Kids Count IN NEBRASKA

2009 REPORT

A PUBLICATION OF VOICES FOR CHILDREN IN NEBRASKA

Credits

Cover Photo

Jaxon, 1 year old

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All children and families pictured in this report

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Wells Fargo

Kids Count 2009

KIDS COUNT is a national and state-by-state effort sponsored by The Annie E. Casey Foundation to track the status of children in the United States by utilizing the best available data. Key indicators measure the educational, social, economic and physical well-being of children.

Kids Count in Nebraska is a children's data and policy project of Voices for Children in Nebraska. An important component of this project is the Technical Team of Advisors who provide data and expertise on child well-being in Nebraska. The Kids Count Technical Team, comprised of representatives from numerous agencies and organizations in Nebraska, maintains important information about child well-being, and other research experts. We could not produce this report without their interest and cooperation and the support of their agencies. **Kids Count in Nebraska**, sponsored by The Annie E. Casey Foundation, began in 1993. This is the project's seventeenth report in Nebraska. Additional funding for this report comes from Wells Fargo and Dr. Thomas Tonniges and Jane Tonniges.

Kids Count photographs featured are all Nebraska children. Several issues and programs may be discussed in a particular section. Children featured in each section may not be directly involved with any or all programs or issues discussed therein.

Additional copies of the **2009 Kids Count in Nebraska** report, as well as reports from 1993 through 2008, are available for $11.00 from:

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Table of Contents

List of Figures and Tables

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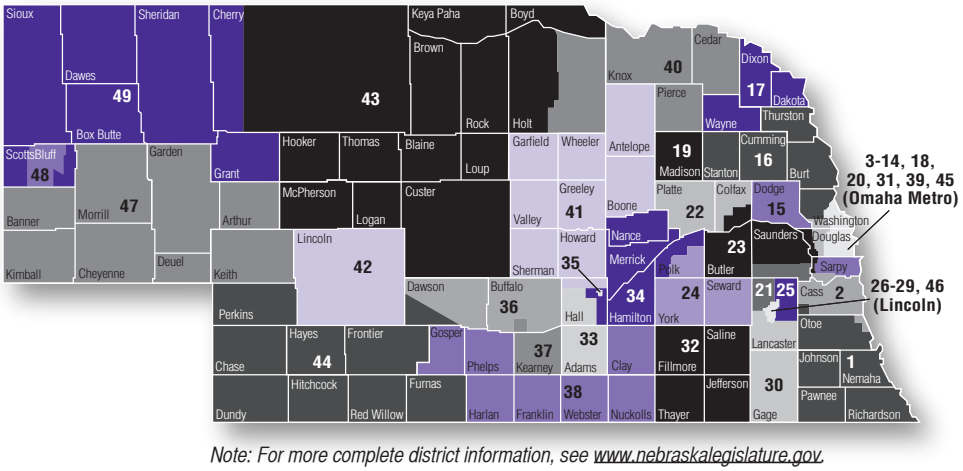

Note: For more complete district information, see www.nebraskalegislature.gov.

Using County Data and the KIDS COUNT Data Center

Kids Count County-Level Fact Sheets

To view child well-being data specific to your county, visit www.voicesforchildren.com. From the homepage, select What We Do, then Kids Count and Data. Next, select County Data.

County-Level Comparisons, Rankings, Line-Graphs, Maps

The KIDS COUNT Data Center, formerly known as CLIKS (Community-Level Information on Kids), provides comprehensive data on the well-being of children collected by *Kids Count in Nebraska* and other grantees across the nation. The system allows users to create profiles of counties and states, generate graphs, maps and ranking tables. All these tools are also available to create comparative profiles of cities and

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Nebraska Legislature

Visit www.nebraskalegislature.gov to view the legislative calendar, read bills, listen live and more. For additional details on Voices priority bills, visit www.voicesforchildren.com. From the homepage, click on What We Do, then Policy, and finally Legislative Agenda.

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states. The KIDS COUNT Data Center is free and easy to use.

How KIDS COUNT Data Center Can Benefit You

- Strengthen the needs assessment portion of grant proposals
- Assess communities
- Create community/state comparisons
- Promote community awareness

How to Access KIDS COUNT Data Center

1. Visit the Voices for Children in Nebraska homepage at www.voicesforchildren.com
2. Select What We Do, then Kids Count and Data, and then Data Center.

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Children in Immigrant Families

Introduction

Voices for Children in Nebraska believes that all children, regardless of the color of their skin, their social or economic status, or the country in which their parents or they themselves were born, should have access to the values and opportunities which we believe help children grow into productive and healthy adults. All children deserve a welcoming and supporting community that offers opportunity for healthy development and education, equal access to public support and justice for their families. However, these shared values are not available for all. Many children in immigrant families, whether they are residing in this country legally or not, are separated from these values of community, opportunity, equality and justice due to the polarizing politics of the immigration debate in this country. A number of other challenges unique to children in immigrant families, such as limited English-proficiency and difficulties with parental citizenship and employment further limit opportunity for immigrant children. Children do not make the decisions about where to grow up, and it is unacceptable and unproductive to punish children for their parent's choices by depriving them of the values and opportunities that we believe all children in Nebraska should have.

As Americans, how quickly we forget that we are largely a nation of immigrants. Our country has been founded upon an openness to those of diverse cultures and countries of origin who have come to the United States seeking a better life than the one they left. The majority of Americans can trace their family trees to their ancestors who first set foot on American soil, and there is a great sense of pride and love of this country that has developed from this sense of history. Unfortunately, the polarizing and unproductive nature of the immigration debate in the last decade has created a cognitive dissonance for many Americans between immigrants of "old" and "new."

Immigrant families have always been and continue to be an important part of the social and economic fabric of the state of Nebraska and our nation as a whole. Immigrant families are boosting our state's population, particularly in

rural areas of Nebraska where the vibrancy of communities had been slowly deteriorating. Immigrant families are building our workforce, creating jobs through their entrepreneurial spirit and strong work ethic, and they are building our tax base. They are revitalizing our communities by contributing to our schools, churches and neighborhoods and offer the diversity of skills, experiences, and strong family values to our society.

As we face a changing population today in Nebraska and throughout the country, it is critically important to continue to build on the strengths and values that immigrant families bring to our communities, our state, and our country. Studies indicate that more than one out of every five children in America, more than 16 million children, are living in immigrant families.[1] Since 1990, the foreign-born population in Nebraska has grown faster than the national average. By identifying viable integration strategies, Nebraska can benefit from the strong work ethic, diversity of talent, family values and tax contribution of immigrant families. We believe that a diverse population brings a variety of strengths and perspectives upon which to build a foundation for healthy, strong and vibrant communities across our state. Proactive and productive strategies of integration are necessary now, since only those states capable of managing the power of diversity in employment, education and the economy are likely to be successful in moving their communities forward.

Promoting positive outcomes for children in immigrant families is critical given that they are among the fastest growing segment of America's youth and will represent a large portion of our future labor force. Children in immigrant families face significant barriers to being part of a community that welcomes and cares for them. They face barriers to opportunity in their educational experiences, in their economic well-being, and in their interaction with a number of other systems in which outcomes are influenced by the color of one's skin and where youth of color generally fare worse than White youth. Children in immigrant families face other barriers to opportunity above and beyond what other kids of color experience. It is important to emphasize that children in immigrant families face not only universal risk factors such as low family income and lack of parental education, but are also adversely affected by factors unique to immigrant families, such as limited English language proficiency and lack of parental citizenship.[2]

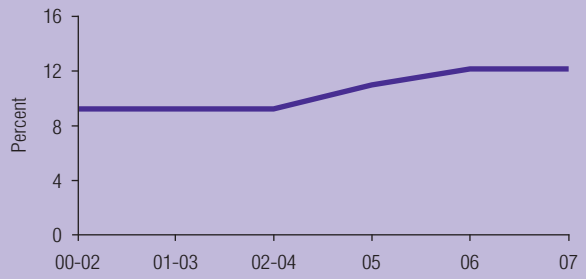
State Level Data on the Well-Being of Immigrant Children in Nebraska

The *Kids Count in Nebraska 2009 Report* commentary addresses the key social and economic challenges facing children in immigrant families and reports state level data, as available. The main sources of data are The Annie E. Casey Foundation's KIDS COUNT Data Center, Population Reference Bureau and the American Community Survey for 2005, 2006 and 2007. The most recent data available on immigrant children are from 2007. However, in some instances 2007 data for Nebraska has been suppressed due to low confidence intervals, therefore we are reporting 2006 data.[3]

Demographic Information

In 2007, there were a total of 52,000 children in immigrant families in Nebraska, nearly 12% of all Nebraska children (Figure 1.1).[4] Immigrant children are defined as 'the share of children under age 18 who are foreign-born or have at least one foreign-born parent.'[5] When we refer to immigrant children, we make no assumptions about citizenship. However, it is important to note that 85%, or more than four out of five children in immigrant families in Nebraska, are U.S. citizens.[6]

Figure 1.1: Children in Immigrant Families in Nebraska (2000-2002 – 2007)



Source: The Annie E. Casey Foundation, KIDS COUNT Data Center, www.kidscount.org/datacenter.

Nationally, 90% of immigrant children are legally residing citizens.[7] What is even more important to note is that more than half of the parents of children in immigrant families are U.S. citizens.[8]

Nebraska children in immigrant families have diverse national origins. The largest group of children in immigrant families in Nebraska has origins in Mexico (52%), followed by Central America (10%) and East Asia (8%).[9]

Promoting positive outcomes for children in immigrant families is critical given that they are among the fastest growing segment of America's youth (ages 0-17) and will represent a large segment of our future labor force. Ignoring the unique needs and challenges of immigrant children and depriving them of access to community, opportunity, equality and justice will threaten the well-being of thousands of children and result in higher costs to our state and our country in the future. Children who are deprived of these values are less likely to develop into successful adults and less likely to benefit our state through their skills, family values and tax contributions, among other things. Also, children in immigrant families do not exist in isolation – their well-being has an influence on all Nebraska children who interact with them in the community and therefore, an influence on us all. Voices for Children believes that immigrant families need access to opportunities to provide the best for their children, just as we believe for all other Nebraska families.

Economic Circumstances

Voices for Children believes that our children, our communities, and our state are stronger when all of Nebraska's families are able to participate fully in the workforce and establish financial stability. We believe that all children should have access to essential food, shelter, education and medical care. We also believe that all parents should have access to programs that educate them, provide assistance when needed, and encourage them to be responsive to their children's needs.

The well-being of children, regardless of their immigration status, is largely determined by their parents' circumstances. While hardship is not unique to immigrant families, it is important to emphasize that children in immigrant families face not only universal risk factors such as family income and parental education, but are also adversely affected by factors unique to immigrant families such as limited English language proficiency and lack of parental citizenship.

The driving factors behind child poverty in immigrant families are somewhat different than the perception of child poverty for America, at large. For example, poverty is often associated with single-parenthood in the United States, but this is not the experience of immigrant children. In 2007, 75% of immigrant children lived in married couple families, as opposed to 73% for children in U.S. born families in Nebraska.[10] The high poverty rate for immigrant families is driven by the large number of immigrants arriving from Latin America with limited English language proficiency, low levels of education and the predominance of low-wage employment. The type of employment available to immigrant families is important to child well-being. For all families, low wage work is insufficient to support a family's basic needs. For many immigrant families, the high child poverty rate is not a reflection of a lack of employment but rather underemployment, at jobs that pay too little and do not provide the security and benefits necessary to promote financial stability for immigrant children.

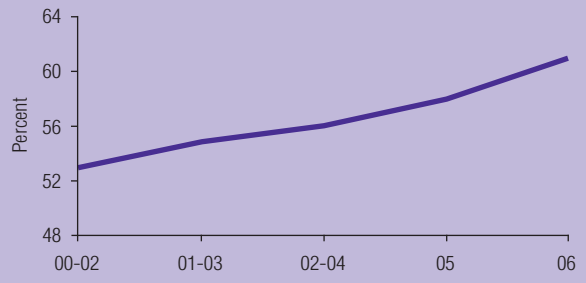
As the economic well-being of children is largely driven by their parent's circumstances, an immigrant's employment prospects in the United States are largely driven by the skills, strengths and resources provided in their country of origin and their circumstances in coming to the U.S. For instance, nationally, children of immigrants from India had among the lowest poverty rates in 2007 at around 4%, while immigrants admitted as refugees from Iraq, Somalia or Sudan had child poverty rates as high as 50%.[11] When we talk about immigrant children in general, it is important to keep in mind the diversity within the U.S. foreign-born population and the variety

of challenges that are presented by the country of origin.

The percentage of children in immigrant families living in low-income families (below 200% of federal poverty threshold) in Nebraska has been steadily increasing during the last decade (Figure 1.2).[12]

In 2006, the percentage of children in immigrant families in Nebraska living in low-income families reached 61%. Additionally, the median annual income for families with immigrant children amounted to $40,500 in 2007, compared to $59,400 in U.S. born families in Nebraska.[13] These economic indicators clearly demonstrate the challenging economic conditions children in immigrant families are facing.

Figure 1.2: Children Living in Low-income Families (Below 200% of the Poverty Threshold) by Children in Immigrant Families in Nebraska (2000-2002 – 2006)



Source: The Annie E. Casey Foundation, KIDS COUNT Data Center, www.kidscount.org/datacenter.

Economic insecurity and hardship are linked to numerous adverse outcomes that limit the opportunities and future productivity of children. Children in low-income families generally face elevated risks of low quality child care, lack of adequate nutrition, unsafe neighborhoods, being uninsured, increased interaction with the juvenile justice system and exposure to environmental toxins. Allowing these risk factors to persist for the most rapidly growing segment of our state's population will lead to a less productive future workforce for the state of Nebraska. For this reason, it is in the best interest of all Nebraskans to support programs and policies that build upon the strengths of immigrant families and ensure that immigrant children have access to the same opportunities we would hope for all children in our state.

English Language Proficiency, Parental Education and Lack of Parental Citizenship

Most children in immigrant families grow up in complex language environments. Since parents provide the primary environment in which children learn to speak, the language skills of parents in immigrant families have a great impact on a child's language acquisition. In 2007, 64% of children in immigrant families in Nebraska lived with parents who had difficulty speaking English.[14] Moreover, in 2006, 40% of children in immigrant families in Nebraska lived with parents of whom neither had a high school diploma or equivalent, compared to only 4% of children in U.S. born families.[15] Lower parental education and limited English language proficiency are tremendous obstacles to immigrant children's well-being, since they limit parents' ability to have secure employment, prevent them from being fully informed about the opportunities in their community and limit their involvement in their children's English-language learning. And finally, only a limited number of government agencies have a culturally competent workforce and the availability of forms and services in different languages, thus the basic benefits that are available can still be inaccessible for children in immigrant families.

Children with undocumented immigrant parents are especially vulnerable since their parents cannot be legally employed and could be deported as a result of random worksite raids that are conducted by Immigration and Customs Enforcement (ICE). These raids result in a severe psychological trauma for children, since they are separated from their parents without any explanation and are left alone without a caregiver until the state's out-of-home care system determines what to do with them. Additionally, undocumented parents are often reluctant to interact with government agencies and miss out on basic services available for their children.[16]

All the risk factors discussed above, such as low family income, minimal parental education, limited English language proficiency and lack of parental citizenship demonstrate the importance of reducing language and literacy barriers for children in immigrant families. Parents' access to

education and language learning courses will ensure improvement in families' economic circumstances by expanding job opportunities and increasing access to public benefits, thus providing children with better opportunities to succeed.

Early Childhood Care and Education

Another significant factor for children's success is early childhood education. Children learn more during their early childhood years than during any other time in their lives. Early experiences create the foundation upon which future success and productivity of a child is built. Toxic stress, such as family tension, weakens this foundation and has a negative impact on a child's intellectual, social and emotional development. Therefore it is critical to invest in children's early childhood care and education so they may later return that investment as productive contributors to our society.

Data on early childhood program enrollment among children in immigrant families in Nebraska are not available, but on the national level children in immigrant families are less likely than children in U.S.-born families to be enrolled in pre-k/nursery schools. Nationally, immigrant groups that tend to have lower enrollment than Whites in U.S.-born families, are children in immigrant families from Mexico and Central America.[17] Since 52% of children in immigrant families in Nebraska have Mexican origins and 10% have origins in Central America, low enrollment is a likely concern in Nebraska.

Often, cultural preferences are cited as a reason for lower enrollment in early education programs, particularly among Hispanics. However, recent research indicates that socioeconomic barriers are also responsible for this gap.[18] One Nebraska program that provides early education services specifically targeted for children in immigrant families is the School Readiness Program in Omaha. This program is a unique collaboration between Heartland Family Services and the YMCA, funded by United Way of the Midlands. The program provides a culturally competent environment and assists parents in preparing their young children for the challenges of entering an American school. The details of the program are highlighted in the impact box below.

Policy Circumstances for Immigrants in Nebraska

Despite very real unmet economic and educational needs and distinct barriers to success for immigrant children, our

IMPACT BOX

School Readiness Program for International Families

By Joanna Lindberg
Community Education Program Director, Heartland Family Services

Omaha is home to a large international community with an estimated population of 10,000 Sudanese; 2,000 Somali and Somali-Bantu; 2,000 Burmese Karen and many others. Upon arrival to the United States, these families are faced with numerous challenges. The School Readiness Program, a unique collaboration between Heartland Family Services and the YMCA, funded by United Way of the Midlands, assists parents to prepare their young children for the challenges of entering an American school. For many of our families, this is the first time anyone in their family has had an opportunity to get an education. We work with the entire family to ensure not only that the child is ready for school, but that the parents and caregivers have an understanding of the expectations as well.

Research indicates that children with a broad range of learning experiences before they enter kindergarten are more successful in school. Through training with parents, group activities with children and field trips for families, this program, in the first nine months, has uncovered a new world for more than 100 families with children ages 3-6 years. Cultural ambassadors interpret and provide educational support to families in their native language. Training is provided on school readiness skills, literacy concepts and family wellness. A holistic approach addresses separation anxiety and incorporates socialization skills along with educational goals.

Our programs serve various populations throughout the city at times

policies toward immigrant children in our state and in our country have not always been in the best interests of all children. Tolerant and forward-thinking policy would implement strategies designed to build upon and manage the power of the diversity of skills, strengths and resources that immigrants bring to our state. As immigrant families make up an even greater portion of our current and future workforce, our state would only benefit by ensuring that the future generations of Nebraskans have every opportunity to grow into productive adults.

To the detriment of our progress as a nation, our public policy has been strongly influenced by the polarizing nature of the immigration debate. While undocumented immigrants have always been barred from accessing the great majority of our country's social safety net, we find that policies have become increasingly exclusionary and restrictive, even for those legally residing in our country, and the requirements of documentation have become so great as to hinder even U.S. born residents from accessing them. These policies have largely been driven by politics. There is very little data to indicate that undocumented persons are accessing the social safety net programs to any significant degree. In fact, many would argue that undocumented persons avoid interaction with government agencies, for fear of being discovered. So even citizen children living in such families are not accessing public benefits and services available to them.

Voices for Children in Nebraska advocates for more tolerant and humane treatment of immigrant families to ensure that all children in Nebraska, including children in immigrant families, have equal opportunities to succeed. Voices for Children supports a more balanced approach to policy that respects the skills, strengths and resources that immigrants have always contributed to this country and one that is focused on supporting the well-being of children who are growing up in this country by no choice, fault or action of their own. The great majority of these children in immigrant families are U.S. citizens and will grow up to play a part in what Nebraska will look like in the future. We want that future to be as bright and productive and rich as possible for us all. To build that future, we must build policies that support community, opportunity, equality and justice for all children in Nebraska.

An example of a policy which we fear may further isolate immigrant families in Nebraska and further hinder child

and locations convenient for them. We serve the Burmese Karen families in their homes where several families gather to take part in our weekly lessons. Parents and children are shown how to use basic supplies, like scissors and crayons, for the first time. Children practice sorting items by color, and the parents encourage the children by learning the words for red and blue in English. Currently we are serving 27 families through these home groups, which include 33 future kindergarteners.

Collaborations among community organizations are the key to the success of our daily and weekly programs, including Lutheran Refugee Services, International Center of the Heartland, Mercy Housing After-School Program, Harvest Church, Sudanese Presbyterian Church, Karen Christian Revival Church, Southern Sudan Association, and others. For example, a program is offered daily at Harvest Church where the adults take English Language Classes. Children spend two hours per day learning basic school readiness skills and practicing good social skills. On Fridays, the children bring their parents to the program, in which the family participates in learning activities together. Since educational child care is provided during the ESL classes, both parents can learn the English language, strengthening the family's ability to help their children succeed in school. Pre- and post-testing is conducted with this group of children. Currently, this single daily program serves 13 families.

In addition to our in-home groups, individual presentations and weekly program components, we also help families enroll their children into quality Early Childhood Education programs. We provide assistance with school-related paperwork, or assist them to set up academic testing if the child experiences significant delays. We offer several referrals to various other services throughout the community to ensure the health and wellness of the entire family.

well-being of immigrant children in our state is LB 403, passed in March 2009. The Nebraska Unicameral passed Legislative Bill 403 (LB 403), which went into effect on October 1, 2009. LB 403 has two distinct parts. First, LB 403 requires state agencies and political subdivisions to verify the work eligibility status of new employees. Second, LB 403 requires state agencies or political subdivisions to verify the lawful presence of applicants for public benefits.

For state and local governments, as well as those that contract with state and local governments, the new law requires using the federal E-Verify system to check the immigration status of new employees being hired after October 1, 2009. On the other hand, private organizations that do not contract with state or local governments are encouraged to use E-Verify. Those private organizations that choose not to use the E-Verify system face the possibility of losing certain Nebraska business tax incentives. The main concern with E-Verify is that the database is not completely accurate and errors can create problems for eligible workers. At the same time, registering and using the system creates an additional burden for employers and may discourage them from employing immigrants with legal work status. Moreover, this requirement is likely to lead to an increase in workplace discrimination as employers choose not to hire someone who looks like an immigrant.

The second verification requirement under LB 403 calls for state agencies and political subdivisions to verify the lawful presence of applicants for public benefits. Under federal law, most public benefits, such as Medicaid and Food Stamps, already require a verification of immigration status. In many ways, LB 403 simply reiterates the federal laws already in place regarding access to public benefits. LB 403 contains a number of exemptions in which lawful presence does not require verification, such as emergency medical care and programs necessary for the protection of life and safety. A further concern with LB 403 is its ambiguity and lack of details on how the bill will affect Nebraska's public benefit programs. Undocumented immigrants are already barred from receiving most public benefits, thus the additional requirements imposed by LB 403 are likely to further discourage even qualified individuals and families from getting help.[19]

Respecting Diversity and Enacting Policies to Foster All Children's Success

Immigrants are an important part of the social and economic fabric of the state of Nebraska and our nation as a whole. Immigrant families are boosting our population and together with other Nebraskans, revitalizing our communities, building our workforce, creating jobs through entrepreneurial spirit, contributing to our schools, churches and neighborhoods and paying taxes. Moreover, immigrants benefit our communities by offering a diversity of skills, experiences and strong family values. Interaction with immigrant children teaches Nebraska children to be more culturally sensitive, appreciative and understanding of people from other cultures.

While the federal government is working on comprehensive immigration reform, immigrant children are struggling with social isolation and language barriers, growing up in poverty and all of the risk factors this entail. Some children have loved ones with no clear legal status and have to live under a constant fear of a system that continues to separate families, divide communities and punish hardworking individuals who want to provide a better life for their children. It is our hope that the state of Nebraska and our local communities will explore ways to effectively integrate immigrants, instead of marginalizing them. This integration approach is reality based and respects the values of community, opportunity, equality and justice that we Nebraskans hold dear. It recognizes the value of immigrants and seeks to maximize the economic, social and cultural benefits immigrants bring to local communities. Since the well-being of children is determined by the well-being of their parents, unfavorable conditions of parents undermine children's potential to become healthy and productive members of the community. In advocating for children's rights in immigrant families we should remember that 85% of the Nebraska children in immigrant families are U.S.

born citizens and have known no other country to be their home.

While our state is pursuing many policies and programs that foster child development and well-being, there is a lack of understanding that such activities are just as important for children in immigrant families as for those in U.S.-born families. Voices for Children in Nebraska believes in the equal treatment of all children. Since children in immigrant families face not only universal risk factors, but are also affected by unique factors such as limited English language proficiency and lack of parental citizenship, special attention is required to assure that children in immigrant families have the same opportunities to succeed as their peers. The focus should be on English language learning, culturally competent early education programs and practical solutions to the lack of parental citizenship. Children in immigrant families deserve a reasonable and humane solutions to our broken immigration system, a solution that will uphold our values of community, opportunity, equality and justice.

[1] Mark Mather. "Children in Immigrant Families Chart New Path." Population Reference Bureau, February 2009.

[2] Karina Fortuny, Randy Capps, Margaret Simms and Ajay Chaudry. "Children of Immigrants: National and State Characteristics." Urban Institute, August 2009.

[3] The estimates from the American Community Survey (ACS) are suppressed when the total confidence interval (upper bound minus lower bound) of the percent estimate, is 10 percentage points or greater.

[4] The Annie E. Casey Foundation, KIDS COUNT Data Center, www.kidscount.org/datacenter. Data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2007 American Community Survey (ACS). Estimates for years 2000 though 2004 are presented by a series of 3-year averages--the first year 2000 to 2002, the second year 2001 to 2003 and the third year 2002 to 2004. The 2005 ACS, is the first year with an expanded sample and is presented by estimates with a single year of data.

[5] The Annie E. Casey Foundation, KIDS COUNT Data Center, www.kidscount.org/datacenter.

[6] Children in Immigrant Families in Nebraska Fact Sheet. The Center for Social and Demographic Analysis. University at Albany, SUNY.

[7] Mark Mather. "Children in Immigrant Families Chart New Path." Population Reference Bureau, February 2009.

[8] The Annie E. Casey Foundation, KIDS COUNT Data Center, www.kidscount.org/datacenter, "Children in immigrant families in which resident parents are not U.S. citizens."

[9] Children in Immigrant Families in Nebraska Fact Sheet. The Center for Social and Demographic Analysis. University at Albany, SUNY.

[10] The Annie E. Casey Foundation, KIDS COUNT Data Center, www.kidscount.org/datacenter, "Children in married-couple families by children in immigrant families."

[11] Mark Mather. "Children in Immigrant Families Chart New Path." Population Reference Bureau, February 2009.

[12] The Annie E. Casey Foundation, KIDS COUNT Data Center, www.kidscount.org/datacenter. This indicator measures the share of children under age 18 living in families whose income was less than twice the federal poverty level by children in foreign-born families. The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2006 American Community Survey (ACS). Estimates for years 2000 though 2004 are presented by a series of 3-year averages computed by PRB--the first year 2000 to 2002, the second year 2001 to 2003 and the third year 2002 to 2004. The 2005 ACS, is the first year with an expanded sample and is presented by estimates with a single year of data.

[13] The Annie E. Casey Foundation, KIDS COUNT Data Center, www.kidscount.org/datacenter, "Median family income among households with children by children in immigrant families: Children in immigrant families (Currency) – 2000-2002 to 2007."

[14] The Annie E. Casey Foundation, KIDS COUNT Data Center, www.kidscount.org/datacenter, "Children in immigrant families in which resident parents have difficulty speaking English (Percent) – 2000-2002 to 2007."

[15] The Annie E. Casey Foundation, KIDS COUNT Data Center, www.kidscount.org/datacenter, "Children whose parents all have less than a high school degree by children in immigrant families: Children in immigrant families (percent) – 2000-2002 to 2007."

[16] Pamela Holcomb, Karen Tumlin, Robin Koralek, Randy Capps and Anita Zuberi. "The Application Process for TANF, Food Stamps, Medicaid, and SCHIP: Issues for Agencies and Applicants, Including Immigrants and Limited English Speakers." 2003. Washington, DC: the Urban Institute.

[17] Children in Immigrant Families in Nebraska Fact Sheet. The Center for Social and Demographic Analysis. University at Albany, SUNY.

[18] Donald J. Hernandez, Nancy Denton and Suzanne Macartney. "Children in Immigrant Families – The U.S. and 50 States: National Origins, Language, and Early Education." Child Trends and Center for Demographic Analysis. University at Albany, SUNY, 2007 Research Brief Series.

[19] Analyses of LB403 provided by Nebraska Appleseed Center for Law in the Public Interest.

Child Abuse and Neglect / Domestic Violence

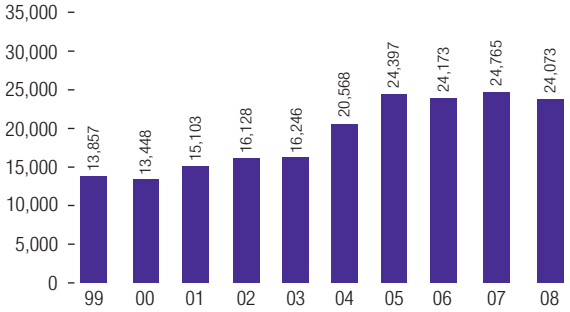
Voices for Children in Nebraska believes that all children should have protection from physical, emotional and sexual abuse, neglect and exploitation. The maltreatment of children affects those individual children, their families, their communities and our society. Violence, whether observed or directly felt by a child, can disrupt growth and development, lower self-esteem, perpetuate a cycle of violence and cause or exacerbate mental health problems. This often results in academic underachievement, violent behaviors, substance abuse and low productivity as adults.

Investigated and Substantiated Cases

Nebraska Department of Health and Human Services System (DHHS) received 29,269 calls to the Child Abuse and Neglect Hotline in 2008. Those calls included 24,073 reports of child abuse and neglect, a decrease from the 24,765 calls alleging child abuse and neglect in 2007. As demonstrated in Figure 2.1, reports alleging abuse or neglect in 2008 were at their lowest in the last four years, after peaking in 2007.

Of the 24,073 child abuse and neglect reports received in 2008, 13,460 (55.91%) were accepted for investigation, also referred to as safety assessment. This is an increase over the 13,319 reports accepted for safety assessment in 2007. From the 13,460 reports accepted for safety assessment, 12,627 assessments were completed as of April 13, 2009. The assessment process determined that from 12,627 reports for which assessment was completed, a total of 9,171 (72.63%) cases were 'safe,' 1,846 (14.62%) were 'unsafe' and 1,610 (12.75%) were undetermined. Of those assessed as 'unsafe,' 1,144 ended up as 'court involved,' 443 ended up as 'non-court involved' and 259 are pending case status determination as of April 13, 2009.

Figure 2.1: Number of Calls to Child Protective Services (CPS) for Alleged Child Abuse and Neglect (1999-2008)



Source: Nebraska Department of Health and Human Services (DHHS).

Of those 12,627 completed assessments, 3,260 reports were substantiated, a 25.82% substantiation rate. There were a total of 4,902 children (unduplicated) identified as victims in one or more of the substantiated reports. This is an increase of 462 children from 4,440 unduplicated children in 2007. Of the 4,902 victims in 2008, 51.73% (2,536) were female and 48.27% (2,366) were male. Figure 2.1, Table 2.1, and Figure 2.2 present a detailed view of abuse and neglect cases over time.

