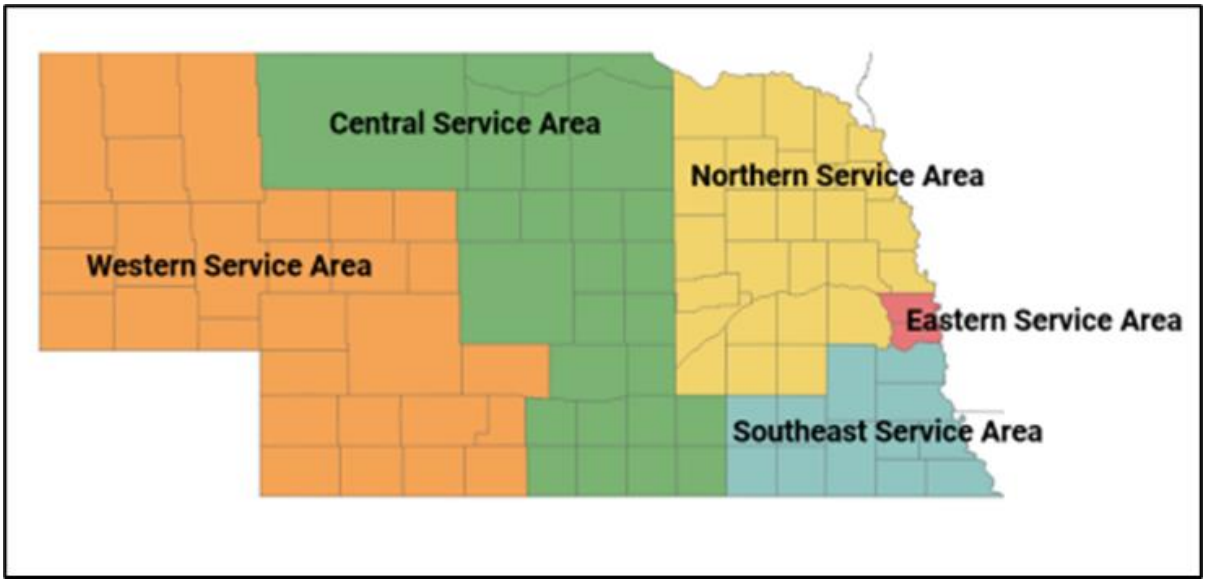
[26] Cree, R. A. (2018). Health Care, Family, and Community Factors Associated with Mental, Behavioral, and Developmental Disorders and Poverty Among Children Aged 2–8 Years—United States, 2016. MMWR. Morbidity and Mortality Weekly Report, 67. https://doi.org/10.15585/mmwr.mm6750a1

[27] Horen, N. M., Sayles, J., McDermott, K., Sippel-Klug, K., Drake-Croft, J., & Long, T. (2024). Infant and Early Childhood Mental Health (IECMH) and Early Childhood Intervention: Intentional Integration. International Journal of Environmental Research and Public Health, 21(7), Article 7. https://doi.org/10.3390/ijerph21070870

[28] Brown, C. M., Copeland, K. A., Sucharew, H., & Kahn, R. S. (2012). Social-Emotional Problems in Preschool-Aged Children: Opportunities for Prevention and Early Intervention. Archives of Pediatrics & Adolescent Medicine, 166(10), 926–932. https://doi.org/10.1001/archpediatrics.2012.793

Figure 3: Percent of Children Receiving Mental Health Services

Service Area	% of Children (0–5) with Mental Health Needs Receiving Services	% of Children (0-18) with Mental Health Needs Receiving Services
Central Service Area (CSA)	62%	85%
Eastern Service Area (ESA)	54%	80%
Northern Service Area (NSA)	54%	74%
Western Service Area (WSA)	33%	70%
Southeast Service Area (SESA)	32%	65%



Although this report does not examine the specific factors contributing to these service area differences, the observed disparities may reflect variations in service availability, referral practices, or other geographic-specific factors that warrant further investigation. Understanding and addressing these differences is essential to ensure that all children in out-of-home care—regardless of where they live—have equitable access to the mental health services they need.

The Role of Evidence-Based Clinical Interventions: CPP and PCIT

Evidence-based clinical interventions are critical for addressing the mental health needs of young children in out-of-home care, many of whom have experienced trauma, disrupted attachments, and instability. Two interventions with a strong research base for this population are Child-Parent Psychotherapy (CPP) and Parent-Child Interaction Therapy (PCIT).[29],[30] Both approaches are designed to improve child outcomes by

[29] Sleed, M., Li, E. T., Vainieri, I., & Midgley, N. (2023). The Evidence-Base for Psychodynamic Interventions with Children Under 5 Years of Age and Their Caregivers: A Systematic Review and Meta-Analysis. Journal of Infant, Child, and Adolescent Psychotherapy, 22(3), 179–214. https://doi.org/10.1080/15289168.2023.2223739

[30] Thomas, R., Abell, B., Webb, H. J., Avdagic, E., & Zimmer-Gembeck, M. J. (2017). Parent-Child Interaction Therapy: A Meta-analysis. Pediatrics, 140(3), e20170352. https://doi.org/10.1542/peds.2017-0352

strengthening caregiver-child relationships and addressing the effects of trauma and behavioral challenges.

Despite their effectiveness, access to CPP and PCIT is limited across Nebraska, in part due to shortages in the behavioral health workforce in general. According to the Behavioral Health Education Center of Nebraska, 88 out of Nebraska's 93 counties meet federal criteria as mental health professions shortage areas, with 29 counties lacking any behavioral health providers entirely.[31] This shortage is particularly acute among early childhood mental health clinicians, limiting access to interventions like CPP and PCIT.[32] Addressing this gap requires ongoing efforts to expand Nebraska's specialized early childhood mental health workforce, particularly in rural and underserved areas.

Understanding the Need: Our Analytic Approach

To better understand the landscape of mental health service access for young children in out-of-home care, we conducted a need and gap analysis for both CPP and PCIT providers across Nebraska. This analysis focused on two key questions:

1. **How many children are likely to need these specialized services?**
2. **How does the current availability of providers compare to the estimated need?**

Because CPP and PCIT serve slightly different populations and clinical needs, we used distinct criteria to estimate service demand:

- For CPP, we focused on Nebraska children ages 5 and younger with substantiated cases of abuse or neglect,[33] as this population faces heightened risks for trauma-related mental health concerns.
- For PCIT, we estimated need based on the population of children ages 2-7, with an assumption that 5% of children in this age range experience externalizing behaviors (e.g., aggression, defiance) that are commonly addressed through PCIT.[34]

This approach allowed us to identify service area disparities in service access, highlight gaps in provider availability, and consider how workforce capacity impacts the delivery of evidence-based mental health interventions for children in out-of-home care.

Figure 4: Provider Availability for CPP

Service Area	CPP Providers	Children Per Provider
Central	19	13:1
Eastern	24	73:1
Northern	10	50:1
Southeast	17	36:1
Western	11	31:1

[31] Robb, J. (2021, December 29). Behavioral health workforce growing but facing challenges. University of Nebraska Medical Center. https://www.unmc.edu/newsroom/2021/12/29/behavioral-health-workforce-growing-but-facing-challenges/
[32] Nebraska Children and Families Foundation. (2021). *Rooted in Relationships: Annual evaluation report*. Nebraska Children and Families Foundation. https://www.nebraskaaeyc.org/uploads/1/1/0/7/110768979/2021_rir_annual_report_final.pdf
[33] Children's Bureau. (2022). Child Maltreatment Data (National Child Abuse and Neglect Data System [NCANDS]). U.S. Department of Health and Human Services. Retrieved February 12, 2025, from https://cwoutcomes.acf.hhs.gov/cwodatasite/byState/nebraska/
[34] Campbell, S. B., Shaw, D. S., & Gilliom, M. (2000). Early externalizing behavior problems: Toddlers and preschoolers at risk for later maladjustment. Development and Psychopathology, 12(3), 467–488. https://doi.org/10.1017/S0954579400003114

Figure 5: Need & Gap Analysis for PCIT Providers

Service Area	PCIT Providers	Children Per Provider
Central	8	94:1
Eastern	25	102:1
Northern	14	76:1
Southeast	14	104:1
Western	6	99:1

Key Findings:

- **For CPP:** Provider-to-child ratios vary widely, with some service areas having as few as **one provider for every 73 children** with substantiated abuse/neglect (Eastern Service Area), while others have a more balanced **one provider for every 13 children** (Central Service Area).
- **For PCIT:** Access is even more limited in certain service areas, with provider-to-child ratios as high as **104:1** (Southeast Service Area), highlighting critical service gaps for children with externalizing behaviors.
- Even in service areas with more providers, such as Eastern, the demand for services remains high, with 102 **children per provider**, reflecting the statewide need for increased mental health service capacity.

These findings highlight critical gaps in access to evidence-based mental health interventions for young children in Nebraska's foster care system. Addressing these gaps will require continued efforts to strengthen the early childhood mental health workforce, expand service capacity, and ensure that children receive timely, effective support regardless of where they live.

Does Access to Services Improve Outcomes?

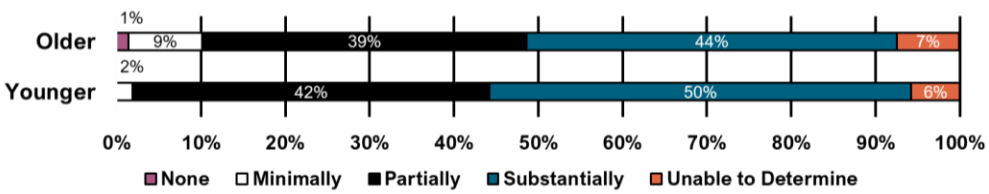
Using data from the Nebraska Foster Care Review Office, we examined mental health progress among children in out-of-home care with identified mental health needs, focusing on differences based on access to mental health services. The descriptive data suggest that children who received mental health services were more likely to show meaningful progress, particularly among younger children. For this analysis, "progress" includes cases marked as **substantial** or **partial** progress, while cases marked as **minimal progress, no progress, or unable to determine** were excluded from the progress composite.

The Effect of Mental Health Services

Among children who received mental health services, the majority demonstrated progress in their mental health outcomes:

- **Ages 6–18 (with services):** 83% showed progress.
- **Ages 0–5 (with services):** 92% showed progress.

Figure 6: Mental Health Progress of Children Receiving Services



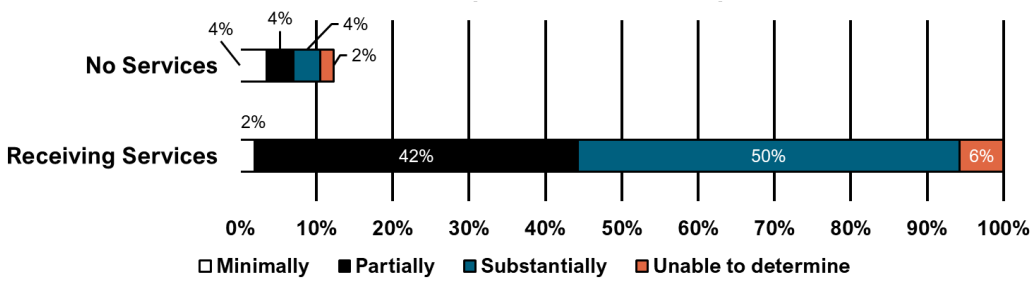
While these descriptive statistics do not establish causality, they highlight a clear pattern of positive outcomes among children with access to mental health services.

Services Make a Difference for Very Young Children's Mental Health Progress

Differences in outcomes were most pronounced for younger children when comparing those who received services to those who did not. Notably, when children were not receiving services, progress data was often left blank, despite these children indicating a mental health need.

- **With services**: 92% showed progress.
- **Without services**: Only 8% showed progress.

Figure 7: Mental Health Progress in Children Ages 0-5



Note: Includes very young children who have indicated a mental health need and compares mental health progress in those receiving and not receiving mental health services.
The percentages for "No Services" do not total 100% because most left the question unanswered.

These findings provide important context for understanding the role of mental health services in supporting children in out-of-home care, particularly in early childhood. The differences in progress between children who received services and those who did not suggest that access to support can make a meaningful difference. While the data are descriptive, they highlight meaningful patterns that warrant further exploration to better understand the impact of service access on child outcomes.

Recommendations for System-Level Change

The findings in this report reveal both critical gaps and opportunities for improving Nebraska's child welfare and mental health systems. While many children in out-of-home care are not receiving the infant and early childhood mental health support they need, the data clearly show that when services are provided, they are associated with meaningful progress, particularly for young children. Addressing these gaps requires a coordinated, system-level response focused on early identification, expanding access to evidence-based interventions, reducing geographic disparities, and strengthening data-driven decision-making.

1. Strengthen Early Identification Practices

Early detection of mental health needs is essential for timely intervention,[35] yet many children, especially those under age five, are likely not being identified. Improving identification practices can help ensure that children receive support when it is most effective.

One way to accomplish this is to **implement universal mental health screening** for all children entering out-of-home care, including infants and toddlers. Standardized, validated tools such as the Brief Infant-Toddler Social and Emotional Assessment (BITSEA) and the Survey of Well-being of Young Children (SWYC) can

[35] Horen, N. M., Sayles, J., McDermott, K., Sippel-Klug, K., Drake-Croft, J., & Long, T. (2024). Infant and Early Childhood Mental Health (IECMH) and Early Childhood Intervention: Intentional Integration. International Journal of Environmental Research and Public Health, 21(7), Article 7. https://doi.org/10.3390/ijerph21070870

enhance early identification of social-emotional and behavioral concerns.[36],[37] The BITSEA is particularly effective for identifying early signs of mental health issues in children ages 12 to 36 months, while the SWYC provides a broad screening framework for developmental delays and behavioral concerns in children from 1 month to 5.5 years. Screening results could be integrated into case planning with clearly defined referral pathways to ensure timely connections to appropriate mental health services and early identification of traumatic and/or adverse events.

Screening efforts that incorporate a trauma-informed lens are particularly important for recognizing the impact of adverse experiences on young children's well-being. Resources such as the *Guide to Understanding & Screening for Trauma in Young Children*, developed by the Nebraska Resource Project for Vulnerable Young Children (NRPVYC), may complement standardized assessments by helping caregivers and professionals recognize behaviors that could indicate trauma exposure.[38] DHHS workers may also find this guide to be a useful resource for supporting trauma-informed case planning and identifying potential trauma-related concerns.

2. Expand Access to Evidence-Based Clinical Interventions

Even when mental health needs are identified, children in out-of-home care often face barriers to accessing effective treatment.[39] Expanding access to evidence-based intervention is essential to ensuring that children receive services that can improve their well-being. Child-Parent Psychotherapy (CPP) and Parent-Child Interaction Therapy (PCIT) are two well-established, research-supported treatments that address trauma and promote healthy attachment between children and caregivers.[40],[41] However, workforce shortages limit the availability of these interventions, particularly in rural and underserved areas**. Increasing the number of providers trained in CPP and PCIT** can help close service gaps, especially when paired with telehealth initiatives, which have been shown to reduce geographic barriers to care.[42] By expanding service capacity through workforce training and development, more children can access the mental health care they need.

