Kids Count IN NEBRASKA

2008 REPORT

A PUBLICATION OF VOICES FOR CHILDREN IN NEBRASKA

Credits

Cover Photo

Annika and Surayo, both 4 years old

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Special Thanks

Community Action Program of
Mid-Nebraska Head Start in Kearney

St. Paul's Christian Child Care Center in
Grand Island

Underwood Hills Elementary, Omaha

All children pictured in this report

Additional Special Thanks

The Annie E. Casey Foundation

Share Our Strength

Jane and Dr. Thomas Tonniges

Wells Fargo

Kids Count 2008

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 is comprised of representatives from numerous agencies and organizations in Nebraska, which maintain 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 sixteenth report in Nebraska. Additional funding for this report comes from Wells Fargo, Jane and Dr. Thomas Tonniges, and Share Our Strength (S.O.S.).

Featured **Kids Count** photographs 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 **2008 Kids Count in Nebraska** report, as well as reports from 1993 through 2007, are available for $11.00 from:

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Table of Contents

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How to Contact My State Senator

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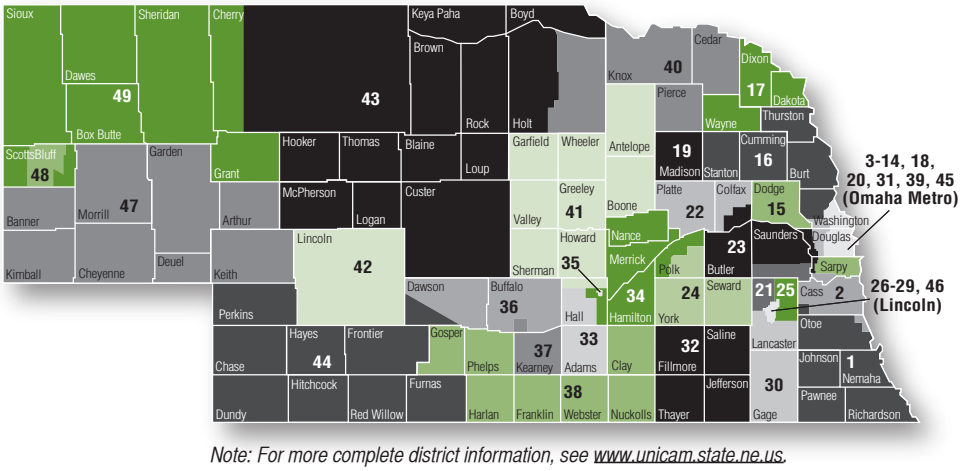

Note: For more complete district information, see www.unicam.state.ne.us.

Using County Data and CLIKS

Kids Count County-Level Fact Sheets

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

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

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 generate profiles about single counties or states, graphs for specific indicators over time, color-coded maps of a state based on CLIKS data and rankings of regions within the state for a specific indicator. The program is free and easy to use.

How CLIKS Can Benefit You

- Strengthen the needs assessment portion of grant proposals
- Assess communities

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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.

Voices for Children in Nebraska E-Updates – advoKID Alerts

Voices for Children in Nebraska provides free electronic updates about the progress of children's issues. Updates are sent in a timely manner to help you respond to the issues affecting children in Congress and the Unicameral. To sign up for e-updates, visit www.voicesforchildren.com and sign up on our home page.

- Create community/state comparisons
- Promote community awareness

How to Access CLIKS

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 CLIKS.

Use CLIKS in 3 Steps or Fewer

1. Select the data format (profile, line graph, map, ranking, or raw data)
2. Select the geographic area (county or state level)
3. Select the indicator (if necessary)

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Barriers to Opportunity: Geography, Poverty & Race Matter

Throughout our history, the foundation of our country's greatness has been our ability to come together as one people to defend the values that make our country remarkable: liberty, justice, equality and opportunity for all. Our Constitution begins with the phrase: "We the people, in order to form a more perfect union." We, the people, are a nation composed of many different ideas, cultures, religions, histories and colors. A more perfect union can be formed by recognizing that we, the people, all have a common stake in each other – we all want to make our country, our state and our communities better for ourselves and for future generations. The path forward calls for all of us to work to narrow the gap that still exists between those American ideals of liberty, justice, equality and opportunity for all and the reality of the country, state and community we live in.