Table 2.1: Child Abuse and Neglect Cases (2004-2008)

Year	Number of Reports Alleging Child Abuse/Neglect	Child Abuse/Neglect Reports Selected for Investigation/Assessment		Number of Reports Substantiated	
		Number	Investigation Assessment Rate*	Number	Substantiation Rate**
2004	20,568	13,291	64.6%	3,336	25.1%
2005	24,397	13,897	57.0%	3,324	23.9%
2006	24,173	12,629	52.2%	3,065	24.3%
2007	24,765	13,319	53.8%	2,894	25.1%
2008	24,073	13,460	55.9%	3,260	25.8%

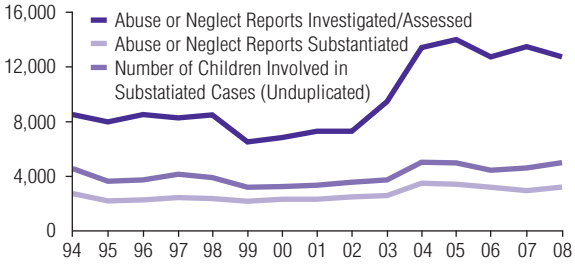
Source: Nebraska Department of Health and Human Services (DHHS)

** Investigation/Assessment Rate – Percent of reports alleging child abuse and neglect that were investigated/underwent safety assessment.*

*** Substantiation Rate – Percent of reports selected for investigsation/assessment of child abuse and neglect that were substantiated. For 2008, the number of investigations completed was 12,627. Thus, the 2008 substantiation rate was calculated using the completed investigation total, and not the total number of cases selected for investigation (3,260/12,627).*

Data show substantiated cases are more likely to involve young children. In 2008, 65.29% of the children involved as substantiated victims were ages eight and under. Children, ages three and under, represented 1,709 (34.86%) of the children involved as substantiated victims. Children aged two and under accounted for 1,359 (27.72%) of the children involved in substantiated cases. Younger children often display stronger evidence of abuse, making it more likely to be reported.

Figure 2.2: Statewide Abuse and Neglect Cases (1994-2008)



Source: Nebraska Department of Health and Human Services (DHHS).

It's the Law!

The state of Nebraska requires all persons who have witnessed or have a reasonable suspicion of child abuse or neglect to report the incident to their local law enforcement agencies or to the Department of Health and Human Services through the Child Abuse and Neglect Hotline at 1-800-652-1999.

Less than 1% of child abuse reports to DHHS or law enforcement come from the children themselves. Children often have strong loyalties to their parent(s) and/or the perpetrator and therefore, are not likely to report their own, or their siblings', abuse or neglect. These children may fear the consequences for themselves, the perpetrator and/or their parent(s). There is also a strong possibility the perpetrator has threatened more serious abuse if they tell. Children may be more likely to tell a trusted adult such as a teacher, care provider or family member if they believe that person will help the family.

Types of Abuse

Neglect, physical abuse and sexual abuse are the three main classifications under the umbrella of child abuse. Because children may experience more than one form of abuse, DHHS records all types of abuse that apply to each child individually. Over the years, neglect has been found to be the most commonly substantiated form of child maltreatment. If a child has not been provided for emotionally, physically and/or medically, it is considered neglect. Infants and children labeled as "failure to thrive" (a child whose physical growth is significantly less than that of peers) are often the result of neglect.

Table 2.2, lists types of abuse that took place in substantiated cases of child abuse in Nebraska in 2008. We have to remember that a unique child can experience more than one type of abuse. That explains why there are 4,902 unique child victims in 2008, while total number of abuse types totals 7,573.

Table 2.2: Types of Substantiated Abuse (2008)

Abuse Type	Gender		Total Substantiated Allegations
	Male	Female	
Physical Abuse	355	325	680
Emotional Abuse	28	33	61
Sexual Abuse	99	399	498
Emotional Neglect	140	168	308
Physical Neglect	3,029	2,995	6,024
Medical Neglect of Handicapped Infant	0	2	2
Totals	3,651	3,922	7,573

Source: Nebraska Department of Health and Human Services (DHHS).

Note: Numbers based on substantiated allegations. The 4,902 unique children involved may have been a victim of more than one alleged abuse type in more than one substantiated case. The table above provides a count of abuse types that were substantiated. The 4,902 victims are included in a total of 7,573 allegations of abuse.

Table 2.3 compares the number of substantiated abuse types in each abuse category between CY 2007 and CY 2008. As the data indicate, there was an 11.84% decrease in the types of substantiated allegations, indicating that there are fewer types of abuses in CY 2008 per unique child victim as compared to CY 2007. The most substantial change is a 68.88% decrease in emotional abuse allegations, followed by a 15.53% decrease in physical abuse allegations. Sexual abuse, emotional neglect and medical neglect of a handicapped infant were the only types of abuses in which the number of substantiated allegations increased. While there was a decrease in the types of substantiated allegations, there was an increase in the number of reports substantiated and in the number of children victims.

Table 2.4 presents a complete summary of child abuse and neglect reports for 2004-2008. Total reports received are broken down into reports alleging abuse and neglect, CAN (Child Abuse and Neglect) reports for which assessment was completed, CAN reports substantiated, CAN reports unfounded, CAN reports unable to locate and CAN reports in process. While we discussed most of these above, it should be noted that there is a considerable decrease in the number of 'in process' reports out of the total number of CAN reports accepted for assessment (13,460) from 13.3% in CY 2007 to 6.2% in CY 2008.

Child Abuse Fatalities in 2007 and 2008

We define child abuse fatalities as deaths that meet the following criteria:

- Caused by an injury resulting from abuse or neglect, or where abuse or neglect was a contributing factor;[1]
- A result of abusive or neglectful behavior by individuals responsible for the care and supervision of their victims (for example, parents/step-parents, other relatives, boyfriends/girlfriends of parent/guardian, baby-sitters, caregivers, day care providers, etc.);[2]
- Fatal child abuse may involve repeated abuse over a period of time (for example, battered child syndrome) or it may involve a single, impulsive incident (for example, shaken baby syndrome);[3]
- Fatal child neglect may not result from anything the

Table 2.3: Changes in Types of Substantiated Abuse (CY 2007 and CY 2008)

	Physical Abuse	Emotional Abuse	Sexual Abuse	Emotional Neglect	Physical Neglect	Medical Neglect of a Handicapped Infant	Total
CY 2007	805	196	449	280	6,860	0	8,590
CY 2008	680	61	498	308	6,024	2	7,573
Percent Change	15.53%	68.88%	10.91%	10.00%	12.19%	200.00%	11.84%
Increase/Decrease	Decrease	Decrease	Increase	Increase	Decrease	Increase	Decrease

Source: Nebraska Department of Health and Human Services (DHHS).

Table 2.4: Child Abuse and Neglect Reports (2004-2008)

Calendar Year	Total Reports Received	Reports Alleging Abuse or Neglect (CAN)		CAN Reports-Completed Assessment		CAN Reports-Substantiated		CAN Reports-Unfounded		CAN Reports Unable to Locate		CAN Reports-In Process	
2004	24,111	20,568	85.3%	12,750	62.0%	3,336	26.2%	9,084	71.2%	330	2.6%	541	2.6%
2005	28,009	24,397	87.1%	13,318	54.6%	3,324	25.0%	9,691	72.8%	303	2.3%	579	2.4%
2006	28,358	24,173	85.2%	12,034	49.8%	3,065	25.5%	8,738	72.6%	231	1.9%	595	2.5%
2007	30,135	24,765	82.2%	11,544	46.6%	2,894	25.0%	8,412	72.7%	238	2.1%	1,775	7.2%
2008	29,269	24,073	82.2%	12,627	52.5%	3,260	25.8%	9,075	71.9%	292	2.3%	833	3.5%

Source: Nebraska Department of Health and Human Services (DHHS).

caregiver does but from the caregiver's failure to act (for example, chronic malnourishment or leaving a baby unsupervised in the bathtub);[4]

- Not a peer-related incident, such as teen violence;
- Child abuse fatalities are not age-limited, thus the death of any child from birth through age 19 may be considered a child abuse fatality, assuming the above conditions are met.

Child death data for 2008 were not available in time for this report. According to data provided by the Nebraska Department of Health and Human Services, there were a total of 12 youth homicides in 2007. Of the 12 youth homicides, 4 Nebraska children appear to have died as a result of child abuse and neglect, 4 deaths were caused by relatives but whether they are due to child abuse or neglect remains unclear at this time, and the remaining 4 appear to be homicides by peers or unrelated adults according to the review and analysis of Voices for Children in Nebraska. According the DHHS, in addition to the 12 youth homicides, 5 potential child abuse and neglect cases are pending review by Child Death Review Team. At the time of this report, the Child Death Review Team within the Department of Health and Human Services has not officially determined the number child abuse and neglect deaths for 2007. In the previous years the number of child deaths due to abuse and neglect have been reported as 11 children in 2006, 12 children in 2005, 9 children in 2004, 10 children in 2003, and 7 children in 2002.[5, 6, 7] In three of the deaths in 2007, the child's parents were the perpetrators, in one case the perpetrator was a foster father and in two deaths a grandfather was a perpetrator. In the remaining cases, a police officer, stranger, impaired cousin, acquaintance and sister and her boyfriend were the perpetrators.

In 1993, the Nebraska State Legislature mandated formation of a Child Death Review Team to review all child deaths. The team is required by statute to review all deaths of children ages 0 to 17 in the state and making recommendations for reducing future deaths. In July 2009, the Nebraska Child Death Review Team released its sixth report, en-compassing findings on 539 child deaths that occurred in 2005 and 2006. We look forward to more regularly published Child Death Review Team reports to provide an accurate record of the number of children who have died due to the tragedy of child abuse.

Domestic Violence/Sexual Assault Programs

Domestic violence, sexual assault, and stalking are prevalent in every country, in every state, and in every community. In Nebraska, there are 22 community based domestic violence/sexual assault programs as well as 4 tribal programs serving the Ponca, Winnebago, Omaha, and Santee Sioux nations. These programs offer a range of services for both adults and children who are victims of domestic and sexual violence, including: 24-hour crisis lines; emergency food, shelter, and sundries; transportation; medical advocacy and referrals; legal


Anonymous

referrals and assistance with protection orders; and ongoing support and information.

The twenty-two (22) local domestic violence/sexual assault programs strive to meet the needs of victims/survivors and to provide a voice to speak on their behalf when needed. Programs also work to hold offenders accountable, and partner with other agencies to increase community awareness and support. During the fiscal year July 2007-June 2008, the 22 domestic violence/sexual assault programs provided the following services.

Close to ten thousand people (9,732) received direct services, including 3,400 children and youth who received direct services.[8] Over a third of the people received shelter (3,701), including 2,564 children.[9] A total of 54,704 shelter beds and 144,629 meals were provided, with 30,665 beds and 80,089 meals provided to children and youth.[10] The program staff and volunteers responded to 51,628 crisis calls through the programs' 24-hour hotlines.[11]

The people who provided demographic information reported 4,448 children as living in the home.[12] Over three hundred (319) were reported as having been physically harmed, 79 were suspected of being victims of child sexual abuse, and 2,498 had witnessed the perpetrator's use of violence.[13]

Over the past few years, domestic violence/sexual assault programs in Nebraska have expressed the need for more services and support for victims and survivors who also experience mental health or substance issues. This need is not unique to Nebraska, as shown by the following statistics:

- National studies indicate that 74-90% of women in sub-

POLICY BOX

Fostering Connections to Success and Increasing Adoption Act

Public Law 110-351, signed into law on October 7, 2008

The *Fostering Connections to Success and Increasing Adoption Act* is said to be the first comprehensive reform of federal child welfare financing in 28 years. The act will increase federal support to states so more children can be placed permanently with relative guardians or adoptive parents. It also provides increased aid for older and former foster youth. Benefits of the act include:

Increasing Adoptions by:

- Expanding Title IV-E adoption assistance to gradually eliminate the requirement that children's birth parents' incomes must be below the 1996 AFDC eligibility level in order for the child to receive federal adoption assistance. This "de-linking" provision will gradually go into effect over the next ten years, beginning with children ages 16 and older.
- Enhancing adoption incentives.
- Increasing adoption tax credit awareness.

Helping Children Find Permanency with Relatives by:

- Enabling states to receive federal funding for guardianship. Nebraska was one of the few states that previously supported subsidized guardianships but did not receive federal funding for those placements. Now Nebraska receives federal support for subsidized guardianships.
- Increased requirements for notifying relatives of children's re-

stance abuse treatment have experienced severe domestic and/or sexual violence from a partner in their lifetime.[14]

- Many women report that they initiated substance abuse to alleviate trauma associated with abuse.[15]
- Nearly one-third of all rape victims develop Rape-Related Post Traumatic Stress Disorder (RR-PTSD) sometime during their lifetimes.[16]
- Across studies of US and Canadian women receiving services for domestic violence, rates of depression ranged from 17% to 72%, and rates of PTSD ranged from 33% to 88%.[17]

In November 2007 the Nebraska Domestic Violence Sexual Assault Coalition added staff to support the domestic violence/sexual assault programs and other agencies in addressing both the trauma of abuse and relating mental health and substance abuse issues. This project focuses on providing accessible, responsive, coordinated services and support for rural victims who are also challenged with substance abuse and/or behavioral health diagnoses. These goals are accomplished through trainings, collaborative work with domestic violence/sexual assault programs and allied organizations, and the creation and dissemination of materials.

[1] The National Child Abuse and Neglect Data System (NCANDS), as quoted in U.S. Department of Health and Human Services, Administration for Children and Families, Child Welfare Information Gateway, http://www.childwelfare.gov/pubs/factsheets/fatality.cfm.

[2] U.S. Department of Health and Human Services, Administration for Children and Families, Child Welfare Information Gateway, http://www.childwelfare.gov/pubs/factsheets/fatality.cfm.

[3] Ibid.

[4] Ibid.

[5] Nebraska Child Death Review Team, "Nebraska Child Death Review Report for 2004," October 2007.

[6] Nebraska Child Death Review Team, "Nebraska Child Death Review Report for 2002-2003," July 2006 found that there were 17 total child deaths as a result of child abuse and neglect in 2002 and 2003.

[7] Nebraska Child Death Review Team, "Nebraska Child Death Review Report for 2005-2006," April 2009.

[8] Program statistics compiled by the Nebraska Domestic Violence Sexual Assault Coalition, July 2009.

[9] Ibid.

[10] Ibid.

[11] Ibid.

[12] Ibid.

[13] Ibid.

[14] Miller, 1994; Krubbs, 2000.

[15] Gutierres and Van Puymbroeck, 2006.

[16] National Center for Victims of Crime & Crime Victims Research and Treatment Center, 1992.

[17] Warshaw and Barnes, Domestic Violence, Mental Health and Trauma: Research Highlights, The Domestic Violence and Mental Health Policy Initiative, April 2003.

moval from their birth family with options for relative involvement.

- Waiving licensing standards for kin on a case-by-case basis.

Promoting Family Connections by:

- Keeping brothers and sisters together.
- Creating a new grant program for up to 30 child welfare agencies to increase family connection services.

Aiding Older Youth by:

- Providing federal reimbursement to states supporting foster youth up to age 19, 20 or 21.
- Extending independent living services and education vouchers.
- Supporting youth as they transition from foster care.

Enhancing Services to Children in Tribal Care by:

- Providing federal funding directly to tribes rather than requiring subcontracts with DHHS.
- Providing technical assistance to tribes for this transition.

Improving Support to Foster Children by:

- Tracking health care needs and services for each foster child.
- Requiring provisions to ensure school continuity and smoother transitions with school changes.
- Expanding use of federal funding for training all child welfare professionals.

The Nebraska Department of Health and Human Services has submitted a plan to the Administration for Children and Families (ACF), stating an intent to implement most or all of the program changes allowed under the Fostering Connections Act. Changes to the Title IV-B plan were submitted June 30, 2009 and the changes to the Title IV-E plan were submitted November 30, 2009.

Early Childhood Care and Education

Voices for Children in Nebraska believes that all children should have access to safe, affordable, high-quality early childhood care and education which strengthens their developmental potential. During this critical period, children will grow and learn more than at any other time in their lives. By investing in the quality development of children at a young age, we can increase their opportunities to develop intellectually, socially and emotionally. Early childhood brain research demonstrates that developmentally appropriate experiences contribute to the healthy development of an infant's brain and make a significant difference in a child's ability to reach his or her potential. Early experiences create the foundation upon which future success and productivity of a child will be built. Whether young children are receiving care in a home based or center based program, children require a high quality, nurturing environment in order to make the most of this developmental stage. Young children who receive quality care will benefit cognitively, socially and emotionally, thus increasing their chances of achieving productivity in adulthood. It is critically important to invest in a child's foundation so they may later return that investment as productive contributors to our society.

Early Education and Care Programs in Nebraska

Head Start and Early Head Start

Head Start and Early Head Start assist families in helping children reach their full potential by providing developmentally appropriate learning environments through parenting education and support, mentoring, volunteering, employment opportunities and collaborations with other quality early childhood programs and community services.

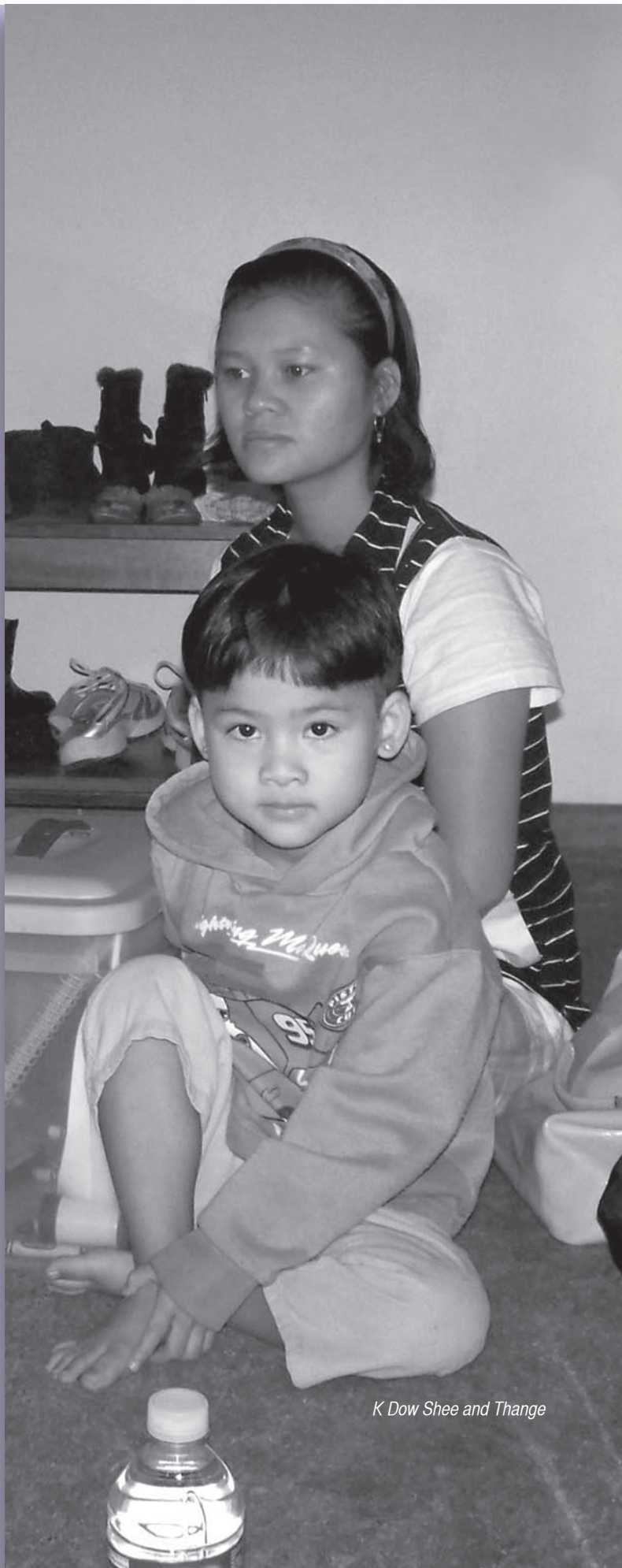
Head Start and Early Head Start are federally funded programs. The programs provide comprehensive services in child development, health and wellness, nutrition and social services to support low-income families who have infants, toddlers and preschool children. Early Head Start also serves pregnant women preparing for the birth of their child. The four cornerstones of Head Start include: child development, family development, staff development and community development. Children participate in various program formats including:

center-based, home-based or a combination to focus on the cognitive, social and emotional development in preparation for the transition to school.

National evaluation research has shown that both children and parents benefit from Early Head Start and Head Start programs, yet neither program has the funding to reach all children in need of services. Early Head Start children, at three-years-old, performed significantly better on a range of measures of cognitive, language and social-emotional development than a randomly assigned control group. In addition, their parents scored significantly higher than control group parents on many aspects of the home environment and parenting behavior. Thus, Early Head Start programs had positive impacts on parents' progress toward self-sufficiency.[1] Evidence also shows that Head Start children experience cognitive, social and physical gains in the short-term, which have meaningful implications for long-term academic performance.[2]

During the 2007-2008 program year, 22 Head Start and 10 Early Head Start programs provided services for young children and their families in 74 of Nebraska's 93 counties. Out of 22 Head Start programs, 15 were grantee programs, 3 delegate agencies, 1 migrant/seasonal program and 3 American Tribe programs. Head Start and Early Head Start services were offered in a variety of settings in the state. Services were provided for children in Head Start centers, in partnership with school districts, in community early childhood centers and family child care homes, as well as in the child's own home. Children and their families were served in full-day, part-day and home-based programs. Head Start programs served 1,138 Nebraska children six or more hours per day, 4-5 days a week. An additional 3,067 children were served in part-day programs, thus less than six hours, 4-5 days a week.

According to the Head Start Program Information Report for the 2007-2008 program year, Nebraska Head Start/ Early Head Start programs served 6,209 children from birth through age 5. Figure 3.1 presents the racial and ethnic breakdown of all children served.



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Moreover, Early Head Start programs served 182 pregnant women, fifteen of whom were under 18 years of age. Of the pregnant women served by Early Head Start, 9.3% (17 women) were without health insurance, and 23.6% (43 women) were considered to have medically 'high risk' pregnancies. Additionally, of the 6,209 children served by Head Start and Early Head Start:

- 2,537 needed child care for full-days and/or the entire calendar year since their parents were working or were in job training. Children in need of full-day or full-year services required additional placements outside of what Head Start could provide. Additional transitions throughout the day and throughout the year decrease the consistency of care for the children.
- A language other than English was spoken as a primary language by 1,355 of those served in Head Start/ Early Head Start.
- There were 834 children served in Head Start/Early Head Start with determined disabilities.

Figure 3.2 provides data on the number of Nebraska's eligible 3- and 4-year-old children enrolled in Head Start and Early Head Start since the 1999-2000 program year.

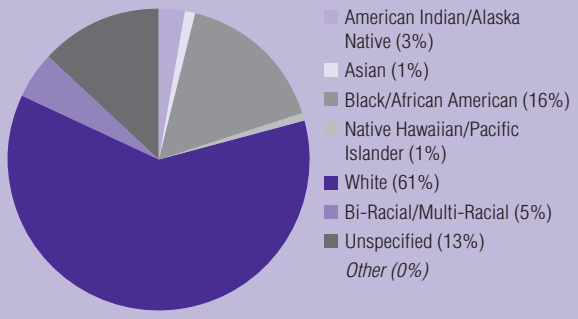
Further details about the programs are provided in Table 3.1.

State Early Childhood Education Grant Program

Nebraska's Early Childhood Education Grant Program, administered by Nebraska Department of Education, is designed to award state funds to schools or Educational Service Units (ESUs) to assist in the operation of early childhood programs. These programs are intended to support the development of children from birth to kindergarten through the provision of comprehensive center-based programs. In 2007-2008, 52 school districts or ESUs across the state received grants to provide early childhood education programs. This is an increase of 14 school districts compared to the last year due to the increased interest from the school districts and the ability of the Nebraska Department of Education to fund more districts in 2007-2008. Grantees were required to collaborate with existing local providers, including Head Start and existing early childhood programs. The collaborative groups combined grant funds with existing resources to operate integrated early childhood programs, thus improving access to services for young children in those communities.

A majority of the 2,299 children served in the Early Childhood Education Grant Program during the 2007-2008 school year were from low-income families, as 77% of children served were eligible for free or reduced school lunch. This represents both an increase in children served, up from 1,618 in the 2006-2007 school year, and an increase in the percentage served that are eligible for free or reduced lunch,

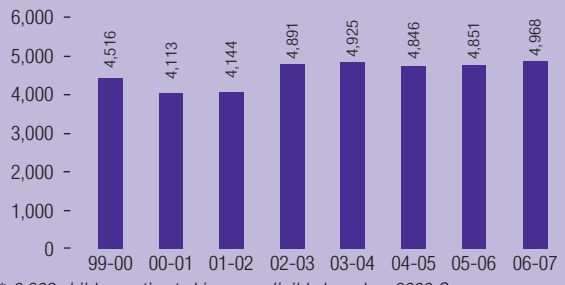
Figure 3.1: Head Start/Early Head Start Enrollment (Program Year 2007-2008)



Source: Head Start Program Information Report for the 2007-2008 program year, Office of Early Childhood, Nebraska Department of Education.

Note: The race of 790 children enrolled in Head Start/Early Head Start was "unspecified."

Figure 3.2: Number of Nebraska's 8,202* Eligible 3- and 4- Year Old Children Enrolled in Head Start/ Early Head Start Programs (1999-2000 – 2006-2007)



** 8,202 children estimated income-eligible based on 2000 Census.*

Source: Office of Early Childhood Education, Nebraska Department of Education.

up from 67% in the previous year. The grant-funded programs predominately served preschool age children. In fact, 95% of the children served were either three or four years old. For 25% of the children served, English was not the primary language used in their home. Of the children served by the Early Childhood Grant Programs in 2007-2008, 65% were White, 24% were Hispanic, 9% were Black or African American and 2% were American Indian/Alaskan Native.

Even Start Family Literacy Programs

The Even Start Family Literacy Program is intended to help break the cycle of poverty and illiteracy and improve the educational opportunities of low-income families by integrating intensive early childhood education, adult literacy and adult basic education. This includes support for English language learners and parenting education. Even Start is a program of the U.S. Department of Education administered through the Nebraska Department of Education, Office of Early Childhood.

In the 2007-2008 grant year, six Even Start programs were funded across Nebraska, a decrease from eight Even Start programs funded last year due to the cut in federal funding. Eligible participants in Even Start programs are parents who qualify for participation in an adult education program with their children, birth through age seven. To be eligible, at least one parent and one or more eligible children must particpate together in all components of the Even Start project. Program components include early childhood education/development, parenting and adult education.

Nebraska's Even Start programs served 141 families, including 160 adults and 208 children. Of all parents served, 61%, or 98 parents, were English language learners. Of the 94 newly enrolled families, 71 (76%) were living at or below the federal poverty level (see page 34 for federal poverty guidelines).

Early Development Network and Early Childhood Special Education

In Nebraska, school districts are responsible for providing

Table 3.1: A Closer Look at Head Start and Early Head Start (Program Year 2007-2008)

Families	Number	Percent
Two Parent Families	2,625	47.19%
Single Parent Families	2,938	52.81%
One or both parents employed	4,127	74.19%
Families receiving emergency/crisis intervention services*	1,877	33.74%
Families receiving adult education (GED programs, college selection, etc.)	1,042	18.73%
Families receiving parenting education	4,264	76.65%
Families receiving at least one family service	5,068	91.10%
Children		
Without health insurance	526	8.47%
With private health insurance	733	11.81%
Up-to-date on all preventative and primary health care tests and physical examinations	5,150	82.94%
Up-to-date on all immunizations	5,378	86.62%
Completed oral health examination (Preschool Programs Only)	4,410	71.03%
Pregnant Women		
Without health insurance	17	10.18%
Medically 'high risk' pregnancies	43	25.75%
Received dental exams or treatment within the last 12 months	57	34.13%
Receiving prenatal and postpartum health care	145	86.83%
Classroom and Staff		
Teachers with ECE or related degree	281	86.20%
Home visitors with ECE or related degree	45	39.13%
Staff who are current or former Head Start Parents (both HS/EHS and contracted)	316	20.33%

Source: Head Start Program Information Report for the 2007-2008 Program Year, Office of Early Childhood, Nebraska Department of Education.

** Emergency/Crisis Intervention services means meeting immediate need for food, clothing, or shelter.*

IMPACT BOX

Early Childhood Data Coalition

By Jennifer Skala, Associate Vice President of Community Impact, Nebraska Children and Families Foundation

The Nebraska Children and Families Foundation, Voices for Children in Nebraska, Together for Kids & Families with the Nebraska Department of Health and Human Services, Lifespan Health Services; Nebraska Department of Education, Office of Early Childhood and Early Childhood Training Center; University of Nebraska Medical Center Munroe-Meyer Institute; University of Nebraska Lincoln, and the Nebraska Head Start-State Collaboration Office recently formed the Early Childhood Data Coalition to address the availability and uniform use of early childhood data.

Currently, various early childhood data sets and systems are being used among local, state and federally funded programs. A process for identifying, collecting, reviewing, monitoring, and reporting these data is needed. The members of the Early Childhood Data Coalition believe that maximizing opportunities to utilize and report on available data may result in improved equitable access to quality early childhood programs. Furthermore, the effective use of data can inform polices and continuous program improvement.

For additional information or interest in participation with the Early Childhood Data Coalition, please contact the Nebraska Children and Families Foundation.

special education and related services to all eligible children in their district, from birth to age 21, who have been verified with a disability. In order for a child to be eligible for special education and related services, the school district must evaluate the child through a multidisciplinary team process (MDT) to determine the educational and developmental abilities and needs of the child. Once the evaluation and assessment for the child have been completed, an Individualized Family Service Plan (for children from birth to age three) or an Individualized Education Program (for children ages 3 to 21) must be developed. Service coordinators with the Early Development Network are available to assist families with children from birth to age three who have disabilities. In 2008, a total of 6,550 children from birth to age three were served by the Early Development Network. On October 1, 2008, there were 1,471 children, birth to age three, receiving special education services and 3,576 children, ages 4 and 5, receiving early childhood special education services in Nebraska.

Services for young children with disabilities are required to be provided in natural environments for children birth to age three, and in inclusive environments for children ages 3 to 5. The terms “natural” and “inclusive” environments are defined as settings that would be natural or normal for the child if he/she did not have a disability. To the greatest extent possible, the early education experience is to be provided for children in partnership with community preschools, child care centers, Head Start programs and other community settings.