3. Address Geographic Disparities

Children in out-of-home care should have access to mental health services regardless of where they live, yet geographic disparities remain a persistent challenge. Ensuring equitable service availability requires a targeted approach to understanding and addressing geographic gaps in provider access. A **comprehensive workforce analysis** can help identify service areas with the greatest shortages, informing strategic recruitment and retention efforts. Additionally, **strengthening cross-system collaboration** among child welfare, behavioral health, and early childhood programs can improve coordination and streamline referral processes. Integrated service models can enhance communication across sectors and reduce barriers to

[36] Briggs-Gowan, M. J., Carter, A. S., Irwin, J. R., Wachtel, K., & Cicchetti, D. V. (2004). The Brief Infant-Toddler Social and Emotional Assessment: Screening for social-emotional problems and delays in competence. *Journal of Pediatric Psychology, 29*(2), 143–155. https://doi.org/10.1093/jpepsy/jsh017

[37] Sheldrick, R. C., & Perrin, E. C. (2013). Evidence-based milestones for surveillance of cognitive, language, and motor development. *Academic Pediatrics, 13*(3), 250–257. https://doi.org/10.1016/j.acap.2013.01.010

[38] Understanding & Screening for trauma in young children. (n.d.). Nebraska Resource Project for Vulnerable Young Children. https://www.nebraskababies.com/resources/pdf-guides/understanding-screening-trauma-young-children

[39] Pecora, P. J., Jensen, P. S., Romanelli, L. H., Jackson, L. J., & Ortiz, A. (2009). Mental health services for children placed in foster care: An overview of current challenges. Child Welfare, 88(1), 5–26.

[40] Child-Parent Psychotherapy (CPP). (n.d.). Nebraska Resource Project for Vulnerable Young Children. https://www.nebraskababies.com/iecmh/services/cpp

[41] Parent-Child Interaction Therapy (PCIT). (n.d.). Nebraska Resource Project for Vulnerable Young Children. https://www.nebraskababies.com/iecmh/services/pcit

[42] Hickey, L., Harms, L., Evans, J., Noakes, T., Lee, H., McSwan, A., Bean, H., Hope, J., Allison, L., Price, S., & Harris, N. (2024). Review: Improving access to mental health interventions for children from birth to five years: A Scoping Review. Child and Adolescent Mental Health, 29(1), 84–95. https://doi.org/10.1111/camh.12652.

timely intervention.[43] Addressing these disparities will require intentional investment in both infrastructure and workforce capacity to ensure children receive appropriate mental health care, regardless of location.

4. Promote Data-Driven Decision-Making

Integrating data-driven approaches into infant and early childhood mental health services may improve service delivery and help ensure that young children in out-of-home care receive interventions that are responsive to their needs and lead to measurable improvements. While early identification and referral pathways are critical first steps, exploring strategies to track service utilization and child outcomes over time could provide valuable insights into intervention effectiveness, service gaps, and equity in access.

One potential approach is **measurement-based care (MBC),** which relies on standardized assessments to monitor children's progress over time and supports more responsive, individualized care planning. Although MBC is widely used in child and youth mental health treatment, its application in the child welfare system remains limited.[44],[45] However, exploring how MBC could complement existing case management and service coordination efforts may offer opportunities to improve care quality and decision making.

Routine outcome monitoring—a key component of MBC—has been shown to improve treatment precision and detect emerging concerns that might otherwise be missed through clinical judgment alone.[46],[47] Standardized tools such as the Brief Infant-Toddler Social and Emotional Assessment (BITSEA) and the Survey of Well-being of Young Children (SWYC) could be integrated into existing data collection efforts to assess whether interventions are leading to meaningful improvements.[48],[49]

Collaboration across agencies would be essential in determining the most appropriate ways to implement these data-driven approaches. Given that case records and clinical updates are primarily managed by DHHS, expanding MBC within DHHS case planning processes may provide an opportunity to strengthen service tracking and enhance care coordination. While FCRO's role is primarily focused on system-level and case review rather than case management, FCRO could support these efforts by reviewing trends, identifying gaps, and facilitating discussions on how data insights can drive service improvements.

By leveraging data to track service gaps, assessing intervention effectiveness, and informing policy decisions, Nebraska's child welfare and behavioral health systems can strengthen care coordination and improve long-term outcomes for children in out-of-home care. Ensuring that mental health needs are not only identified early but continuously assessed can help create a more responsive and effective system of care. FCRO can support these efforts by identifying trends, informing data-driven strategies, and fostering

[43] Hickey, L., Harms, L., Evans, J., Noakes, T., Lee, H., McSwan, A., Bean, H., Hope, J., Allison, L., Price, S., & Harris, N. (2024). Review: Improving access to mental health interventions for children from birth to five years: A Scoping Review. Child and Adolescent Mental Health, 29(1), 84–95. https://doi.org/10.1111/camh.12652.

[44] Bickman, L., Kelley, S. D., Breda, C., de Andrade, A. R., & Riemer, M. (2011). Effects of routine feedback to clinicians on mental health outcomes of youths: Results of a randomized trial. Psychiatric Services (Washington, D.C.), 62(12), 1423–1429. https://doi.org/10.1176/appi.ps.002052011

[45] Jacobson, J. H., Pullmann, M. D., Parker, E. M., & Kerns, S. E. U. (2019). Measurement Based Care in Child Welfare-Involved Children and Youth: Reliability and Validity of the PSC-17. Child Psychiatry & Human Development, 50(2), 332–345. https://doi.org/10.1007/s10578-018-0845-1

[46] Breslin, F. C., Sobell, M. B., Sobell, L. C., Buchan, G., & Cunningham, J. A. (1997). Toward a stepped care approach to treating problem drinkers: The predictive utility of within-treatment variables and therapist prognostic ratings. Addiction (Abingdon, England), 92(11), 1479–1489.

[47] Carlier, I. V. E., Meuldijk, D., Van Vliet, I. M., Van Fenema, E., Van der Wee, N. J. A., & Zitman, F. G. (2012). Routine outcome monitoring and feedback on physical or mental health status: Evidence and theory. Journal of Evaluation in Clinical Practice, 18(1), 104–110. https://doi.org/10.1111/j.1365-2753.2010.01543.x

[48] Briggs-Gowan, M. J., Carter, A. S., Irwin, J. R., Wachtel, K., & Cicchetti, D. V. (2004). The Brief Infant-Toddler Social and Emotional Assessment: Screening for social-emotional problems and delays in competence. *Journal of Pediatric Psychology, 29*(2), 143–155. https://doi.org/10.1093/jpepsy/jsh017

[49] Sheldrick, R. C., & Perrin, E. C. (2013). Evidence-based milestones for surveillance of cognitive, language, and motor development. *Academic Pediatrics, 13*(3), 250–257. https://doi.org/10.1016/j.acap.2013.01.010

cross-agency collaboration to improve service coordination and ensure all children in out-of-home care receive the support they need to thrive.

For questions regarding this special study, please contact **Emily Starr** at estarr3@huskers.unl.edu or **Pamela Jordan** at pamela.caudill@unl.edu. Additional resources on early childhood mental health are available at Nebraskababies.com.

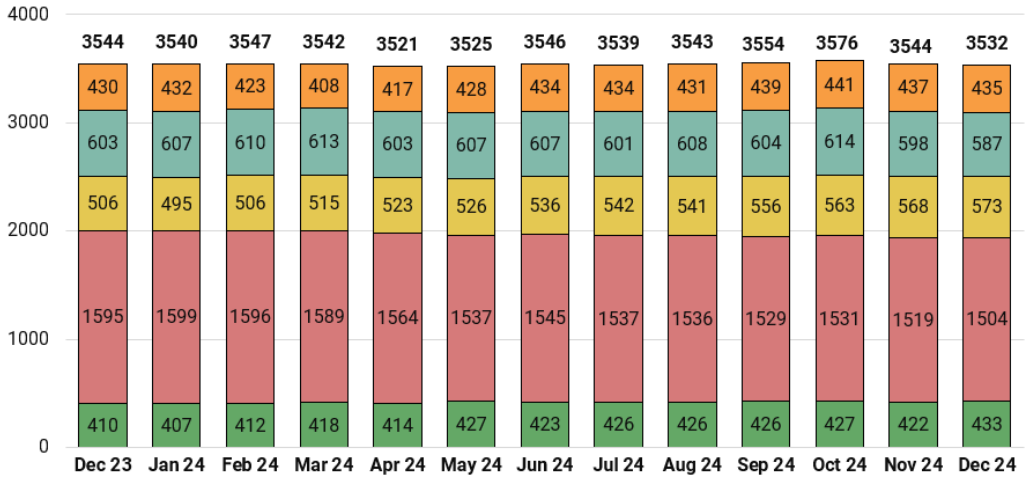
OUT-OF-HOME TRENDS

This section includes Average Daily Population as well as Entry and Exit data for court-involved children in out-of-home care or a trial home visit involved with DHHS and/or Probation. Youth who were involved with both DHHS and Probation simultaneously (dually involved youth) are included in both system trends; youth who were placed at a YRTC are included with the Probation-involved youth.

CHILD WELFARE TRENDS

Average Daily Population. Figure 8 represents the average daily population (ADP) per month of all DHHS-involved children in out-of-home care or a trial home visit, including those simultaneously served by Probation, from December 2023 to December 2024. There were 0.3% fewer DHHS wards in out-of-home care on average in December 2024 compared to December 2023.

Figure 8: Average Daily Population of DHHS Wards, December 2023-December 2024



The colors refer to the service area (SA), as shown in the map below. Totals at the top of the chart may be slightly different than the sum of the service areas due to rounding.

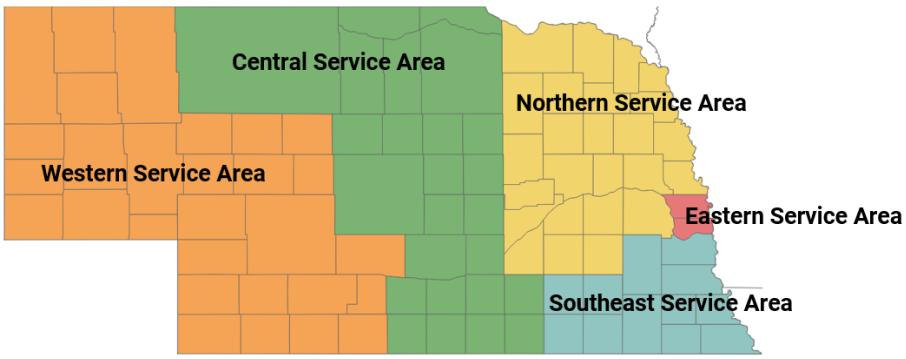


Figure 9 indicates the percent change in average daily population varied throughout the state and illustrates the differences between service areas (geographic regions).

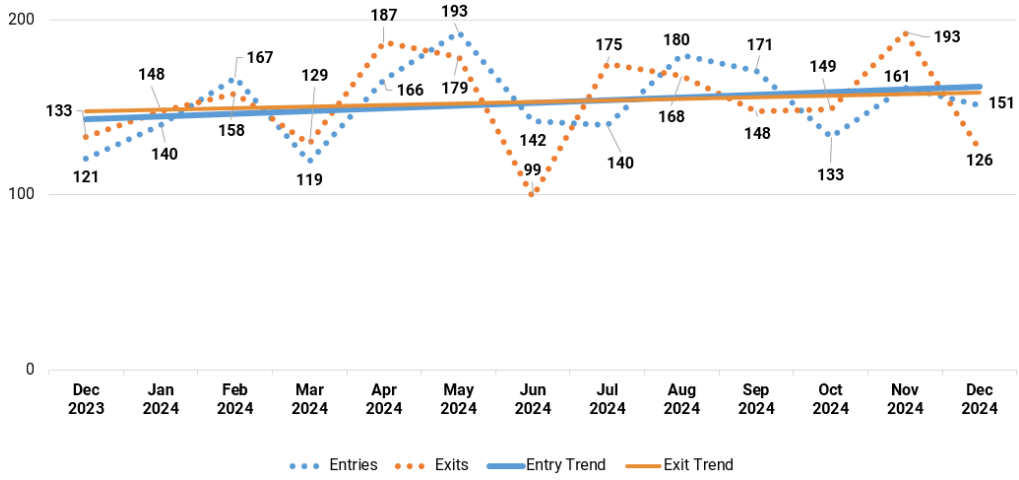
Figure 9: Percent Change in Average Daily Population of DHHS Wards by Service Area, December 2023 to December 2024[50]

Service Area (SA)	Dec-23	Dec-24	% Change
Central SA	410	433	5.6%
Eastern SA	1,595	1,504	-5.7%
Northern SA	506	573	13.2%
Southeast SA	603	587	-2.7%
Western SA	430	435	1.2%
Statewide	**3,544**	**3,532**	**-0.3%**

Entries and Exits. Population changes of children in out-of-home care and trial home visits can be influenced by many factors, including changes in the number of children entering the system, changes in the number of children exiting the system, and changes in the amount of time children spend in the system. Some patterns tend to recur, such as more exits toward the end of the school year, prior to holidays, during reunification or adoption days, and more entrances just before summer and after school starts (when reports of abuse or neglect tend to increase).

Figure 10 represents exits and entrances per month of all DHHS-involved children in out-of-home care or a trial home visit, including those simultaneously served by Probation, from December 2023 to December 2024.

Figure 10: Monthly Entries and Exits of DHHS Wards, December 2023-2024

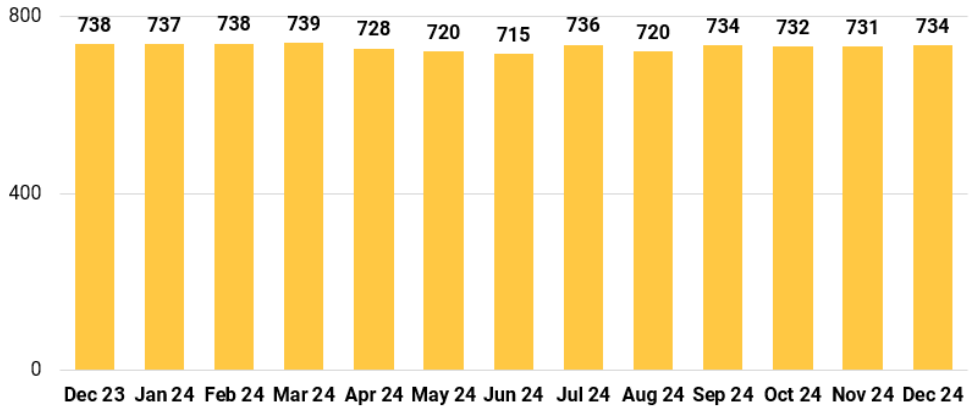


[50] Averages for each column may not be exactly equal to the sum of the service areas due to rounding.