We must begin by working to create that more perfect union here in Nebraska. Our cities and towns are changing to reflect the cultural, linguistic, racial, and ethnic mosaic of the rest of the United States. The diversity of our state is increasing with each generation. According to the UNO Center for Public Affairs Research 2007 Nebraska Population Report, "The minority population is estimated to represent more than 25% of the under five population and more than 15% of the state's total population in 2007."[1] According to that same report, the White Not-Hispanic population grew in only 10 of Nebraska's 93 counties between 2000 and 2007, while the minority population grew in all but two Nebraska counties.[2] Some counties are experiencing minority population growth as high as 90% and greater.[3] Between 2000 and 2007, the Black Alone, Not Hispanic population grew by 8.2% in metropolitan counties (Douglas, Lancaster and outlying counties) and by 55% in the non-metropolitan counties.[4] In that same time period, Hispanic or Latino populations have increased by nearly 50% in metropolitan counties and 33% in non-metropolitan counties.[5] As Nebraska is changing, we must recognize that a diverse population brings a variety of strengths and perspectives on which to build a foundation for healthy, strong, and vibrant communities across our state.

Nebraska Total Population Changes Between 2000 and 2007 by Race/Ethnicity

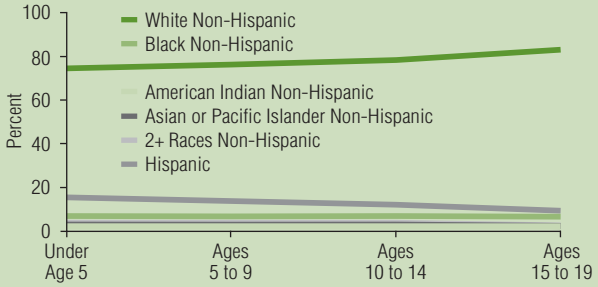
	% of Population	
Race/Ethnicity	**4/1/00**	**7/1/07**
White Alone	92.7%	91.6%
Black Alone	4.1%	4.4%
American Indian or Alaska Native Alone	0.9%	1.0%
Asian Alone	1.3%	1.7%
Hispanic	5.5%	7.5%
Majority Population (White Alone, Not Hispanic)	87.5%	84.5%
Minority Population	12.5%	15.5%

Source: UNO Center for Public Affairs Research, 2007 Nebraska Population Report.

Throughout this *Kids Count in Nebraska 2008 Report*, there has been a deliberate effort to increase the amount of data broken down by geography, poverty and race and ethnicity. Responding to the needs of a changing population, Voices for Children in Nebraska has begun to look beyond data at the state and county level to also examine child well-being among different racial and ethnic groups. Nebraska's systems, institutions, and communities must be able to adapt to the needs of the changing population and ensure that all Nebraskans are able to grow and flourish with the same opportunities afforded to Nebraska generations of the past. At Voices for Children, we believe that every child counts. In order to serve all Nebraska

children equitably, we must recognize the barriers to opportunity that exist for children based on geography, poverty and race. It is our responsibility to do our very best to design systemic and community solutions to overcome those barriers and help the next, more diverse generation of Nebraskans to continue to experience "The Good Life" here in our state.