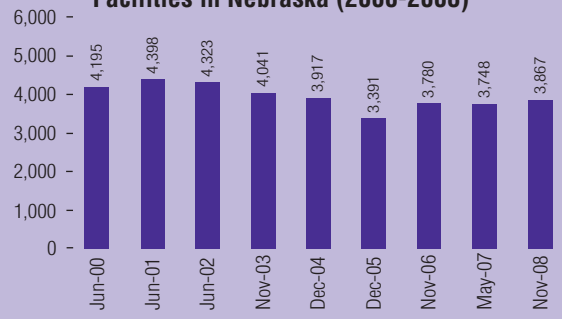
Child Care Facilities and Subsidies

To be able to fully participate in the workforce, families need safe, high quality child care that supports a full range of children’s developmental needs. According to the U.S. Census Bureau, 132,092 children were under age 5 in Nebraska in 2008.[4] The vast majority of these children will require child care outside the household at some point in their young lives, as 95% of children under age 6 in Nebraska have either one or two working parents.[5] The lack of quality and licensed child care in Nebraska often results in long waiting lists and

families' use of unlicensed care. In Nebraska, a child care provider or facility providing care for four or more children from more than one family must be licensed by the Nebraska Department of Health and Human Services (DHHS). Data pulled from the Nebraska Department of Health and Human Services in November 2008 indicates that Nebraska had a total of 3,867 child care facilities with a total capacity of 99,902 children. In 2008, both the number of licensed providers, as well as their total capacity, increased; this is a diversion from a trend of past years in which the number of licensed child care providers decreased while the total capacity in licensed child care programs increased. The number of facilities over time is presented in Figure 3.3 below.

In 2008, families who had previously received Aid to Dependent Children (ADC) with incomes at or below 185% of the federal poverty level (see Economic Well-Being section of this report for poverty levels, page 34), could utilize child care subsidies. Families who had not received ADC were eligible only if their income was at or below 120% of the federal poverty level. Throughout SFY 2008, DHHS subsidized the child care of 32,793 unduplicated children, an increase from 32,515 children in 2007. The monthly average of children provided subsidy was 16,857. This is also an increase from 16,534 children served monthly in 2007. With an average annual payment of $2,172 per child, $71,610,046 federal and state dollars were used for child care subsidies in Nebraska.

Figure 3.3: Number of Licensed Child Care Facilities in Nebraska (2000-2008)



Source: Nebraska Department of Health and Human Services (DHHS).

Note: Due to the point-in-time nature of this data collection, we are unable to obtain data fom previous years for the same month each year. We hope to obtain data in November from 2008 forward and correct this problem.

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Subsidies are paid directly to the providers. While not all children receive subsidy for 12 months, the average subsidy payment per child paid by the DHHS during SFY 2008 was approximately $352 per month. DHHS rates for SFY 2008 ranged from $2.25 to $5.00 per hour for infants ($13.50 to $34 per day) and $2.25 to $3.50 per hour for toddlers, preschool and school-age children ($13.50 to $28.75 per day). For in-home care, in which the child care provider comes to the home of the child, DHHS uses the federal minimum wage rate – set at $6.55 per hour in SFY 2008.

[1] "Early Head Start Benefits Children and Families," *Early Head Start Research and Evaluation Project*, April 2006.

[2] Barbara L. Devaney, Marilyn R. Ellwood, and John M. Love, "Programs that Mitigate the Effects of Poverty on Children," *The Future of Children Journal*, Volume 7, No. 2, Summer/Fall 1997.

[3] Emergency/Crisis intervention services means meeting immediate need for food, clothing, or shelter.

[4] U.S. Census Bureau, 2008 Population Estimates, as published in the "2008 Nebraska Population Report," prepared by David Drozd and Jerry Deichert at the UNO Center for Public Affairs Research.

[5] U.S. Census Bureau, 2008 American Community Survey, Table B23008.

Economic Well-Being

Voices for Children in Nebraska believes that all children should have essential food, shelter, and medical care. We also believe that all parents should have access to programs which educate them, provide assistance when needed and encourage them to be responsive to their children's needs. Our children, communities and state are stronger when all of Nebraska's families are able to participate fully in the workforce, the economy and establish financial stability. The general definition of economic self-sufficiency is a family earning enough income to provide for their basic needs without public assistance. A basic needs budget consists of food, housing, health care, transportation, child care, clothing and miscellaneous items, including personal and household expenses.[1] Public assistance provides a vital safety net for families who are temporarily unable to provide these necessities on their own.

Poverty in Nebraska

Economic insecurity and hardship are linked to numerous adverse outcomes that limit the opportunities and future productivity of children. Impoverished and low-income children face elevated risks for the following:

- Lack of adequate nutrition;
- Low-quality child care and the absence of positive early learning opportunities;
- Unsafe neighborhoods and schools;
- Trauma, abuse and/or neglect;
- Parental substance abuse, parental depression and domestic violence;
- Exposure to environmental toxins;
- Being uninsured, leading to a lack of access to quality and preventive care; and
- Increased interaction with the juvenile justice and child welfare systems.

Families must receive fair returns on their work to produce stable income and develop savings and assets that help them survive crises and plan for the future. When these conditions are unable to be met, families need a strong, deep and effective safety net to sustain them during times of economic downturn and help them return to financial stability.

Poverty in Nebraska has increased since 2000, following a period of decline in the 1990s. As table 4.1 indicates, all three poverty rates (overall, family and child) have experienced a statistically significant increase since 2000.

Statewide, our child and family poverty rates reveal distinct disparities, particularly among the Black or African American and Native American populations as presented in Table 4.2. While poverty brings risks for all children, these risk factors are particularly acute when interwoven with racial and ethnic systemic barriers to opportunity. These disparities have been created and exacerbated by structural inequities in our public and private systems which treat people differently based upon race. Embedded structural inequality still exists

Tila and Mom

Table 4.1: Poverty Rate in Nebraska (2000 and 2008)

	2000	2008
Child Poverty Rate	10.0%	13.4%
Family/Household Poverty Rate	6.5%	6.8%
Overall Poverty Rate	9.6%	10.8%

Source: U.S. Census Bureau, 2008 American Community Survey, Tables B17001, B17010, and B17001, respectively.

Table 4.2: Poverty Rate by Race and Ethnicity* (2008)

Race	Child Poverty Rate (Under 18)	Overall Poverty Rate
White Alone	10.27%	9.25%
Black or African American Alone	40.06%	29.03%
American Indian and Alaska Native Alone	57.38%	41.75%
Asian Alone	7.16%	13.05%
Some Other Race Alone	33.20%	22.35%
Two or More Races	16.96%	16.50%
Ethnicity		
White Alone, Not Hispanic or Latino	9.00%	8.65%
Hispanic or Latino	27.75%	21.41 %

Source: U.S. Census Bureau, 2008 American Community Survey, Tables C17001 A-I.

** Racial and ethnic groups are based on those used by the U.S. Census Bureau. The sample was not large enough for the Native Hawaiian and Other Pacific Islander Alone category to develop poverty estimates.*

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in job markets, school systems, health care systems, criminal justice systems, housing markets and various other systems. These structural inequalities have led to greater barriers to opportunity for people of color and higher rates of poverty as a result. With more children of color growing up in poverty and an increasing child poverty rate overall, we must work to overcome the structural inequities that people in poverty and people of color face to ensure all children are provided the greatest opportunities to succeed.

Single Parent Families

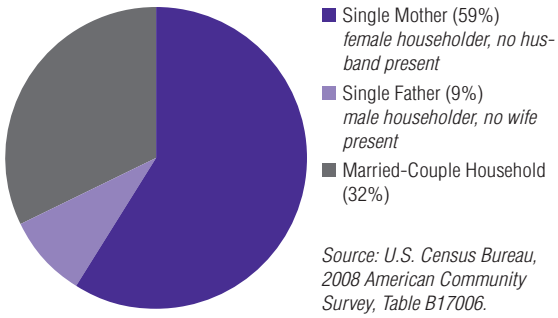
In 2008, 25.86% of Nebraska children lived in a single-parent household.[2] The economic burden of raising children for single-parent families is often difficult to bear. Single parents are struggling with the costs of child care, balancing work and home duties and spending quality time with their children. A lack of essential resources and few supports have been linked with parental stress which can lead to a greater occurrence of child abuse or neglect.[3] In 2008, 20.9% of Nebraska families headed by a single parent lived in poverty, as compared to only 3.2% of married couples.[4] Figure 4.1 illustrates all children in poverty by family type.

Temporary Assistance to Needy Families (TANF)

Temporary Assistance to Needy Families, as the program is known at the federal level, provides non-cash resources and education to foster self-sufficiency among program recipients. Aid to Dependent Children (ADC) remains the title of government 'cash assistance' in Nebraska. Nebraska's Employment First program was created to assist parents in acquiring and sustaining self-sufficiency through employment. Medicaid coverage, child care services and subsidies and job support are all provided through Employment First; cash assistance may be drawn for a total of 60 months in one's lifetime. While reading this section, it is important to note, that data presented in this section precedes the current economic downturn.

In Nebraska, children comprise 75% of total ADC enrollment, according to a snapshot of program recipients from June 2008. There was a monthly average of 17,609 children receiving ADC benefits in state fiscal year (SFY) 2008, a decrease from 19,281 in SFY 2007. ADC was provided to a

Figure 4.1: Nebraska Children in Poverty by Family Type (2008)



Source: U.S. Census Bureau, 2008 American Community Survey, Table B17006.

monthly average of 8,994 Nebraska families in SFY 2008, a significant decrease from a monthly average of 10,313 families in SFY 2007. The total amount of monthly payments equaled $35,170,649, an average of $325.86 per family per month in 2008. This is a $31.24 decrease in average payments per family from 2007. Approximately 65% of the cost of ADC benefits was paid for by state general funds, and the remaining 35% was provided by federal TANF funds.

The maximum ADC payment amounts to 27.1% of the federal poverty level as prescribed by Nebraska law (see the federal poverty guidelines on page 34). Nebraska ranks 29th in the country for the adequacy of benefit levels relative to federal poverty guidelines.[5] Figure 4.2 presents a historic view of ADC utilization since 1998. The average number of Nebraska families receiving ADC monthly has steadily decreased from a slight peak in 2004.

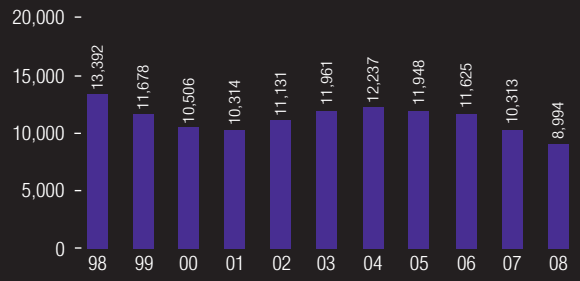
A June snapshot of ADC recipients, broken down into age groups, shows that the 0-5 age group is the largest recipient of ADC benefits (see Figure 4.3). Figure 4.4 presents a June snapshot of ADC recipients by race, indicating that white Americans accounted for 40% of ADC benefits, followed by black Americans who accounted for 32%.

With any decline in ADC enrollment, as is the case in Nebraska since 2004, we would hope to see an increase in employment as well as a decrease in the number of individuals, families, and children living in poverty. Unfortunately, the decline in enrollment occurred as our state was experiencing a simultaneous increase in unemployment throughout fiscal year 2008 and into 2009 and an increase in individual, family and child poverty over the 2000 rates.[6] If ADC is to fulfill its goal of helping families to support themselves without public assistance, we must ensure that those leaving the program are able to meet their needs through high-quality employment.

Divorce and Child Support

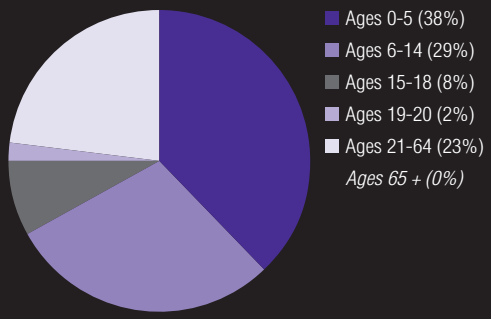
Last year we reported divorce data for 2006 since 2007 data were not available at the time the report went to print. This year we have obtained both 2007 and 2008 data. In 2008,

Figure 4.2: Average Number of Nebraska Families Receiving ADC Monthly (1998-2008)



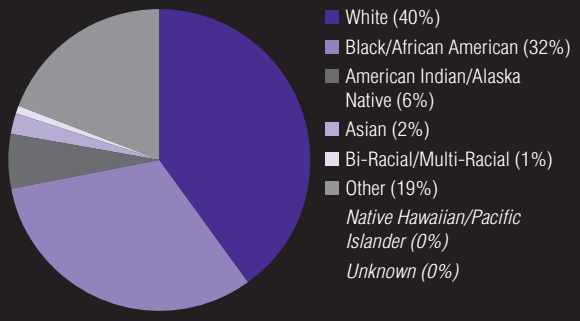
Source: Financial Services, Operations, Nebraska Department of Health and Human Services (DHHS).

Figure 4.3: ADC Recipients by Age (June 2008)



Source: Financial Services, Operations, Nebraska Department of Health and Human Services (DHHS).

Figure 4.4: ADC Recipients by Race (June 2008)



Source: Financial Services, Operations, Nebraska Department of Health and Human Services (DHHS).

12,353 couples were married and 5,885 marriages ended in divorce. The number of marriages in 2008 was higher than in 2007 (12,164 marriages) and number of divorces was lower than in 2007 (6,105). In 2008, divorce affected 5,442 children, a decrease from 2007 when 5,785 children were affected. Of the divorces granted in 2008, custody was awarded to mothers 1,958 times (2,063 times in 2007), to fathers 331 times (342 times in 2007) and joint custody was awarded 664 times (716 times in 2007). Child support is be awarded to the custodial parent, however, court awarded child support is not always paid to the custodial parent.

A parent can request DHHS assistance if they are not receiving the child support they are owed. The assistance will be provided by Child Support Enforcement (CSE). In FY 2008, CSE provided assistance to 105,269 cases. Families dependent on Aid to Dependent Children (ADC) filed 8,420 and non-ADC families filed 96,859 cases. In FY 2008, CSE collected a total of $208,752,665 in child support payments and disbursed a total of $196,553,460.

Federal and State Tax Credits for Families

The Earned Income Tax Credit (EITC) was created by the federal government in an effort to assist low- and moderate-income working families retain more of their earned income. In 2008, a total of $229,865,000 was claimed as the federal Earned Income Tax Credit on 120,110 Nebraska federal tax returns. In addition, 158,000 families claimed the federal Child Tax Credit, receiving $217,426,000 and 53,760 families claimed the federal Child and Dependent Care Credit, receiving $25,932,000.

In 2006, the Nebraska State Legislature voted to enact the state Earned Income Tax Credit (EITC), which provided

IMPACT BOX

Individual Development Accounts

Voices for Children in Nebraska believes that all children and families should have equitable access to financial stability and opportunity. The key to gaining financial stability lies not in income alone but also in savings, investments and ownership. Access to such assets provides families with the necessary means to weather financial hardships that may occur, such as a job loss or disability, and to invest in long-term financial goals and security.

Whether through direct outlays or tax policy, incentives do exist to encourage and assist in savings and asset ownership. Direct outlays are dollars allocated in the federal budget for grants and programs such as the Community Development Block Grant, Small Business Administration's MicroLoan Program and the Home Investment Partnership Program where as tax expenditures can include exclusions, deductions, carryovers and credits. Such policies tend to benefit those with middle- to upper-level incomes and/or those who already have savings and assets on which to build. Generally, families with lower-level incomes have access to income supports through public benefit programs but these programs often discourage individuals from building up savings and purchasing assets.

In the past two decades, significant research and program development has introduced new opportunities for lower-income individuals and families to access equitable opportunities to financial stability through asset development. One tool that has been particularly successful is the process of Individual Development Accounts (IDAs).

Individual Development Accounts, in brief, are matched savings accounts that function similar to a matched 401(k) account for retirement savings and are targeted toward those with little to no income and/or assets. IDA programs can be established by government agencies, businesses and non-profits and work to incentivize savings through matched contributions for a specified period of time. Upon reaching one's savings goal, the IDA participant must utilize those savings for an asset investment such as a home, business start-up or expansion, or post-secondary education. Additional components of the IDA program include mandatory financial education, asset-specific education and credit counseling.

Currently, 41 states have enacted legislation or administrative

a refundable tax credit equaling 8% of the federal EITC for working families. Nebraska was the 19th state to enact this crucial tax relief plan for hard-working, low-income families. During the 2007 legislative session, the Nebraska legislature voted to increase the state refundable EITC to 10%, providing greater tax relief to Nebraska's working families. In 2008, the Nebraska state EITC was claimed on 115,807 returns (an increase from 113,117 returns in 2007), and $22,579,000 was refunded. The Nebraska Child and Dependent Care Credit was claimed on 56,825 Nebraska state income tax returns, and the total amount received, including both the refundable and non-refundable credit, was $12,300,000 in 2008. Nebraska also offers free tax assistance to families statewide through a collaboration of state and local agencies. To access free tax assistance, call 2-1-1 or visit www.canhelp.org/EITC.htm.

Homeless Assistance Programs

The Nebraska Homeless Assistance Program (NHAP) of the Nebraska Department of Health and Human Services (DHHS) funds emergency shelters, transitional housing and services for people who are homeless and at risk of becoming homeless. The objective of the 2008 Nebraska Homeless Assistance Program was to assist in the immediate alleviation of homelessness of Nebraska citizens using the Department of Housing and Urban Development's (HUD) Emergency Shelter Grant Program (ESGP) funds and the Nebraska Homeless Assistance Trust Fund.

The state strongly supports a collaborative approach to addressing the needs of people who are homeless through a 'Continuum of Care' process, which was initiated by the U.S. Department of Housing and Urban Development (HUD) in 1994. The process promotes a coordinated, strategic plan-

policy change to provide state-support for IDA programs and most recently, 21 states have committed current year funding to IDA programs within the state.[1] While Nebraska is not included in the 41 states with state-supported IDA policy, there are 4 IDA programs in Nebraska, which are currently funded through the national Assets for Independence Grant, private financial institutions, businesses, and philanthropic foundations:

- Family Housing Advisory Services in Omaha
- Family Housing Advisory Services and the Independent Youth Council in Omaha for Foster and Former Foster Youth
- Lincoln Action Program in Lincoln
- Community Action Partnership of Western Nebraska in Gering

The success of IDAs has been validated time and time again through programs within the state and through The American Dream Demonstration, a national five-year study which provided evidence that everyone, even those in poverty or with low incomes, can and will save with the right supports and incentives. Families with savings and assets not only have what is necessary to withstand economic hardship and provide greater security to their children, but research also indicates that access to wealth building opportunities provides additional benefits such as increased social connectedness, civic participation, investment in education and improved future-goal setting.[2]

Due to the significant impact IDAs have on the lives of families and children, several partners across the state have been working to develop and implement a statewide Individual Development Account Program for Nebraska. The mission of the Nebraska IDA Task Force is to engage traditional and non-traditional partners in maximizing resources and program support to ensure low- and moderate-income households have equitable incentives and opportunities to save and build wealth. Our goal in 2010 is to secure the necessary funding to invest in capacity and growth of existing programs and develop several new programs throughout the state of Nebraska.

[1] Resource Guide: State IDA Program Support, CFED, 2009-2010 Assets and Opportunity Scorecard.

[2] Michael Sherraden, "Inclusion in Asset Building - Testimony for Hearing on 'Building Assets for Low-Income Families,' Subcommittee on Social Security and Family Policy, Senate Finance Committee," April 28, 2005.

ning approach for programs that assist families and individuals who are homeless and near homeless. This approach is an effective community and regional-based process that provides a comprehensive and coordinated housing and service delivery system. NHAP-funded agencies are required to be active participants in their local and regional continuums of care. During the July 1, 2008-June 30, 2009 grant year, 65 programs of grantees statewide provided Continuum of Care services to people who were homeless and near homeless.

All NHAP-funded agencies are required to participate in a Homeless Management Information System (HMIS). The 2008-2009 NHAP grant cycle was the second full grant year that NHAP-funded agencies reported via the new system. System administrators assist end users at funded agencies. The NHAP has a grant agreement with the Nebraska Management Information System (NMIS) and a Memorandum of Understanding with the Nebraska Domestic Violence Sexual Assault Coalition to obtain the required year-end data from both organizations. The 2008-2009 grant year was the second full year NHAP ensured that grantees used the HMIS-ServicePoint software developed by Bowman. This greatly minimizes rates of the duplication of counts between agencies within a Continuum.

For the 2008-09 grant cycle, funded agencies collaborated to assist 18,169 individuals who were homeless and 43,029 individuals who were near homeless. The Panhandle, North Central, and Southwest regions reported decreases in the number of individuals who were homeless (-28.1%, 2.1%, and 10.3%, respectively). The Southeast (+23.9%), Northeast (+53.2%) and Lincoln (+6.4%) all experienced increases in the number of homeless served. Some of the regional increases may also be attributed to better data collection methods. There was a slight decrease (-1.0%) in the overall reported number of near homeless during the 2008 program year for Regions 1 through 6 (Panhandle-Lincoln). The North Central, Southeast, and Northeast regions all reported decreases (-24.7%, -27.3%, and -1.0%, respectively). Lincoln reported a 26.7 percent increase in the number of near homeless assisted.

Table 4.3: Federal Poverty Guidelines (2008)

Persons in family or household	Gross Annual Income			
	100% Poverty (Poor)	130% Poverty*	185% Poverty*	200% Poverty* (Low-Income)
1	$10,400	$13,520	$19,240	$20,800
2	$14,000	$18,200	$25,900	$28,000
3	$17,600	$22,880	$32,560	$35,200
4	$21,200	$27,560	$39,220	$42,400
5	$24,800	$32,240	$45,880	$49,600

Source: Federal Register, Vol. 74, No. 14, January 23, 2008, pp. 3971-3972.
** Approximations based on 100% of the federal poverty level.*

It is important to note that the 2008-2009 grant year marked the second full year of HMIS/ServicePoint implementation; it was anticipated that data would generally lower, as ServicePoint allows agencies to unduplicate data.

Statewide homeless and near homeless data on children specifically are not yet available via HMIS/ServicePoint. However, based on historic data, families who are homeless represent over 30 percent of the homeless population. Families with children who are at-risk of becoming homeless have, historically, represented from 50 to 70 percent of the population at-risk of homelessness.

[1] Diana Pearce, PhD with Jennifer Brooks, "*The Self-Sufficiency Standard for Nebraska*," Prepared in collaboration with Nebraska Appleseed Center for Law in the Public Interest, November 2002, www.neappleseed.org.

[2] U.S. Census Bureau, 2008 American Community Survey, Table B09005.

[3] Jill Goldman, Marsha K. Salus with Deborah Walcott, and Kristie Y. Kennedy, "A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice," *U.S. Department of Health and Human Services, Administration on Children and Families, Children's Bureau, Office on Child Abuse and Neglect*, 2003.

[4] U.S. Census Bureau, 2008 American Community Survey, Table B17010.

[5] *Center for the Study of Social Policy*, "Policy Matters 2008," http://www.cssp.org/policymatters/pdfs/5.%20Income%20and%20Work%20Supports%20-%202008.pdf.

[6] U.S. Department of Labor, Bureau of Labor Statistics (Unemployed Persons) for the months of fiscal year 2007 (July 2006 through June 2007).

Education

Voices for Children in Nebraska believes that all children should have high-quality education regardless of the size, wealth or geographic location of the community in which they reside. It is common knowledge that children who do well in school are more likely to become successful adults. The correlation between higher education levels and income is undeniable. Higher education is often linked to lower divorce rates, lower crime rates, higher income and higher job satisfaction.[1] By ensuring that all children have access to high-quality educational opportunities, we are investing in the future of our communities, our state and our economy.

To the detriment of our children and their future, there remains a significant achievement gap between children of color and White children in our education system. Due to high poverty rates among minorities that have resulted from historical conditions and structural inequities, children of color are disproportionately concentrated in low-income areas. Low-income geographies have a smaller tax capacity and consequently are less able to support the high quality education experiences that may be available in higher income areas. This issue is not just affecting urban schools but rural areas as well.

Brittney

High School Graduates

During the 2007-2008 school year, 22,195 Nebraska high school students were awarded diplomas. The 2007-2008 graduation rate was 89.78% compared to 89.30% in 2006-2007 and 88.81% for the 2005-2006 school year. Table 5.1 presents graduation rates by race, ethnicity and gender.

Table 5.1: Graduation Rates by Race, Ethnicity and Gender (2007-2008 School Year)

Students*	Graduation Rate**
White	93.12%
Black	70.11%
Asian	91.78%
Hispanic	74.76%
Indian	69.41%
Female	91.46%
Male	88.14%
Nebraska Total	89.78%

Source: Nebraska Department of Education.

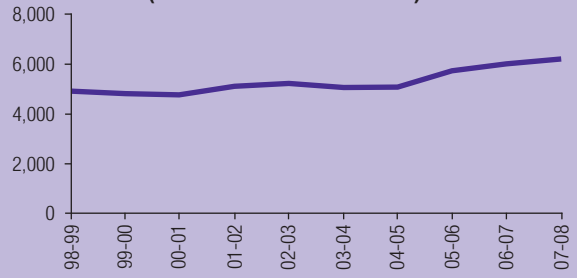
** Racial/ethnic groups are reflective of those referenced by the data source.*

*** Graduation rate is calculated using the NCES formula.*

Since 2002-2003, Nebraska has adopted the national definition for graduation rate developed by the National Center for Education Statistics (NCES). The NCES definition calculates a four-year rate by dividing the number of graduates with regular diplomas in a given year by the sum of the number of dropouts in each of the four years, as the class moved through high school, and the high school diploma recipients *(Ex. High school diploma recipients in year 4 divided by dropouts year 1 + dropouts year 2 + dropouts year 3 + dropouts year 4 + high school diploma recipients year 4)*. Beginning with the 2007-2008 school year, Nebraska began to accumulate data to allow the state to calculate the new graduation rate as defined by the U.S. Department of Education. The new definition utilizes net transfers rather than dropouts to calculate the graduation rate. Nebraska will be able to publish the new NGA rate in 2011.

Nebraska parents or legal guardians have the option to provide educational opportunities for their children outside of approved or accredited public or non-public schools. During the 2007-2008 school year, there were 6,134 exempt, or "home school", students in Nebraska. Figure 5.1 demonstrates the trends in the number of home schooled children since 1998-1999 school year.

Figure 5.1: Exempt or "Home School" Students (1998-1999 – 2007-2008)



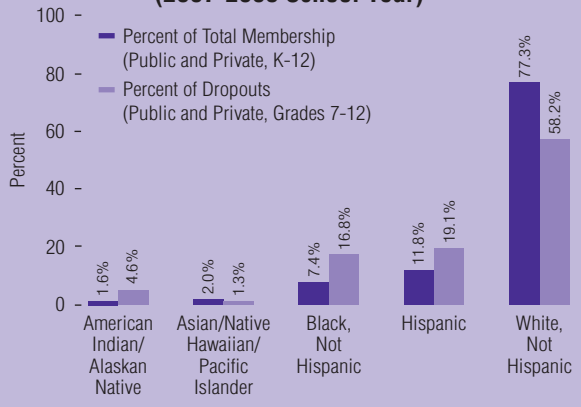
Source: Nebraska Department of Education.

In addition, 1,061 students ages 16 through 18 took all or portions of the General Equivalency Diploma (GED) test in 2008. Of these, 760 students successfully completed the tests and qualified for a GED.

School Dropouts

During the 2007-2008 school year, 2,377 Nebraska students dropped out of school, 1,360 male and 1,017 female (dropouts are calculated using grades 7-12). This was a decrease of 332 dropouts from the previous year. Research indicates that minority groups have higher dropout rates than White students due to reasons such as poverty, level of segregation

Figure 5.2: Percent of Dropouts Compared to Percent of Enrollment by Race and Ethnicity* (2007-2008 School Year)



Source: Nebraska Department of Education.

** Racial/ethnic groups are reflective of those referenced by the data source.*

IMPACT BOX

America's Promise / Nebraska's Call to Action Drop Out Summit: Focusing Attention on Our State's Most At Risk Youth

By Jennifer Skala, Associate Vice President of Community Impact, Nebraska Children and Families Foundation

Working with a variety of state and local partners, and funded by a grant from the America's Promise Alliance, the Nebraska Children and Families Foundation hosted a statewide Drop Out Prevention summit in Lincoln on May 15, 2009.

Recent research quantifies what many of us instinctively know – dropping out of school is a decision that can have devastating, life long consequences for youth. Many drop outs frequently spend their lives on the margins of society, with much higher teen pregnancy, incarceration and poverty rates than graduates from similar backgrounds. Recent research also points out the significant, lifetime net fiscal costs that drop outs place on society as a whole. This Summit, which is part of a series of statewide summits funded by America's Promise, brought together teams of school and civic leaders from Nebraska communities struggling with higher than state average drop out rates to develop action plans they could use to address this growing problem in their communities.

Using data collected as part of the Nebraska Coordinating Commission for Postsecondary Education's 2009 Nebraska Higher Education Progress Report, 14 districts that accounted for almost 73% of Nebraska's total number of drop outs during the 2007-08 school year were identified. School-community teams from these districts were invited to come together for this one day workshop in which they could hear information placing their districts' situations into a larger national context, share examples of promising practices and begin developing school-community action plans that they could implement on their own.

The approximately 200 attendees were welcomed by Governor Heineman, who challenged them to consider unconventional, preventative approaches to drop out prevention, including expanded early learning and extended day and year programs, which would allow more children to avoid the chain of events which leads some youth to drop out.

Other speakers included Nebraska's newly appointed Commissioner of Education Roger Breed and Johns Hopkins University professor Nettie Legters, a national expert on high school drop outs. Dr. Legters noted that she was impressed with Nebraska's commitment to this topic given that Nebraska's overall percentage of graduates is among the highest in the nation. She and other speakers noted, however, that this macro-level success masks micro level failures. Indeed, a closer look at graduation rates reveals a disturbingly high percentage of Nebraska's African American and Latino students fail to complete high school.

Speakers from districts across the state mapped out a variety of activities – including expanded early learning programs, afterschool activities, service learning projects, interventions targeting key transition points and high school programs offering alternative pathways to graduation – intended to enable more students to have the support and stimulation needed to graduate. Thirty five table top sessions allowed participants to learn about other promising practices, including comprehensive school health, innovative GED outreach, community mentorship programs, among many others, all designed to be key components in a community's comprehensive drop out prevention strategy.

Conversation shifted to small group sessions in which school-community action teams utilized worksheets developed as part of a new resource called ***Grad Nation***, a comprehensive drop out prevention tool kit developed by America's Promise, to outline a series of next steps that communities could take to continue this important dialogue following the summit.

The overarching message from the Summit was that schools cannot be expected to solve the drop out crisis on their own. The challenge was to develop new partnerships and relationships that allow schools and communities to work together to develop approaches that meet the needs of all youth.

A series of activities are taking place across the state to continue the focus on exactly this type of community development. Omaha's Building Bright Futures process is structured around providing the supports that all Omaha youth need to successfully complete their education and launch a career. Community conversations around drop out prevention are underway in Lincoln and Grand Island, other communities are also involved in similar activities. We are excited about the contribution that these and other community-based initiatives can make to helping ensure that all Nebraska youth have the education that they need to enjoy Nebraska's Good Life.

and proportion of non-White students in school.[2] Figure 5.2 on page 36 compares percent of dropouts to percent of enrollment by race and ethnicity.

Expelled Students

During the 2007-2008 school year, 1,000 Nebraska students (unduplicated, grades 7-12), were offered alternative education in response to expulsion from customary education. Table 5.2 presents number of statewide expulsions staring with 1998-1999 school year.