JUVENILE JUSTICE-PROBATION TRENDS

Average Daily Population. Figure 11 below represents the average daily population (ADP) per month of all Probation supervised youth in out-of-home care, including those simultaneously served by DHHS, from December 2023 to December 2024. The average daily population decreased over the last year. There were 0.5% fewer Probation supervised youth in out-of-home care on average in December 2024 compared to December 2023.

Figure 11: Average Daily Population of Probation Supervised Youth in Out-of-Home Care, December 2023 to December 2024



Seven of the 12 districts experienced a decline in the population of Probation supervised youth in out-of-home care, as demonstrated in Figure 12.

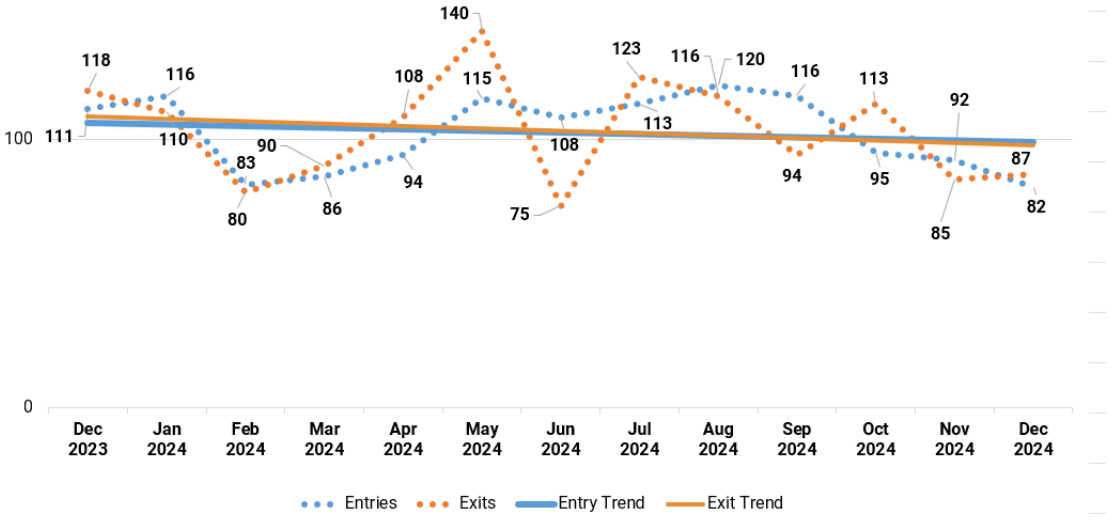
Figure 12: Percent Change in Average Daily Population of Probation Supervised Youth by Probation District, December 2023 to December 2024[51]

Probation District	Dec-23	Dec-24	% Change
District 1	24	16	-36.0%
District 2	41	33	-20.6%
District 3J	126	124	-2.2%
District 4J	259	278	7.3%
District 5	40	43	6.7%
District 6	37	44	18.6%
District 7	48	43	-10.0%
District 8	12	10	-13.9%
District 9	44	50	12.8%
District 10	33	24	-28.0%
District 11	48	49	1.9%
District 12	24	21	-12.4%
State	**738**	**734**	**-0.5%**

[51] Averages for each column may not be exactly equal to the sum of the probation district due to rounding.

Entries and Exits. Probation-related placements are frequently long-term (6-12 months) placements, focused on community safety and rehabilitation of the youth. Under statute, the FCRO can track and review Probation supervised youth if they are in an out-of-home placement. For Probation supervised youth, the end of an episode of out-of-home care does not necessarily coincide with the end of their probation supervision; therefore, the FCRO is unable to report on successful or unsuccessful releases from Probation.

Figure 13: Monthly Entries and Exits of Probation Supervised Youth, December 2023-December 2024



POINT-IN-TIME TREND OVERVIEW BY AGENCY

The following tables represent a trend comparison of the number of children and youth in out-of-home care or trial home visits by agency type over the last eight point-in-time quarters. The DHHS/CFS and Dually Involved tables below show the statewide total as well as the breakout by service area. Probation displays the statewide total and the breakout by probation district. Finally, YRTC represents the statewide total and the breakout by gender.

DHHS/CFS	3/31/23	6/30/23	9/30/23	12/31/23	3/31/24	6/30/24	9/30/24	12/31/24
Statewide	3,584	3,530	3,480	3,398	3,388	3,446	3,426	3,397
CSA	409	407	404	378	393	407	404	428
ESA	1,643	1,612	1,581	1,536	1,503	1,496	1,458	1,424
NSA	500	508	495	489	503	521	533	550
SESA	590	549	554	570	585	589	590	570
WSA	442	454	446	425	404	433	441	425

- For children and youth involved only with DHHS/CFS, the most recent point-in-time data shows a 0.8% statewide decrease over the previous quarter.
- Three of the five service areas experienced a decrease with the largest decrease occurring in the WSA at 3.6%; whereas CSA had the largest increase at 5.9%.

Dually Involved	3/31/23	6/30/23	9/30/23	12/31/23	3/31/24	6/30/24	9/30/24	12/31/24
Statewide	127	129	127	138	138	119	132	141
CSA	17	19	15	18	17	12	16	12
ESA	60	56	57	62	63	58	67	79
NSA	15	18	15	14	20	20	24	24
SESA	21	20	25	28	24	17	16	19
WSA	14	16	15	16	14	12	9	7

- For youth who were dually involved with DHHS/CFS and Probation, the most recent point-in-time data shows a 6.8% statewide increase over the previous quarter.
- Two of the five service areas (ESA and SESA) experienced an increase while two service areas (CSA and WSA) had decreases over the previous quarter.
- One service area (NSA) had no change from the previous quarter.

Probation	3/31/23	6/30/23	9/30/23	12/31/23	3/31/24	6/30/24	9/30/24	12/31/24
Statewide	419	435	473	483	480	486	475	479
District 1	13	16	20	18	18	19	13	8
District 2	27	31	30	35	34	29	30	28
District 3J	66	75	79	82	72	77	84	85
District 4J	121	125	139	151	155	163	154	156
District 5	28	32	37	32	35	29	31	32
District 6	26	37	32	28	25	30	30	33
District 7	32	20	28	28	30	26	20	28
District 8	6	8	7	6	4	4	6	6
District 9	41	32	30	29	38	37	40	34
District 10	16	15	22	24	25	27	19	17
District 11	22	30	29	34	30	31	28	35
District 12	21	14	20	16	14	14	20	17

- For youth who were only involved with Probation, the most recent point-in-time data shows a 0.8% statewide increase over the previous quarter.
- Six of the 12 probation districts had an increase, with the largest increase occurring in District 7 at 40.0%, followed by District 11 at 25.0%, District 6 at 10.0%, District 5 at 3.2%, District 4J at 1.3%, and District 3J at 1.2%.
- Five probation districts had a decrease over the previous quarter, with the largest decrease occurring in District 1 at 38.5%, followed by District 9 at 15.0%, District 12 at 15.0%, District 10 at 10.5% and lastly District 2 at 6.7%.
- District 8 had no change from the previous quarter.

YRTCs	3/31/23	6/30/23	9/30/23	12/31/23	3/31/24	6/30/24	9/30/24	12/31/24
Statewide	82	84	78	74	96	95	103	91
Females	22	22	12	14	25	29	22	15
Males	60	62	66	60	71	66	81	76

- For youth who were placed at a YRTC, the most recent point-in-time data shows an 11.7% total population decrease over the previous quarter.
- The population of females at the YRTCs decreased by 31.8% and the population of males decreased by 6.2% over the previous quarter.

SYSTEM-WIDE TRENDS

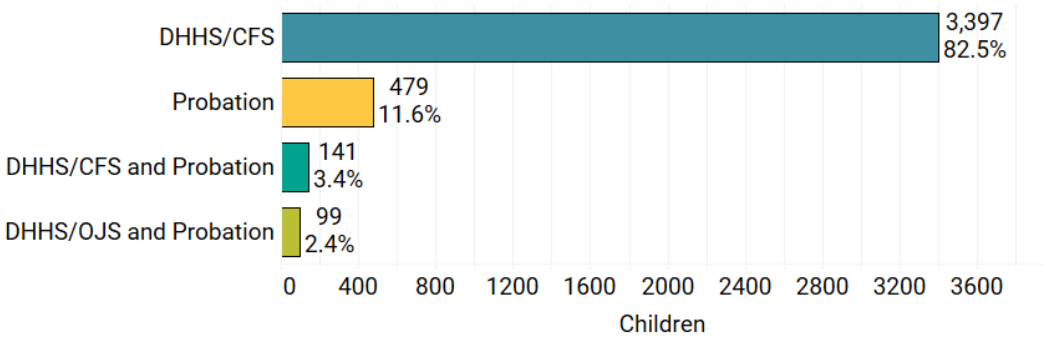
This section includes point-in-time data for court-involved children and youth under DHHS/CFS, DHHS/OJS, and/or the Administrative Office of the Courts and Probation – Juvenile Services Division (hereafter referred to as Probation) in out-of-home care or a trial home visit.

On 12/31/2024, 4,116 Nebraska children were in out-of-home or a trial home visit placement[52] under DHHS/CFS, DHHS/OJS, and/or Probation.

Over the course of a year, a child may enter or exit out-of-home care one or more times and may be involved with one or more state agencies. Additionally, children may be involved in voluntary placements, court-ordered placements, or both throughout a year.

Figure 14 provides a snapshot of the agency involvement of non-duplicated children in out-of-home care on 12/31/2024.

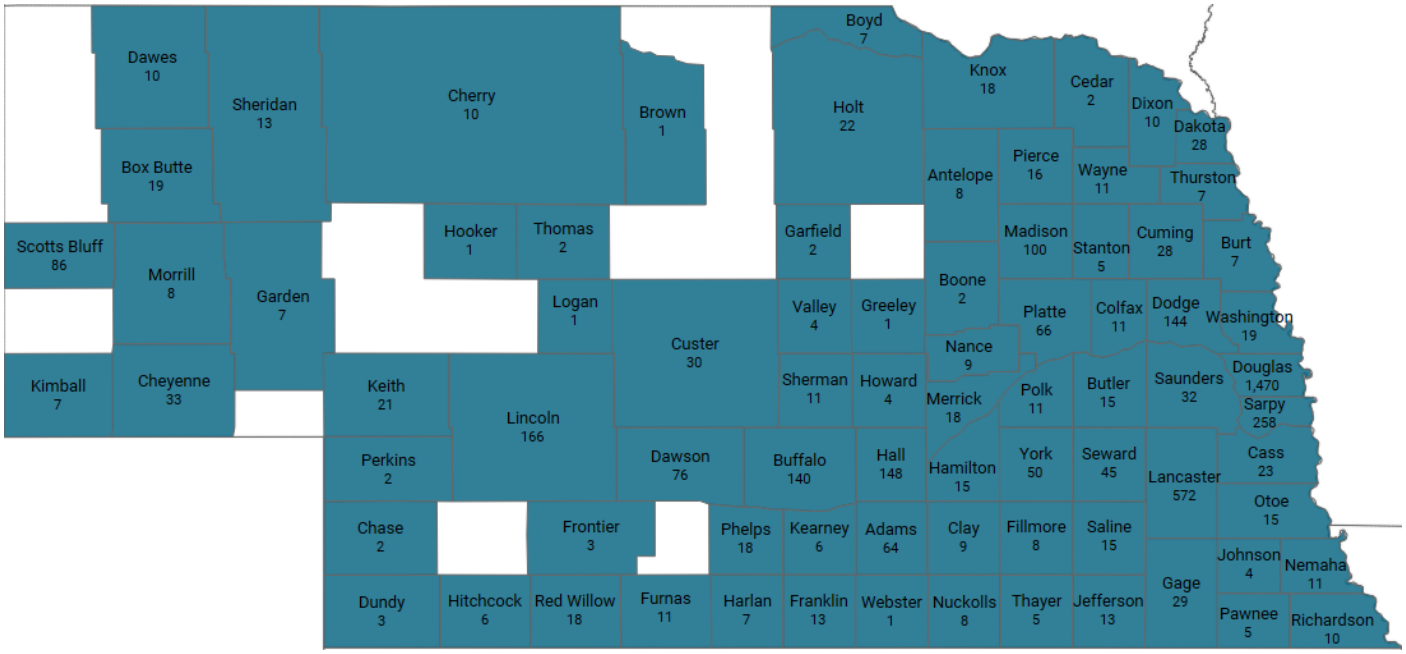
Figure 14: All Court-Involved Children in Out-of-Home Care or a Trial Home Visit by Agency Involved on 12/31/2024, n[53]=4,116



[52] This section does not include children in non-court Approved Informal Living Arrangements, tribal wards, or children that have never had a removal from the home.
[53] See Appendix B for a glossary of terms and a description of acronyms.

Children in out-of-home care come from across the entire state of Nebraska. Figure 15 represents the county of court jurisdiction for the 4,116 court-involved children who were in out-of-home care on 12/31/2024 (which excludes AILAs).[54]

Figure 15: County of Court Jurisdiction for all Nebraska Court-Involved Children in Out-of-Home Care or a Trial Home Visit on 12/31/2024, n=4,116



*Counties with no description or shading did not have any children in out-of-home care. These are predominately counties with sparse populations of children. Children who received services in the parental home without experiencing a removal and children placed directly with a non-custodial parent are not included as they are not within the FCRO's authority to track or review.

The 4,116 shown above is a 0.4% increase compared to 12/31/2023 when 4,098 court-involved children were in out-of-home care.

The next sections of this report will summarize the sub-populations of all children in out-of-home care based on the agency or agencies involved.

[54] See Appendix B for a glossary of terms and a description of acronyms.