Nebraska Population in 2007 by Age Groups

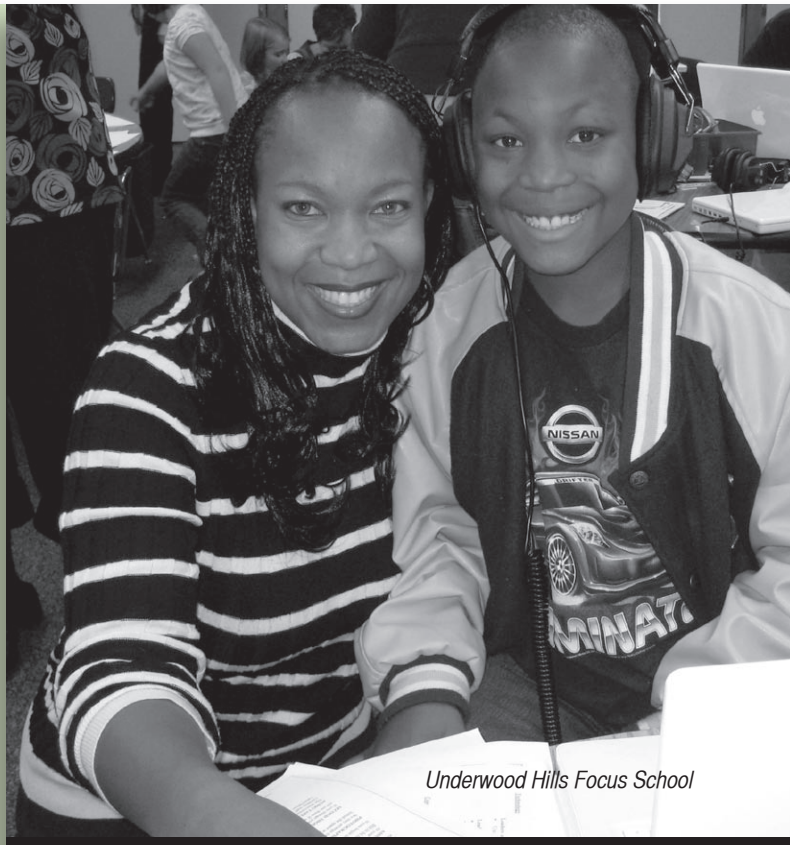


Source: UNO Center for Public Affairs Research, 2007 Nebraska Population Report.

Geography Matters

Where one lives determines the resources and opportunities that are available and accessible. High opportunity areas contain quality and affordable housing, accessible public transportation, health care facilities, affordable food, quality schools, early childhood education programs and childcare options, after school programs, safety from violence, access to parks and open spaces and quality employment opportunities. Unfortunately, such opportunities are often geographically clustered in a few communities, leaving other neighborhoods and communities largely isolated. The availability of such advantages and disadvantages for geographic regions plays a dominant role in determining outcomes for entire groups of people, as many low-income communities and, particularly, communities of color tend to be spatially isolated and segregated in low-opportunity geographies. According to the Kirwan Institute for the Study of Race and Ethnicity:

> *"In these neighborhoods, under-resourced schools struggle to meet the myriad of needs of children in poverty; parents shop at grocery stores with overpriced and low-quality food;*



Underwood Hills Focus School

Geography Matters Facts:

- *Residents of low-income neighborhoods have 30% fewer supermarkets in their communities.*[i]
- *Residents of low-income communities reside in or near central cities while job growth has been greater in outlying suburban communities.*[ii]
- *80% of rural areas lack public transportation, making car ownership critical to keeping a job, while low-income rural residents are relegated to the subprime auto finance industry that charges exorbitant interest rates.*[iii]
- *Only 9 of Nebraska's 93 counties have a physician-to-population ratio above the 2004 national average.*[iv]
- *A study in Chicago found that 34 times as many jobs were created in high-opportunity communities over a five-year period as in the lowest-opportunity communities.*[v]

Ian and Marigold

Poverty Matters Facts:

- *Subprime financing, the only available option for many poor workers, is very expensive. The nation's largest subprime finance companies typically charge interest rates of 18% or higher – or about three times the average current interest rates that mainstream borrowers pay – in addition to asking for large down payments. On a five-year, $10,000 loan, this translates into more than $3,600 in additional interest.*[vi]
- *Poverty is strongly correlated with teen childbearing and sexual health.*[vii]
- *The wealthiest 10% of U.S. school districts spend nearly 10 times more than the poorest 10%.*[viii]
- *A study in Chicago concluded that less than 4% of the housing in high-opportunity areas is affordable to households with limited incomes.*[ix]
- *Over 90% of all new single-family homes built between 2000 and 2002 were not affordable to more than 75% of all African American and Hispanic households.*[x]

and people motivated to work lack connection to meaningful, sustainable employment. This geographic isolation from opportunity creates artificial barriers to improvement for these residents and significantly diminishes their quality of life."[6]

Poverty Matters

Poverty matters in influencing opportunity. Wealth and income determine where a family can afford to live and what level of resources they can provide to their families and to the betterment of their communities. Where you can afford to live essentially determines the opportunities available to you and your family. Research has shown that households with limited incomes have few housing options in opportunity-rich neighborhoods. Thus, those in poverty tend to live in low-opportunity areas. Low-income, low-opportunity communities maintain a much smaller tax capacity, leading to a greater inability to support quality social services, particularly education. Many low-income communities are spatially isolated and segregated from critical opportunities such as high-performing schools, sustainable employment, health care and safe communities.[7]

Race Matters

Race matters in determining opportunity. Systemic and embedded racial and ethnic inequities still exist today and are maintained, often inadvertently, by policies and practices that contain inherent barriers to opportunity. Our laws, systems, institutions and markets need not be explicitly racist in order to disempower communities of color; they only need to perpetuate unequal historical conditions.[8] The effects of structural inequities are manifest across various systems.

A historical example of embedded racial inequity began following World War II, when the U.S. government offered benefits to returning veterans – "benefits of such magnitude that they literally created the modern day middle class and today's suburbs."[9] One of the benefits provided was a low-interest mortgage and down payment waiver that enabled many veterans to purchase homes for their families. However, because of restrictive lending practices, far more White families were

able to purchase homes in newly constructed suburban neighborhoods. White families benefitted disproportionately from this benefit and were able to start the process of wealth-building through home ownership. Because of unequal access to the mortgage benefit, African American and Latino veterans and their families were forced to rent in segregated neighborhoods, where the high proportion of rental housing provided less support for schools, services and public safety. While the new class of White homeowners was able to borrow from their home equity to send their children to college, the following generation of Latino and African American veterans faced far more barriers to moving out of poverty. In the Race Matters Toolkit produced by the Annie E. Casey Foundation, this situation is described as one in which racism was not explicitly written into the policy, but the way the policy was administered produced unequal opportunity:

> *"It is estimated that the social policies of the 1930s and 1940s, which created the platform for today's inequities, transferred $100 billion from the federal government to White families, giving them an extraordinary head start in educational achievement and wealth development. Many of the racial disparities we see today are the fruits of policy seeds planted over 50 years ago."*[10]

Another example of embedded inequity for American Indians is the Dawes Act of 1887. This policy allowed the U.S. government to divide up Indian reservations – allocating tracts of land to individual Indians and open "surplus" land to homesteaders.[11] The intent of the Dawes Act was to break up tribes and promote the assimilation of Native Americans into American society. The head of each Indian family was given a portion of land, and the remaining tribal lands were declared "surplus" and opened up for Whites. Before the Dawes Act, some 150 million acres belonged to Native Americans. Within 20 years, nearly two-thirds of their land was gone.[12] Not only that, Native Americans received highly inadequate payment for the land they lost. The fractionated ownership created barriers to Indians' ability to use land

Race Matters Facts:

- *The probability of receiving a prepayment penalty on buying a home rises significantly when a borrower lives in a zip code area with a relatively high minority population.*[xi]
- *Pesticide processing facilities are located in communities with a 55% higher percentage of people of color than the national average.*[xii]
- *For children entering kindergarten in public schools, Black, Hispanic, and Asian children, in relation to their White counterparts, enter schools that have larger class sizes, undertake less outreach to parents to ease the transition to first grade, have less well-prepared and experienced teachers, and are located in areas where safety is an issue.*[xiii]
- *While 61% of qualified White high school graduates enter college, only 44% of similarly qualified Hispanic graduates and 28% of similarly qualified Black high school graduates enter college.*[xiv]
- *Even after controlling for differences in skills, White applicants are more likely than equally qualified Black applicants to receive job offers.*[xv]
- *State level studies find that White welfare recipients are more likely to be referred to educational programs, given transportation assistance, and treated more favorably by caseworkers and employers.*[xvi]
- *Even when White, African American, and Latino/a youth with no prior admissions are charged with the same offense, African American youth are 6 times more likely and Latino/a youth are 3 times more likely than White youth to be incarcerated.*[xvii]
- *The Institute of Medicine has found that individuals of color experience more discrimination when seeking health care and experience a lower quality of care.*[xviii]
- *African American homebuyers encountered discrimination in 17% of their efforts to purchase homes and Hispanic home buyers experienced discrimination at a rate of 20%.*[xix]

as an asset, which had and continues to have a devastating impact on the economic and social well-being of Native Americans living on reservations.[13]

Historically and today, differential treatment toward people of color and the resulting disproportionate outcomes are embedded in many of our public and private sector systems, institutions and markets:

- In our schools, through discipline and expulsion rates and per pupil expenditures;
- In our universities, through a lack of diversity in academic appointments;
- In our criminal justice system, through racial profiling, access to adequate legal representation, sentencing disparities and disparate incarceration rates;
- In the job market, through quality of employment, wage inequality, mobility opportunities and hiring practices;
- In the housing market, through affordability, availability, homeownership rates, discrimination in lending; and
- In the quality of and access to health care through delivery, financing, research and health outcomes.

While opportunity begets opportunity, the pervasive barriers created by these historical conditions and their cumulative effects have created a cycle of inequity that has proven difficult to break. These imbedded racial and ethnic inequities have led to persistent barriers to opportunity and thus disproportionate rates of poverty among communities of color.

Concentrated poverty, more often experienced by persons of color because of embedded racial/ethnic inequities, racial segregation, and disproportionate poverty rates, results in a very low-opportunity structure for minority communities. While White poverty certainly exists, it is often less concentrated than the poverty experienced by people of color. According to a report by the Institute on Race and Poverty, only one-fourth of poor White families live in neighborhoods with poverty levels over 20%, compared to three-quarters of poor Black families and two-thirds of poor Latino families.[14] African American children today are more likely to be isolated in segregated schools than they were in 1970.[15] School segregation reflects neighborhood segregation. This, again, is an outcome of a history and ongoing practice of government decisions to isolate affordable housing in areas of concentrated poverty and segregated, or segregating, neighborhoods.[16] This segregation of class and race reinforces the reciprocal implications of low-opportunity geographies. Racial, ethnic and income segregation result in isolation from other critical life-changing opportunities such as living-wage employment, high-quality education and safe, healthy neighborhoods for children."[17]

Geography, Poverty and Race Matter

Geography, poverty and race matter. Individually, each condition presents its own opportunity structure. When the three are combined, the barriers to opportunity are extensive. When these structures of disadvantage and barriers to opportunity plague entire communities of people, the likelihood of success becomes all the more challenging. While many Americans from all socioeconomic groups are struggling to achieve the American dream, research shows that even when income and education levels are similar, people of color face greater challenges than White people in education, health care, criminal justice and other opportunity domains.[18] Although individual characteristics do play a role in which individuals excel in our society, geography, poverty and race largely determine where opportunities are readily available for the greatest number of people and can impede or promote even the most motivated individuals.