Table 5.2: Statewide Expulsions (1998-1999 – 2007-2008)

School Year	Number of Expulsions
1998-1999	849
1999-2000	824
2000-2001	770
2001-2002	816
2002-2003	857
2003-2004	858
2004-2005	924
2005-2006	928
2006-2007	959
2007-2008	1,000

Source: Nebraska Department of Education.

In general, public school students are provided with an alternative school, class or educational program upon expulsion. In Nebraska, a student can be expelled from a school but not from the school system, allowing for the student to continue their education in either a formal alternative program or his or her home. Prior to expulsion, it is necessary for the student and his/her parents to develop a written plan outlining behavioral and academic expectations in order to be retained in school. Some schools are developing creative and motivational alternative programs to meet the needs of students.

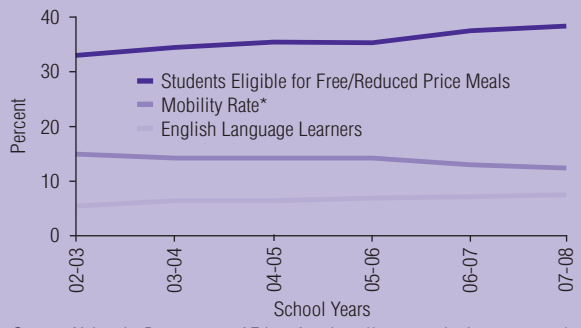
The School Discipline Act of 1994 requires expulsion for students found in intentional possession of a dangerous weapon and/or using intentional force in causing physical injury to another student or school representative.

Special Education

On October 1, 2008, 47,023 Nebraska students from birth to age 21 received special education services. It is important for a child's development and education that the need for special education be identified at an early age. There were 6,252 preschool children, birth to age five, with a verified disability receiving special education services (this is a point in time count for October 1, and includes only those children who are in special education services, not those children who were in a regular program). School districts reported 40,771 students ages 6 to 21 with disabilities during 2007-2008 school year.

Figure 5.3 below demonstrates additional important trends in student characteristics in Nebraska public schools. Three indicators highlighted in the Figure 5.3 are mobility rate, eligibility for free/reduced meals and English language learning.

Figure 5.3: Nebraska Public Schools Trends in Student Characteristics (2002-2003 – 2007-2008)



Source: Nebraska Department of Education, http://reportcard.nde.state.ne.us/.

** Mobility Rate – Any child who enters or leaves school between the last Friday in September and the last day of school divided by total K-12 enrollment on the last Friday in September. An individual child is only counted once.*

[1] Seastrom, M., Hoffman, L., Chapman, C., and Stillwell, R., "The Freshman Graduation Rate for Public High Schools from the Common Core of: School Years 2002-2003 and 2003-2004," U.S. Department of Education, National Center for Education Statistics, Washington, D.C.: 2006.

[2] Orfield, G., Losen, D., Wald, J., & Swanson, C., (2004). *Losing Our Future: How MinorityYouth are Being Left Behind by the Graduation Rate Crisis*, Cambridge, MA: The Civil RightsProject at Harvard University. Contributors: Advocates for Children of New York, The Civil Society Institute.

Health – Physical and Behavioral

Voices for Children in Nebraska believes that all children should have access to quality and affordable health care. There must be adequate levels of immunization in Nebraska, as well as public health measures implemented to prevent disease and disability in children. Good health, both physical and behavioral, is an essential element of a productive life. It is no surprise that children who receive preventive health care throughout their lives become healthier adults. It is also critically important to acknowledge the role of maternal health and its effects on birth outcomes.

Too many children in Nebraska face significant barriers to leading healthy and productive lives. Poor nutrition, a lack of access to preventive care, poor environmental conditions and delayed and inadequate diagnosis and treatment are all linked to inferior school attendance and performance and worse

Cooper and Chad

Table 6.1: Selected Preconception Risk Factors

Isotretinoins	Use of isotretinoins (e.g., Accutane®) in pregnancy to treat acne can result in miscarriage and birth defects. Effective pregnancy prevention should be implemented to avoid unintended pregnancies among women with childbearing potentional who use this medication.
Alcohol misuse	No time during pregnancy is safe to drink alcohol, and harm can occur early, before a woman has realized that she is or might be pregnant. Fetal alcohol syndrome and other alcohol-related birth defects can be prevented if women cease intake of alcohol before conception.
Anti-epileptic drugs	Certain anti-epileptic drugs are known teratogens.* Recommendations suggests that before conception, women who are on a regimen of these drugs and who are contemplating pregnancy should be prescribed a lower dosage of these drugs.
Diabetes	The three-fold increase in the prevalence of birth defects among infants of women with type 1 and type 2 diabetes is substantially reduced through proper management of diabetes.
Folic acid deficiency	Daily use of vitamin supplements containing folic acid has been demostrated to reduce the occurrence of neural tube defects by two thirds.
Hepatitis B	Vaccination is recommended for men and women who are at risk of acquiring hepatits B virus (HBV) infection. Preventing HBV infection in women of childbearing age prevents transmission of infection to infants and eliminates risk to the woman of HBV infection.
HIV/AIDS	If HIV infection is identified before conception, timely antiretroviral treatment can be administered, and women (or couples) can be given additional information that can help prevent mother-to-child transmission.
Hypothyroidism	The dosages of Levothyroxine® required for treatment of hypothyroidism increase during early pregnancy. Levothyroxine® dosage needs to be adjusted for proper neurological development of the fetus.
Obesity	Adverse perinatal outcomes associated with maternal obesity include neural tube defects, preterm delivery, diabetes, caesarean section, and hypertensive and thromboembolic disease. Appropriate weight loss and nutritional intake before pregnancy reduce these risks.
Oral anticoagulant	Warfarin, which is used for the control of blood clotting, has been demonstrated to be a teratogen.* To avoid exposure to warfarin during early pregnancy, medications can be changed to a nonteratogenic anticoagulant before the onset of pregnancy.
STD	*Chlamydia trachomatis* and *Neisseria gonorrhoeae* have been strongly associated with ectopic pregnancy, infertility, and chronic pelvic pain. STDs during pregnancy might result in fetal death or substantial physical and developmental disabilities, including mental retardation and blindness. Early screening and treatment prevents adverse birth outcomes.
Smoking	Preterm birth, low birth weight, and other adverse perinatal outcomes associated with maternal smoking in pregnancy can be prevented if women stop smoking before or during early pregnancy. Because only 20% of women successfully control tobacco dependence during pregnancy, cessation of smoking is recommended before pregnancy.

** Teratogen refers to any agent that causes a structural abnormality following fetal exposure during pregnancy.*

Source: Center for Disease Control and Prevention, Morbidity and Mortality Weekly Report, April 21, 2006, Vol. 55, No. RR-6.

health outcomes for children.[1] Low-income and minority children experience less access to quality care due to a high rate of uninsurance and the corresponding lack of preventive care and culturally competent services. The spatial segregation of many low-income and minority neighborhoods translates into limited access to resources that improve health such as medical facilities, pharmacies, and safe recreational areas.[2] Low-income neighborhoods are often disproportionately exposed to air, water and soil pollutants and lead hazards, as well.[3] Finally, troubling disparities have been revealed in the quality of care that children receive based on their race/ethnicity. Studies of a variety of medical treatments document that racial and ethnic minority patients receive a lower quality and intensity of health care than white patients.[4] A lower quality of treatment leads to worse medical outcomes among minorities.

Due to the implementation of new birth, death and fetal death certificates, as well as system changes in data collection, 2008 data were not available in time for this report. This report provides data for 2007 on child birth, infant mortality and child death.

Maternal Health, Preconception and Prenatal Care

Many of the factors that determine pregnancy outcomes for women and infants occur very early in pregnancy, often before women enter prenatal care or even know they are pregnant. During the first weeks (before 52 days' gestation) of pregnancy, exposure to alcohol, tobacco and other drugs; lack of essential vitamins (e.g., folic acid); and workplace hazards, among many other factors, can adversely affect fetal development and result in pregnancy complications and poor outcomes for both the mother and infant.

The purpose of preconception care is to identify risks and improve the health of each woman before pregnancy and thereby positively impact the future health of the woman, her child and her family. Table 6.1 presents selected preconception risk factors.

The goal of prenatal care is to monitor pregnancy progress and to identify potential problems before they become serious for either mom or baby. Women who see a health care provider regularly during pregnancy have healthier babies, are less likely to deliver prematurely and are less likely to have other serious problems related to pregnancy. The Centers for Disease Control and Prevention recommend starting prenatal care as early as possible, even prior to pregnancy. Prenatal care is measured by the Kotelchuk Index to calculate the adequacy of care.

In 2007, 3,724 (14.24%) births were recorded to mothers who reported inadequate prenatal care and 3,482 (13.32%) to those who reported intermediate prenatal care (out of 26,146 births in Nebraska that had known Kotelchuk Index). This is an increase in the number of mothers reporting inadequate prenatal care by 8.9% and a decrease in the number reporting intermediate care by 11.53%. Mothers reporting adequate or adequate plus prenatal care comprised 72.44% of all births in which the quality of prenatal care was measured in 2007. Table 6.2 presents data on the adequacy of prenatal care by race and ethnicity.

Table 6.2: Mothers Reporting Adequate or Adequate Plus Prenatal Care by Race or Ethnicity (2007)

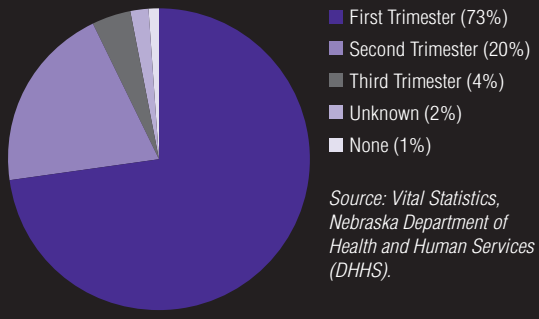
Race or Ethnicity*	Percentage
American Indian	50.22%
Other	60.37%
Black	61.99%
Hispanic	63.91%
Asian	69.57%
White	75.59%

** Racial and ethnic groups are reflective of those referenced by the data source.*

Source: Vital Statistics, Nebraska Department of Health and Human Services (DHHS).

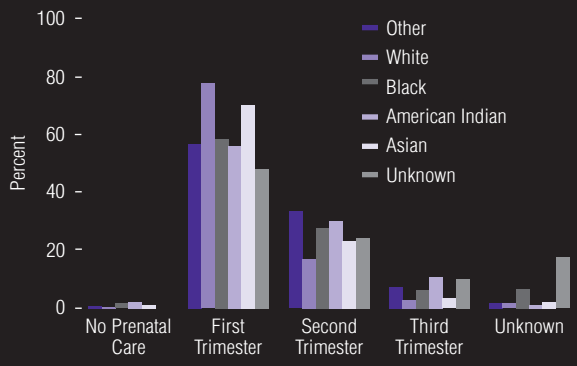
Uninsured women face greater barriers to prenatal care than insured women, even in the presence of strong safety net institutions that are well known in their communities for providing care to the uninsured.[5] Other than being uninsured, commonly cited barriers to adequate prenatal care among low-income women are a lack of transportation, not knowing where to go to find care, not liking the way they were treated at the clinic and language barriers, ignorance as to the importance of prenatal care (particularly for subsequent

Figure 6.1: Trimester Prenatal Care Began, All Births (2007)



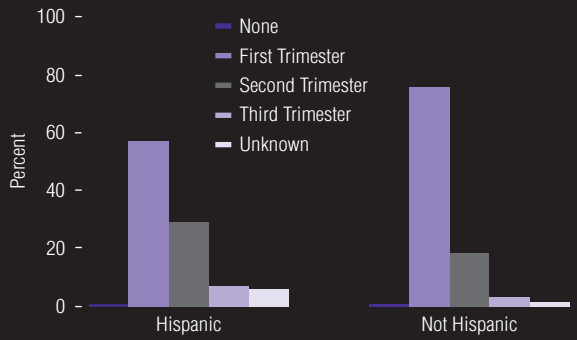
Source: Vital Statistics, Nebraska Department of Health and Human Services (DHHS).

Figure 6.2: Trimester Prenatal Care Began by Race, All Births (2007)



Source: Vital Statistics, Nebraska Department of Health and Human Services (DHHS).

Figure 6.3: Trimester Prenatal Care Began by Ethnicity, All Births (2007)



Source: Vital Statistics, Nebraska Department of Health and Human Services (DHHS).

pregnancies), and not knowing whether or not they wanted the baby/ambivalence about pregnancy.[6] Figures 6.1, 6.2 and 6.3 present data on prenatal care.

Nebraska Births

In 2007, there were a total of 26,935 live births to Nebraska residents.

Infant Mortality

Infant mortality rates are frequently used as an indicator of the standard of well-being in a community. Currently, 2008 infant mortality data are not available. In 2007, the Nebraska infant mortality rate (deaths per 1,000 births) was 6.8, which represents an increase from 2006 rate of 5.62 and is the highest rate recorded in Nebraska since 2001. A total of 183 infant deaths occurred in Nebraska in 2007.

Table 6.3: Infant Mortality Rates* by Race and Ethnicity

	2006	2007
White	5.63	6.80
Black	11.42	15.29
American Indian	6.24	14.20
Asian	4.85	4.72
Hispanic	6.00	5.17
Overall	5.54	6.80

Source: Vital Statistics, Nebraska Department of Health and Human Services (DHHS).

** Infant Mortality Rate is calculated as the number of infant deaths per 1,000 births.*

Nebraska residents lost 1,650 babies under the age of one from 1998-2007. Birth defects, accounting for 45 infant deaths (30.4%) in 2006 and 39 deaths (21.3%) in 2007, were the leading causes of infant death during these years. Sudden Infant Death Syndrome (SIDS), accounted for 18 deaths (12.2%) and 18 (9.8%) deaths in 2006 and 2007, respectively. Premature births were the cause of 8 (5.4%) infant deaths in 2006 and 16 (8.7%) in 2007.

Low Birth Weight

The highest predictor of death and disability in the United States is low birth weight. A newborn weighing below 2,500 grams, or 5.5 pounds, is considered of low birth weight and a newborn weighing less than 1,500 grams, or 3.3 pounds, is

considered of a very low birth weight. In 2007 in Nebraska, 1,894 newborns were of low birth weight (7.03% of all births) and 350 (1.30%) were born with a very low birth weight.

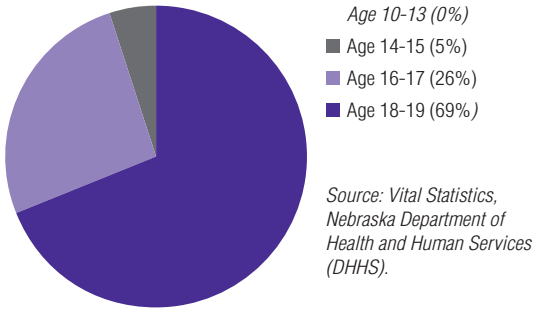
Smoking is an attributable cause of low weight births. Pregnant women who smoke cigarettes are nearly twice as likely to have a low birth weight baby as women who do not smoke.[7] The smoking rate among pregnant women in Nebraska was 15.2% in 2007.[8] Other factors related to low birth weight are low maternal weight gain, chronic maternal illness and infections, fetal infections, metabolic and genetic disorders and alcohol and illicit drug use.[9]

Births to Teens

While teen birth rates have been falling in the United States, we still have the highest teenage pregnancy rate among comparable countries.[10] Pregnancy certainly occurs at all socioeconomic levels, but teenage mothers are more likely to come from economically disadvantaged families, to be experiencing minimal educational success and to be coping with substance abuse and behavioral problems.[11] Research shows having children as a teenager can limit a young woman's educational and career opportunities, increase the likelihood that she will need public assistance and can have negative effects on the development of her children. Children born to teen mothers are more likely to experience health problems, experience abuse and neglect, do poorly in school, run away from home and serve time in prison.[12] Teen birth is also highly correlated to child poverty. According to The National Campaign to Prevent Teen Pregnancy, two-thirds of families begun by a young unmarried mother are poor.[13] The children of teen parents are also more likely to become teen parents themselves, thus perpetuating the cycle of teen pregnancy and generational poverty.[14]

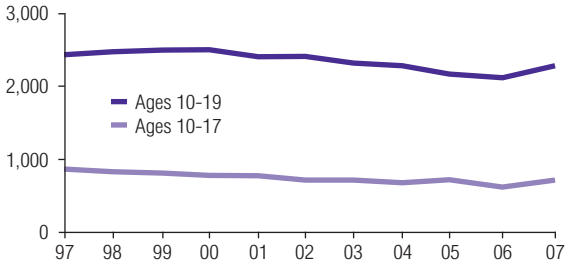
In 2007, 2,303 babies were born to girls ages 19 and under which represents 8.54% of all babies born in Nebraska in 2007. This is an increase from 2006, when girls ages 19 and under gave birth to 2,143 babies (8.02% of total births). Across a ten-year span since 1998, 7,471 babies were born to mothers ages 17 and under. The number of births to teens ages 10-17 has seen a steady decline since 1998, but we saw an increases in 2005 and in 2007. The percentage of births to teen mothers ages 10-17 in 2007 that were not the mother's first birth was 9.42%. Of the 711 babies born to teen mothers ages 10-17 in 2007, 356 (50.07%) had White mothers, 139 (19.55%) were born to Black mothers, 39 (5.49%) had American Indian mothers and 10 (1.41%) were born to Asian mothers. In addition, 167 (23.49%) births were attributed to teen mothers identified as Other. Teen females ages 10-17 of Hispanic ethnicity gave birth to 228 (32.07%) babies. Figure 6.4 and Figure 6.5 present data on teen births by age and teen birth trends.

Figure 6.4: Teen Births by Age (2007)



Source: Vital Statistics, Nebraska Department of Health and Human Services (DHHS).

Figure 6.5: Teen Birth Trends (1997-2007)

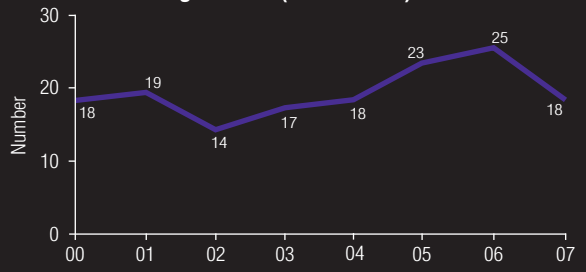


Source: Vital Satistics, Nebraska Department of Health and Human Services (DHHS).

Out-of-Wedlock Births

The risk of having children with adverse birth outcomes, such as low birth weight and infant mortality, are greater for unmarried mothers than for married mothers. The number of unwed parents grew again in 2008, with 8,987 (33.37%)

Figure 6.6: Child Death Rates by Suicide, Ages 1-19 (2000-2007)



Source: Vital Satistics, Nebraska Department of Health and Human Services (DHHS).

Table 6.4: Selected Causes of Child Death (Ages 1 to 19)

Causes	Frequency 1997-2006	1998-2007
Motor Vehicle Accidents	612	601
Non-Motor Vehicle Accidents	232	219
Suicide	186	187
Homicide	123	119
Cancer	125	127
Birth Defects	57	59
Heart	58	51
Cerebral Palsy	31	31
Asthma	22	20
Pneumonia	14	16
HIV/AIDS	2	1
All Other Causes	258	263
TOTAL	1,720	1,694

Source: Vital Statistics, Nebraska Department of Health and Human Services (DHHS).

babies born out-of-wedlock. Nebraska children living with single parents were more likely to live in poverty (20.9% poverty rate), than children living in married-couple households (3.2% poverty rate) in 2008.[15] The likelihood that a mother will be married upon the birth of the child increases with the age of the mother.

Immunizations

The national goal set by the U.S. Centers for Disease Control and Prevention (CDC) is that 90% of all children be immunized with the primary immunization series by the age of two. The 2008 U.S. national average was 76.1%. According to the National Immunization Survey for 2008, 71.5% of Nebraska two-year-olds (19-35 months of age) had received four DTaP (diphtheria-tetanus-pertussis) shots, three polio shots, one MMR (Measles-Mumps-Rubella) shot, three HIB (H. influenza type B and three Hepatitis B immunizations and one Varicella (chicken pox) shot. This is an 11.4% decrease from 2007. The major contributing factor for this decrease is a two-year national shortage of the Hib vaccine (Haemophylous influenza type B which prevented the full immunization of all children. The lack of the vaccine is due to a temporary lack of production – there is only one company currently manufacturing Hib and the other company is awaiting approval from the U.S. Food and Drug Administration (FDA) to resume production.

There were 276 cases of pertussis (whooping cough) and one death due to pertussis reported in Nebraska in 2008. This is a considerable increase in cases of pertussis from 2007, which had only 70 cases. During the last two years, there was an outbreak of pertussis that affected most states. Prior to that outbreak, Nebraska rarely had more than 15 cases of pertussis each year. Most of the pertussis cases have been in the teen and young adult population; however it can easily be passed to young children who do not have the lung capacity to get their breath and may result in hospitalization. Although there has been only one death in recent years, pertussis is a potentially deadly disease for young children. The outbreak has highlighted a need for a booster for pertussis. In response to

that need, the Centers for Disease Control and Prevention, along with the American Academy of Pediatrics and the American Academy of Family Physicians, recommended in 2005 that one dose of the newly licensed tetanus, diphtheria and acellular pertussis booster dose (Tdap) be given at the 7th grade visit instead of Td which contains no pertussis. This has helped reduce the cases of pertussis in Nebraska and has interrupted its spread. A Nebraska law which goes into effect on July 1, 2010, will require all 7th graders to provide proof of booster dose of Tdap for school.

Child Deaths

Child death data for 2008 were unavailable at the time this report went to print. In 2006, there were 174 child deaths, ages 1-19 in Nebraska. This is an increase from 155 in 2005. However, in 2007, the number of child deaths, ages 1-19, decreased to 156. The leading cause of child death in Nebraska is motor vehicle accidents. In 2006, 61 children, ages 1-19, were killed in motor vehicle accidents (35.06% of all child deaths ages 1-19). In 2007, 58 children, ages 1-19, lost their lives in motor vehicle accidents (37.18% of all child deaths ages 1-19). Child deaths due to non-motor vehicle accidents accounted for 27 and 17 child deaths in 2006 and 2007, respectively. Eight child deaths were attributed to cancer in 2006 and ten in 2007. Nebraska saw a steady increase in child suicide from 2004 to 2006, however 2007 numbers show a considerable decline. Suicide was the third leading cause of child death among children ages 1-19 in Nebraska in 2006 at 25 deaths and the second leading cause in 2007 at 18 deaths. Fifteen children ages 1-19 were lost to homicide in 2006 and 13 in 2007. Figure 6.6 and Table 6.3 present historical data on child deaths by suicide and selected causes of child death respectively.

Additional child death data are available from the Child Death Review Team. The team is charged by statute with reviewing all deaths of children ages 0 to 17 in the state and making recommendations for reducing future deaths. The most recent Nebraska Child Death Review Report for 2005-2006 was released on July 24, 2009.

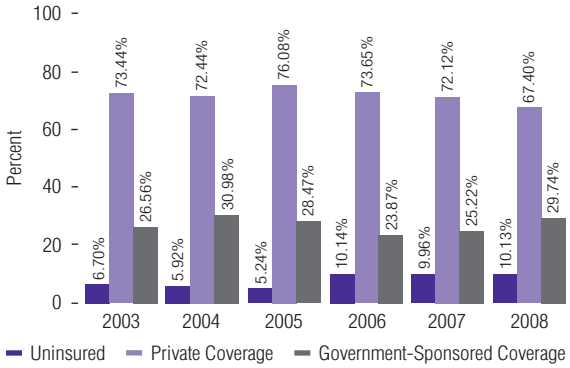
We would like to see more regularly published Child Death Review Team reports to provide an accurate record of the number of children who have died due to the tragedy of child abuse, to begin to identify strategies to prevent these deaths and to monitor child death trends.

Access to Health Care

Uninsured children tend to live in employed families that do not have access to insurance. Most often in these cases the employer does not offer insurance, the insurance offered is too expensive or the insurance does not cover the necessary medical needs of the family. In 2008, there were 46,000 uninsured children, ages 17 and under, in Nebraska.[16]

According to the U.S. Census Bureau, there were 32,000 uninsured children, 18 and under, who were considered low-income (living below 200% the federal poverty level or annual income of $41,400 for a family of four) in 2008.[17] In 2007, the number of uninsured low-income children, 18 and under, was 27,000, while the overall uninsured child total (17 and under) was 45,000. Figure 6.7 presents a historical data on health coverage of Nebraska children.

Figure 6.7: Health Coverage for Nebraska's Children, Ages 17 and Under (2003-2008)

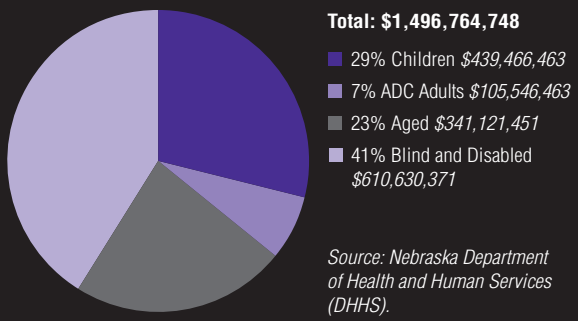


Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements 2003-2008.

Many of these uninsured low-income children are eligible for Kids Connection, which provides low-cost health care coverage for children living in families at or below 185% of the federal poverty level (annual income of approximately

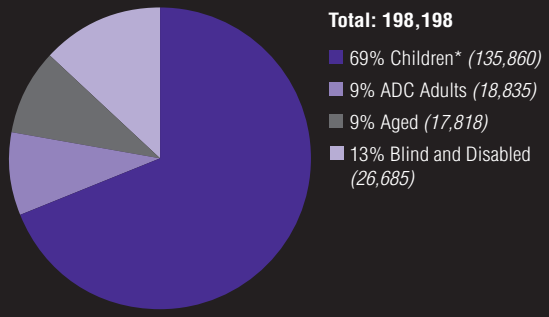
Bounakouth

Figure 6.8: Nebraska Medicaid Expenditures by Category (State Fiscal Year 2008)



Source: Nebraska Department of Health and Human Services (DHHS).

Figure 6.9: Nebraska Medicaid Average Monthly Eligible Persons by Category (State Fiscal Year 2008)



Source: Nebraska Department of Health and Human Services (DHHS).
**Children's category combines both Medicaid and SCHIP coverage.*

$38,220 for a family of four in 2008). In 2009, LB 603 expended eligibility for Kids Connection from 185% of poverty to 200% (see policy box on page 46). Kids Connection includes both the State's Children's Health Insurance Program (SCHIP) and the Nebraska Medical Assistance Program (Medicaid). Kids Connection provided health coverage for 135,860 children (109,986 Medicaid and 25,874 SCHIP) ages 18 andunder. Figures 6.8 and 6.9 provide data on Nebraska Medicaid expenditures and average monthly eligibility in SFY 2008 respectively.

Blood Lead Levels

Elevated blood lead levels (EBLL) can cause: increased behavioral problems, malnutrition and significant detrimental physical and cognitive development problems. Lead poisoning can be fatal. Blood lead testing is recommended for all children at 12 to 24 months of age and any child under seven

POLICY BOX

LB 603: A First Step Towards Meeting the Mental and Behavioral Health Needs of Children and Families

The Nebraska Unicameral Legislature made a first step towards creating a statewide children's behavioral health system during the first session of the 101st Legislature in 2009. This commitment of the Legislature followed Nebraska's difficult experience with our original Safe Haven law, which provided a legal avenue by which any person could leave a child of any age at a hospital without fear of prosecution and that child would become a ward of the state. Although the Safe Haven law was subsequently changed in a 2008 Special Session of the Legislature to apply only to infants 30 days old and younger, the utilization of Safe Haven for predominantly older children with mental and behavioral health needs sheds light on a critical absence of support and services and challenges with accessing adequate services for these children and families. As a result, the Legislature crafted a package of bills to provide a multi-faceted approach to addressing the issues that led over thirty children to be left to the state's care during the last half of 2009. The "Safe Haven Package" of legislation included:

years of age who has been exposed to lead hazards. In 2007 and 2008, there were 22,291 and 26,153 Nebraska children under six years-old tested for blood lead levels, respectively.

The DHHS Childhood Lead Poisoning Prevention Program (CLPPP) continues to collect data from laboratories which perform blood lead tests on children 0-6 years of age. This information is tracked in a database which generates reports, identifies children with elevated test results and allows the program to provide appropriate case management.

In 2007, 416 children (1.87% of children tested) had blood lead levels in the range in which detrimental effects on health have been clearly demonstrated. In 2008, 441 children (1.69% of children tested) had elevated blood lead levels. However, it is difficult to obtain the number of children poisoned as some parents do not bring children back into clinics for confirmatory tests.

Children are commonly exposed to lead through lead-based paints often present in houses built prior to 1950. Some homes built as recently as 1978 may also contain lead-based paint. The best way to protect children at risk of living in homes with lead-based paint is to maintain freshly painted walls so as to avoid chipping and peeling paint. It is also important to keep these areas clean and dust free. The best approach to eliminate lead poisoning is to prevent exposure in the first place.

Mental Health and Substance Abuse Treatment

The Nebraska Department of Health and Human Services (DHHS) funds mental health and substance abuse services for children. Children who utilize these services are most often from lower-income Nebraska families or are involved in the court system. Services paid for by private insurance are not

- The expansion of eligibility for Nebraska's public health insurance program for children, Kids Connection, to all low-income families living at or below 200% of the federal poverty level – see page 34 for 2009 income guidelines. (Effective September 1, 2009).
- The creation of a statewide Children and Family Support hotline, intended to provide 24/7 behavioral health screening, assessment, and referral for children and families unsure of where to go to seek support and services (To be established no later than January 1, 2010).
- The development of the Family Navigators program to provide peer support and connection to existing community-based services (To be established no later than January 1, 2010).
- The provision of voluntary post-adoption/guardianship case management services (To be offered to adoptive and guardianship families of former state wards to be established no later than January 1, 2010).
- A $1.5 million dollar investment in children's behavioral health services through the six Behavioral Health Regions around the state.
- As a long-term strategy to improve provision of and access to behavioral health care, the Behavioral Health Education Center was created at the University of Nebraska Medical Center to train additional psychiatrists, improve training and telehealth utilization, and facilitate interdisciplinary communication among behavioral health workers.

After the First Step of LB 603

With this legislation taking a first step toward creating a children's behavioral health system in the state of Nebraska, a Children's Behavioral Health Oversight Committee of the Legislature has been created to assess the impact of policies implemented as part of LB 603 and other child welfare and juvenile justice initiatives. Even more importantly, this Oversight Committee can develop recommendations for next steps, building upon the progress made by the Legislature with the passage of LB 603, as well as a number of research efforts on children's mental health in the state of Nebraska that have preceded it. Voices for Children in Nebraska will continue to advocate for the creation of a broad array of affordable services that will support parents in meeting the mental and behavioral health needs of their children to avoid more costly interventions through the deeper-end child welfare and juvenile justice systems.

included in the data, and therefore, the total is an underestimate of the number of children receiving these services in the state.