CHILD WELFARE CHILDREN

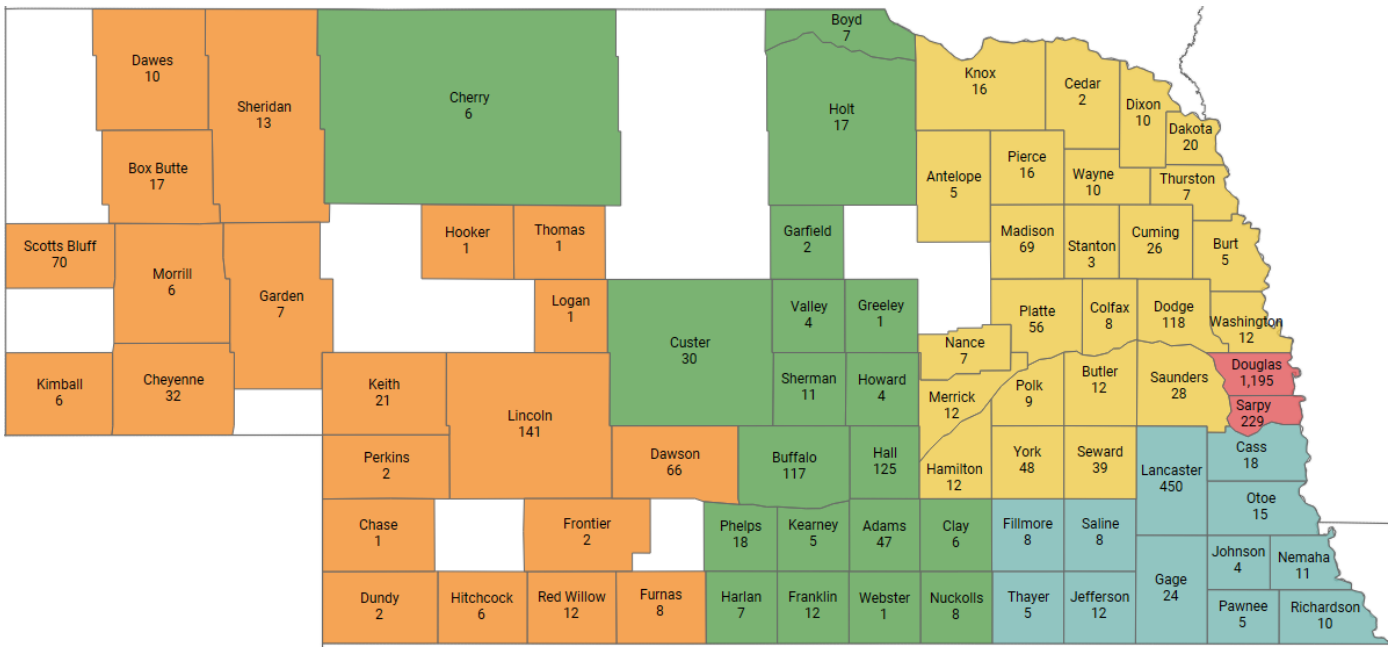
DHHS/CFS COURT-INVOLVED CHILDREN IN CARE THROUGH THE CHILD WELFARE SYSTEM

This section includes point-in-time data for DHHS/CFS only court-involved children in out-of-home care or a trial home visit in the child welfare system (abuse and neglect). This does not include children and youth dually involved with DHHS/CFS and Probation.

POINT-IN-TIME DEMOGRAPHICS AND PLACEMENTS

County. Figure 16 shows the county of court jurisdiction for the 3,397 children solely involved with DHHS/CFS in out-of-home care or a trial home visit on 12/31/2024. This compares to 3,398 on 12/31/2023.

Figure 16: County of Court Jurisdiction for DHHS/CFS Wards in Out-of-Home Care or Trial Home Visit on 12/31/2024, n=3,397



*Counties with no description or shading did not have any children in out-of-home care with DHHS/CFS involvement. These are predominately counties with sparse populations of children. Children who received services in the parental home without experiencing a removal and children placed directly with a non-custodial parent are not included as they are not within the FCRO's authority to track or review.

Figure 17: Service Areas for DHHS/CFS Wards in Out-of-Home Care or Trial Home Visit on 12/31/2024, n=3,397

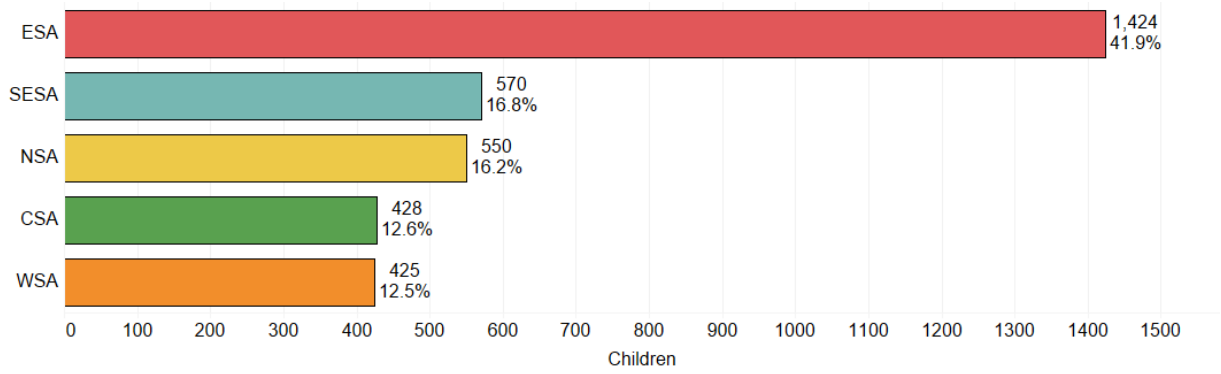


Figure 18 represents the top 10 counties by rate of DHHS/CFS wards in care per 1,000 children in the population, ages 0 up to 19, on 12/31/2024. While the three most populous counties in Nebraska (Douglas, Lancaster, and Sarpy) make up approximately 55% of DHHS/CFS wards, these counties are not within the top 10 counties with the highest rates. Some rural counties, like Lincoln County (North Platte), which had the fourth highest count of children who are DHHS/CFS wards, have higher rates of children in out-of-home care. Statewide, the rate of DHHS/CFS wards in care per 1,000 children was 6.3.

Figure 18: Top 10 Counties by Rate of DHHS/CFS Wards in Care per 1,000 Children in the Population on 12/31/2024

County	Children in Care	Total Age 0-19[55]	Rate per 1,000 Children	Family Count
Boyd	7	355	19.7	2
Garden	7	361	19.4	5
Franklin	12	649	18.5	5
Lincoln	141	8,325	16.9	91
Sherman	11	710	15.5	5
Cheyenne	32	2,392	13.4	18
York	48	3,781	12.7	28
Dodge	118	10,303	11.5	75
Keith	21	1,848	11.4	13
Sheridan	13	1,144	11.4	5

[55] U.S. Census Bureau, Population Division, County Characteristics Datasets: Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin: July 1, 2023.

Figure 19: Service Areas by Rate of DHHS/CFS Wards in Care per 1,000 Children in the Population on 12/31/2024

Service Area	Children in Care	Total Age 0-19[56]	Rate per 1,000 Children	Family Count
CSA	428	62,732	6.8	231
ESA	1,424	219,710	6.5	759
NSA	550	91,884	6.0	312
SESA	570	115,153	4.9	327
WSA	425	46,805	9.1	261

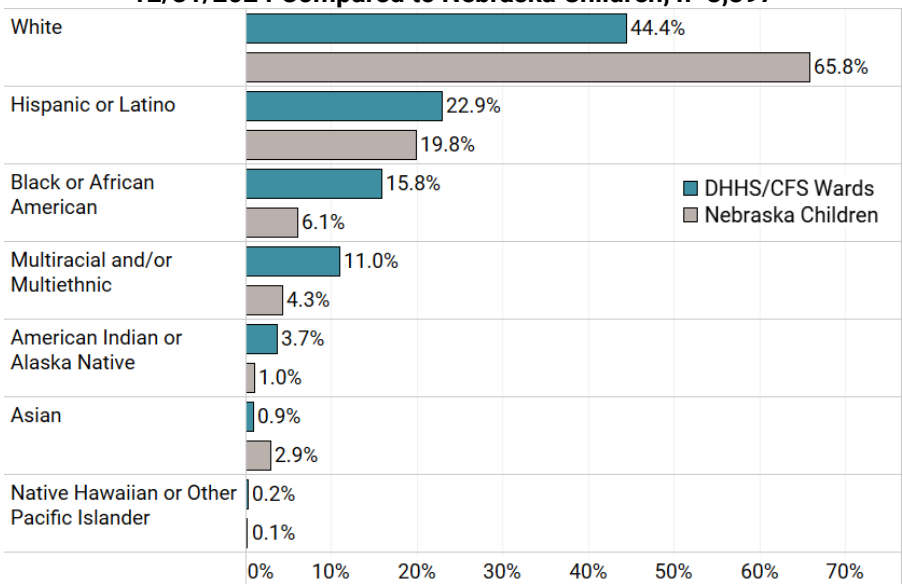
Age. The median age was 8 years old for both males and females who were DHHS/CFS wards in care on 12/31/2024.

- 36.1% of the children in out-of-home care or trial home visits on 12/31/2024 were age 5 and under.
- 35.2% of the children were age 6-12.
- 28.8% of the children were age 13-18.

Gender. Males (49.3%) and females (50.7%) are nearly equally represented in the number of DHHS/CFS wards in care.

Race. Figure 20 compares the race and ethnicity of children in out-of-home care or a trial home visit to the number of children in the state of Nebraska. Children of color continue to be overrepresented in the out-of-home population. This overrepresentation is very similar to the data presented last year. A truly equitable out-of-home care system should reflect a population composed of race/ethnicity ratios in out-of-home care equivalent to the ratios of children in the general population per census records.

Figure 20: Race and Ethnicity of DHHS/CFS Wards in Out-of-Home Care and Trial Home Visits on 12/31/2024 Compared to Nebraska Children, n=3,397



[56] U.S. Census Bureau, Population Division, County Characteristics Datasets: Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin: July 1, 2023.

Times in Care Over Lifetime. The average number of times in care over their lifetime for current DHHS/CFS wards as of 12/31/2024 was 1.3.

Median Length of Stay. For those in care on 12/31/2024, the median number of days in care for DHHS/CFS wards was 431 days.

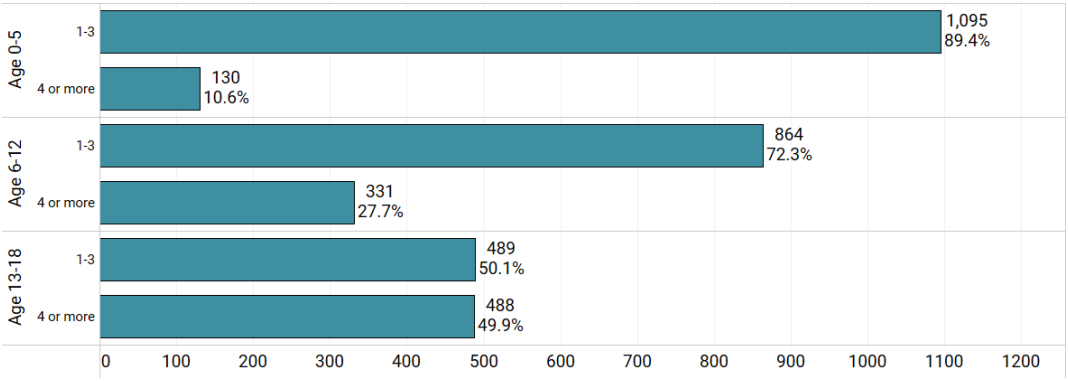
Number of Placements. Research indicates that children experiencing multiple placements over their lifetime puts them at greater risk for negative outcomes, such as delays in permanency, academic challenges, and difficulties forming meaningful attachments.[57] However, children who have experienced consistent, stable, and loving caregivers are more likely to have better long-term mental and physical health outcomes.[58]

On 12/31/2024, DHHS/CFS wards had an average of 3.3 placements in their lifetime.

Figure 21 shows the number of lifetime placements for DHHS/CFS wards by age group. It is unacceptable that 10.6% of children ages 0-5, and 27.7% of children ages 6-12 have been moved between caregivers four or more times. This has implications for children's health and safety at the time of review and throughout their lifetime.

By the time children reach their teen years, nearly half (49.9%) have exceeded four lifetime placements.

Figure 21: Lifetime Placements for DHHS/CFS Wards in Care 12/31/2024, n=3,397



The percentage with four or more lifetime placements varies by service area, as shown in Figure 22.

Figure 22: Lifetime Placements for DHHS/CFS Wards in Care by Service Area 12/31/2024, n=3,397

Age Group	CSA	ESA	NSA	SESA	WSA
0-5	7.2%	12.3%	12.1%	8.3%	10.1%
6-12	21.1%	35.0%	25.6%	22.9%	19.5%
13-18	48.1%	55.7%	41.4%	46.4%	47.0%

[57] sbrown@casey.org. 2024. "Placement Stability Impacts - Casey Family Programs." Casey Family Programs. May 22, 2024. https://www.casey.org/placement-stability-impacts

[58] sbrown@casey.org. 2024.

Placement Restrictiveness. It is without question that "children grow best in families." While temporarily in foster care, children need to live in the least restrictive, most home-like placement possible for them to grow and thrive. Thus, placement type matters. The least restrictive placements are home-like settings, moderate restrictive placements include non-treatment group facilities, and the most restrictive are the facilities that specialize in psychiatric, medical, or juvenile justice related issues and group emergency placements.

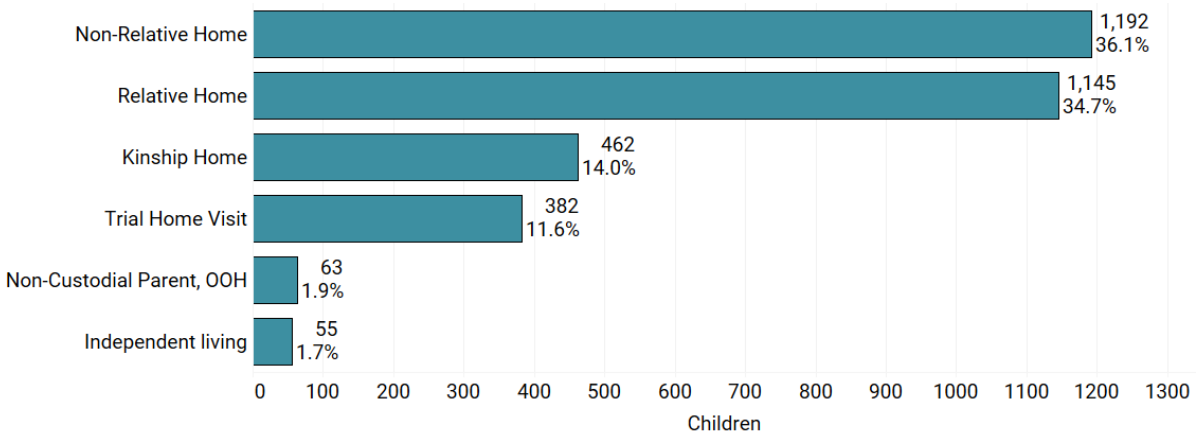
- The vast majority (97.1%) of DHHS/CFS state wards in care on 12/31/2024 were placed in the least restrictive placement, well above the 2021 national average of 90%.[59] This is a continuing trend.
    - Of the children placed in family-like settings (not including trial home visits), 55.1% were in a relative or kinship placement.[60]

Formalized relative and kinship care was put in place to allow children to keep existing and appropriate relationships and bonds with family members, or similarly important adults, thus lessening the trauma of separation from the parents.