Overcoming Barriers to Opportunity

Voices for Children in Nebraska is committed to improving the well-being of all Nebraska's children. If we know that access to opportunity has profound implications for child well-being and the future success and productivity of children, we must take steps to identify where barriers to opportunity exist and remove them. The effects of geography, poverty and embedded racial/ethnic inequities are highly interconnected

and affect children and families in a multitude of ways. While parents have the primary responsibility for raising young children well, and while motivated individual initiative can overcome insurmountable odds, we cannot deny the role that opportunity structures play in determining outcomes for larger groups and communities. Allowing these barriers to remain will produce "depressed and uneven educational and economic outcomes, which hinders the ability of the region to become a vibrant, sustainable residential and employment magnet."[19] Each Nebraskan has a common stake in ensuring opportunity for all of Nebraska's children. Using data that is disaggregated by geography, poverty and race and ethnicity, we can identify where embedded structural inequities exist. We can then develop systems, policies and strategies to better serve all children in our state. Our neighborhoods, our communities, our cities and our state will be a better place when we can connect more children to greater opportunity and work towards creating a more perfect union.

In an effort to maintain the integrity of the data provided to us by the state agencies and other sources, the racial and ethnic groups identified throughout the report always correspond to those used in the original data source.

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12 Nebraskastudies.org, "The Dawes Act 1887," www.nebraskastudies.org.

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16 Ibid.

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i Annie E. Casey Foundation, "Unequal Opportunities for Neighborhood Vitality," Race Matters Toolkit, www.aecf.org.

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xii Ibid.

xiii Annie E. Casey Foundation, "Unequal Opportunities for School Readiness," Race Matters Toolkit, www.aecf.org.

xiv Annie E. Casey Foundation, "Unequal Opportunities for Family and Community Economic Success," Race Matters Toolkit, www.aecf.org.

xv Annie E. Casey Foundation, "Unequal Opportunities for Income Security," Race Matters Toolkit, www.aecf.org.

xvi Ibid.

xvii Annie E. Casey Foundation, "Unequal Opportunities for Juvenile Justice," Race Matters Toolkit, www.aecf.org.

xviii Annie E. Casey Foundation, "Unequal Opportunities for Adolescent Reproductive Health," Race Matters Toolkit, www.aecf.org.

xix Annie E. Casey Foundation, "Unequal Opportunities for Neighborhood Vitality," Race Matters Toolkit, www.aecf.org.

Child Abuse and Neglect / Domestic Violence

Voices for Children believes that all children in Nebraska 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 use and low productivity as adults.

Investigated and Substantiated Cases

The Nebraska Department of Health and Human Services System (DHHS) received 30,135 calls to the Child Abuse and Neglect Hotline in 2007. Those calls included 24,765 reports of child abuse and neglect, an increase from the 24,173 calls alleging child abuse and neglect in 2006. Reports alleging abuse or neglect in 2007 were at their highest in the last eight years. The hotline averaged 82.6 calls per day. Of the 24,765 child abuse and neglect reports received, 13,319, or 53.8%, were investigated or were in the process of investigation as of May 1, 2008. This is an increase in both the number of reports investigated and a slight increase in the percent of reports investigated. As of May 1, 2008, 11,544 of the 13,319 cases accepted for investigation stemming from reports in 2007 had been completed. Of those 11,544 completed investigations, 2,894 reports were substantiated, a 25.1% substantiation rate. There were a total of 4,440 children (unduplicated) identified as a victim in one or more of the substantiated reports. This is an increase from 4,335 unduplicated children in 2006. Of the 4,440 victims in 2007,

Year	Number of Reports Alleging Child Abuse and Neglect	Child Abuse and Neglect Reports Investigated		Number of Investigations Substantiated	
		Number	Investigation 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%

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

** Investigation rate – Percent of reports alleging child abuse and neglect that were investigated.*

*** Substantiation rate- Percent of investigated reports of child abuse and neglect that were substantiated.*

**** For 2007, the number of investigations completed by May 1, 2008 was 11,544. Thus, the 2007 substantiation rate was calculated using the completed investigation total, and not the total number of cases investigated (13,319).*

Note: Data have been updated to reflect those published in DHHS's 2007 Child Abuse or Neglect Annual Report.

exactly 50% (2,220) were female and the remaining 50% were male.