Regional Centers

In Calendar Year 2008, inpatient and residential mental health and substance abuse services were provided to adolescents at the Lincoln and Hastings Regional Centers. The adolescent program at the Lincoln Regional Center (LRC) consisted of a 16-bed residential program (two 8-bed units) and an eight-bed treatment group home, all located on the Whitehall campus. The Hastings Regional Center (HRC) operated a 40-bed Chemical Dependency Program for youth from the Youth Rehabilitation and Treatment Center (YRTC) in Kearney.

During calendar year 2008, a total of 199 youth (unduplicated count) under the age of 19 received services from a regional center: 160 males received services from the Hastings Regional Center; 27 youth were served in the LRC adolescent programs; and 12 youth received outpatient evaluations. The Norfolk Regional Center does not have specialized services for children or adolescents and therefore did not serve anyone under the age of 19 during CY 2008.

By race, 141 of the 199 youth were White (70.9%), 38 were Black or African American (19.1%), 8 were American Indian (4.0%), 5 were multiracial (2.5%), and 7 listed their race as "other" (3.5%).

Community-Based Services

Mental health and substance abuse services are provided to youth in an array of prevention and treatment services. These services may be provided by the following divisions within the Department of Health and Human Services: the Division of Behavioral Health, the Division of Children and Family Services and the Division of Medicaid and Long-Term Care.

Mental health services include the Professional Partner Program (a community-based multi-systemic intensive case management approach), crisis respite (a temporary caregiver relieving family for short periods of time either in the home or at another location) and traditional residential and non-residential therapy. Substance abuse services funded for youth include intensive short-term residential programs on Regional Center campuses to community-based residential and non-residential alternatives (most notably youth outpatient therapy). Substance abuse prevention services are conducted by community-based programs across the state in an effort to repeatedly carry the message of no alcohol use before age 21 or tobacco use before age 18.

Of the community based programs funded by the Division of Behavioral Health, services were provided to an unduplicated count of 3,698 children under age 19 in SFY 2008. Mental health services only were received by 2,731 children under age 19, a total 810 youth received substance abuse services only, 75 children received both community based mental health and substance abuse services and 82 youth received services but could not be discerned in regard to the three major classifications in SFY 2008.[18]

Youth Risk Behaviors

Youth risk behaviors include activities such as alcohol, tobacco and drug use, inadequate nutrition, lack of physical activity and inappropriate sexual conduct. To monitor and measure the prevalence of these behaviors, the National Center for Disease Control and Prevention developed several surveys such as the Youth Risk Behavior Survey (YRBS) and Youth Tobacco Survey (YTS). In addition, the Nebraska Department of Health and Human Services (DHHS) administers the Nebraska Risk and Protective Student Survey. In recent years, participation in these surveys has been poor due to the burden on schools and confusion around multiple surveys. The participation rates have been so low that data remains unweighted and the results cannot be used to draw statewide conclusions about youth risk behaviors. To make this process easier, the Nebraska Department of Health and Human Services has decided to administer all three surveys at one point in time and rebrand them under one name – Nebraska Student Health and Risk Prevention Survey (SHARP).

The SHARP survey will be administered during the fall of each even calendar year, starting in 2010.

Youth Risk Behavior Survey

Developed by the National Centers for Disease Control and Prevention and prepared by the Nebraska Department of Health and Human Services (DHHS), the Youth Risk Behavior Survey (YRBS) includes self-reported health information from a sample of Nebraska 9-12 graders. The questions asked in the survey cover topics such as alcohol, tobacco and drug use, nutrition and physical activity, sexual activity and violence. The goal of the survey is to determine the prevalence of health-risk behaviors among students, assess trends in these behaviors and increase the delivery of health services that can positively affect these risky behaviors. Unfortunately, due to low participation rates, the 2007 and 2009 YRBS conducted in Nebraska are not available as a weighted sample of the population. This limits our ability to assess the health behaviors, observe trends and deliver vital services where needed.

Alcohol and Other Drugs

The 2005 YRBS found that alcohol is used heavily by youth in Nebraska, a finding supported by other surveys as well. Nearly 43% of the students surveyed had consumed alcohol in the last 30 days prior to the survey and 29.8% had reported episodic heavy drinking in that same time period. While this is a small decrease from the previous report, it is still of concern. The report goes on to say that youth alcohol use is associated with increased occurrence of unprotected sex and sex with multiple partners, marijuana use, lower academic performance and fighting. Some of the other drugs youth utilized were marijuana (17.5%), inhalants such as glue, paints or aerosols (11.3%), methamphetamines (5.8%) and cocaine (3.3%).

Tobacco

In Nebraska, 21.8% of the students surveyed report that they currently smoke cigarettes, according to the 2005 YRBS. Females and males report an almost equal usage of cigarettes, with 21.8% of teen girls and 21.6% of teen boys reporting current cigarette use. Fifty-three percent of those surveyed reported they had smoked at some point in their life. In addition, 8.7% indicated they currently use smokeless tobacco and 16.8% use cigars.

Adam and Jenna

Youth Tobacco Survey (YTS) was developed by the National Center for Disease Control to monitor tobacco use among youth grades 6-12. Due to the poor participation both recent YTS and YRBS data remain unweighted, however detailed data on underage smoking should be available once the SHARP survey is conducted in 2010 and response rates are increased.

According to information provided by the Campaign for Tobacco Free Kids, 19.7% of high school students smoked in 2007 in Nebraska. Moreover, 4.7 million packs of cigarettes are illegally bought or smoked by youth each year in Nebraska and 2,100 youth under age 18 become new daily smokers each year in Nebraska.[19]

Motor Vehicle Crashes and Seat Belt Use

The leading cause of Nebraska deaths among youth ages 15-24 is automobile crashes. According to the 2005 YRBS,

35.6% of students reported, in the last 30 days, riding in a vehicle driven by someone who had been drinking alcohol. In addition, 17.3% had driven a motor vehicle themselves one or more times in the past 30 days when they had consumed alcohol.

According to the Nebraska Department of Roads, 24 Nebraska children age 17 and younger died in motor vehicle traffic accidents in CY 2008. That is a considerable decrease from 31 deaths in 2007. Moreover, 215 children suffered disabling injuries due to accidents, also a decrease from 260 in 2007. In the period of 1999-2008, 365 Nebraska children age 17 and younger have died due to vehicle accidents.

Teen Sexual Behavior

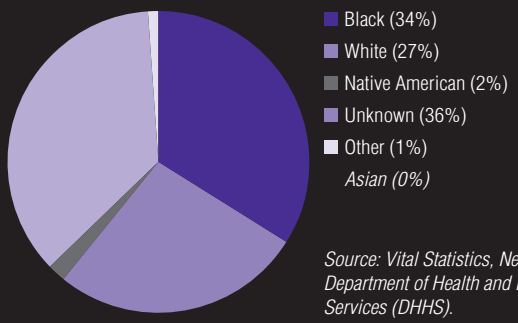
According to the 2005 YRBS, 40.8% of the adolescents surveyed reported that they had experienced sexual intercourse at least one time in their life, a decrease of 2.2% from 2003. Twenty-four percent of the adolescents who reported having had sexual intercourse used alcohol or drugs prior to their last sexual intercourse experience. The majority of these teens, 61.6%, reported using a condom the last time they had sexual intercourse, lessening their chances of contracting a sexually transmitted disease or becoming pregnant. Just over 4% of the respondents reported having had sexual intercourse before the age of 13, and 11.9% had experienced intercourse with four or more people during their life.

Sexually Transmitted Diseases (STDs) and HIV/AIDS Among Youth

There were 2,633 cases of sexually transmitted diseases reported by children ages 19 and under in Nebraska in 2008. This is a increase from 2,323 cases in 2007. Figure 6.10 presents reported cases of STD by race.

According to the Centers for Disease Control and Prevention (CDC), young people, especially youth of minority races and ethnicities, are at persistent risk for HIV infection. HIV infection often slowly progresses to AIDS among in-

Figure 6.10: Reported STD Cases By Race, 19 and Under (2008)



Source: Vital Statistics, Nebraska Department of Health and Human Services (DHHS).

fected young people. In Nebraska, there were four children living with HIV ages 0-11 and 16 children ages 12-19, a total of 20 child HIV cases as of 2007. Six children were diagnosed with HIV or AIDS in 2007, all of which were 12-19 years old at the time of diagnosis. Twelve people under age 19 at the time of AIDS diagnosis have died from the disease between 1983 and 2007. This data was not available for 2008.

According to the CDC, youth need accurate and age-appropriate information about HIV infection and AIDS, including how to reduce or eliminate risk factors, where to get tested for HIV and how to use a condom correctly before they engage in sexual behaviors that may put them at risk for infection.

Obesity, Dieting and Eating Habits

The 2005 YRBS student respondents were requested to include their height and weight measurements on their surveys. In 2005, 32.5% of students described themselves as being either slightly or very overweight. However, only 11% were actually considered to be overweight, or at risk of becoming overweight, based on their Body Mass Index (BMI). Nearly 40% of the females surveyed described themselves as overweight, however only 12.8% were at risk of becoming overweight, while 7.8% were overweight, according to their BMI. Although only 7.8% of the female students met the BMI criteria for overweight, 64.8% of the females surveyed reported that they were trying to lose weight at the time of the survey. Twenty-nine percent of the males surveyed were also trying to lose weight at the time of the survey.

Only 36.5% of the students reported to have met the recommended levels of physical activity, which is defined by the YRBS as 60 minutes of an activity that increases the heart rate for at least 5 out of 7 days in a week. Seventy-one percent met previously recommended levels, which equaled either 20 minutes of vigorous activity or 30 minutes of moderate activity on at least five days during the week. Nearly 8% reported to have not participated in any vigorous or moderate physical activity. Eighty-six percent ate less than five servings of fruits and vegetables per day during the seven days prior to the survey and 81% reported that they did not regularly consume milk during the seven days preceding the survey.

[1] Annie E. Casey Foundation, "Unequal Opportunities for Health and Wellness," *Race Matters Tool Kit*, http://www.aecf.org/knowledgecenter/publicationsseries/racematters.aspx.

[2] Ibid.

[3] Ibid.

[4] *Institute of Medicine (IOM)*, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," National Academy of Sciences: Washington, D.C., 2002.

[5] Marsha Regenstein, Ph.D., Linda Cummings, Ph.D., and Jennifer Huang, M.S., "Barriers to Prenatal Care: Findings from a Survey of Low-Income and Uninsured Women Who Deliver at Safety Net Hospitals," *National Public Health and Hospital Institute*, Prepared for the March of Dimes, October 2005.

[6] Ibid.

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[8] Nebraska Department of Health and Human Services.

[9] *March of Dimes*, "Quick Reference Fact Sheets: Low Birthweight," November 2005, http://www.marchofdimes.com/professionals/14332_1153.asp.

[10] The National Campaign to Prevent Teen Pregnancy, "Why It Matters: Linking Teen Pregnancy Prevention to Other Critical Social Issues," www.teenpregnancy.org.

[11] Annie E. Casey Foundation, "Why Teens Have Sex: Issues and Trends," *KIDS COUNT Special Report*, 1998.

[12] Annie E. Casey Foundation, "Unequal Opportunities for Adolescent Reproductive Health," *Race Matters Tool Kit*, http://www.aecf.org/knowledgecenter/publicationsseries/racematters.aspx.

[13] *The National Campaign to Prevent Teen Pregnancy*, "Why It Matters: Linking Teen Pregnancy Prevention to Other Critical Social Issues," www.teenpregnancy.org.

[14] Annie E. Casey Foundation, "Unequal Opportunities for Adolescent Reproductive Health," *Race Matters Tool Kit*, http://www.aecf.org/knowledgecenter/publicationsseries/racematters.aspx.

[15] U.S. Census Bureau, 2008 American Community Survey, Table B17010.

[16] U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement, Table HI05.

[17] U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement, Table HI10.

[18] In January of 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to programs prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in our system significantly. The Division uses social security numbers and dates of birth to identify unique clients in the data system and to obtain unduplicated client counts. Prior attempts at identifying unique clients included additional variables not used in this SFY 2008 count.

[19] Campaign for Tobacco Free Kids. Available at: http://www.tobaccofreekids.org/reports/settlements/toll.php?StateID=NE.

IMPACT BOX

Low level lead poisoning

By Lelia M. Coyne, PhD, MST, NE-Certified Lead-based Paint Risk Assessor
Independent Researcher

"She could do better if she would."
"He would do better if he could."

Two familiar sides of a perennial debate on whether motivation or intrinsic ability is the better predictor of academic and personal success. It hardly matters if we can't optimize both. We have control over one seriously neglected aspect of our efforts to nurture healthy, responsible children, but only if we will take it. That is exposure to lead, particularly during the years of most rapid neural development – prenatal through age seven. If lead exposure is not minimized, we may find our best efforts at early childhood education degraded, if not defeated.

That blood lead levels (BLLs) even in the range long designated as "safe" or "normal" have multiple disturbing impacts on intellectual, behavioral, and physical development is incontrovertibly demonstrated by emerging prospective and epidemiological studies. Underlying or superposed on lowered IQ, mental retardation, and lowered verbal and math scores on the SAT, are decreased frustration tolerance, deficits in attention, hyperactivity, weak executive control functions, lowered impulse control, aggressive behavior, and conduct disorder, all of which are implicated in school failure and juvenile delinquency.[1, 2] All also are factors in the staggering association between early childhood lead exposure and later criminal arrests for violent, property, drug, and serious motor vehicle offenses, fraud, obstruction of justice, and disorderly conduct.[3-6] Maternal elevated blood lead level (EBLL = BLL >10µg/dL) results in doubling of the early adult incidence of schizophrenia in prenatally exposed offspring.[7]

Many studies have shown association of BLL > 10µg/dl with other such conditions and diseases of industrialized societies as hearing loss, tooth decay, spontaneous abortion, low birth weight, renal disease, anemia, cardiovascular disease, and some cancers, to name only the best recognized. However, evidence is growing for an influence of lower levels of lead on these, as well.[8]

Centers for Medicare and Medicaid Services (CMS) mandated universal testing of Medicaid-eligible children according to a defined schedule in 1989. In 1997, the Centers for Disease Control (CDC) recommended continued universal screening of Medicaid-eligible children and development of state screening plans consistent with state and local risk patterns.[9] Nebraska has never required reporting the Medicaid status of EBLL children to the State. The screening rate of all Nebraska children from 1-6 years of age peaked at 14.6% in 2005, the last year of federal funding for testing.[10] In 2005, six counties reported no screening at all, and 34 others screened less than 5%. Since that time, screening rates in most counties in NE have plummeted.

The National Health and Nutrition Examination Study (NHANES) of 1988-2004 estimates a 1.4 % prevalence, nationally, of EBLLs.[11] However, comparison of Nebraska surveillance statistics spanning 2001-2005 with the characteristics of this population statistical study from NHANES reveals that the extent of testing in Nebraska fell far below that of the NHANES sample, and that the number of Nebraska houses constructed prior to 1978 is far above that in the "nationally representative sample."[12.13] Deteriorated lead-based paint (LBP) from pre-1978 houses is thought to constitute the greatest single present-day risk of lead poisoning.

These discrepancies in screening rates and age of housing stock between the NHANES and Nebraska demographics insure that the estimation of 1.4% cited as nationally representative cannot be assumed to represent EBLL prevalence in any county of Nebraska. Superficial appearance of similarly dropping levels of EBLL incidence in Nebraska, based on statistically insignificant

Nebraska surveillance data can most likely be attributed to the fact that overall national diminution of airborne lead remained the dominant factor in overall diminution of EBLL incidence over these years.[14]

Data from the recent NHANES study indicate that the gap between Medicaid children and others narrowed over the years of the reported study.[12,13] As a result, CDC is now recommending that testing be less specifically targeted to Medicaid children, and more generally to "at risk" children based on local assessment of pertinent risk factors. However, it is the exceptional Nebraska community where surveillance is adequate even to assess what its local risk factors are, much less to quantify them.

This lack of compliance with long-standing Federal recommendations is particularly unfortunate, preceding imminent enactment of the Environmental Protection Agency's (EPA's) Renovation, Repair & Painting (RR&P) Rule to take full effect on April 22, 2010.[15] The RR&P Rule extends requirements for lead-safe renovation practices and clearances from work only on federally owned and assisted properties and privately operated child-care facilities to include that on privately owned homes and public buildings, including schools. Although it is well acknowledged that unsafe renovation practices constitute a very common source of serious lead poisoning, relatively few studies have quantified this sporadic risk relative to that from prolonged living in poorly maintained older properties.

Very recent analysis of the societal costs of lead poisoning estimates that reducing blood lead levels to less than 1 µg/dL among all U.S. children between birth and 6 years would reduce crime and increase on-time high school graduations rates later in life.[16] This remarkably conservative study predicts that the net societal benefits arising from this decrease would amount to $50,000/child annually, in 2008 dollars. The resultant overall savings are estimated to be 1.2 trillion, and to produce an additional 4.8 million quality adjusted life years for the U.S. society as a whole.

[1] Bruce P. Lanphear, Richard Hornung, Jane Khoury, Kimberly Yolton, Peter Baghurst, David C. Bellinger, Richard L. Canfield, Kim N. Dietrich, Robert Bornschein, Tom Greene, Stephan J. Rothenberg, Herbert L. Needleman, Lourdes Schnaas, Gail Wasserman, Joseph Graziano, and Russell Roberts, "Low-Level Environmental Lead Exposure and Children's Intellectual Function: An International Pooled Analysis" *Environmental Health Perspectives* Vol.113, No. 7, July 2009 (894-899).

[2] Nevin, R., Trends in preschool lead exposure, mental retardation and scholastic achievement: association or Environ. Res. (2009), doi:10.1016/j.envres.2008.12.003Res. (2009) doi:10.1016/j.envres.2008.12.003.

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[4] Rick Nevin "Understanding International Crime Trends: The Legacy of Preschool Lead Exposure*," Environmental Research,* Vol.104, 2007 (315-336).

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[6] Joe M. Braun, Robert S. Kahn, Tanya Froehlich, Peggy Aulinger, and Bruce P. Lanphear, "Exposures to Environmental Toxicants and Attention Deficit Hyperactivity Disorder in U.S. Children," *Environmental Health Perspectives,"* Vol. 114, No. 12 December, 2006 (1904-1909).

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[8] "Air Quality Criteria for Lead, Vol. 1," United States Environmental Protection Agency, October, 2006, EPA/600/R-05/44bF.

[9] Anne M. Wengrovitz, Mary Jean Brown "Recommendations for Blood Lead Screening of Medicaid-Eligible Children Aged 1-5 Years: an Updated Approach to Targeting a Group at High Risk" *Advisory Committee on Childhood Lead Poisoning, Division of Environmental and Emergency Health Services, National Center for Environmental Health, MMWR Recommendations and Reports*, August, 2009.

[10] "Childhood Blood Lead Poisoning Surveillance Report 2001-2005" *Nebraska Department of Health and Human Services, Division of Public Health,* December 2007.

[11] Robert L Jones, David M. Homa, Pamela A. Meyer, Debra J. Brody, Kathleen L. Caldwell, James L. Pirkle, and Mary Jean Brown "Trends in Blood Lead Levels and Blood Lead Testing Among U.S. Children Aged 1 to 5 Years, 1988-2004 *Pediatrics,* 2009, Vol. 123 (e376-e385).

[12] Joanna M. Gaitens, Sherry L. Dixon, David E. Jacobs, Jhothi Nagaraja, Warren Strauss, Jonathan W. Wilson, and Peter J. Ashley "Exposure of U.S. Children to Residential Dust Lead, 1999 – 2004 I. Housing and Demographic Factors" *Environmental Health Perspectives,* Vol.117, No. 3, March 2009 (461-467).

[13] Sherry L. Dixon, Joanna M. Gaitens, David E. Jacobs, Warren Strauss, Jyothi Nagaraja, Tim Pivetz, Jonathon W. Wilson, and Peter J. Ashley "Exposure of U.S. Children to Residential Dust Lead, 1999 – 2004 II. The Contribution of Lead-Contaminated Dust to Children's Blood Lead Levels" *Environmental Health Perspectives,* Vol. 117, No. 3, March 2009 (468-473).

[14] Lelia M. Coyne "A New Slant on Pediatrics' Report of Falling Elevated Blood Lead Levels" http://pediatrics.aapublications.org/cgi/eletters/123/3e376 (In Response to Ref 11).

[15] EPA's Renovation, Repair, and Painting Program Final Rule 40 CFR Part 745 http://www.epa.gov/lead/pubs/lrrpfinal/pdf and additional information at www/afhh.org and www.nchh.org

[16] Peter Muennig, "The Social Costs of Childhood Lead Exposure in the Post=Lead Regulation Era" *Archives Pediatrics & Adolescent Medicine,* Vol. 163, No. 9, September 2009 (844-849).

Juvenile Justice

Voices for Children in Nebraska believes that all children have a right to due process and equal protection under the law, access to judicial systems that provide appropriate, fair and lawful determination and rehabilitative social services where needed. Children can find themselves involved in the juvenile justice system for a variety of reasons ranging from truancy to homicide. Family problems including child abuse, domestic violence, poverty, mental health issues and self-esteem can all be factors that influence a juvenile's behavior. We must create systems of support which reduce the number of children entering the juvenile system and develop policies and programs to ensure that once a youth has entered the system, he or she has quality resources available, such as adequate mental health treatment and educational experiences, that will greatly improve the odds of success for youth.

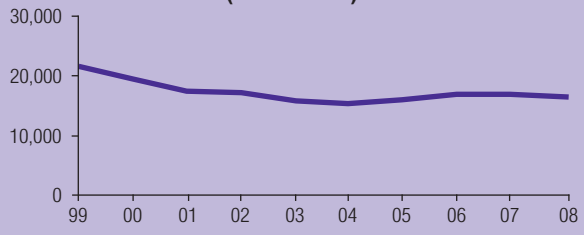
Despite the promise of equal protection under the law, national research has shown that racial bias has contributed to an overrepresentation of youth of color in the juvenile justice system. This overrepresentation is often a product of decisions made at early points in the juvenile justice system, such as the decision to make the initial arrest, the decision to hold a youth in detention pending investigation, the decision to refer a case to juvenile court or adult court, the prosecutor's decision to petition a case, and the judicial decision and subsequent sanction.[1] Where racial differences are found to exist, they tend to accumulate as youth are processed deeper into the system.[2]

Juvenile Arrests

In calendar year (CY) 2008, 15,700 Nebraska juveniles were arrested. Figure 7.1 presents a historical view of juvenile arrest since 1999.

Female juvenile offenders comprised 32.73% (5,139) of all juvenile arrests in 2008, and male offenders made up the remaining 67.27% (10,561). These averages are consistent with the percentages of female and male juvenile offenders over the last several years. Violent crime arrests comprised only 1.6% of all juvenile arrests in 2008. Table 7.1 presents Juvenile arrests by offence and gender.

Figure 7.1: Juvenile Arrests, 17 and Under (1999-2008)



Source: Nebraska Commission on Law Enforcement and Criminal Justice. Data pulled on October 2, 2009.

While we can track juvenile arrest by race, unfortunately, we are unable to report juvenile arrests by ethnicity statewide

Anonymous

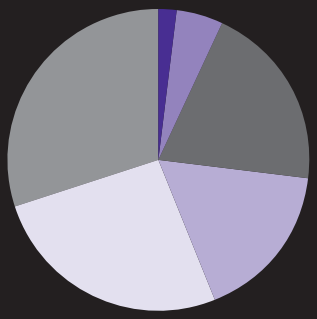
Table 7.1: Selected Nebraska Juvenile Arrests by Offense and Gender (2008)*

Offense	Males	Females	Total
Violent Offenses	212	36	248
Felony Assault	119	31	150
Robbery	70	5	75
Forcible Rape	18	0	18
Murder and Manslaughter	5	0	5
Non-Violent Offenses	10,183	5,023	15,206
Larceny Theft (Except Motor Vehicle)	1,790	1,302	3,092
Liquor Laws	1,461	1,024	2,485
All Other Offenses (Except Traffic)	1,530	714	2,244
Misdemeanor Assault	1,337	677	2,014
Drug Abuse Violations	948	237	1,185
Vandalism- Destruction of Property	883	164	1,047
Disorderly Conduct – Disturbing the Peace	636	295	931
Runaways	240	205	445
Curfews and Loitering Law Violations	299	188	487
Burglary- Breaking or Entering	310	31	341
Driving Under the Influence	202	82	284
Weapons: Carrying, Possessing, etc.	187	12	199
Sex Offense (Except Forcible Rape and Prostitution)	110	15	125
Stolen Property: Buy, Receive, Possess, Conceal	179	33	212
Offenses Against Family and Children	19	26	45
Arson	39	11	50
Forgery & Counterfeiting	12	7	19
Prostitution and Commercialized Vice	1	0	1

Source: Nebraska Commission on Law Enforcement and Criminal Justice.

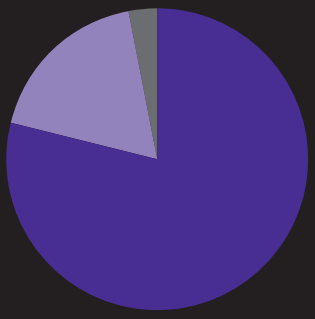
** This does not include all arrest or offense types.*

Figure 7.2: Juvenile Arrests by Age (2008)



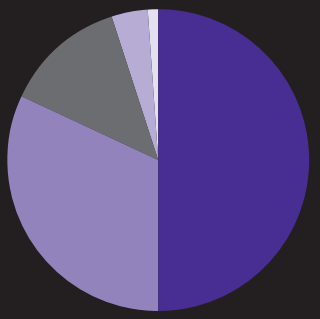
Source: Nebraska Commission on Law Enforcement and Criminal Justice.

Figure 7.3: Juvenile Arrests by Race (2008)



Source: Nebraska Commission on Law Enforcement and Criminal Justice.

Figure 7.4: Juveniles Held in Juvenile Detention by Race (2008)



Source: Lancaster County Juvenile Detention Center, North East Nebraska Juvenile Services, Scotts Bluff County Detention Center and Douglas County Youth Center.

Note: Scotts Bluff County Detention Center does not provide ethnicity data.

since the Omaha Police Department and the Douglas County Sheriff's Office do not track the ethnicity of juveniles arrested. For this reason, we have no way of knowing whether or not Hispanic juveniles are overrepresented in juvenile arrest in the largest and most diverse city and county in the state. Figures 7.2 and 7.3 present juvenile arrests in 2008 by age and race.

Juvenile Detention

For 2008, Voices for Children is unable to report an accurate statewide total of juvenile detention due to difficulties in data collection. At the time this report went to print, 2008 data from the Scotts Bluff County Detention Center were unavailable from the Nebraska Commission on Law Enforcement and Criminal Justice. In September 2007, the Scotts Bluff County Detention Center consolidated facilities, which has resulted in data collection challenges for the state. Consequently, 2008 detention data for juveniles ages 17 and under, presented in Table 7.2, do not provide an accurate reflection of youth detention in Nebraska.

In our data collection process, Voices for Children in Nebraska did contact each of the four detention centers to request 2008 data. Each center was able to provide 2008 data, by race and ethnicity, for youth ages 17 and under. A snapshot of these data is provided in Table 7.3. The data provided by individual detention centers differ slightly from the statewide data totals provided by the Nebraska Commission on Law Enforcement and Criminal Justice.

There were 148 juveniles under age 18 held in adult detention facilities in 2008. Juveniles detained in adult facilities must be separated by "sight and sound" from adult detainees, according to the federal Juvenile Justice and Delinquency Prevention Act (JJDPA). Females spent fewer days in adult detention facilities, averaging 10.2 days, while males averaged 28 days. Black juveniles experienced the longest periods of detention in adult jails and lockups, averaging 45.25 days. Hispanic juveniles were detained in adult jails for an average of 32.28 days. White juveniles followed with an average stay of 23.93 days, and Native American juveniles averaged 19.71 days of detention in adult jails and lockups.

Probation

In 2008, there were 5,802 juveniles supervised on probation, a slight decrease from the 5,842 juveniles in 2007. Of those juveniles placed on probation in 2008, 66% were White, 14% were Black, 3% were Native American, 1% were Asian, and 16% were of a race classified as "Other." Moreover, 17% of juveniles placed on probation were Hispanic. During 2008, 2,393 juveniles were successfully released from probation. Of those juveniles successfully released from probation, 70.92% were White, 11.37% were Black, 2.05% were Native American, 0.67% were Asian, and 15% were classified as "Other." Of those juveniles successfully released from probation,16.26% were Hispanic.

Both, the number of juveniles placed on probation for a misdemeanor offense and the number of juveniles placed on probation for a felony offense decreased slightly from 2007 levels amounting to 2,603 and 281 respectively in 2008.

Youth Rehabilitation and Treatment Centers (YRTC)

The two Youth Rehabilitation and Treatment Centers in Ne-

Table 7.2: Juveniles Held in Juvenile Detention Facilities By Race (2008)

Agency	American Indian/ Alaskan Native	Asian/Pacific Islander	Black	White	Unknown	Total	Count
Lancaster County Attention Center (Lancaster County)	3.07%	2.55%	23.88%	68.97%	1.53%	100.00%	783
North East Nebraska Juvenile Services (Madison County)	10.95%	0.86%	8.93%	77.52%	1.73%	100.00%	347
Scotts Bluff County Detention Center (Scotts Bluff County)*	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0
Douglas County Youth Center	0.84%	0.78%	51.23%	46.95%	0.19%	100.00%	1,542
Statewide Total	2.81%	1.31%	37.72%	57.37%	0.79%	100.00%	2,672

**Due to the issues related to the consolidation of facilities, Nebraska Commission on Law Enforcement and Criminal Justice has not received data from Western Nebraska Juvenile Services since 9/07. This issue that is currently under investigation.*

Note: Row totals may not equal 100% exactly due to rounding.

Source: Nebraska Commission on Law Enforcement and Criminal Justice.

Table 7.3: Juveniles Held in Juvenile Detention Facilities as Reported by Individual Facilities (2008)

(Youth Served Age 17 and Under)

Agency	Female	Male	White	Black	American Indian/ Alaskan Native	Asian/ Pacific Islander	Hispanic	Other	Unknown	Total
Lancaster County Attention Center (Lancaster County)	180	620	56.25%	23.75%	2.88%	2.50%	13.00%	1.63%	–	800
North East Nebraska Juvenile Services (Madison County)	207	565	56.99%	8.29%	9.20%	.26%	25.26%	–	0.00%	772
Scotts Bluff County Detention Center (Scotts Bluff County)*	62	164	78.32%	3.54%	17.26%	.44%	*	–	.44%	226
Douglas County Youth Center	415	1,229	38.08%	50.79%	0.85%	.73%	9.55%	0.00%	–	1,644

**Scotts Bluff County Detention Center does not provide ethnicity data.*

Source: Lancaster County Juvenile Detention Center, North East Nebraska Juvenile Services, Scotss Bluff Detention Center and Douglas County Youth Center.

braska are located in Kearney (established for males in 1879) and Geneva (established for females in 1892).

The YRTC Kearney mission is: *To help youth live better lives through effective services affording youth the opportunity to become law abiding and productive citizens*.

The YRTC in Geneva's mission is: *To protect society by providing a safe, secure and nurturing environment in which the young women who come to us may learn, develop a sense of self, and return to the community as productive and law abiding citizens*.