If a maternal or paternal relative or family friend is an appropriate placement, children suffer less disruption by being placed with persons they already know, who make them feel safe and secure; however, it is not required that relatives have a pre-existing relationship with the child in order to be placed with them.

When considering Figure 23, remember that some children in out-of-home care do not have any adult relatives available for consideration, while others may have relatives, but the relatives are not suitable to provide care.

Figure 23: Additional Details on Least Restrictive Placement Type for DHHS/CFS Wards in Out-of-Home Care or Trial Home Visit on 12/31/2024, n=3,299



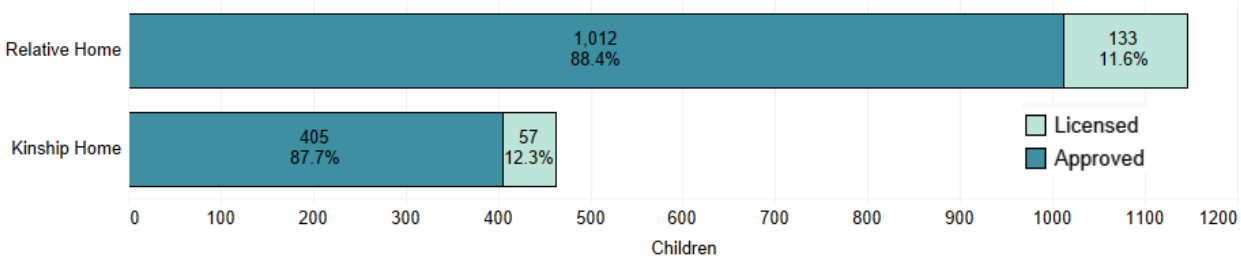
[59] Children in foster care by placement type: Kids Count Data Center. Children in foster care by placement type | KIDS COUNT Data Center. (n.d.). https://datacenter.aecf.org/data/line/6247-children-in-foster-care-byplacement-type?loc=1&loct=1#1/any/true/2048/asc/2622,2621,2623,2620,2625,2624,2626/12995

[60] Neb. Rev. Stat. §71-1901 defines relative care as placement with a relative of the child or of the child's sibling through blood, marriage, or adoption. Kinship care is with a fictive relative, someone with whom the child has had a significant relationship prior to removal from the home. Other states may use different definitions of kin, making comparisons difficult.

Licensing of Relative and Kinship Foster Homes. Compliance to the new DHHS relative and kinship foster home approval process approved by the Administration for Children and Families (ACF) is crucial to ensure placement safety and stability, as well as to increase the amount of federal Title IV-E funding accessed by the state.[61] Completion of the Reasonable and Prudent Parenting Standards training should support these approved caregivers so they are better able to cope with the types of behaviors that children with a history of abuse or neglect can exhibit, along with intra-familial issues present in relative care that are not present in non-family situations. These approved caregivers will also need ample information on the workings of the foster care system and supports available to them and the children.

Current License Status. Due to the prior fiscal impact and caregiver training issues, the FCRO looked at the licensing status for relative and kinship placement types. As shown in Figure 24, in keeping with the FCRO's focus on individual children, we see that relatively few are in a licensed placement. Since 12/31/2023, children in licensed relative placements have decreased from 24.7% to 11.6% and children in licensed kinship placements have decreased from 18.7% to 12.3%. Slow progress was being made in prior years, but it is now trending in the opposite direction.

Figure 24: Licensing for DHHS/CFS Wards in Relative or Kinship Foster Homes on 12/31/2024, n=1,145 (Relatives) and n=462 (Kinship)



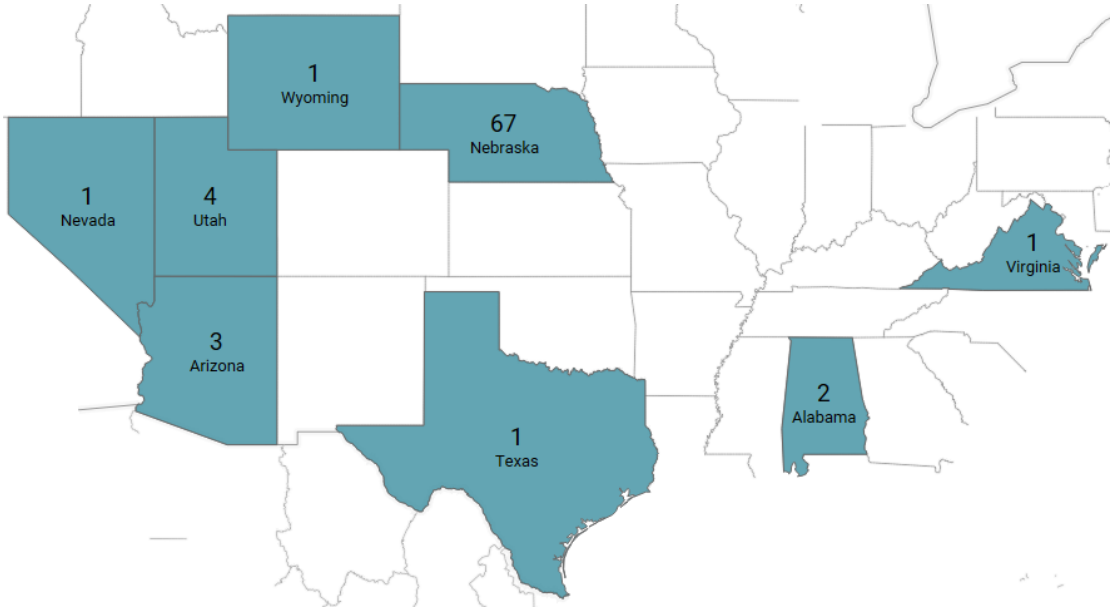
Missing from Care. On 12/31/2024, there were 17 DHHS/CFS wards missing from care. Of those missing, 10 were female and seven were male. This is always a serious safety issue that deserves special attention. While unaccounted for, these children have a higher likelihood of having experiences with sex trafficking or other poor outcomes.

[61] Per a DHHS news release from May 8, 2024: On April 17, 2024, the Administration for Children and Families (ACF) approved Nebraska's plan to utilize a separate relative and kinship approval process. The new process will allow Nebraska to draw additional federal dollars for child welfare services.

Congregate Care. A majority (83.8%) of DHHS/CFS wards in congregate care facilities[62] are placed in Nebraska (Figure 25).

- DHHS/CFS had 80 children in congregate care, resulting in a large increase from 60 on 12/31/2023.

Figure 25: DHHS/CFS Wards in Congregate Care on 12/31/2024 by State of Placement, n=80



[62] Congregate care includes non-treatment group facilities, group facilities that specialize in psychiatric, medical, or juvenile justice related issues, and group emergency placements.

CASEWORKER CHANGES

Caseworkers are charged with ensuring children's safety while in out-of-home care, and they are critical for children to achieve timely and appropriate permanency. The number of different caseworkers assigned to a case is significant because worker changes can create situations where there are gaps in the information and client relationships must be rebuilt, causing delays in permanency. It is also significant to the child welfare system because funding is directed to training new workers instead of serving families.

A study still frequently quoted from Milwaukee County, Wisconsin, found that children who only had one caseworker achieved timely permanency in 74.5% of the cases, as compared with 17.5% of those with two workers, and 0.1% of those having six workers.[63] Caseworker turnover has been associated with more placement disruptions, time in foster care, incidents of maltreatment, and re-entries into foster care.[64] Turnover is also significant to the child welfare system because resources are directed to recruiting, hiring, and training new workers instead of serving families. Every time a caseworker leaves the workforce, the cost to the agency is approximately 70% to 200% of the exiting employee's annual salary.[65]

The FCRO receives information from DHHS/CFS about the caseworkers children have had while in out-of-home care or trial home visits during their current episode.[66] Due to system changes over the past couple of years, the following explanations are necessary:

- In the Eastern Service Area, ongoing casework was done by lead agency (contractor) Family Permanency Specialists (FPS) until March 2022. Since then, it has been conducted by DHHS/CFS Case Managers. Thus, the count for the Eastern Service Area may include workers in each category. The FCRO was careful not to duplicate the counts for previous lead agency workers who were hired by DHHS/CFS if they continued to serve the same family.[67]
- In the rest of the state, the data represents the number of DHHS/CFS Case Managers assigned to a case.

[63] Review of Turnover in Milwaukee County Private Agency Child Welfare Ongoing Case Management Staff, January 2005. Authors C. Flower, J. McDonald, and M. Sumski. Inquiries regarding the report should be directed to Child Welfare Associates LLC in Wheaton, IL. turnoverstudy.pdf (uh.edu)

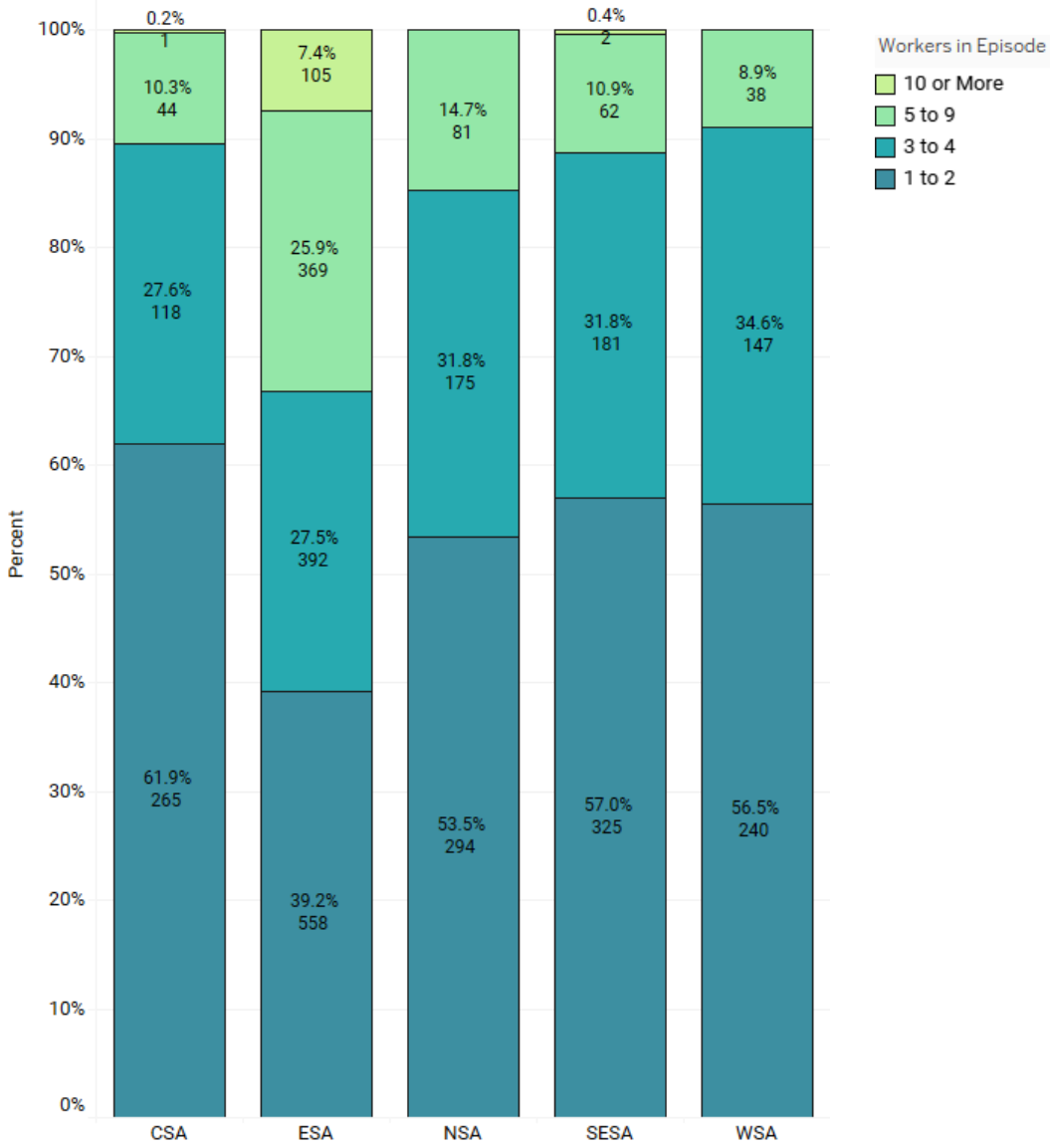
[64] "How Does Turnover Affect Outcomes - Casey Family Programs." 2017. Casey Family Programs. December 29, 2017. https://www.casey.org/turnover-costs-and-retention-strategies/.

[65] "How Does Turnover Affect Outcomes - Casey Family Programs." 2017

[66] The FCRO has determined that there are issues with the way that DHHS reports the number of caseworker changes. Therefore, this information is issued with the caveat "as reported by DHHS."

[67] PromiseShip held the lead agency contract with DHHS until 2019 when DHHS rebid the contract and awarded to Saint Francis Ministries. Cases transferred in the fall of 2019. Many former PromiseShip caseworkers were subsequently employed by Saint Francis. Then in spring 2022 the contract was discontinued, and many Saint Francis workers were hired as DHHS/CFS Case Managers. Throughout those transfers if the same worker remained with the child's case without a break of service, the FCRO ensured that the worker count was not increased. Counts were only increased during each transfer period if a new person became involved with the child and family.

Figure 26: Number of Caseworkers This Episode for DHHS Wards in Care 12/31/2024, n=3,397



Over a fifth (20.7%) of the children served by DHHS/CFS have had five or more caseworkers during their current episode in care. Children in the Eastern Service Area (ESA), which had been served by a private contractor, were disproportionately impacted by caseworker changes, and had a much higher percentage of children with five or more caseworkers than any other service area in the state. In fact, many children (33.3%) in the ESA had five or more workers, and of those, 105 children (7.4% of the ESA total) had 10 or more workers in their current episode in care, just slightly less than the previous year. This does not include caseworkers that may have worked with the child during a previous episode in out-of-home care or a non-court, voluntary case. The FCRO encourages DHHS/CFS to continue to decrease the number of children who have had five or more caseworkers in their most recent episode in care.

DUALLY INVOLVED YOUTH

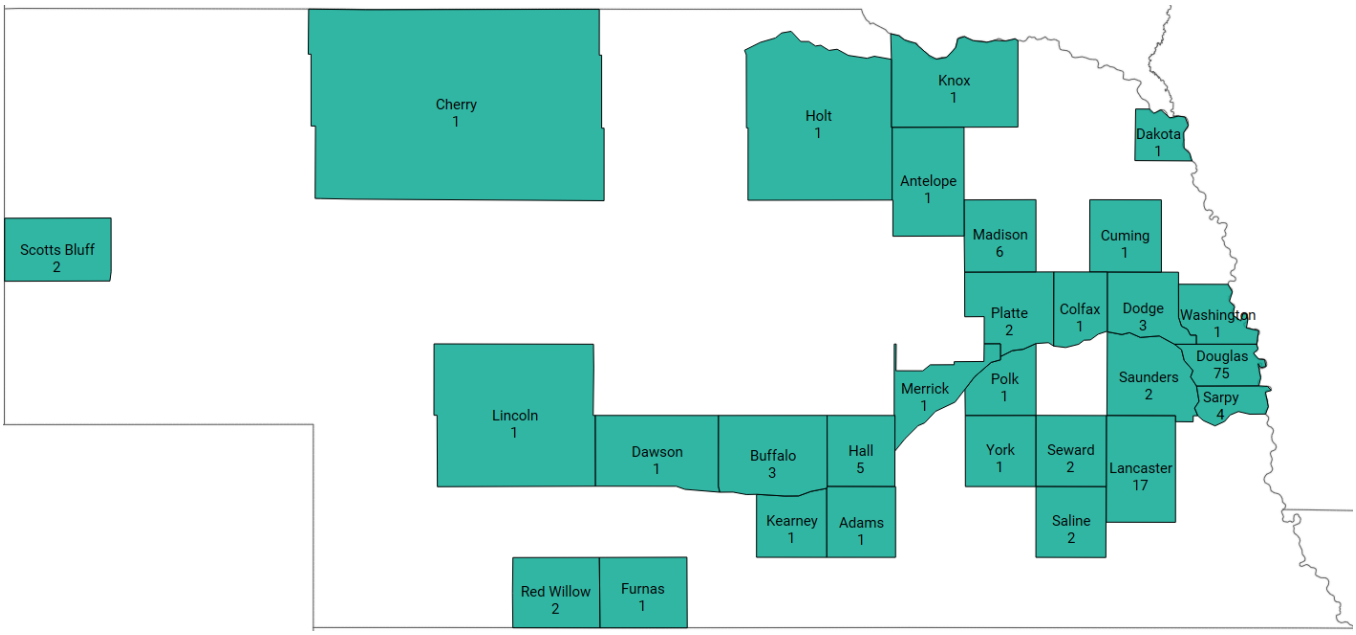
COURT-INVOLVED YOUTH IN CARE THROUGH CHILD WELFARE AND SUPERVISED BY THE ADMINISTRATIVE OFFICE OF COURTS AND PROBATION – JUVENILE SERVICES DIVISION

This section includes point-in-time data for court-involved youth in out-of-home care, or a trial home visit simultaneously involved in the Child Welfare System (abuse and neglect) and supervised by the Administrative Office of Courts and Probation – Juvenile Services Division.

POINT-IN-TIME DEMOGRAPHICS AND PLACEMENTS

County. On 12/31/2024, there were 141 dually involved youth in out-of-home care. (See Appendix A for a list of counties and their respective judicial districts and service areas).

Figure 27: County of Origin for Dually Involved Youth on 12/31/2024, n=141



*Counties with no description or shading did not have any youth in out-of-home care simultaneously involved with DHHS/CFS and Probation. These are predominately counties with sparse populations of children and youth. Youth who received services in the parental home without experiencing a removal and children and youth placed directly with a non-custodial parent are not included as they are not within the FCRO's authority to track or review.

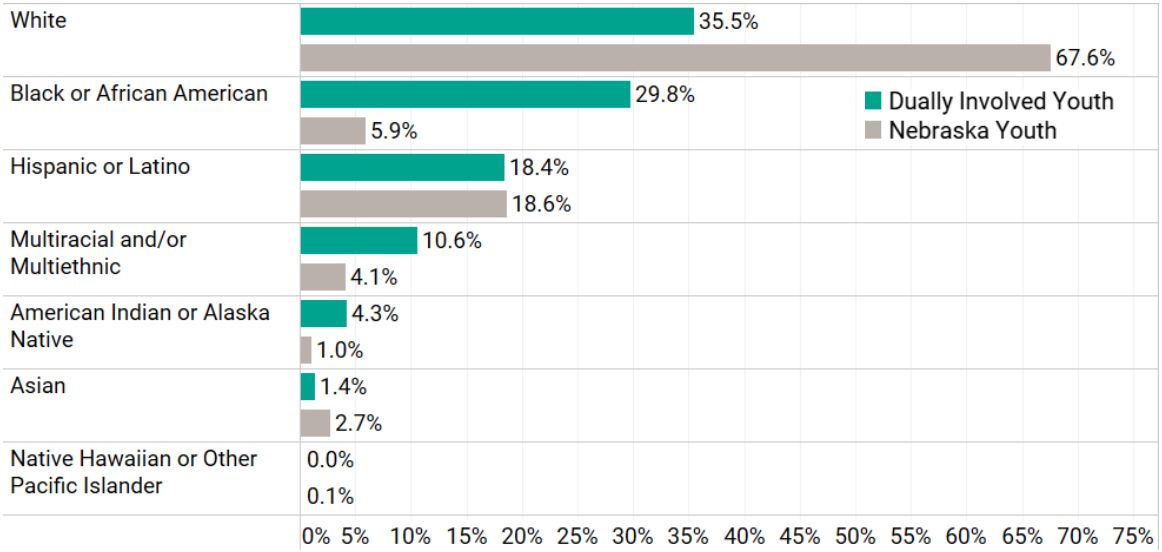
Age. The median age for dually involved youth was 16 years old for both males and females.

- 4 (2.8%) were age 11-12.
- 22 (15.6%) were age 13-14.
- 60 (42.6%) were age 15-16.
- 55 (39.0%) were age 17-18.

Gender. Males outnumbered females among dually involved youth (63.1% to 36.9%, respectively).

Race and Ethnicity. As discussed throughout this report, there is racial disproportionality in this group also. Many racial and ethnic groups of color are overrepresented, while white youth are underrepresented.

Figure 28: Race and Ethnicity of Dually Involved Youth in Out-of-Home Care Compared to Nebraska Youth on 12/31/2024, n=141



Times in Care Over Lifetime. The average number of times in care over their lifetime for current dually involved youth as of 12/31/2024 was 1.8.

Median Length of Stay. For those in care on 12/31/2024, the median number of days in care for dually involved youth was 669 days.

Number of Placements. The average number of placements over their lifetime for dually involved youth on 12/31/2024 was 10.2.

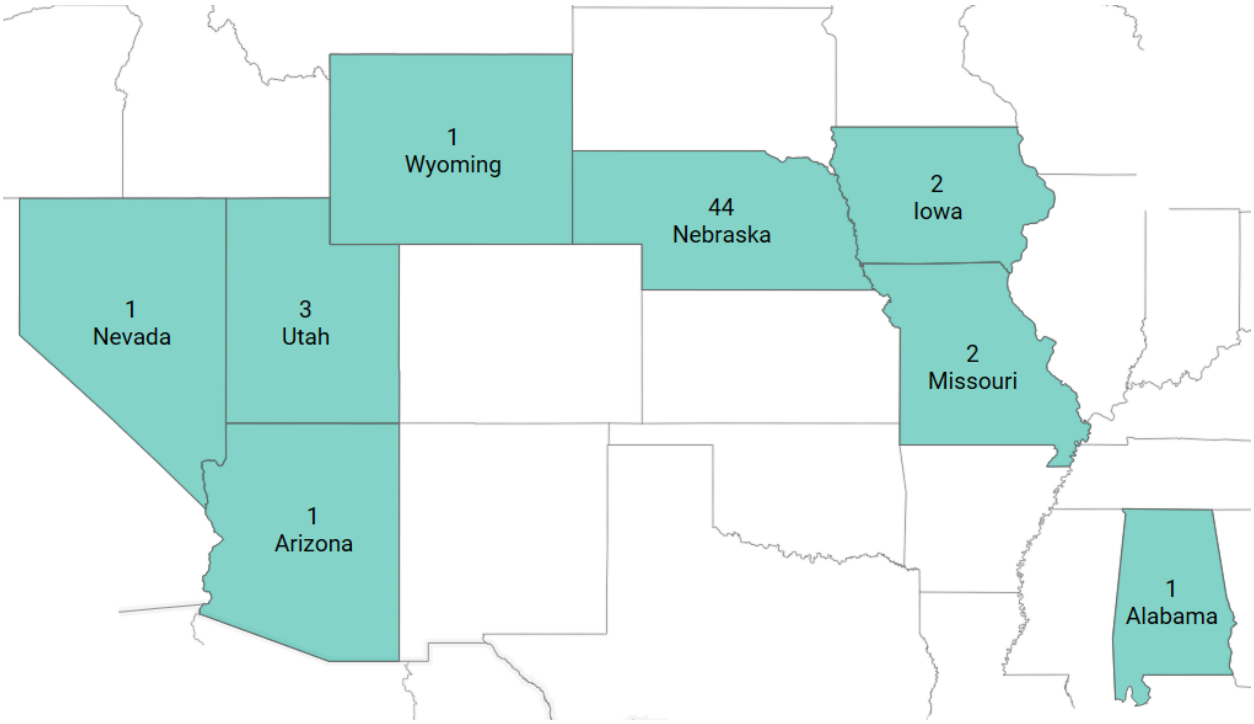
Placement Types. On 12/31/2024:

- 49.6% were in family-like settings (relative, kin, or non-relative foster care).
- 13.5% were in a corrections related placement.
- 11.3% were in non-treatment congregate care, excluding corrections related placements (see above).
- 8.5% were in treatment congregate care.
- 6.4% were missing from care.
- 5.7% were in emergency placements.
- 4.3% were in independent living.
- 0.7% were on a trial home visit.

Missing from Care. On 12/31/2024, there were nine dually involved youth missing from care. Of the missing youth, three were female and six were male.

Congregate Care. Most (80.0%) dually involved youth in congregate care were placed in Nebraska.

Figure 29: Placement State for Dually Involved Youth in Congregate Care on 12/31/2024, n=55



PROBATION YOUTH

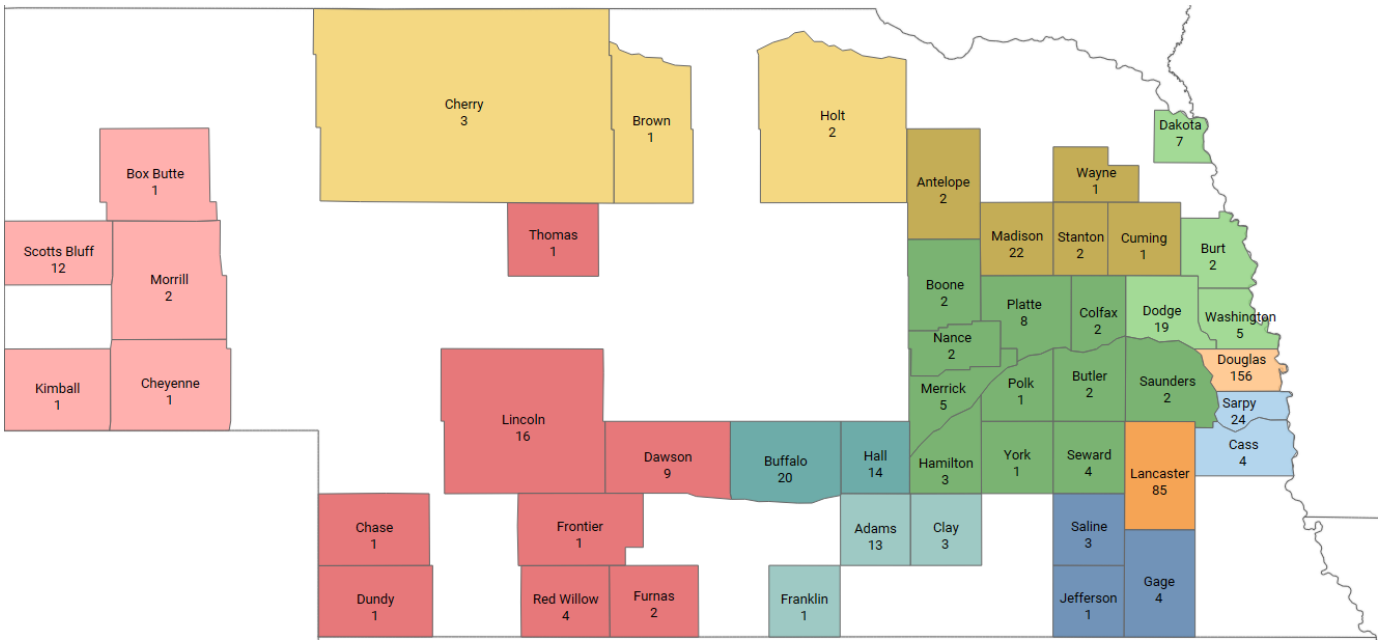
YOUTH IN OUT-OF-HOME CARE SUPERVISED BY THE ADMINISTRATIVE OFFICE OF THE COURTS AND PROBATION – JUVENILE SERVICES DIVISION

This section includes point-in-time data for court-involved youth in out-of-home care for Probation only supervised youth.

POINT-IN-TIME DEMOGRAPHICS AND PLACEMENTS

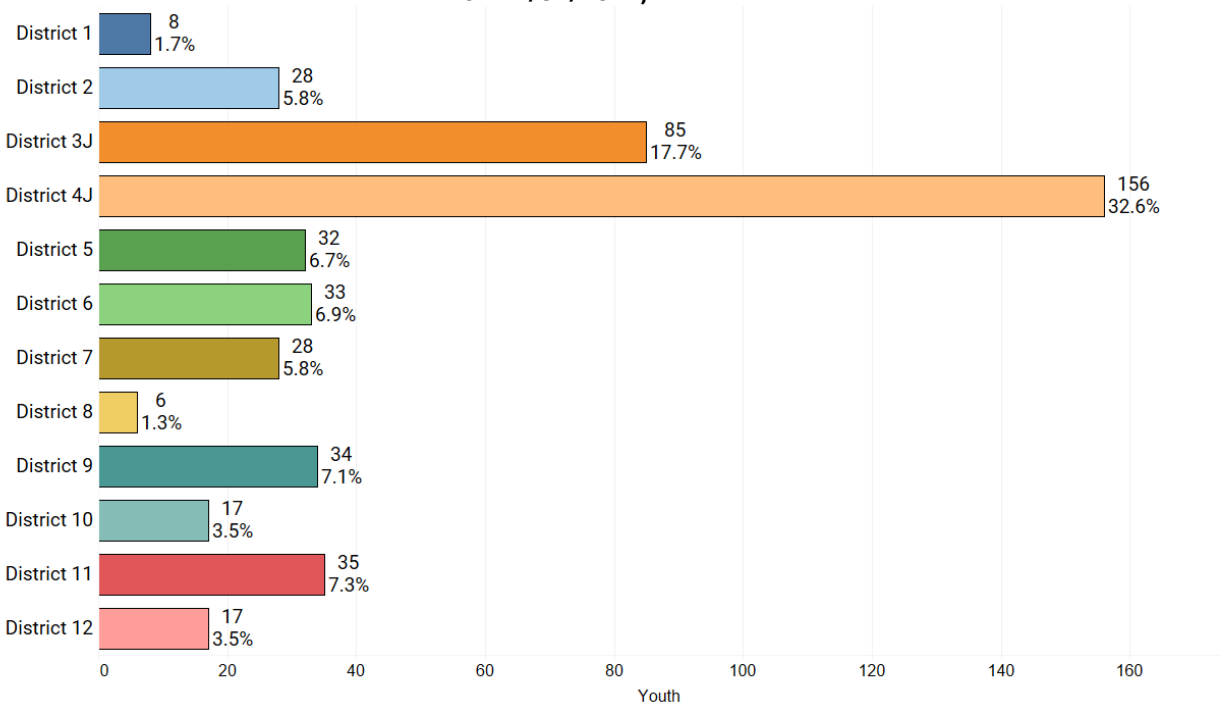
***County*.** Figure 30 shows the county of court jurisdiction for Probation supervised youth in out-of-home care on 12/31/2024, based on the judicial district. On 12/31/2024, there were 479 youth in out-of-home care supervised by Probation compared to 483 on 12/31/2023, a 0.8% decrease. (See Appendix A for a list of counties and their respective districts).