In the fiscal year 2007-2008, 466 males were admitted for treatment to Kearney and 153 females to Geneva for a total of 619 youth committed to YRTC care from July 2007-June 2008.[3] This was a increase of 59 total YRTC commitments over the previous year.

YRTC Kearney had an average daily population of 170 in SFY 2007-2008 (this does not include youth that have been paroled from YRTC Kearney to the Hastings Juvenile Chemical Dependency Program). Males at Kearney remained an average of 172 days and average age at admission was 16. Of all young men committed to Kearney, 46% were White, 25% were African American, 23% were Hispanic, 4% were Native American and 2% were Asian. The major offenses committing males to YRTC Kearney were assault (23.18%), theft (20.39%) and possession of drugs (11.59%). Forty six students earned their General Equivalency Diplomas (GED) while at Kearney. The average per diem cost for 2007-2008 at Kearney was $149.28 per youth. In 2007-2008, YRTC Kearney paroled 96 youth to Hastings Juvenile Chemical Dependency Program.

Geneva provided services for an average of 71 females per day in SFY 2007-2008. The average female committed to Geneva was 16 years old at admission and remained there 7.3 months. The top offenses (excluding those committed for parole safekeeping, which means that youth were returned to Geneva until a hearing could be held to determine if parole should be revoked) were assault (25.49%), shoplifting (14.38%) and theft (8.50%). Twenty students received their high school diplomas in 2007-2008. The majority of females placed at YRTC Geneva were White/Non-Hispanic 42%, 23% were Hispanic, 19% were Black/Non-Hispanic, and 16% were American Indian. The per diem cost of Geneva for 2007-2008 was $252.86.

Juveniles Treated As Adults

There are fundamental differences between the culpability of juveniles and adults in the justice system. Adolescents do not have the same capacity to understand long-term consequences, control impulses, handle stress and resist peer pressure as adults. New brain-development research has revealed

POLICY BOX

Life Without the Possibility of Parole

When a youth commits a serious crime, they should be held accountable. However, they should be held accountable in a manner that reflects their age, emotional and neurological immaturity, and capacity for rehabilitation. Sentencing a youth to life without the possibility of parole, as Nebraska has done in the case of 24 former youth currently serving life sentences in state prisons, ignores everything we know about adolescent brain development. It is, in effect, a sentence to death in prison, and it denies those sentenced any opportunity to demonstrate change or growth as they enter into, and live out the rest of their adult lives.

Research surrounding the brain development of adolescents has found that, since they are experiencing changes in the emotional and decision-making centers of the brain, youth tend to overstate rewards without fully evaluating the long-term consequences or risks involved in a situation.[i] Studies have also demonstrated that youth are particularly susceptible to peer pressure, and that, when placed in stressful situations, they are more likely to make decisions based on emotion rather than reason.[ii, iii]

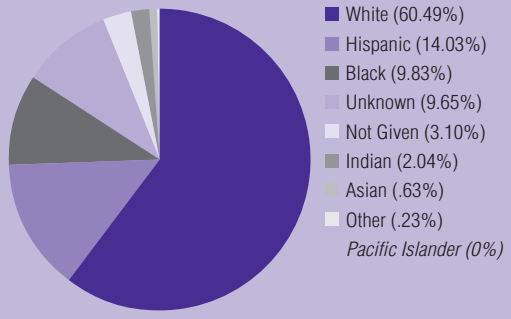
The US Supreme Court took note of the emerging scientific research on adolescent brain development in a 2005 ruling, in which they found that youth are less culpable for their crimes than adults. Due to their decreased culpability, the Court ruled that it constituted cruel and unusual punishment to impose the death penalty on youth under the age of 18. In support of

the systems of the brain which govern "impulse control, planning and thinking ahead are still developing well beyond age 18."[4] Research consistently indicates that treating children as adults in the justice system is neither an effective deterrent, nor does it produce any benefits in preventing or reducing violence. In fact, the CDC has found that "transfer of youth to the adult criminal justice system typically results in greater subsequent crime, including violent crime, among transferred youth."[5] Nebraska has no minimum age at which a juvenile can be tried as an adult, and we currently allow juveniles to be sentenced to life without parole. While young people must accept responsibility for their actions and the consequences of those actions, our justice systems must acknowledge the fundamental differences between juveniles and adults to effectively pursue the goals of promoting public safety and improving the odds of success for troubled youth.

In 2008, the cases of 5,545 Nebraska juveniles were filed in adult court. Out of 5,545 cases, 1,429 were later transferred to the juvenile court while the remaining 4,116 cases were tried in adult courts. This is over 26% of all juveniles arrested in 2008. Figure 7.5 presents cases of juveniles who filed in adult courts by race.

Once processed through the adult system and committed to adult prisons, research shows that juveniles have fewer

Figure 7.5: Number of Juveniles Whose Cases Were Filed in Adult Courts (2008)



Note: Out of 5,545 cases initially filed in adult court, 1,429 were later transferred to the juvenile court.

Source: Nebraska Administrative Office of the Courts.

treatment opportunities in the adult correctional system than youth held in juvenile facilities.[6] Nationally, youth in adult jails and prisons face high rates of victimization, particularly sexual assault or beatings, and are more likely to commit suicide.[7] In 2008, 68 Nebraska youth, ages 17 and under, were processed through the adult system and housed in a Nebraska Correctional Youth Facility. This is an increase from 52 youth in 2007. Of these 68 youth, 13 were incarcerated for robbery, 18 for assault and 2 for homicide. Additionally, 27.94% of the youth incarcerated in adult prisons in Nebraska were 16 and under. Of all youth 17 and under incarcerated in adult prisons, 70.59% were youth of color (classified as Black, Hispanic or Native

its decision the Court cited youths' lack of maturity, lower level of mental and emotional development, and inability to make sound judgments.[iv]

Even before brain research was available, our recognition of youths' emotional immaturity was apparent in the special restrictions we applied to young people. We do not allow youth under the age of majority to buy alcohol or cigarettes, vote, or serve on juries. Ensuring that those convicted as juveniles will have the possibility of parole would bring consistency to the treatment of youth under the law. As things stand, current Nebraska inmates have been sentenced to die in prison for crimes committed before the law recognized them as responsible enough to get behind the wheel of a car.

That adolescents' brains are still developing means that their personalities are not fixed or stagnant, and that they are therefore particularly good candidates for rehabilitation. Providing for the possibility of parole allows us to come together as a community, many years from now, and evaluate whether a youth offender still poses a threat to society. Certainly in some cases we will find that they do, and their parole can be denied, but everything we know about youth and their capacity for change demands that we at least reexamine the question and the sentence of life without parole for juveniles.

[i] Neir, Eshel, et. al., "Neural Substrates of Choice Selection in Adults and Adolescents," *Neuropsychologia*, Vol. 45, No. 6 (2007).

[ii] Gardner, Margo, and Laurence Steinberg, *Peer Influence on Risk Taking*, Vol. 41, No. 4 (2005).

[iii] Casey. B.J., et. al., "The Adolescent Brain," *Developmental Review*, Vol. 28, No. 1 (2008)

[iv] *Roper v. Simmons*, 543 U.S. 551, 569-70 (2005).

Table 7.3: Juvenile Interaction with the Justice System by Race (2008)

	Teen Population[i]	Arrests	Youth in Detention Facilities[ii]	Placed on Probation[iii]	YRTC Commitments[iv]	Juveniles Tried in Adult Court[v]	Juveniles Incarcerated in Adult Prison[vi]
White	80%	79%	49%	66%	45%	62%	28%
Black	6%	18%	32%	14%	23%	6%	51%
Native American	1%	3%	4%	3%	7%	2%	9%
Asian	2%	0%	1%	1%	2%	1%	0%
Other	12%	–	14%	16%	23%	16%	12%
Unknown	–	–	0%	–	–	13%	–
Total	100%	100%	100%	100%	100%	100%	100%

Note: Numbers are rounded to the nearest whole number.

[i] The "Teen Population" in this figure comprises youth in Nebraska ages 10 through 19 in 2008. We were unable to obtain data for just juveniles 10-17. "Other" includes 2% of "two or more races, Not Hispanic" and "Hispanic" categories.

[ii] Data was provided by individual detention facilities. The "other" category includes .38% "other" and 13.25% youth of Hispanic ethnicity from three out of four detention facilities. The Scotts Bluff County Detention Center does not track ethnicity. As a result, the "other" category does not include Hispanic youth from the Scotts Bluff facility, instead, any Hispanic youth would be represented in other race categories.

[iii] Out of the total of 5,802 juveniles on probation, 1,044 or 18% were Hispanic. Since race and ethnicity are captured separately, they are not included in the table.

[iv] This is the total of YRTC commitments at both Geneva and Kearney. The Geneva totals by race and ethnicity include commitments of parole safekeepers, those offenders being held until a hearing to determine whether or not parole should be revoked. The Kearney totals do not include parole safekeepers. Also, YRTC totals are broken down by both race and ethnicity, so the "Other" percentage represents Hispanics committed to the YRTCs in fiscal year 2008.

[v] Juveniles Tried in Adult Court is broken down by race and ethnicity, so the "Other" percentage encompasses 16% Hispanic and 0.3% Other."Unknown" encompasses unknown and "not given."

[vi] Juveniles in Adult Prison is broken down by race and ethnicity, so the "Other" percentage encompasses 10.19% Hispanic and 1.47% Other.

American), 27.94% were White and 1.47% were classified as "Other."

As of August 2008, there were 24 persons serving life sentences without the possibility of parole that were sentenced for crimes committed before age 18.[7] Eleven (45.83%) of these persons sentenced to life without parole as juveniles are Black. One person is Native American, and the remaining are White. Fourteen (nearly 60%) of these persons were sentenced in Douglas County.

Racial Disparities in the Juvenile Justice System

Nationally, the problem of the overrepresentation of youth of color in our juvenile justice system is pervasive and troubling. It is critical that data are collected and analyzed at every phase of the juvenile justice process to identify at what point of interaction with the system the disparate outcomes are taking place. Table 7.3 presents data on juvenile interaction with the justice system by race.

[1] "And Justice for Some: Differential Treatment of Youth of Color in the Justice System," *National Council on Crime and Delinquency*, January 2007.

[2] Ibid.

[3] The racial breakdown of males adds up to 464. An official from Kearney stated that the difference is due to the fact that some youth do not spend enough time in the center for the racial information to be collected.

[4] "Less Guilty by Reason of Adolescence," *MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice*, Issue Brief No. 3, available at www.adjj.org/downloads/6093issue_brief_3.pdf.

[5] *Centers for Disease Control and Prevention*, November 30, 2007, "Effects on Violence of Laws and Policies Facilitating the Transfer of Youth From the Juvenile to the Adult Justice System: A Report on Recommendations of the Task Force on Community Prevention Services," *Morbidity and Mortality Weekly Report*, Vol. 56, No. RR-9, available at www.cdc.gov/mmwR/pdf/rr/rr5609.pdf.

[6] *Center for the Study and Prevention of Violence*, "CSPV Fact Sheet, Judicial Waivers: Youth in Adult Courts," FS-008, 1999, available at www.colorado.edu/cspv.

[7] Fagan, J., M. Frost, and T.S. Vivona, "Youth in Prisons and Training Schools: Perceptions and Consequences of the Treatment-Custody Dichotomy," *Juvenile and Family Court*, 1989, as qtd in *The Annie E. Casey Foundation*, 2008 KIDS COUNT Data Book.

[8] Nebraska Department of Correctional Services, Inmate Database, http://dcs-inmatesearch.ne.gov/Corrections/COR_download.htm, Accessed 9.21.09.

Nutrition

Voices for Children in Nebraska believes that all children should have access to adequate nutrition. Nutrition serves as the foundation for children's health, academic achievement and overall development. Being undernourished can inhibit a child's ability to focus, absorb information and exhibit appropriate behavior at home and school. Good nutrition can prevent illnesses and encourage proper physical growth and mental development. Supplemental food programs that include access to nutritious foods and offer education can assist families in providing healthy food for their children.

USDA Nutrition Programs

Supplemental Nutrition Assistance Program (SNAP)

The Supplemental Nutrition Assistance Program (SNAP) is a highly successful program created to reduce food insecurity among low-income and impoverished people in the United States. The federal government pays for 100% of SNAP benefits, while administrative costs are covered by the states. SNAP benefits, distributed via Electronic Benefit Transfer (EBT) cards, are provided by the United States Department of Agriculture

Tayler

(USDA) to aid families that have incomes at or below 130% of the federal poverty level (FPL) in order to maintain a low-cost, healthy diet. The Nebraska Department of Health and Human Services (DHHS) has been particularly successful in administering the SNAP. SNAP is a critically important part of Nebraska's low-income safety net, and DHHS must be commended for their effective administration of benefits.

With the passage of the 2008 Farm Bill, several improvements have been made to the Food Stamp Program. The name of the program has been changed to the Supplemental Nutrition Assistance Program or SNAP. Also, benefits are no longer issued in stamp form. The utilization of EBT cards, similar to credit or debit cards, is expected to enhance program integrity and reduce the stigma associated with receiving food stamps.

In SFY 2008, the use of food stamps continued to rise over previous years. The Nebraska Department of Health and Human Services (DHHS) distributed food stamps to an average of 120,851 persons or 52,162 households monthly in SFY 2008. The average payment was $207.68 per house-hold or $89.64 per person totaling $129,995,851 (99.75% of the funding was provided by the federal government). There were 62,518 children, ages 18 and under, who received food stamps in Nebraska in June of 2008. This is a decrease from 63,752 children in June of 2007. Figure 8.1 and 8.2 demonstrate food stamp participation by age and race, respectively.

School Lunch

Families are eligible for free or reduced price lunches based on their income level through the USDA School Lunch Program. Families must have an income at or below 130% FPL to re-

IMPACT BOX

Summer Food Service Program

By Joan Orender, Program Specialist, Summer Food Service Program

Summer time can be a difficult time for low-income families and their children since they have less access to nutritious meals, especially in this economy. Good nutrition is the basis of a young person's development. Summer should never be a break in any young person's development. Poor nutrition harms developing young minds.

For many children school lunch or breakfast are often the only full meals they will get all day. When a young person hasn't had a nutritious breakfast before school, teachers have observed decreased alertness, poor concentration, disruptive behavior, low energy levels, and lower test scores.

Providing nutritious meals is an investment in our future. The Summer Food Service Program (SFSP) helps deliver: lunch, breakfast, even snacks to youngsters in the summer.

The Summer Food Service Program is a federally funded program operated nationally by the U.S. Department of Agriculture (USDA) and administered by Nutrition Services at the Nebraska Department of Education. The USDA Food and Nutrition Service (FNS) Summer Food Service Program provides support to sponsors to run SFSP programs in low income areas through:

- Schools
- Local government agencies
- Private non-profit organizations
- Non-profit colleges and universities
- Non-profit residential camps or non-residential summer camps

These organizations may have programs in: Open (low income) Sites, Migrant Sites, Enrolled Sites, or Camp Sites.

The Summer Food Service Program's purpose is to provide meals to children when school is not in session. The USDA recognizes the importance of the SFSP in attracting young people to positive summer activities located in safe institutions in their neighborhoods. Additionally, USDA promotes the SFSP to ensure that children are "better prepared to return to school ready to learn."

ceive free lunch and at or below 185% FPL to receive reduced price meals (see the Economic Well-Being section, page 34, for federal poverty levels). Through this program, the USDA subsidizes all lunches served in schools. During the 2007-2008 school year, 433 districts participated with 1,018 sites. There were 112,950 children found to be income eligible for free and reduced meals on the last Friday in September of 2008 (See the County Data section for a new indicator on the percent of children eligible for free and reduced meals in each county).

School Breakfast

The USDA provides reimbursements to schools for breakfast as they do for lunch. Unfortunately, fewer schools choose to participate in the breakfast program. During the 2007-2008 school year, 716 schools in 262 districts participated in the school breakfast program.

Anonymous

Support from the USDA is very helpful in this economy. The breakfast reimbursement is a minimum of $1.78 per meal; lunch/supper reimbursement is $3.13; and snacks are reimbursed at 73.5 cents. For more information on the program, go to www.fns.usda.gov/cnd/summer.

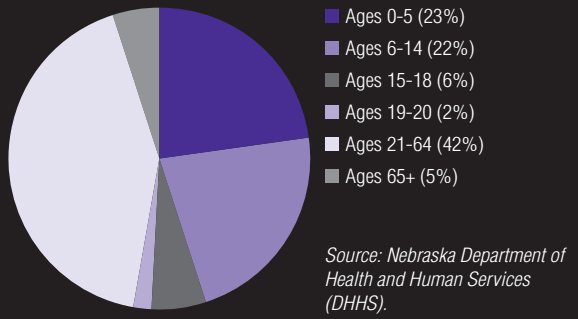
Through the SFSP, programs can provide up to two healthy meals or snacks per day to youngsters age 18 years and younger at approved sites in low-income areas. Meals and snacks are also available to persons with mental or physical disabilities, over age 18 who participate in school programs. Nebraska has 51 Sponsors or institutions participating in the SFSP with 190 Sites across the state.

If you can make it work in your area, you will help the economy and end summer hunger, while investing in the future of our young people.

To find the Nebraska Summer Food Service Program (SFSP) sponsors serving your county go to: http://www.nde.state.ne.us/NS/sfsp_sponsors.htm.

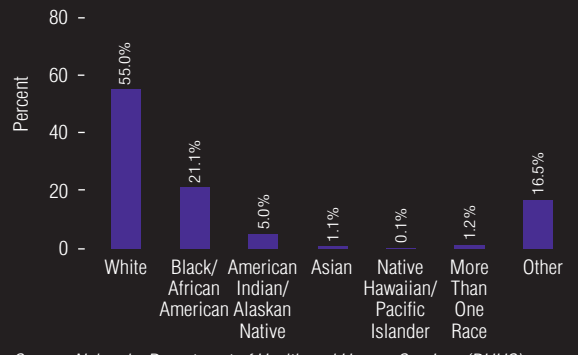
For a listing of all Nebraska sponsors and sites participating in the SFSP go to http://www.nde.state.ne.us/NS/sfsp/2009sfsplist.pdf.

Figure 8.1: Nebraska Food Stamp Participants by Age (June 2008)



Source: Nebraska Department of Health and Human Services (DHHS).

Figure 8.2: Food Stamp Recipients by Race (June 2008)



Source: Nebraska Department of Health and Human Services (DHHS).

In 2007-2008 school year, the USDA reimbursed a total of $49,456,442 for all free/reduced breakfast and lunches. The state of Nebraska match for free/reduced lunch and breakfast was $315,080.

Summer Food Service Program (SFSP)

The USDA Summer Food Program was created to meet the nutritional needs of children and low-income adults during the summer (See Impact Box on page 62 for more information). An average of 27,049 meals were served daily to Nebraska children and their families through the SFSP in 2008. In 2008, 27 of the 93 Nebraska counties offered the SFSP.

Commodity Distribution Program

The USDA purchases surplus commodities through price support programs and designates them for distribution to low-income families and individuals through food banks, soup kitchens and pantries. In FY 2008 (July 1, 2007 to June 30, 2008), a total of 140,748 Nebraska households were served with Pantry Baskets through the Commodity Distribution Program, an average of 11,729 households per month. This represents a considerable increase from FY 2007 when a total of 82,533 households were served with Pantry Baskets. Moreover, in FY 2008, the Commodity Distribution Program served a monthly average of 29,297 persons in soup kitchens, totaling 351,563 persons served. This on the other hand, represents a considerable decrease from FY 2007 when 52,854 persons were served monthly.

Commodity Supplemental Food Program (CSFP)

Women who are pregnant, breast-feeding and postpartum or families with infants and children up to age six who are at or below 185% of poverty are eligible for the USDA Commodity Supplemental Food Program. The program provides surplus commodity foods such as non-fat dry milk, cheese, canned vegetables, juices, fruits, pasta, rice, dry beans, peanut butter, infant formula and cereal. For federal fiscal year (FY) 2008, a monthly average of 935 women, infants and children were

POLICY BOX

WIC Revamps Food Choices

By Lynn Goering, WIC Administrative Operations Coordinator, Department of Health and Human Services

Research shows that poor nutrition during early childhood increases the chance of anemia, adds to health care costs, and limits memory development and a child's ability to learn. WIC has improved children's health, growth and development, and prevented health problems for 35 years. Poor nutrition during a baby's first five years will affect that baby for the rest of its life. During this critical period of a child's development, WIC provides a safe, nurturing environment for education, healthcare and social service referrals, as well as free access to nutritious foods. WIC children enter school ready to learn, showing better cognitive performance.

The centerpiece of WIC is nutritious foods which have not changed significantly since the programs beginning in 1974. Participants receive monthly vouchers or coupons for specific foods: *Milk, eggs, iron fortified cereal, 100% juice, beans and peanut butter, infant formula, and tuna for breastfeeding women.*

In October 2009 Nebraska revamped its WIC nutrition program to reflect the latest science on healthy diets and address obesity. These changes will help families to eat less fat and more fiber, eat fewer overall calories, eat more vegetables and fruit and drink fewer sweetened beverages.

Among the changes are:

1. Addition of fresh vegetables and fruit: All women and children (1-5

served by CSFP with 11,220 food packages. This is a 1.6% decline in the number served from FY 2007. Seniors, age 60 or older, who are at or below 130% of poverty, may also participate in the program. In FY 2008, a monthly average of 11,972 seniors was served with 143,664 food packages. This is a 3.5% increase in the number of seniors served from FY 2007. The CSFP serves all 93 counties through 8 local nonprofit agencies and 20 warehouses across the state. Each year the number of individuals served and fund allocation is determined by USDA.

Women, Infants and Children (WIC)

The special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a short-term intervention program designed to influence lifetime nutrition and health behaviors in a targeted, high-risk population. WIC provides nutrition and health information, breastfeeding support and monthly vouchers or coupons for specific food such as milk, juice, cheese, eggs, beans, peanut butter and cereal to Nebraska's pregnant, postpartum and breastfeeding mothers, as well as infants and children up to age five. Eligible participants must meet the income guidelines of 185% of poverty and have a nutritional risk. Parents, guardians and foster parents are encouraged to apply for benefits. Program participation helps ensure children's normal growth, reduce levels of anemia, increase immunization rates, improve access to regular health care and improve diets. In October 2009, Nebraska revamped its WIC nutrition program to reflect the latest science on healthy diets and address obesity. These changes will provide families with better access to food with less fat and more fiber, to consume fewer overall calories, eat more vegetables and fruit and drink fewer sweetened beverages. The details of the revamped program are covered in the policy box below.

Research has shown that the WIC Program plays an important role in improving birth outcomes and containing health care costs. A series of reports published by the United States Department of Agriculture (USDA), based on a five-state study of WIC and Medicaid data for over 100,000 births,

years old) will receive monthly checks valued from $6-10 for the purchase fresh vegetables and fruits. The amounts of juice are reduced for women and children.

2. Baby food fruits and vegetables: Infants 6 months and older will receive jars of baby food fruits and vegetables rather than juice.
3. Reduced, low- or non-fat milk only for all women and children (over the age of 2): Whole milk will only be offered to children who are between 12 and 24 months of age.
4. Whole grain options added: 100% whole wheat bread or brown rice are now part of the monthly food package. Also more than half of the iron-fortified cereal options are whole grain cereals.
5. Canned Beans are now available as an additional option in addition to dried beans or peanut butter: This option adds convenience for participants to eat more nutrient rich beans.
6. Breastfeeding incentives for mother and infant: The food benefits for the breastfeeding mother and her infant provide the greatest amount of food.
7. Soy milk will be available to women as a substitute for milk.

In total, the new WIC foods are lower in saturated fat, total fat, provide more whole grains and fiber as well as being lower in sugar.

The first three years of a child's life are when life-long habits are set. The improvements to the WIC program foods will be an integral part of exposing young children to healthy foods, establishing positive eating patterns and preventing childhood obesity.

Persons eligible for WIC must live in Nebraska, have an income less than or equal to 185 percent of poverty ($40,793 annually for a family of 4) and have their nutritional needs assessed by a WIC nutrition professional.

found that every $1 spent on WIC resulted in $1.77 to $3.13 savings in health care costs for both the mother and the newborn, longer pregnancies, fewer premature births, lower incidence of moderately low and very low birth weight infants and a greater likelihood of receiving prenatal care.[4] Children participating in WIC also demonstrate better cognitive performance. In FY 2008, Nebraska WIC served a monthly average of 44,740 participants (10,688 women, 10,944 infants and 23,108 children) per month through 110 clinics. Participation in the WIC program has continued to steadily increase. While 2008 Nebraska birth data were not available at the time this report was published, 57% of the 26,935 babies born in 2007 were enrolled in the WIC program. The 2008 average cost for food benefits and nutrition services for a pregnant woman participating in the Nebraska WIC Program was approximately $702 per year (fiscal year). Tables 8.1 and 8.2 demonstrate WIC participation by category and average number of participant since 1999 respectively.

Table 8.1: WIC Participation by Category (Federal Fiscal Year 2008)*

Breastfeeding Women	2,776
Postpartum Women	3,352
Pregnant Women	4,560
Infants	10,944
Children	23,108
Total	44,740

**This data reflects Average Participation per Month during that fiscal year.*

Source: Nebraska Department of Health and Human Services (DHHS).

Table 8.2: Average Monthly WIC Participants (1999-2008)

Year	Participants
1999	32,379
2000	32,194
2001	33,797
2002	36.454
2003	37,731
2004	39,087
2005	40,252
2006	40,733
2007	41,482
2008	44,740

Source: Nebraska Department of Health and Human Services (DHHS).

[1] Congressional Budget Office as quoted in Stacy Dean, Colleen Pawling and Dorothy Rosenbaum, "Implementing New Changes to the Food Stamp Program: A Provision By Provision Analysis of the 2008 Farm Bill," *Center of Budget and Policy Priorities*, Revised July 2008.

[2] Stacy Dean, Colleen Pawling, Dorothy Rosenbaum, "Implementing New Changes to the Food Stamp Program: A Provision By Provision Analysis of the 2008 Farm Bill," *Center of Budget and Policy Priorities*, Revised July 2008.

[3] "USDA Food Stamp Program: Making America Stronger," *U.S. Department of Agriculture*, http://www.fns.usda.gov/cga/FactSheets/food_stamps.pdf.

[4] Barbara Devaney, Linda Bilheimer, Jennifer Schore, "The Savings in Medicaid Costs for Newborns and their Mothers From Prenatal Participation in the WIC Program: Volume 2," *United States Department of Agriculture*, Food and Nutrition Service, Office of Analysis and Evaluation, April 1991.

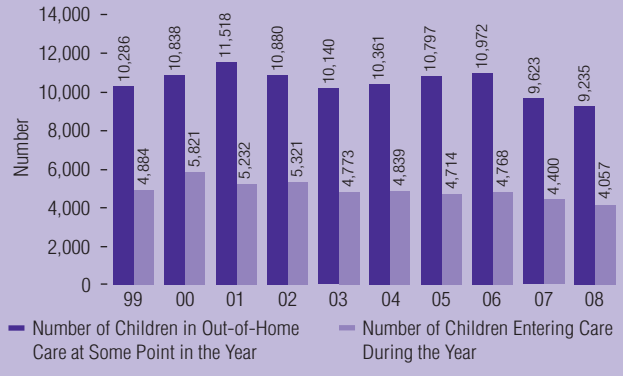
Out-of-Home Care and Adoption

Voices for Children in Nebraska believes that all children should have protection from physical, emotional and sexual abuse, neglect, and exploitation. Nebraska children may be placed in out-of-home care as a result of abusive or neglectful behavior by their parent/guardian or their own delinquent or uncontrollable behavior. Nebraska Department of Health and Human Services (DHHS) is responsible for most of the children in out-of-home care because they are court ordered into care as wards of the state. There are a small number of children placed in private residential facilities who are not considered wards of the state. A child in out-of-home care may reside in a variety of placements such as foster homes, group homes, residential treatment facilities or juvenile rehabilitation and treatment facilities.

How Many Children Are in Out-of-Home Care?

A total of 9,235 Nebraska children were in out-of-home care at some point in 2008. This was a decrease of 388 children from 2007. During CY 2008, 4,057 entered care (a decrease from 2007) while 4,615 children exited (a decrease from 2007). Of the 4,057 children who entered care in 2008, 2,393 (58.98%) were placed in out-of-home care for the first time and 1,664 (41.02%) for the second time or more. A total of 4,620 children were in care on December 31, 2008 – 423 fewer children in care than the previous year. Of the 4,620 children in care on December 31, 2008, 4,549 were DHHS wards. Figure 9.1 presents a historical view of the number of children in out-of-home care since 1999.

Figure 9.1: Children in Out-of-Home Care (1999-2008)



Source: State Foster Care Review Board.

Minority children represent 23.6% of Nebraska's child population (ages 19 and under).[1] However, children 18 and under of a minority race or ethnicity make up 43.46% of children in out-of-home care on December 31, 2008 (calculated by subtracting "White, Not Hispanic" and "unreported, Not Hispanic" from the total and dividing by the total). These data is presented in Table 9.1 on page 68.

Research continues to show that parents of color are no more likely than White parents to abuse or neglect their children.[2] Despite this fact, minority children continue to be overrepresented in the Nebraska out-of-home care system. National research has shown that race is one of the primary determinants in de-

Table 9.1: Out-of-Home Care Children by Race and Ethnicity (December 31, 2008)

Race/Ethnicity	Number	Percent
American Indian, Not Hispanic	322	7.0%
Asian, Not Hispanic	30	0.6%
Black, Not Hispanic	881	19.1%
White, Not Hispanic	2,591	56.1%
Other, Not Hispanic	182	3.9%
Hispanic	503	10.9%
Multi-Racial	90	1.9%
Unreported, Not Hispanic	21	0.5%
Total*	4,620	100%

** Percent total may not equal exactly 100% due to rounding.*
Source: State Foster Care Review Board.

cisions of child protective services at the stages of reporting, investigation, substantiation, placement, and exit from care.[3]

State Foster Care Review Board (FCRB)

In 1982, the FCRB was created as an independent agency responsible for reviewing the plans, services and placements of foster children. These reviews fulfill Federal IV-E review requirements. Over 280 trained citizen volunteers serve on local FCRBs to engage in this important review process. Completed reviews are shared with all parties legally involved with the case. The FCRB also has an independent tracking system for all Nebraska children in out-of-home care and regularly disseminates information on the status of those children. With the exception of the approved and licensed foster care home data and state ward adoption data, all of the data in this section were provided by the FCRB through their independent tracking system.

Neglect is the most frequently recorded cause for removal of children from the home of their parent(s) or guardian(s). Neglect has several forms that range from outright abandonment to inadequate parenting skills which affect child well-being. Parental drug abuse is the second most prevalent cause of placement followed by parental alcohol abuse and substandard or unsafe housing. Table 9.2 presents a summary of reasons children entered foster care in 2008.

Out-Of-Home Care Placements

There are a variety of placement possibilities for children in out-of-home care. Of the 4,620 children in care on December 31, 2008, there were 1,956 (42.34%) in foster homes, 965 (20.89%) placed with relatives, 865 (18.72%) in group homes, residential treatment centers or centers for development disabled, 407 (8.81%) in jail/youth development centers, 170 in emergency shelters, 131 were runaways/whereabouts unknown and 49 were living independently as they were near adulthood. The remaining 77 children were involved in: Job Corps/schools; psychiatric, medical, or drug/alcohol treatment facilities; or child caring agencies.

Of the 4,615 children who left foster care during 2008, a total of 3,125 (67.71%) were returned to their parents and 572 (12.9%) children were adopted. The number of completed adoptions in 2008 represents a sharp increase in completed adoptions compared to the 462 adoptions in 2007. In 2008, 329 (7.13%) children reached the age of majority and became independent and 206 (4.46%) children left corrections (presumably returned to their parents). Eight children died while in foster care in 2008.

Licensed and Approved Foster Homes

In December 2008, there were 2,263 licensed foster homes, a decrease of 75 homes from December 2007. In becoming a licensed or approved foster home, the candidates must go through local, state and national criminal background checks as well as child and adult abuse registry checks and the Sex Offender registry. Licensed providers must also participate in a home study, which includes a series of interviews, and complete initial and ongoing training. Approved providers are relatives or individuals known to the child or family prior to placements. In December 2008, there were 1,885 approved foster homes, an increase of 40 approved foster homes from

2007. There was a large increase in licensed and approved foster homes between December 2005 and December 2006, which is attributed to concerted efforts by DHHS to place children with relatives or friends of the family if a child needed to be in out-of-home care. The gains made were partly reversed between December 2006 and December 2007, losing 258 licensed homes and 1,062 approved homes. However, this year the losses are considerably smaller, only 75 licensed homes and an increase of 40 approved homes. In general, some of the loss in licensed homes may occur due to a decrease in the number of youth in foster care or because the licensed homes adopt the children whom they were fostering and then, decided against fostering more children. Also, as approved homes can only be used for children who are relatives or close friends of the child, these homes are closed to further placements as soon as the specific child leaves the home. In 2007, the DHHS data system implemented an automated "closure" of approved homes when no child is place in an approved home.

Lack of Foster Care Homes

According to DHHS, a total of 4,148 approved or licensed homes were available in Nebraska in December 2008. This is a decrease of 35 possible placements from December 2007. Nebraska faces an ongoing need for foster placements. Foster care providers are always needed, particularly for children who are teenagers, who have special needs (i.e., lower functioning and/or significant acting-out behaviors) and sibling groups of three or more. Foster homes provide the least restrictive, most family-like out-of-home placement for children who cannot remain at home.

Note: If you are interested in making a difference in a child's life by becoming a foster parent, please call 1-800-7PARENT for information.

Multiple Placements

Unfortunately, it is not unusual for a child to be moved repeatedly while in out-of-home care. The FCRB tracking system counts each move throughout the lifetime of the child as

Table 9.2: Summary of Reasons Children Entered Foster Care (Reviewed 2008)[i]

			By Number of Removals			
	All children reviewed		Children who were in foster care for the first time		Children who were in foster care at least once previously	
Category						
Neglect[ii]	1,973	61.0%	1,245	59.9%	728	62.9%
Parental Drug Abuse	1,238	38.3%	835	40.2%	403	34.8%
Parental Meth Abuse[iii]	517	16.0%	380	18.3%	137	11.8%
Parental Alcohol Abuse	487	15.0%	295	14.2%	192	16.6%
Housing Substandard/Unsafe	805	24.9%	485	23.3%	320	27.7%
Physical Abuse	678	21.0%	377	18.1%	301	26.0%
Parental Incarceration	351	10.8%	230	11.1%	121	10.5%
Abandonment	274	8.4%	166	8.0%	108	9.3%
Parental Illness/Disability	330	10.2%	199	9.6%	131	11.3%
Sexual Abuse[iv]	265	8.2%	170	8.2%	95	8.2%
Death of Parent(s)	34	1.1%	21	1.0%	13	1.1%
Relinquishment	25	0.8%	2	0.1%	23	2.0%
Child's Behaviors	554	17.1%	242	11.6%	312	27.0%
Child's Mental Health	92	2.8%	36	1.7%	56	4.8%
Child's Disabilities	86	2.7%	44	2.1%	42	3.6%
Child's Drug Abuse	76	2.3%	40	1.9%	36	3.1%
Child's Meth Abuse	0	0.0%	0	0.0%	0	0.0%
Child's Alcohol Abuse	32	1.0%	11	0.5%	21	1.8%
Child's Illness	45	1.4%	28	1.4%	17	1.5%
Child's Suicide Attempt	7	0.2%	1	0.1%	6	.5%

[i] Up to ten reasons for entering foster care could be identified for each child reviewed. Multiple reasons may be selected for each child. This chart contains the reasons identified at the time of removal.

[ii] Neglect is failure to provide for a child's basic physical, medical, educational and/or emotional needs.

[iii] Parental meth abuse is a subset of parental drug abuse.

[iv] Children and youth often do not disclose sexual abuse until after removal from the home. This chart includes only sexual abuse identified as an initial reason for removal and does not reflect later disclosures.

Note: The percentages are based on 3,236 individual children reviewed. Of those children 2,079 were in foster care for the first time, while 1,157 had been in care at least once previously.

Source: State Foster Care Review Board.

Table 9.3: Number of Placements by Race and Ethnicity (December 31, 2008)

	Placements			
Race/Ethnicity	**1 to 3**	**4 to 6**	**7 to 9**	**10+**
American Indian, Not Hispanic	42.5%	26.1%	9.3%	22.0%
Asian, Not Hispanic	43.3%	30.0%	10.0%	16.7%
Black, Not Hispanic	36.1%	27.4%	13.2%	23.4%
Multiple, Not Hispanic	53.3%	21.1%	11.1%	14.4%
Other, Not Hispanic	51.1%	19.8%	12.1%	17.0%
White, Not Hispanic	46.5%	22.8%	12.2%	18.5%
Hispanic	47.1%	27.0%	11.1%	14.7%

Source: State Foster Care Review Board.

a placement. Therefore, if a child is placed in a foster home, then sent to a mental health facility, then placed in a different foster home, three placements would be counted. However, a hospitalization for an operation would not be counted. Again, the ideal situation for a child placed in out-of-home care is to experience only one placement creating the consistency recommended for positive child well-being.

Note: Numbers for multiple placements vary between the Nebraska Foster Care Review Board and the Department of Health and Human Services based on differing definitions of the term 'multiple placements.' DHHS uses the federal definition in order to meet federal standards and to be able to compare placement rates across states. The FCRB closely matches the federal definition for placement setting changes, with modifications based on statute and best practice.

Of children in care on December 31, 2008, 55.22% had experienced four or more placements. This is an increase over the number of youth experiencing four or more placements on December 31, 2007, which was 51.68%. Generally, Black and American Indian youth experienced the most placements, compared to all other youth in foster care. For example, on December 31, 2008, 22.0% of American Indian youth and 23.4% of Black youth in care had experienced 10 or more placements compared to 18.5% of White youth. Table 9.3 provides data on the number of placements in foster care by race and ethnicity. Moreover, Figure 9.2 demonstrates consecutive time in foster care by race and ethnicity.

Adoption Services

As adoption is the preferred permanency plan for children who cannot be safely reunited with their biological family, efforts are being made to encourage the adoption of state wards. The Nebraska Foster and Adoptive Parent Association (NFAPA), in conjunction with Nebraska Department of Health and Human Services and Nebraska Public Policy Group, Inc., has developed a book of information on adoption and adoption subsidies for adoptive parents.

In calendar year 2008, there were 572 adoptions of state wards finalized in Nebraska. This is a considerable increase from 2007 when 462 adoptions were finalized. Contributing factors to the rise in adoptions were the "Through the

POLICY BOX

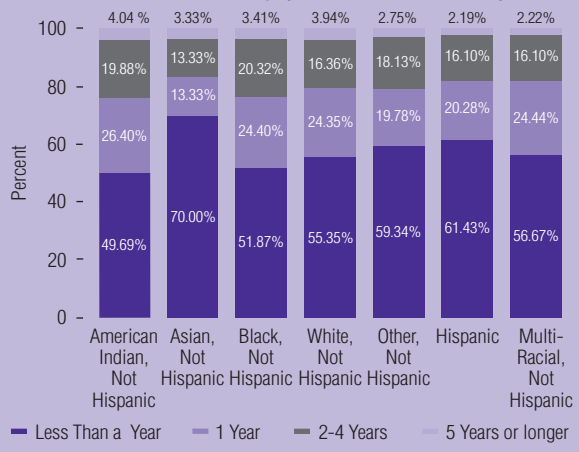
Child Welfare/Juvenile Services Reform

By Todd Reckling, Director of Division of Children and Family Services, Department of Health and Human Services

The Division of Children and Family Services (CFS) provides safety, permanency and well-being for children and youth. We are committed to: increasing safety and community safety; increasing the timeliness of reunification and adoption; increasing placement stability; and reducing the percentage of children and youth in out-of-home care from 70% to 30%.

On July 1, 2008, the Department began contracting with five lead agencies to provide a wide array of Safety and In-Home Services to CFS clients. This array provides the necessary safety services to allow the child to remain safely in the parental home, while change services are put in place to build parental capacity to safely care for their children without CFS intervention or court involvement. The implementation of the Safety and In-Home Service Contracts reduced the number of contracts to be monitored by over 100, allowing the State to begin to build a Contract Monitoring system to ensure oversight of contract implementation.

Figure 9.2: Consecutive Time* in Foster Care by Race and Ethnicity (December 31,2008)



Source: Foster Care Review Board.

**Consecutive time in foster care since last removal from the home.*

Note: Column totals may not equal 100% due to rounding.

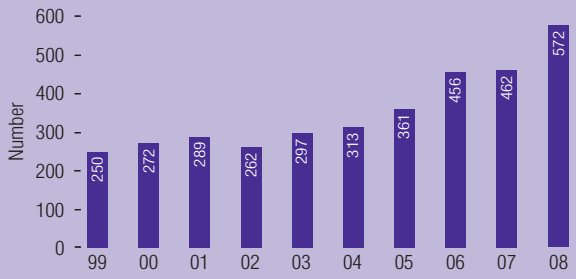
Eyes of the Child" Initiative of the Nebraska Supreme Court and Governor Heineman's Child Welfare Initiative. His directive to focus on activities that would lead to the achievement of permanency for children resulted in a prioritization of efforts to complete adoption and guardianship paperwork and subsidy requests. Figure 9.3 presents a historical data on adoption since 1999.

Safe Haven

Safe Haven laws have been enacted in all 50 states to address infant abandonment and infanticide in response to an increase in the abandonment of infants. The first Safe Haven law passed in Texas in 1999 to allow "mothers in crisis to safely relinquish their babies to designated locations where the babies are protected and provided with medical care until a permanent home can be found."[4] Safe Haven laws are intended to allow a parent of an infant, or an agent of the parent of an infant, to remain anonymous and to be shielded from prosecution for abandonment or neglect in exchange for surrendering the baby safely.

In 2007, two bills were introduced with the intention of creating a Safe Haven law in Nebraska – LB 6 and LB 157. As originally written, LB 6 would have allowed a parent or designee to leave a child 30 days or younger at a hospital, police or fire station with the child then being placed in the custody of DHHS to proceed with abandonment proceedings in order to free the child for adoption. The bill encouraged the receiving entity to

Figure 9.3: Number of State Ward Adoptions in Nebraska (CY 1999-2008)



Source: Nebraska Department of Health and Human Service (DHHS).

The process includes reporting of performance outcomes each quarter which are posted publically on the DHHS Web site at http://www.dhhs.ne.gov/performancegauges.htm.

In the fall of 2008, CFS took the next step in improving services to children, youth, and their families through the release of the Out-of-Home Care Reform Framework. This framework combines all Safety, In-Home and Out-of-Home non-treatment services into a continuum of services provided directly to the family. Contract staff will provide service coordination and address the day-to-day needs of each child and family, while the CFS staff will provide case management oversight and will continue to serve as the primary decision maker. These performance based contracts include accountability for achievement of contractor performance. An Implementation Contract allowed time for the Contractors to hire and train staff, develop their infrastructure and to work with CFS to ensure a smooth transition for the children, youth and families served. Full implementation of the continuum of services and service coordination is expected to be completed by April 1, 2010.

The Children and Family Services Reform gives us a unique opportunity to join together with qualified and experienced agencies and many other stakeholders and partners to improve the lives of children and their families.

Jaxon and Nicky

seek information about the child's birth place, medical history and other information. LB 6 also encouraged DHHS to develop a public information program about the law and to report annually to the Legislature.

LB 157 as written allowed a parent or designee to leave a child 72 hours or younger with a firefighter or hospital employee at their work locations. The receiving entity was directed to turn the child over to law enforcement within four hours with DHHS subsequently filing a petition to terminate parental rights and placing the child with prospective adoptive parents. This bill also required DHHS to submit a report to the Legislature documenting the number of cases annually.

Neither bill passed in its' original form. The Safe Haven bill (LB 157) that eventually passed did not include any age limit, public education campaign or legislative reporting requirement. The Nebraska Safe Haven law went into effect on July 18, 2008 and allowed for the relinquishment of a child or children without prosecution by leaving the child in the custody of an employee on duty at a hospital licensed by the State of Nebraska.

On November 23, 2008, Nebraska's Safe Haven law was modified during a special legislative session by LB 1, which changed the age limit for Safe Haven to a child no more than 30 days old.

In 2008, prior to the amended version of the law that limited its scope to infants, a total of 36 children, ranging in age from 1 to 17 years old, were relinquished under the Safe Haven law. Teenagers ages 13-17 composed 61% (22 children) of all children who were relinquished under Safe Haven. Out of the 36 children, 23 were males and 13 were females. Of these children, 34 had received prior mental health treatment, 12 of whom had received treatment at a level higher than outpatient. Moreover, 20 of the children had previously been state wards, 14 had been adopted or were in guardianships or relative placements. Of the 36 children who came into the state's custody under Safe Haven, 23 were White, 11 were Black, 1 was Native American and 1 was identified as "other" race/ethnicity.

As of September 2009, approximately 14 months after the Safe Haven law had gone into effect, 20 of the children who came into the state's custody under Safe Haven were in foster care and 16 of those cases have closed. Eight of the closed resulted in a guardianship or adoption, 6 youth were returned to their home state, 1 was returned home and 1 was transferred to the adult court system.

[1] U.S. Census Bureau, 2008 Population Estimates Program – Age, Sex, and Race/Ethnicity Estimates for Counties.Compiled by Center for Public Affairs Research, University of Nebraska Omaha.

[2] Robert B. Hill, Ph.D., Senior Researcher, Westat, "Synthesis of Research on Disproportionality in Child Welfare: An Update," *Casey-CSSP Alliance for Racial Equity in the Child Welfare System*, October 2006.

[3] Ibid.

[4] Child Welfare Information Gateway: Infant Safe Haven Laws, State Statute Series, http://www/childwelfare.gov/systemwide/laws_policies/statutes/safehaven.cfm.

2009 County Data Notes

1. TOTAL COUNTY POPULATION IN 2008

Source: U.S. Census Bureau, 2008 Population Estimates Program – Age, Sex, and Race/Ethnicity Estimates for Counties. Compiled by Center for Public Affairs Research, University of Nebraska Omaha.

2. CHILDREN 19 AND UNDER IN 2008

Source: U.S. Census Bureau, 2008 Population Estimates Program – Age, Sex, and Race/Ethnicity Estimates for Counties. Compiled by Center for Public Affairs Research, University of Nebraska Omaha.

3. CHILDREN UNDER 5 IN 2008

Source: U.S. Census Bureau, 2008 Population Estimates Program – Age, Sex, and Race/Ethnicity Estimates for Counties. Compiled by Center for Public Affairs Research, University of Nebraska Omaha.

4. MINORITY CHILDREN 19 AND UNDER IN 2008

Includes Census race/ethnic categories: Black Non-Hispanic, American Indian Non-Hispanic, Asian or Pacific Islander Non-Hispanic, 2+ Races Non-Hispanic, and Hispanic.

Source: U.S. Census Bureau, 2008 Population Estimates Program – Age, Sex, and Race/Ethnicity Estimates for Counties. Compiled by Center for Public Affairs Research, University of Nebraska Omaha.

5. PERCENT OF CHILDREN AGES 17 AND UNDER IN POVERTY IN 2000

Source: 2000 U.S. Census of Population, Summary File 3, Table PCT 52.

6. PERCENT OF CHILDREN UNDER 5 YEARS OF AGE LIVING IN POVERTY IN 2000

Source: 2000 U.S. Census of Population, Summary File 3,Table P87.

7. PERCENT OF MINORITY CHILDREN AGES 17 AND UNDER IN POVERTY IN 2000

Includes Census race/ethnic categories: Black or African American Alone, American Indian or Alaska Native Alone, Asian Alone, Native Hawaiian and Other Pacific Islander Alone, Some Other Race Alone, Two or More Races, and Hispanic or Latino.

Source: 2000 U.S. Census of Population, Summary File 3, Tables PCT 52 and PCT 76I.

8. PERCENT OF CHILDREN AGES 17 AND UNDER IN POVERTY WHO LIVE IN SINGLE PARENT HOUSEHOLDS

Source: 2000 U.S. Census of Population, Table PCT 52.

9. PERCENT OF CHILDREN AGES 17 AND UNDER IN POVERTY WHO LIVE IN MARRIED-COUPLE FAMILIES

Source: 2000 U.S. Census of Population, Table PCT 52.

10. PERCENT OF MOTHERS WITH CHILDREN UNDER 6 YEARS OF AGE WHO ARE IN THE LABOR FORCE

Source: 2000 U.S. Census of Population, Table P45.

11. AVERAGE MONTHLY NUMBER OF FAMILIES ON ADC IN 2008

Fractional figures have been rounded to display whole numbers. The state total does not include a monthly average of 12 families on ADC in 2008 that were labeled 'out-of-state' and are not attributed to any county.

Source: Financial and Program Services, DHHS.

12. AVERAGE MONTHLY NUMBER OF CHILDREN ELIGIBLE FOR MEDICAID AND SCHIP SERVICES IN 2008

In this context, "eligible" means that a child has been determined eligible and is participating in the program. These are average monthly eligible figures. Fractional figures have been rounded to display whole numbers. This total includes 1,293 out-of-state eligibles in 2008.

Source: Financial and Program Services, DHHS.

13. NUMBER OF CHILDREN AGES 18 AND UNDER RECEIVING FOOD STAMP BENEFITS IN JUNE 2008

There were 145 children labeled "out-of-state" that are included in the Nebraska total but not attributed to any county.

Source: Financial and Program Services, DHHS.

14. NUMBER OF WOMEN, INFANTS AND CHILDREN PARTICIPATING IN WIC SERVICES IN SEPTEMBER 2008

Source: DHHS.

2009 County Data Notes continued

15. AVERAGE NUMBER OF FREE/REDUCED LUNCHES SERVED DAILY IN OCTOBER 2008

Calculated as the total free and reduced lunches served by all sponsors within a given county divided by the average number of days sponsors served meals within a given county.

Source: Nebraska Department of Education.

16. PERCENTAGE OF STUDENTS ELIGIBLE FOR FREE AND REDUCED PRICE MEALS (LAST FRIDAY IN SEPTEMBER OF 2008)

For counties with multiple school districts, district percentages were averaged to create a county average. Data only includes public schools. Percentages by school district and school building are available on the NDE's website.

Source: State of the Schools Report, Nebraska Department of Education.

17. AVERAGE DAILY NUMBER OF MEALS SERVED BY THE SUMMER FOOD PROGRAM IN 2008

The Summer Food Program average daily number of meals is calculated by dividing the total number of meals served in a month at each site by the number of operating days. Some sites serve breakfast only, lunch only, or both breakfast and lunch. To calculate a daily average, the meal (either breakfast or lunch) with the greatest number of meals served was selected to calculate the daily average for each site. Then all average daily meals at each site in a county were averaged to create a county average.

Source: Nebraska Department of Education.

18. TOTAL BIRTHS IN 2007

2008 data were not available.

Source: Vital Statistics, DHHS.

19. PERCENTAGE OF BIRTHS TO MOTHERS AGES 17 AND YOUNGER OUT OF TOTAL BIRTHS WITHIN A COUNTY IN 2007

Source: Vital Statistics, DHHS.

20. NUMBER OF BIRTHS TO TEENS AGES 10 TO 17 YEARS OLD FROM 1998 to 2007

2008 data were not available.

Source: Vital Statistics, DHHS.

21. NUMBER OF OUT-OF-WEDLOCK BIRTHS FROM 1998 TO 2007

2008 data were not available.

Source: Vital Statistics, DHHS.

22. NUMBER OF INFANT DEATHS FROM 1998 to 2007

2008 data were not available.

Source: Vital Statistics, DHHS.

23. CHILD DEATHS (AGES 1 TO 19) FROM 1998 to 2007

2008 data were not available.

Source: Vital Statistics, DHHS.

24. NUMBER OF INFANTS BORN AT LOW BIRTH WEIGHTS IN 2007

2008 data were not available.

Source: Vital Statistics, DHHS.

25. HIGH SCHOOL GRADUATES 2007-2008 SCHOOL YEAR

*******States are required to maintain the confidentiality of data under No Child Left Behind. Data under a specified limit is masked at the county-level but counted in the state total.***

Source: Nebraska Department of Education.

26. DROPOUTS (SEVENTH TO TWELTH GRADES) FOR THE 2007-2008 SCHOOL YEAR

*******States are required to maintain the confidentiality of data under No Child Left Behind. Data under a specified limit is masked at the county-level but counted in the state total.***

Source: Nebraska Department of Education.

27. NUMBER OF CHILDREN WITH VERIFIED DISABILITY RECEIVING SPECIAL EDUCATION ON OCTOBER 1, 2008

Source: Nebraska Department of Education.

28. COST PER PUPIL FOR THE 2007-2008 SCHOOL YEAR BY AVERAGE DAILY MEMBERSHIP

Source: Nebraska Department of Education.

29. HEAD START and EARLY HEAD START ENROLLMENT FOR NOVEMBER 2008

Source: Nebraska Department of Education (Data is self-reported by Head Start programs).

30. CHILDREN IN FOSTER CARE TOTAL, BY COUNTY OF COMMITMENT, ON DECEMBER 31, 2008.

Statewide total includes 60 voluntary, unreported, and tribal court commitments not included in county breakdowns.

Source: Nebraska Foster Care Review Board.

31. REPORTED NUMBER OF YOUTH 19 AND YOUNGER WITH STD'S IN YEARS 1999-2008

The state total includes 36 cases of STDs which were geographically unidentified or labeled 'missing.'

Source: DHHS.

32. JUVENILE ARRESTS 2007

Five juvenile arrests, included in the state total, occurred on state property, but were not allocated to any county.

Source: Nebraska Commission on Law Enforcement and Criminal Justice.

NOTE: Data included on County Data pages are reflective of county specific data only. Data from agencies that include data from outside sources such as "out of state, other, etc." may not be included. Column totals may vary from the statewide total/average due to rounding.

County Data Methodology Changes:

County Data Indicators #1 through #4 have now been updated to reflect the most current population estimates available, provided by the U.S. Census Bureau, 2008 Population Estimates Program – Age, Sex, and Race/Ethnicity Estimates for Counties, released 5-14-09: Compiled by Center for Public Affairs Research, University of Nebraska Omaha. We had previously reported data from the U.S. Census Bureau's 2000 Census of Population. The population estimates produced by the U.S. Census Bureau's Population Estimates Program are based on Census 2000 data and include demographic components of population change calculated for that time period (such as births, deaths, net domestic migration, net foreign-born international migration, net movement to/from Puerto Rico, net overseas Armed Forces movement, net native migration to/from the United States, and the changes in group quarters population). These data are directly comparable to measure population change over time. From this point forward, Kids Count in Nebraska will use data from the U.S. Census Bureau's Population Estimates Program for County Data Indicators #1 through #4. Note, however, that County Data Indicator #2 "Children 19 and Under" will not be comparable because Census 2000 data that previously provided the number of children 17 and under.

2009 County Data

	1. Total Population in 2008	2. Children 19 & Under in 2008	3. Children Under 5 in 2008	4. Minority Children 19 & Under in 2008	5. % of Children 17 & Under in Poverty (2000)	6. % of Children Under 5 in Poverty (2000)	7. % of Minority Children 17 & Under in Poverty (2000)	8. % of Children 17 & Under in Poverty in Single Parent House hold (2000)	9. % of Children 17 & Under in Poverty in Married-Couple Family (2000)	10. % of Mothers with Children Under 6 Years of Age Who Are in the Labor Force (2000)	11. Families on ADC (2008)	12. Medicaid and SCHIP Eligible Children (2008)	13. Food Stamp Participation Children 18 & Under (June 2008)	14. WIC Participation (September 2008)	15. Free/Reduced School Lunch (October 2008)	16. % Students Eligible for Free/ Reduced Meals (Last Friday in September of 2008)	17. Average Daily Number of Meals Served by the Summer Food Program (2008)
	33,238	9,070	2,236	1,504	10	12	17	68	32	73	180	2,531	1,024	806	1,675	38%	407
Adams	6,679	1,576	358	70	17	19	39	41	59	87	9	517	167	148	509	0%	0
Antelope	338	89	28	4	15	20	50	38	62	100	1	28	5	1	0	0%	0
Arthur	735	150	26	22	19	8	69	31	69	59	1	55	16	11	57	54%	0
Banner	428	90	20	3	22	32	0	3	97	70	1	53	24	14	113	59%	0
Blaine	5,446	1,360	267	47	12	15	18	28	72	81	8	266	93	111	317	34%	0
Boone	11,043	2,966	717	768	14	18	37	68	32	73	51	952	469	335	557	34%	41
Box Butte	2,090	434	69	8	20	16	0	21	79	76	4	137	35	68	150	45%	0
Boyd	3,149	646	134	20	15	22	46	45	55	83	3	227	65	75	149	36%	0
Brown	45,354	13,038	3,357	1,649	11	14	24	71	29	79	180	3,380	1,564	1,044	2,083	33%	596
Buffalo	7,023	1,666	380	142	12	9	13	56	44	80	20	412	154	115	326	30%	0
Burt	8,326	2,127	441	126	10	14	33	29	71	77	10	432	184	135	589	30%	0
Butler	25,598	6,987	1,612	479	7	12	5	68	32	76	54	1,352	467	342	946	26%	0
Cass	8,407	2,244	526	67	11	8	0	23	77	85	3	391	120	119	471	36%	0
Cedar	3,629	777	200	116	11	16	15	41	59	69	11	271	91	93	232	38%	0
Chase	5,609	1,372	345	192	13	17	22	44	56	72	16	545	159	138	288	38%	0
Cherry	9,965	2,572	688	332	12	15	31	57	43	74	21	625	240	186	459	30%	392
Cheyenne	6,270	1,535	337	194	13	16	26	40	60	75	20	434	158	135	271	0%	183
Clay	9,989	3,194	980	1,808	14	16	21	26	74	73	42	930	253	567	1,110	52%	0
Colfax	9,306	2,397	595	431	10	14	24	34	66	74	11	461	164	170	925	36%	0
Cuming	10,842	2,729	623	130	16	20	26	36	64	79	23	892	283	299	572	40%	0
Custer	20,174	6,712	1,796	3,605	15	17	23	67	33	70	90	2,260	957	1,225	1,755	51%	810
Dakota	8,724	2,414	507	379	14	31	32	47	53	77	30	716	333	175	343	43%	166
Dawes	24,665	7,854	2,172	3,813	14	16	21	48	52	72	124	2,598	973	1,206	2,264	57%	691
Dawson	1,880	374	98	21	12	13	29	42	58	94	8	137	83	41	129	41%	0
Deuel	6,293	1,566	384	242	12	17	12	46	54	85	9	331	116	129	251	34%	0
Dixon	35,872	9,385	2,521	1,568	10	14	22	53	47	73	163	2,936	1,446	1,215	2,073	39%	419
Dodge	502,032	149,055	41,970	51,878	13	14	31	77	23	72	4,607	45,666	23,714	13,694	30,105	38%	12,594
Douglas	2,002	421	79	56	16	16	31	24	76	91	2	157	36	35	180	50%	0
Dundy	6,001	1,488	303	128	8	11	21	56	44	72	9	437	145	130	320	26%	0
Fillmore	3,103	665	138	18	17	15	43	41	59	77	7	207	62	48	115	44%	157
Franklin	2,584	611	117	18	10	10	10	30	70	74	5	175	77	52	193	36%	0
Frontier	4,645	1,021	217	54	15	17	44	45	55	69	13	391	142	107	538	44%	0
Furnas	23,035	5,504	1,340	357	10	13	26	53	47	84	67	1,552	746	521	892	32%	0
Gage	1,765	307	69	17	22	22	52	26	74	92	4	141	41	29	140	58%	102
Garden	1,710	375	73	15	12	11	0	8	92	85	2	171	47	60	95	32%	0
Garfield	1,926	418	96	22	11	6	0	22	78	89	3	102	34	27	72	31%	0
Gosper	604	125	23	0	17	21	0	50	50	33	1	44	9	16	50	41%	0
Grant	2,290	574	134	34	22	23	0	46	54	73	2	184	35	92	298	60%	0
Greeley	56,401	16,742	4,752	6,163	16	20	29	59	41	71	355	6,196	2,636	2,498	4,810	49%	1,992
Hall	9,300	2,474	518	115	10	10	37	51	49	80	12	488	151	178	387	25%	0
Hamilton	3,322	716	160	31	14	20	4	17	83	77	8	202	86	46	118	41%	0
Harlan																	