Figure 30: County of Court Jurisdiction for Probation Supervised Youth in Out-of-Home Care on 12/31/2024, n=479



*Counties with no description or shading did not have any youth in out-of-home care under Probation supervision. These are predominately counties with sparse populations of children and youth. Youth who received services in the parental home without experiencing a removal and youth placed directly with a non-custodial parent are not included as they are not within the FCRO's authority to track or review.

Figure 31: Probation Districts for Probation Supervised Youth in Out-of-Home Care or a Trial Home Visit on 12/31/2024, n=479



Age. The median age of Probation supervised youth in out-of-home care on 12/31/2024 was 16 years old for both males and females.

- 5 (1.0%) were age 11-12.
- 68 (14.2%) were age 13-14.
- 226 (47.2%) were age 15-16.
- 180 (37.6%) were age 17-18.

Gender. Males were 70.6% of the population of Probation supervised youth in out-of-home care, females were 29.4%.

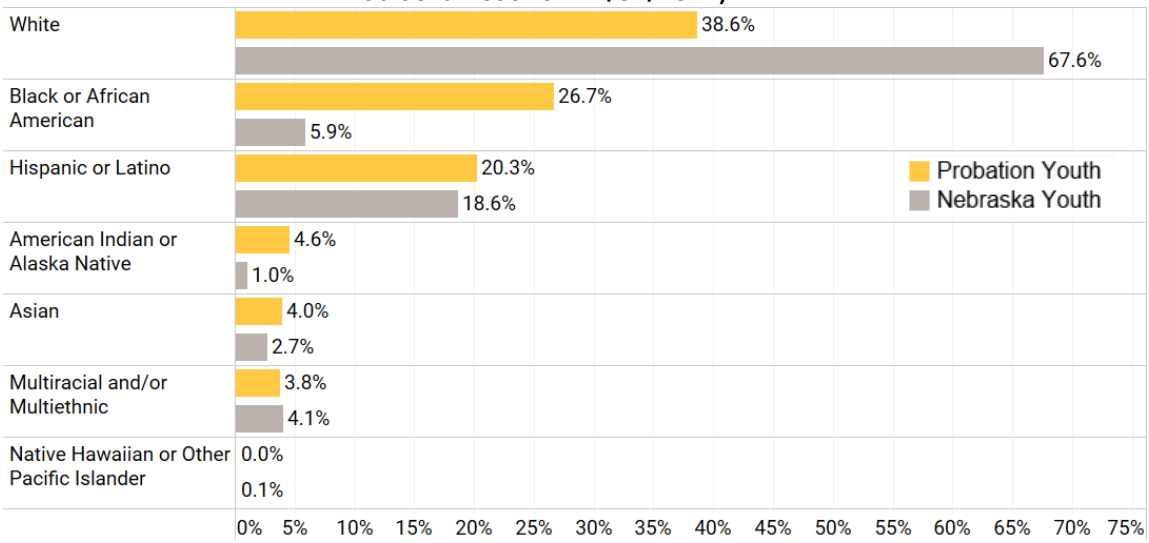
Race. Black or African American and American Indian or Alaska Native youth were disproportionately represented in the population of Probation supervised youth in out-of-home care.

- As shown in Figure 32, Black or African American youth make up 5.9% of Nebraska's youth population but represent 26.7% of the Probation supervised youth in out-of-home care.
- American Indian or Alaska Native youth are just 1.0% of Nebraska's youth population, but 4.6% of the Probation supervised youth in out-of-home care.[68]

The disproportionality for Black or African American youth has increased 4.5% and the disproportionality for American Indian or Alaska Native youth has slightly decreased from the previous year (22.2% and 7.0%, respectively).

[68] The number of American Indian or Alaska Native youth in out-of-home care while on probation does not include those involved in Tribal Court.

Figure 32: Race and Ethnicity of Probation Supervised Youth in Out-of-Home Care Compared to Nebraska Youth on 12/31/2024, n=479

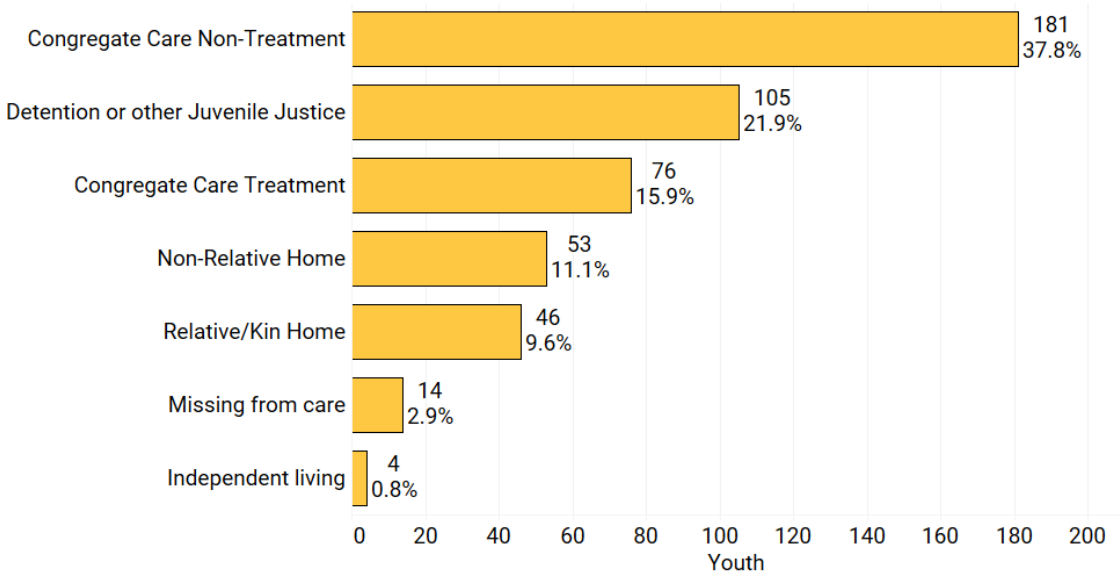


Times in Care Over Lifetime. The average number of times in care over their lifetime for Probation supervised youth as of 12/31/2024 was 2.1.

Median Length of Stay. For those in care on 12/31/2024, the median number of days in care for Probation supervised youth was 161 days.

Placement Type. Probation supervised youth in out-of-home care were most frequently placed in a non-treatment group care facility (Figure 33). Of note, 21.9% were in a detention-type setting and only 15.9% were in a treatment facility.

Figure 33: Probation Supervised Youth in Out-of-Home Care on 12/31/2024 by Placement Type, n=479

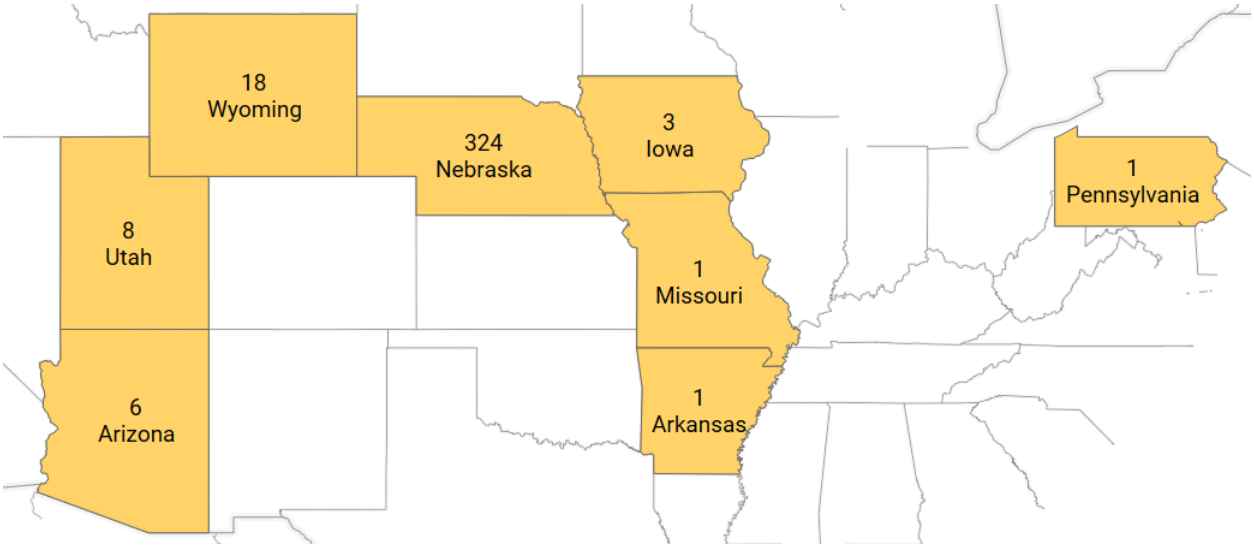


Number of Placements. The average number of lifetime placements as of 12/31/2024 for Probation supervised youth was 5.0 placements.

Missing from Care. On 12/31/2024, there were 14 Probation supervised youth missing from care. Of the missing youth, four were female and 10 were male.

Congregate Care. Comparing 12/31/2024 to 12/31/2023, there was a 0.3% decrease in the number of Probation supervised youth placed in congregate care facilities (362 and 363, respectively). On 12/31/2024, 89.5% were placed in Nebraska.

Figure 34: Probation Supervised Youth in Congregate Care on 12/31/2024 by State of Placement, n=362



YRTC YOUTH

YOUTH PLACED AT THE YOUTH REHABILITATION AND TREATMENT CENTERS

This section includes point-in-time data for youth placed at a Youth Rehabilitation and Treatment Center (YRTC). There are currently three YRTC facilities in the state; they are located in Lincoln, Hastings, and Kearney. Data describes population trends, snapshot distributions, and point-in-time data for youth at the YRTCs.

Over the past few years, the YRTC system has gone through some substantial changes, including to the program, the educational structure, and even the physical locations. While some changes were in response to COVID-19, other changes were aimed to improve the programs within the YRTC system. Only the most pertinent measures are included in this section.

POINT-IN-TIME DEMOGRAPHICS

County. On 12/31/2024, there were 99 youth involved with OJS and Probation; 91 of these youth were placed at a YRTC. Of the eight remaining youth not at a YRTC, six were placed at a detention center or juvenile justice facility, one was in a foster family home, and one was missing from care. Figure 35 illustrates the county of court of each of the 91 youths placed at a YRTC.

Figure 35: Youth Placed by a Juvenile Court at a YRTC on 12/31/2024 by County of Court, n=91

*Counties with no shading had no youth at one of the YRTCs on that date.

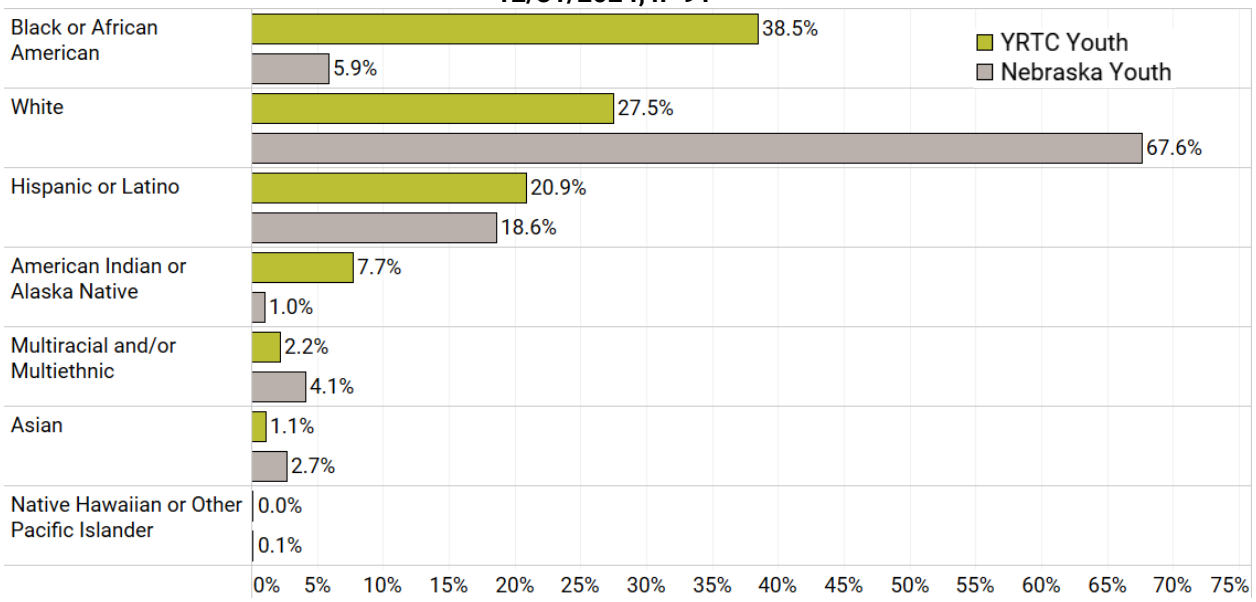
Age. By law, youth placed at a YRTC range in age from 14 to 18. On 12/31/2024, the median age for both males and females was 16 years old.

Gender. On 12/31/2024, there were 76 males, and 15 females placed at a YRTC.

Race and Ethnicity. Youth of color are disproportionately represented at the YRTCs. In particular:

- Black or African American and American Indian or Alaska Native youth were disproportionately represented in the YRTC population on 12/31/2024.
    - Black or African American youth make up 5.9% of Nebraska's youth population but were 38.5% of the YRTC population on 12/31/2024. This is an overrepresentation of more than six times their census population.
    - American Indian or Alaska Native youth make up only 1.0% of Nebraska's youth population but were 7.7% of the YRTC population on 12/31/2024, meaning they are overrepresented by almost eight times their census population.

Figure 36: Race and Ethnicity of Youth Placed at a YRTC Compared to Nebraska Youth on 12/31/2024, n=91



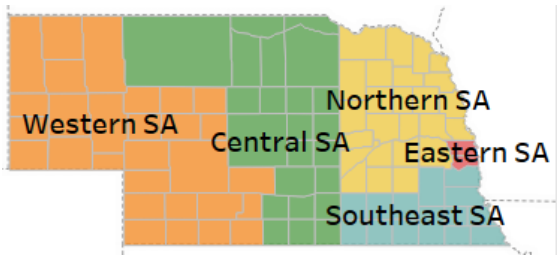
Times in Care Over Lifetime. The average number of times in care over their lifetime for youth at a YRTC on 12/31/2024 was 2.7.

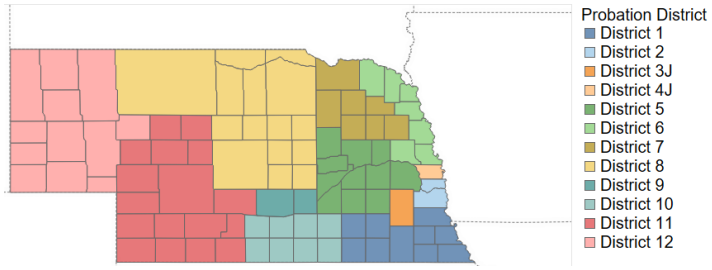
Median Length of Stay. For those in care on 12/31/2024, the median number of days in care for youth at a YRTC was 393 days.

Number of Placements. The average number of placements over their lifetime for youth at a YRTC on 12/31/2024 was 9.7.

Appendix A

County to DHHS Service Area and Judicial (Probation) District[69]





County	DHHS Service Area	Probation District
Adams	Central SA	District 10
Antelope	Northern SA	District 7
Arthur	Western SA	District 11
Banner	Western SA	District 12
Blaine	Central SA	District 8
Boone	Northern SA	District 5
Box Butte	Western SA	District 12
Boyd	Central SA	District 8
Brown	Central SA	District 8
Buffalo	Central SA	District 9
Burt	Northern SA	District 6
Butler	Northern SA	District 5
Cass	Southeast SA	District 2
Cedar	Northern SA	District 6
Chase	Western SA	District 11
Cherry	Central SA	District 8
Cheyenne	Western SA	District 12
Clay	Central SA	District 10
Colfax	Northern SA	District 5
Cuming	Northern SA	District 7
Custer	Central SA	District 8

County	DHHS Service Area	Probation District
Dakota	Northern SA	District 6
Dawes	Western SA	District 12
Dawson	Western SA	District 11
Deuel	Western SA	District 12
Dixon	Northern SA	District 6
Dodge	Northern SA	District 6
Douglas	Eastern SA	District 4J
Dundy	Western SA	District 11
Fillmore	Southeast SA	District 1
Franklin	Central SA	District 10
Frontier	Western SA	District 11
Furnas	Western SA	District 11
Gage	Southeast SA	District 1
Garden	Western SA	District 12
Garfield	Central SA	District 8
Gosper	Western SA	District 11
Grant	Western SA	District 12
Greeley	Central SA	District 8
Hall	Central SA	District 9
Hamilton	Northern SA	District 5
Harlan	Central SA	District 10

[69] District boundaries in statute effective July 20, 2018, Neb. Rev. Stat. §24-301.02. DHHS service areas per Neb. Rev. §Stat. 81-3116.

County	DHHS Service Area	Probation District
Hayes	Western SA	District 11
Hitchcock	Western SA	District 11
Holt	Central SA	District 8
Hooker	Western SA	District 11
Howard	Central SA	District 8
Jefferson	Southeast SA	District 1
Johnson	Southeast SA	District 1
Kearney	Central SA	District 10
Keith	Western SA	District 11
Keya Paha	Central SA	District 8
Kimball	Western SA	District 12
Knox	Northern SA	District 7
Lancaster	Southeast SA	District 3J
Lincoln	Western SA	District 11
Logan	Western SA	District 11
Loup	Central SA	District 8
Madison	Northern SA	District 7
McPherson	Western SA	District 11
Merrick	Northern SA	District 5
Morrill	Western SA	District 12
Nance	Northern SA	District 5
Nemaha	Southeast SA	District 1
Nuckolls	Central SA	District 10
Otoe	Southeast SA	District 1
Pawnee	Southeast SA	District 1
Perkins	Western SA	District 11
Phelps	Central SA	District 10
Pierce	Northern SA	District 7
Platte	Northern SA	District 5
Polk	Northern SA	District 5
Red Willow	Western SA	District 11
Richardson	Southeast SA	District 1

County	DHHS Service Area	Probation District
Rock	Central SA	District 8
Saline	Southeast SA	District 1
Sarpy	Eastern SA	District 2
Saunders	Northern SA	District 5
Scotts Bluff	Western SA	District 12
Seward	Northern SA	District 5
Sheridan	Western SA	District 12
Sherman	Central SA	District 8
Sioux	Western SA	District 12
Stanton	Northern SA	District 7
Thayer	Southeast SA	District 1
Thomas	Western SA	District 11
Thurston	Northern SA	District 6
Valley	Central SA	District 8
Washington	Northern SA	District 6
Wayne	Northern SA	District 7
Webster	Central SA	District 10
Wheeler	Central SA	District 8
York	Northern SA	District 5

Appendix B

Glossary of Terms and Acronyms

Adjudication is the process whereby a court establishes its jurisdiction for continued intervention in the family's situation. Issues found to be true during the court's adjudication hearing are to subsequently be addressed and form the basis for case planning throughout the remainder of the case. Factors adjudicated by the court also play a role in a termination of parental rights proceeding should that become necessary.

AILA is an Approved Informal Living Arrangement for children who are involved with DHHS/CFS and placed in out-of-home care voluntarily by their parents. AILA cases are not court-involved.

Child is defined by statute [Neb. Rev. Stat. §43-245(2)] as being age birth through eighteen; in Nebraska a child becomes a legal adult on their 19th birthday.

Congregate care includes non-treatment group facilities, facilities that specialize in psychiatric, medical, or juvenile justice related issues, and group emergency placements.

Court refers to the Separate Juvenile Court or County Court serving as a Juvenile Court. Those are the courts with jurisdiction for cases involving child abuse, child neglect, and juvenile delinquency.

Delinquency refers to offenses that constitute criminal behavior in adults – misdemeanors, felonies, or violations of a city ordinance.

DHHS/CFS is the Nebraska Department of Health and Human Services Division of Children and Family Services. DHHS/CFS serves children with state involvement due to abuse or neglect (child welfare).

DHHS/OJS is the Department of Health and Human Services (DHHS) Office of Juvenile Services. **OJS** oversees the **YRTCs**, which are the Youth Rehabilitation and Treatment Centers for delinquent youth.

Disproportionality/overrepresentation refers to instances where the rate of what is measured (such as race or gender) in the foster care population significantly differs from the rate in the overall population of Nebraska's children.

Dually involved youth are court-involved youth in care through the child welfare system (DHHS/CFS) simultaneously supervised by the Administrative Office of Courts and Probation - Juvenile Services Division.

Episode refers to the period between removal from the parental home and the end of court action. There may be THV placements during this time.

FCRO is the Foster Care Review Office, the author of this report.

Guardian Ad Litem (GAL) is to "stand in lieu of a parent of a protected juvenile who is the subject of a juvenile court petition…" and "shall make every reasonable effort to become familiar with the needs of the protected juvenile which shall include…consultation with the juvenile." according to Neb. Rev. Stat. §43-272.01.

ICWA refers to the Indian Child Welfare Act.

Kinship home. Per Neb. Rev. Stat. §71-1901(7) "kinship home" means a home where a child or children receive out-of-home care and at least one of the primary caretakers has previously lived with or is a trusted adult that has a preexisting, significant relationship with the child or children or a sibling of such child or children as described in Neb. Rev. Stat. §43-1311.02(8).

Missing from care includes children and youth whose whereabouts are unknown. Those children are sometimes referred to as runaways and are at a much greater risk for human trafficking.

n= refers to the number of individuals represented within the dataset.

Neglect is a broad category of serious parental acts of omission or commission resulting in the failure to provide for a child's basic physical, medical, educational, and/or emotional needs. This could include a failure to provide minimally adequate supervision.

Normalcy includes extracurricular, or other enrichment and fun activities designed to give any child the skills that will be useful as adults, such as strengthening the ability to get along with peers, leadership skills, and skills common for hobbies such as those in 4-H, choir, band, scouts, athletics, etc.

Out-of-home (OOH) care is 24-hour substitute care for children placed away from their parents or guardians and for whom a state agency has placement and care responsibility. This includes but is not limited to, foster family homes, foster homes of relatives or kin, group homes, emergency shelters, residential treatment facilities, child-care institutions, pre-adoptive homes, detention facilities, youth rehabilitation facilities, and children missing from care. It includes court-ordered placements only unless noted.

> The FCRO uses the term "out-of-home care" to avoid confusion because some researchers and groups define "**foster care**" narrowly as only care in foster family homes, while the term "**out-of-home care**" is broader.

Probation is a shortened reference to the Administrative Office of the Courts and Probation – Juvenile Services Division. Geographic areas under Probation are called districts.

Psychotropic medications are drugs prescribed with the primary intent to stabilize or improve mood, behavior, or mental illness. There are several categories of these medications, including antipsychotics, antidepressants, anti-anxiety, mood stabilizers, and cerebral/psychomotor stimulants.[70,71]

Relative placement. Neb. Rev. Stat. §71-1901(9) defines "relative placement" as one in which the foster caregiver has a blood, marriage, or adoption relationship to the child or a sibling of the child; and for American Indian children they may also be an extended family member per the child's Tribe's definition of extended family.

Structured Decision Making (SDM) is a proprietary set of evidence-based assessments that DHHS/CFS used to guide decision-making. Per the CFS Field Guidance on Assessments of Family, made effective December 1, 2023; previously used SDM assessments are no longer required.

Service Area (SA) is the geographic region within the state of Nebraska responsible for DHHS wards. The service areas are broken out as Central, Eastern, Northern, Southeast, and Western. Counties in each are listed in Appendix A.

SFA is the federal Strengthening Families Act. Among other requirements for the child welfare system, the Act requires courts to make certain findings during court reviews.

Siblings are children's brothers and sisters, whether full, half, or legal.

System Oversight Specialists (SOS) are FCRO staff members that perform reviews, facilitate board meetings, and work directly with volunteers who provide recommendations to the court for each individual child reviewed in out-of-home care.

Status offense is a term that applies to conduct that would not be considered criminal if committed by an adult, such as truancy or leaving home without permission.

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[70] American Academy of Child and Adolescent Psychiatry. February 2012. "A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents. Available at: https://www.aacap.org/App_Themes/AACAP/docs/press/guide_for_community_child_serving_agencies_on_psychotropic_medications_for_children_and_adolescents_2012.pdf

[71] State of Florida Department of Children and Families Operating Procedure. October 2018. "Guidelines for the Use of Psychotherapeutic Medications in State Mental Health Treatment Facilities." Available at: https://www.myflfamilies.com/sites/default/files/2022-12/cfop_155-01_guidelines_for_the_use_of_psychotherapeutic_medications_in_state_mental_health_treatment_facilities.pdf

Termination of Parental Rights (TPR) is the most extreme remedy for parental deficiencies. With a TPR, parents lose all rights, privileges, and duties regarding their children and children's legal ties to the parent are permanently severed. Severing parental ties can be extremely hard on children, who in effect become legal orphans; therefore, in addition to proving one or more of the grounds enumerated in Neb. Rev. Stat. §43-292, it requires proof that the action is in the children's best interests.

Trial home visits (THV) by statute are a temporary placement with the parent from which the child was removed and during which the Court and DHHS/CFS remain involved. This applies only to DHHS wards, not to youth who are only under Probation supervision.

Youth is a term used by the FCRO in deference to the developmental stage of children involved with the juvenile justice system and older children involved in the child welfare system.

Appendix C

The Foster Care Review Office

The Foster Care Review Office (FCRO) celebrated 42 years of service on July 1, 2024. The FCRO is the independent state agency responsible for overseeing the safety, permanency, and well-being of children in out-of-home care in Nebraska. Through a process that includes case reviews, data collection and analysis, and accountability, we are the authoritative voice for all children and youth in out-of-home care.

Mission. Ultimately, our mission is for the recommendations we make to result in meaningful change, great outcomes, and hopeful futures for children and families.

Data. Tracking is facilitated by the FCRO's independent data system, through collaboration with our partners at DHHS and the Administrative Office of the Courts and Probation. Every episode in care, placement change, and caseworker/probation officer change is tracked; relevant court information for each child is gathered and monitored; and data relevant to the children reviewed is gathered, verified, and entered into the data system by FCRO staff. This allows us to analyze large scale system changes and select children for citizen review based on the child's time in care and certain upcoming court hearings.[72]

Once a child is selected for review, FCRO System Oversight Specialists track children's outcomes and facilitate citizen reviews. Local board members, who are community volunteers who have successfully completed required initial and ongoing instruction, conduct case file reviews, and make required findings.[73]

Oversight. The oversight role of the FCRO is two-fold. During each case file review, the needs of each specific child are reviewed, the results of those reviews are shared with the legal parties on the case, and if the system is not meeting those needs, the FCRO will advocate for the best interest of the individual child. Simultaneously, the data collected from every case file review is used to provide a system-wide view of changes, successes, and challenges of the complicated worlds of child welfare and juvenile justice.

Looking forward. The recommendations in this report are based on the careful analysis of the FCRO data. The FCRO will continue to tenaciously make recommendations and to repeat unaddressed recommendations as applicable, until Nebraska's child welfare and juvenile justice systems have a stable, well-supported workforce that utilizes best practices and a continuum of evidence-based services accessible across the state, regardless of geography.

[72] Data quoted in this report are from the FCRO's independent data tracking system and FCRO completed case file reviews unless otherwise noted.

[73] Children and youth are typically reviewed at least once every six months for as long as they remain in care.

ADDITIONAL INFORMATION IS AVAILABLE

The Foster Care Review Office can provide additional information on many of the topics in this Report. For example, much of the data previously presented can be further divided by judicial district, DHHS/CFS service area, county of court involved in the case, and various demographic measures.

Some of the most requested data is publicly accessible with easy-to-use sort and limitation features at the FCRO's data dashboard:

https://fcro.nebraska.gov/data_dashboards.html

If you are interested in more data on a particular topic, or would like a speaker to present on the data, please contact us with the specifics of your request at:

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