County Indicator	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.
Hayes	1,005	218	36	16	26	26	46	3	97	54	1	46	11	5	45	29%	0
Hitchcock	2,836	627	147	37	23	26	37	33	67	64	5	255	113	70	109	37%	0
Holt	10,233	2,480	582	127	15	13	22	14	86	80	22	773	218	313	645	41%	327
Hooker	736	145	37	4	5	6	0	30	70	71	1	45	14	11	74	48%	0
Howard	6,593	1,668	400	91	14	13	24	35	65	79	13	442	150	128	411	38%	0
Jefferson	7,405	1,625	363	87	10	15	8	51	49	72	21	489	231	136	533	40%	169
Johnson	4,499	957	247	247	11	11	11	40	60	79	16	267	95	97	244	37%	181
Kearney	6,479	1,618	375	115	10	10	2	56	44	78	15	409	133	111	264	28%	0
Keith	7,821	1,811	440	180	13	20	25	40	60	69	19	545	258	156	360	32%	0
Keya Paha	836	219	55	20	34	46	0	12	88	48	2	57	2	11	49	60%	0
Kimball	3,534	817	182	86	12	13	22	29	71	82	9	328	110	73	168	35%	0
Knox	8,498	2,089	496	445	20	23	36	27	73	72	28	736	326	102	645	47%	71
Lancaster	278,728	77,225	20,928	14,828	10	12	24	67	33	77	1,056	17,986	8,968	6,402	9,467	31%	2,685
Lincoln	35,582	9,634	2,522	1,342	12	16	21	64	36	74	149	2,749	1,430	996	1,604	32%	629
Logan	735	184	54	6	13	18	11	32	68	100	3	49	23	21	65	25%	0
Loup	619	133	18	9	23	23	9	5	95	56	0	32	4	4	55	52%	0
Madison	514	126	31	5	13	17	32	55	45	76	151	2,951	1,303	1,171	2,114	34%	182
McPherson	34,020	9,642	2,529	2,162	22	11	100	19	81	70	1	42	25	12	0	0%	0
Merrick	7,700	1,933	404	127	10	10	25	61	39	76	14	506	171	185	365	32%	0
Morrill	4,989	1,233	284	264	20	24	36	27	73	69	16	504	230	131	453	56%	109
Nance	3,550	863	207	42	17	24	23	30	70	76	3	221	79	68	258	34%	0
Nemaha	7,085	1,675	419	147	13	20	0	35	65	70	27	488	256	117	308	33%	0
Nuckolls	4,467	966	256	54	17	17	39	33	67	83	9	268	87	80	1,013	39%	0
Otoe	15,549	3,970	937	449	9	14	28	53	47	81	49	889	422	295	743	29%	0
Pawnee	2,602	534	105	25	14	14	0	37	63	75	5	159	64	47	221	50%	0
Perkins	2,884	659	168	55	20	25	17	24	76	63	5	169	57	45	104	31%	0
Phelps	9,127	2,323	538	187	12	12	34	43	57	75	25	601	235	210	404	30%	0
Pierce	7,231	1,925	430	77	14	18	28	30	70	84	10	366	128	116	386	24%	0
Platte	32,072	9,084	2,309	1,925	9	11	20	43	57	75	89	1,972	756	828	1,757	31%	317
Polk	5,122	1,232	308	85	7	11	48	42	58	77	8	261	86	65	369	35%	0
Red Willow	10,704	2,732	651	261	11	14	17	65	35	85	22	806	347	305	526	33%	0
Richardson	8,294	1,902	425	210	11	15	29	60	40	75	20	636	334	184	581	39%	43
Rock	1,508	296	85	6	36	36	63	22	78	65	3	126	28	40	70	45%	0
Saline	13,771	3,832	954	1,162	9	7	21	51	49	71	33	936	239	497	804	31%	0
Sarpy	150,467	47,029	12,895	8,573	5	6	8	60	40	74	377	6,061	2,635	2,153	3,635	18%	1,548
Saunders	20,034	5,288	1,235	286	7	10	8	46	54	75	25	931	371	285	815	26%	0
Scotts Bluff	36,554	9,945	2,638	3,423	22	26	42	58	42	73	213	4,039	2,040	1,199	2,138	45%	1,230
Seward	16,758	4,586	1,013	293	6	8	9	43	57	78	15	604	224	191	510	22%	0
Sheridan	5,337	1,303	333	386	20	27	42	48	51	72	20	576	232	141	371	53%	271
Sherman	2,994	668	154	21	19	33	0	27	73	59	5	208	61	72	239	54%	0
Sioux	1,287	272	58	20	24	12	0	26	74	58	1	53	14	6	0	0%	0
Stanton	6,310	1,742	405	147	7	5	25	68	32	82	8	300	103	66	161	39%	0
Thayer	5,104	1,156	262	59	15	16	51	55	45	77	10	289	70	99	257	35%	0
Thomas	583	122	32	4	21	10	0	14	86	76	0	38	3	14	33	30%	0
Thurston	7,102	2,813	799	2,172	33	34	41	61	39	69	222	1,692	1,121	41	965	64%	737
Valley	4,182	934	223	62	16	17	58	47	53	74	6	293	81	90	196	33%	0
Washington	19,812	5,146	1,149	356	8	12	13	46	54	79	36	767	347	188	709	16%	0
Wayne	9,274	2,519	506	254	11	16	40	48	52	80	21	393	148	109	454	30%	0
Webster	3,508	728	131	30	14	12	27	30	70	65	9	234	87	71	78	28%	0
Wheeler	807	201	36	3	28	32	100	19	81	56	0	60	13	10	226	52%	0
York	14,199	3,698	895	473	10	13	56	41	59	79	17	941	286	341	647	30%	0
State Total	1,783,432	500,347	132,092	118,091	12	14	27	60	40	74	8,994	135,860	62,518	44,544	93,575	36%	27,049

2009 County Data

	18. Total Births (2007)	19. % of Births to Mothers Ages 17 and Younger out of Total Births Within a County (2007)	20. Number of Births to Mothers Ages 10-17 (From 1998-2007)	21. Number of Out-of-Wedlock Births (From 1998-2007)	22. Infant Deaths (From 1998-2007)	23. Child Deaths Ages 1-19 (From 1998-2007)	24. Low Birth Weight (2007)	25. Graduates (2007-2008)	26. Dropouts (2007-2008)	27. Special Education (October 1, 2008)	28. Cost Per Pupil (2007-2008) by ADM	29. Head Start (November 2008)	30. Foster Care (December 31, 2008)	31. STDs 19 & Under (1999-2008)	32. Juvenile Arrests in CY 2008
Adams	415	3.13%	142	1,284	29	25	28	395	27	969	$9,906.52	162	99	285	315
Antelope	83	1.20%	11	154	6	7	2	114	***	198	$12,656.20	36	4	15	2
Arthur	5	0%	0	5	0	1	1	***	0	14	$16,798.29	0	0	1	0
Banner	5	0%	0	7	1	0	1	17	0	16	$14,786.52	0	1	0	0
Blaine	3	0%	0	2	1	0	1	***	0	23	$15,943.97	0	0	1	0
Boone	64	4.69%	11	124	3	8	6	97	***	132	$12,001.19	17	1	13	4
Box Butte	149	4.70%	45	457	5	12	11	165	***	317	$9,980.29	84	10	43	225
Boyd	25	0%	3	26	1	3	4	31	0	69	$14,452.68	0	1	3	7
Brown	29	0%	10	77	1	6	0	32	***	70	$11,188.89	26	1	16	7
Buffalo	663	2.11%	118	1,590	35	37	43	557	31	1,207	$9,011.82	116	69	403	567
Burt	80	1.25%	20	210	2	9	9	99	***	222	$10,093.16	32	10	20	30
Butler	86	0%	12	202	1	10	3	135	***	206	$10,174.38	0	31	11	17
Cass	311	1.61%	73	761	21	26	19	297	***	619	$9,741.57	140	50	129	37
Cedar	102	0.98%	12	152	4	15	2	166	0	205	$11,914.54	17	0	8	11
Chase	61	3.28%	13	112	1	6	6	62	***	83	$12,649.51	10	5	3	12
Cherry	64	3.13%	21	209	3	7	6	78	0	95	$13,095.76	30	8	2	17
Cheyenne	141	1.42%	36	367	13	18	12	133	***	255	$10,952.73	40	21	18	86
Clay	68	2.94%	15	173	2	11	7	73	***	148	$11,471.68	36	7	16	0
Colfax	201	5.97%	100	732	19	17	13	170	11	239	$9,621.25	75	23	25	2
Cuming	104	0.96%	32	288	6	6	7	167	***	286	$9,998.11	38	16	18	29
Custer	134	0.75%	31	270	9	10	12	155	***	338	$11,418.86	27	14	20	50
Dakota	419	4.77%	160	1,557	23	23	26	275	13	586	$9,419.39	150	36	168	273
Dawes	116	1.72%	21	288	3	2	8	92	24	147	$10,746.51	76	6	140	44
Dawson	377	2.65%	184	1,540	30	51	26	323	13	828	$9,348.75	61	55	121	412
Deuel	26	7.69%	8	57	0	5	1	35	***	61	$15,638.64	15	3	1	2
Dixon	86	3.49%	23	213	3	4	7	88	***	188	$9,395.02	0	3	16	30
Dodge	478	3.35%	133	1,511	34	43	39	449	46	1,180	$9,008.33	125	91	267	268
Douglas	8,655	3.40%	2,753	26,895	583	435	666	6,013	1,113	13,622	$9,065.53	1,088	1,743	13,132	4,267
Dundy	15	0%	4	40	0	4	0	27	***	70	$13,965.97	10	4	2	2
Fillmore	60	3.33%	19	140	5	13	5	88	***	283	$12,858.09	17	15	76	8
Franklin	32	0%	5	66	0	1	4	23	***	46	$11,278.18	32	4	1	8
Frontier	32	0%	7	54	1	6	2	45	***	98	$12,352.94	10	8	9	8
Furnas	52	1.92%	16	97	2	6	1	79	***	198	$12,465.19	20	13	11	11
Gage	312	2.88%	71	751	16	32	35	243	17	655	$9,467.76	87	33	77	175
Garden	19	0%	2	36	1	3	0	22	0	37	$15,003.62	7	1	8	1
Garfield	17	0%	3	24	2	2	0	31	0	52	$11,776.21	19	2	1	1
Gosper	14	0%	7	51	4	2	0	23	0	67	$10,735.87	10	1	3	4
Grant	8	0%	0	6	0	4	1	***	0	20	$21,433.69	0	0	3	0
Greeley	28	0%	7	51	4	3	4	32	***	108	$13,489.58	16	4	3	0
Hall	1,010	4.16%	407	3,549	71	57	74	680	66	1,483	$8,607.29	185	186	426	685
Hamilton	83	1.20%	23	185	5	7	8	130	***	287	$9,850.75	18	14	16	8
Harlan	24	0%	4	62	1	3	2	27	0	63	$10,204.43	10	9	4	3

County Indicator	18.	19.	20.	21.	22.	23.	24.	25.	26.	27.	28.	29.	30.	31.	32.
Hayes	11	0%	2	11	0	3	0	27	0	18	$18,322.75	0	2	1	0
Hitchcock	25	0%	3	59	3	2	3	23	0	39	$15,474.18	10	1	1	9
Holt	120	0.83%	27	250	8	14	5	161	***	304	$12,596.46	46	7	19	21
Hooker	6	0%	1	10	0	0	1	19	0	25	$12,809.15	0	1	0	1
Howard	63	3.17%	16	186	1	2	1	111	***	179	$9,813.01	24	6	16	1
Jefferson	87	2.30%	28	199	5	8	7	128	***	372	$10,763.26	31	12	26	34
Johnson	51	3.92%	15	124	2	8	2	40	***	113	$11,399.98	0	15	24	2
Kearney	80	2.50%	17	152	7	8	7	115	***	300	$10,284.84	17	4	13	26
Keith	101	0.99%	36	280	9	8	13	92	***	175	$10,493.49	17	17	19	68
Keya Paha	3	0%	3	11	0	0	0	***	0	2	$17,020.15	0	0	0	2
Kimball	42	2.38%	11	140	2	2	2	46	***	70	$12,879.96	20	8	14	15
Knox	100	1.00%	30	305	8	19	7	127	24	250	$11,680.65	55	3	18	4
Lancaster	4,170	1.53%	928	10,297	246	175	238	2,696	455	6,537	$8,861.55	600	942	3,650	3,262
Lincoln	515	2.33%	132	1,520	27	39	53	414	10	1,050	$9,188.33	70	151	205	103
Logan	6	0%	2	12	1	2	1	16	0	36	$13,303.28	0	0	3	1
Loup	12	0%	1	6	0	1	1	13	0	28	$13,142.65	0	0	0	0
Madison	540	3.70%	192	1,854	36	32	28	477	35	1,001	$10,167.48	116	71	273	590
McPherson	9	0%	1	10	0	1	2	***	0	9	$19,478.06	0	0	1	0
Merrick	83	1.20%	11	192	4	10	5	100	***	159	$9,538.36	16	19	16	0
Morrill	60	10.00%	25	172	6	9	5	59	***	109	$11,340.68	20	11	27	41
Nance	32	0%	14	105	3	8	2	69	***	102	$10,106.53	16	8	8	23
Nemaha	84	4.76%	21	198	2	7	5	98	***	190	$8,983.18	32	12	27	28
Nuckolls	37	2.70%	16	104	4	6	4	87	***	246	$13,185.61	35	3	19	2
Otoe	209	1.44%	58	557	15	22	14	215	***	458	$9,103.22	55	22	66	123
Pawnee	21	0%	4	47	1	2	3	36	***	93	$11,605.62	17	4	5	22
Perkins	35	0%	4	56	1	2	2	41	***	64	$13,935.07	10	2	2	2
Phelps	121	0.83%	20	266	5	5	4	119	***	334	$9,366.23	17	22	13	23
Pierce	85	4.71%	16	166	4	9	11	131	***	218	$10,419.98	4	2	21	23
Platte	466	2.15%	145	1,296	34	38	31	414	37	818	$8,751.48	189	46	151	564
Polk	58	0%	7	109	2	9	1	95	***	189	$10,961.76	0	4	15	7
Red Willow	131	0.76%	34	363	5	10	5	169	***	343	$8,723.88	18	23	54	147
Richardson	67	5.97%	35	280	7	13	6	130	***	284	$11,281.34	52	6	44	70
Rock	13	0%	4	15	1	0	0	14	***	24	$16,531.71	0	0	1	10
Saline	206	2.91%	56	584	7	12	9	187	11	405	$9,374.41	52	18	75	71
Sarpy	2,570	1.63%	368	4,232	113	90	184	1,701	43	3,156	$8,665.74	185	212	1,063	1,643
Saunders	266	0.38%	36	443	15	23	16	269	11	445	$9,470.02	44	9	49	67
Scotts Bluff	557	3.59%	287	2,088	38	51	31	398	26	747	$9,251.27	334	119	356	546
Seward	197	1.02%	23	316	9	14	12	233	13	359	$9,544.91	17	32	38	78
Sheridan	62	1.61%	21	240	5	6	5	76	0	130	$13,574.64	50	4	26	78
Sherman	35	2.86%	7	72	5	4	4	45	***	80	$10,974.74	23	4	6	1
Sioux	11	0%	1	11	0	0	0	***	0	9	$21,940.12	0	0	1	0
Stanton	76	2.63%	20	157	0	7	3	38	***	81	$11,022.55	17	1	15	62
Thayer	59	0%	7	97	2	10	6	75	***	193	$13,524.81	17	4	10	13
Thomas	5	20.00%	3	8	1	3	0	***	0	14	$18,064.47	0	0	2	0
Thurston	181	4.97%	129	1,142	16	16	10	92	34	340	$13,675.21	211	65	302	0
Valley	51	1.96%	8	90	3	5	6	67	***	92	$12,237.24	22	7	10	6
Washington	219	0.46%	28	444	13	17	15	255	***	501	$8,645.78	18	16	95	93
Wayne	109	0.92%	11	252	10	10	10	124	***	206	$9,402.45	18	6	49	17
Webster	42	2.38%	8	88	3	5	1	50	***	111	$10,539.19	37	2	8	9
Wheeler	6	0%	0	15	2	1	0	***	0	13	$17,074.70	0	0	0	3
York	184	5.43%	37	486	8	6	11	190	***	405	$10,639.33	51	35	32	156
State Total	26,935	2.64%	7,471	74,492	1,650	1,694	1,894	22,195	2,377	47,216	$9,528.66	5,425	4,620	22,460	15,700

Methodology, Data Sources and Definitions

General

Data Sources: Sources for all data are listed below by topic. In general, data were obtained from the state agency with primary responsibility for children in that category and from reports of the U.S. Census Bureau and the U.S. Department of Commerce.

Population Data – With respect to population data, the report utilizes data from the U.S. Census Bureau 2000 Census of Population and Housing and the U.S. Census Bureau 2007 Population Estimates Program (released 8-7-08) and compiled by the Center for Public Affairs Research at the University of Nebraska Omaha.

Race/Ethnicity – Throughout this report, race/ethnicity is reported based on definitions/categories of race and ethnicity that are used by the data provider. In an effort to maintain the integrity of the data provided to us by the state agencies and other sources, racial/ethnic groups used in the report always correspond to those used in the original data source.

Rate – Where appropriate, rates are reported for various indicators. A rate is the measure of the likelihood of an event/case found in a specific population. For example, child poverty rates reflect the number of children living below the poverty line as a percentage of the total child population.

Selected Indicators for the 2008 Report – The indicators of child well-being selected for presentation in this report reflect the availability of state data, the opinion and expertise of the Kids Count in Nebraska project consultants and advisors, and the national KIDS COUNT indicators.

Indicators of Child Well-Being

Child Abuse and Neglect/Domestic Violence

Data Sources: Data were provided by the Nebraska Department of Health and Human Services (DHHS), the Nebraska Child Death Review Team and the Nebraska Domestic Violence Sexual Assault Coalition.

The Nebraska Child Death Review Team (CDRT) was created in 1999 by the Nebraska Legislature. The CDRT reviews the numbers and causes of deaths of children ages 0 through 17. CDRT members also try to identify cases where a person or community could reasonably have done something to prevent the death. All child deaths are reviewed.

Abuse –

- ***Physical:*** Information indicates the existence of an injury that is unexplained; not consistent with the explanation given; or is non-accidental. The information may also only indicate a substantial risk of bodily injury.
- ***Emotional:*** Information indicates psychopathological or disturbed behavior in a child which is documented by a psychiatrist, psychologist or licensed mental health practitioner to be the result of continual scapegoating, rejection or exposure to violence by the child's parent/caretaker.
- ***Sexual:*** Information indicates any sexually oriented act, practice, contact, or interaction in which the child is or has been used for the sexual stimulation of a parent, a child or other person.

Neglect –

- ***Emotional neglect:*** Information indicates that the child is suffering or has suffered severe negative effects due to a parent's failure to provide the opportunities for normal experiences which produce feelings of being loved, wanted, secure and worthy. Lack of such opportunities may impair the child's ability to form healthy relationships with others.
- ***Physical neglect:*** The failure of the parent to provide for the basic needs or provide a safe and sanitary living environment for the child.
- ***Medical Neglect of Handicapped Infant:*** The withholding of medically indicated treatment (appropriate nutrition, hydration and medication) from disabled infants with life-threatening conditions. Exceptions include those situations in which the infant is chronically and irreversibly comatose; the provision of this treatment would merely prolong dying or not be effective in ameliorating or correcting all of the infant's life-threatening conditions; and the provisions of the treatment itself under these conditions would be inhumane.

Findings: There are five categories of findings –

- ***Court Substantiated:*** A District Court, County Court, or Separate Juvenile Court has entered a judgment of guilty on a criminal complaint, indictment, or information, or an adjudication of jurisdiction on a juvenile petition under Section 43-247 (3)(a), and the judg-

ment or adjudication relates or pertains to the same matter as the report of abuse or neglect.

- ***Court Pending:*** A criminal complaint, indictment, or information or a juvenile petition under Section 247(3)(a), has been filed in District Court, County Court, or Separate Juvenile Court, and the allegations of the complaint, indictment, information, or juvenile petition relate or pertain to the same subject matter as the report of abuse or neglect. Previously, "Petition to Be Filed."
- ***Inconclusive:*** The evidence indicates it is more likely than not (preponderance of evidence standard) that the child abuse or neglect occurred and a court adjudication did not occur.
- ***Unable to Locate:*** Subjects of the maltreatment report have not been located after a good-faith effort on the part of the Department.
- ***Unfounded:*** All reports not classified as "court substantiated," "court pending," "inconclusive" or "unable to locate" will be classified as "unfounded."
- ***Safety Assessment:*** A focused information gathering, decision-making and documentation process conducted in response to a child abuse/neglect or dependency report in which possible threats to child safety are identified, analyzed and understood. Through the collection and analysis of discrete information sets, the safety assessment guides decisions about the presence or absence of present danger or impending danger to a vulnerable child, resulting in a decision as to whether a child is safe or unsafe. Safety assessment is continuous and is used to guide key decisions throughout the involvement with the family.
- ***Court Involved case:*** A case in which the child or children in the family are determined to be unsafe during the safety assessment process, and for whom ongoing services are necessary to address identified safety threats, and the involvement of the court is required to assure the necessary oversight of the family's progress and the child's safety.
- ***Non-court Involved case:*** A case in which the child or children in the family are determined to be unsafe during the safety assessment process, and for whom ongoing services are necessary to address identified safety threats and the family can and is willing to work with DHHS without the involvement of the court.
- ***Safe:*** Children are considered safe when there is no present or impending danger or the caregivers' protective capacities control existing threats.
- ***Unsafe:*** Children are considered unsafe when they are vulnerable to present of impending danger, and caregivers are unable or unwilling to provide protection.

Victim – For the purpose of Child Welfare and Child Abuse and Neglect a victim is always a child. A child involved in an allegation as being abused is identified as a victim. For the purpose of this report, "victim" refers to a child who was abused/neglected, and the action has been substantiated with a finding of "court substantiated," "court pending," or "inconclusive."

Child Abuse Fatality – We define child abuse fatalities as deaths that meet the following criteria, largely drawn from the U.S. Department of Health and Human Services, Administration for Children and Families:

- Caused by an injury resulting from abuse or neglect, or where abuse or neglect was a contributing factor;
- A result of abusive or neglectful behavior by individuals responsible for the care and supervision of their victims (for example, parents/step-parents, other relatives, boyfriends/girlfriends of parent/guardian, baby-sitters, caregivers, day care providers, etc.);
- Fatal child abuse may involve repeated abuse over a period of time (for example, battered child syndrome) or it may involve a single, impulsive incident (for example, shaken baby syndrome);
- Fatal child neglect may not result from anything the caregiver does but from the caregiver's failure to act (for example, chronic malnourishment or leaving a baby unsupervised in the bathtub);
- Not a peer-related incident, such as teen violence;
- Child abuse fatalities are not age-limited, thus the death of any child from birth through age 19 may be considered a child abuse fatality, assuming the above conditions are met.

Domestic Violence/ Sexual Assault Programs – Programs for adults and children whose health/safety are threatened by domestic violence and sexual assault. In this section, "victim" may refer to both adults and children.

Early Care and Education

Data sources: The number of children under five in Nebraska was determined by the U.S. Census Bureau 2007 Population Estimates Program (released 8-7-08) and compiled by the Center for Public Affairs Research at the University of Nebraska Omaha. The number of children with parents in the workforce was obtained from the U.S. Census Bureau's 2006 American Community Survey. Data concerning child care subsidies and licensed child care were provided by DHHS. Data concerning Early Head Start/Head Start, and early childhood initiatives were obtained from the Nebraska Department of Education, Office of Early Childhood.

Child Care Subsidy – DHHS provides full and partial child care subsidies utilizing federal and state dollars. Eligible families include those on Aid to Families with Dependent Children and families previously on ADC at or below 185% of poverty. As of July 1, 2002, the eligibility level was reduced to at or below 120% poverty for families not receiving ADC. Most subsidies are paid directly to a child care provider, while some are provided to families as vouchers.

Licensed Child Care – State statute requires DHHS to license all child care providers who care for four or more children from more than one family on a regular basis for compensation. A license may be provisional, probationary or operating. A provisional license is issued to all applicants for the first year of operation.

Center-Based Care – Child care centers which provide care to many children from a number of families. State license is required.

Family Child Care Home I – Provider of child care in a home to between 4 and 8 children from families other than provider's at any one time. State license is required. This licensure procedure begins with a self-certification process.

Family Child Care Home II – Provider of child care serving 12 or fewer children at any one time. State license is required.

Head Start – The Head Start program includes health, nutrition, social services, parent involvement and transportation services. This report focuses on the largest set of services provided by Head Start – early childhood education. Head Start programs can consist of grantee programs, delegate programs, migrant/seasonal programs and American Tribe programs. A delegate is a subcontractor of a grantee.

Economic Well-Being

Data Sources: Data on poverty levels and single parent families in Nebraska were obtained from the 2007 American Community Survey of the U.S. Census Bureau. Data related to Temporary Assistance for Needy Families (or Aid to Dependent Children as it is called in Nebraska), poverty guidelines and child support collections were provided by DHHS. Data concerning divorce and involved children were taken from Vital Statistics provided by DHHS. Data on federal and state tax credits for families were provided by the Nebraska Department of Revenue.

Education

Data Sources: Data on high school completion, high school graduates, secondary school dropouts, expulsions, exempt students and children with identified disabilities were provided by the Nebraska Department of Education.

Dropouts – A dropout is an individual who: 1.) was enrolled in school at some time during the previous year and was not enrolled at the beginning of the current school year, or 2.) has not graduated from high school or completed a state or district-approved educational program. A dropout is not an individual who: 1.) transferred to another public school district, private school, home school (Rule 12 or Rule 13), state or district-approved education program, or 2.) is temporarily absent due to suspension, expulsion, or verified legitimate approved illness, or 3.) has died.

Graduation – As of the 2002-2003 school year, Nebraska has adopted the national definition for graduation rate. The definition was developed by the National Center for Education Statistics (NCES). For the past several years, Nebraska has published a twelfth grade graduation rate which simply compares high school diploma recipients to twelfth grade membership at the beginning of that same year. The NCES definition attempts to calculate a four-year rate. These are two totally different approaches; one is a one-year retention rate, while the other is a four-year retention rate. For most districts, and for Nebraska as a whole, the graduation rate will decline under the new definition; however for a few districts the graduation rate will increase.

The rate incorporates four years worth of data and thus is an estimated cohort rate. It is calculated by dividing the number of high-school completers by the sum of the dropouts for grades nine through twelve respectively, in consecutive years, plus the number of completers.

Expulsion – Exclusion from attendance in all schools within the system in accordance with Section 79-283. Expulsion is generally for one semester unless the misconduct involved a weapon or intentional personal injury, for which it may be for two semesters (79-263).

Special Education – Specially designed instruction to meet the individual needs of children who meet the criteria of a child with an educational disability provided at no extra cost to the parent. This may include classroom support, home instruction, instruction in hospitals and institutions, speech therapy, occupational therapy, physical therapy and psychological services.

Health – Physical and Behavioral

Data Sources: Data related to prenatal care, births, infant mortality, low birth weight, teen births, out-of-wedlock births, and child mortality are based on DHHS 2005 and 2006 Vital Statistics Report. Data for Medicaid and Kids Connection participants were provided by DHHS. Data on health coverage and uninsured children were obtained from the U.S. Census Bureau's, Current Population Survey, Annual Social and Economic Supplements 2003-2008. Data related to pertussis, immunizations, STDs, HIV/AIDS and blood lead levels were provided by DHHS. Data related to adolescent risk behaviors, sexual behaviors and use of alcohol, tobacco, and other drugs were taken from the 2005 Youth Risk Behavior Survey. Data enumerating motor vehicle accident related deaths and injuries were provided by the Nebraska Department of Roads.

Data pertaining to children receiving mental health and substance abuse treatment in public community and residential treatment facilities were provided by Nebraska Department of Health and Human Services, Division of Behavioral Health Services, Behavioral Health Data System operated by Magellan Behavioral Health Services.

Prenatal Care – Data on prenatal care are reported by the mother on birth certificates in the form of the Kotelchuk Index.

Low Birth Weight – A child weighing less than 2,500 grams, or approximately 5.5 pounds at birth.

Very Low Birth Weight – A child weighing less than 1,500 grams, or 3.3 pounds, at birth.

Juvenile Justice

Data Sources: Data concerning total arrests and the number of juveniles in detention centers were provided by the Nebraska Commission of Law Enforcement and Criminal Justice (Crime Commission). Data concerning juveniles currently confined or on parole was provided by DHHS, Office of Juvenile Services. Data on youth committed to YRTC programs were provided by DHHS, Office of Juvenile Services. Data on youth arrested/convicted of serious crimes and juvenile victims of sexual assault were provided by the Crime Commission. Data concerning juveniles on probation were provided by the Administrative Office of the Courts and Probation.

Juvenile Detention – Juvenile detention is the temporary and safe custody of juveniles who are accused of conduct subject to the jurisdiction of the Court, requiring a restricted environment for their own or the community's protection, while legal action is pending.

Youth Rehabilitation and Treatment Center (YRTC) – A long-term staff secure facility designed to provide a safe and secure environment for Court adjudicated delinquent youth. A YRTC is designed to provide services and programming that will aid in the development of each youth with a goal of successfully reintegrating the youth back into the community.

Age of Juvenile – According to Nebraska Revised Statutes 43-245 Section 4, juveniles are defined as youth 17 and under.

Nutrition

Data Sources: Data on households receiving food stamps, the USDA Special Commodity Distribution Program, the USDA Commodity Supplemental Foods Program, and the WIC Program were provided by DHHS. Data related to the USDA Food Programs for children were provided by the Nebraska Department of Education.

Out-of-Home Care

Data Sources: Data on approved and licensed foster care homes and adoption data were provided by DHHS. All other data were provided by the Nebraska State Foster Care Review Board.

Approved Foster Care Homes – DHHS approves homes for one or more children from a single family. Approved Homes can only be used for children who are relatives or close friends of the child; therefore, those homes must be closed for future placements as soon as the specific child leaves the approved home. Approved homes are not reviewed for licensure. Data on approved homes have been maintained by DHHS since 1992.

Licensed Foster Care Homes – Must meet the requirements of DHHS. Licenses are reviewed for renewal every two years.

Multiple Placements –

- ***From the Foster Care Review Board (FCRB):*** The FCRB tracking system counts each move throughout the lifetime of the child as a placement; therefore, if a child is placed in a foster home, then sent to a mental health facility, then placed in a different foster home, three placements would be counted; however, a hospitalization for an operation would not be counted. Again, the ideal situation for a child placed in out-of-home care is to experience only one placement creating the consistency recommended for positive child well-being.
- ***From Department of Health and Human Services (DHHS):***
  - Federal Description: Number of Previous Placement Settings During This Removal Episode
  - State Interpretation: The number of places the child has lived, including the current setting, during the current removal episode.

  Does not include when the child remains at the same location, but the level of care changes, i.e.:

  Foster Home A, who becomes
  Adoptive Home A = 1 placement

  Does not include when the child runs away or is with parent and returns to the same foster home, i.e.:

  Foster Home A ▶ Runaway or with Parent ▶
  Foster Home A = 1 placement

  Foster Home A ▶ Runaway or with Parent ▶
  Foster Home B = 2 placements

  There are certain temporary living conditions that are not placements, but rather represent a temporary absence from the child's ongoing foster care placement. As such, the State must exclude the following temporary absences from the calculation of the number of previous placement settings for foster care:

  a) Visitation with a sibling, relative, or other caretaker (i.e., preplacement visits with a subsequent foster care provider or preadoptive parents)
  b) Hospitalization for medical treatment, acute psychiatric episodes or diagnosis
  c) Respite care
  d) Day or summer camps
  e) Trial home visits
  f) Runaway episodes

Out-of-Home Care – 24-hour substitute care for children and youth. Out-of-home care is temporary care until the child/youth can be returned to his or her family, placed in an adoptive home, receive a legal guardian or reach the age of majority. Out-of-home care includes the care provided by relatives, foster homes, group homes, institutional settings and independent living.

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** Any opinions, views, or policy positions expressed in this Kids Count in Nebraska report can only be attributed to Voices for Children in Nebraska. These opinions do not necessarily represent the views of any members of the Technical Team.*

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MISSION STATEMENT

Voices for Children is an independent, non-profit organization committed to serving Nebraska's children by:

- Advocating for the best interests of children;
- Equipping parents, professionals and volunteers to effectively meet the deepest needs of Nebraska's children;
- Inspiring all Nebraskans to put the needs of children first.

VISION STATEMENT

Voices for Children in Nebraska is recognized as the vital resource, trusted advisor and influential leader – advocating for Nebraska's children.

STATEMENT OF PURPOSE

Voices for Children is a statewide, non-profit child advocacy organization committed to educating the public about the needs of children and improving conditions when and where necessary. We work cooperatively with community groups and individuals to give children a voice in the classroom, the courtroom, the legislative chambers and the media.