Data show substantiated cases are more likely to involve young children. In 2007, 65.5% of the children involved as substantiated victims were ages eight and under. The average age of a child as a substantiated victim was between 5 and 6 years old. Children ages three and under represented 1,581, or 35.61%, of the children involved as substantiated victims. Children ages two and under accounted for 1,289 of the children involved in substantiated cases (29.03% of the victims). Younger children often display stronger evidence of abuse, making it more likely to be reported.

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.

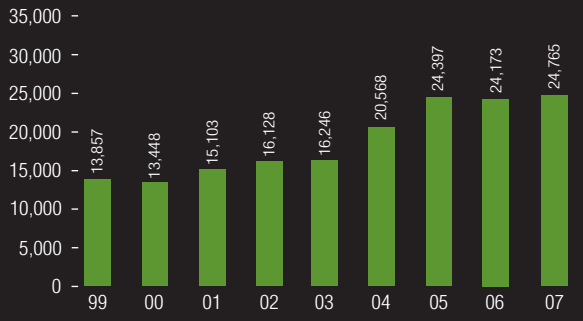
Less than 1% of child abuse reports to DHHS or law enforcement come from the children themselves. Children often have strong loyalties to their parent(s) and/or the perpetrator and therefore, are not likely to report their own, or their siblings', abuse or neglect. These children may fear the consequences 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 that fall 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 maltreat-

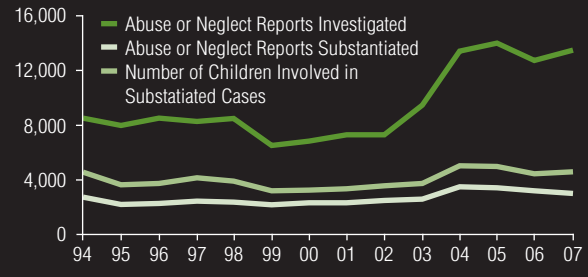
Anonymous

Number of Calls to Child Protective Services (CPS) for Alleged Child Abuse and Neglect (1999-2007)



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

Statewide Abuse and Neglect Cases (1994-2007)



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

Note: As of May 1, 2008, 13,319 allegations were being investigated, but only 11,544 investigations stemming from reports made in 2007 had been completed.

Data have been updated to reflect those published in DHHS's Child Abuse or Neglect Annual Reports 2003-2007.

ment. 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.

There were significant changes in substantiated types of abuse between Calendar Year (CY) 2006 and CY 2007 (see table at right). There was a 10.48% increase in substantiated abuse types between CY 2006 and CY 2007, despite a 5% decrease in the number of substantiated cases. This indicates an increase in multiple types of abuse occurring per child. All things being equal, we would expect a relatively even distribution of the increase in all abuse types. In the table on page 15, it is evident that the types of abuse did not increase equally but experienced rather sizable redistributions. The most substantial change is a 55.45% decrease in emotional abuse substantiations (a decrease of 244 substantiated allegations from 2006), and then a 59.09% increase in emotional neglect (an increase of 104 cases from 2006). There were increases in every other abuse type except medi-

Types of Substantiated Abuse in 2007

Type of Substantiated Abuse Allegation	Female	Male	Total Substantiated Allegations
Physical Abuse	396	409	805
Emotional Abuse	102	94	196
Sexual Abuse	358	91	449
Emotional Neglect	147	133	280
Physical Neglect	3,328	3,532	6,860
Medical Neglect of Handicapped Infant	0	0	0
Totals	4,331	4,259	8,590

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

Note: Numbers based on substantiated allegations. The 4,440 unique children may have been a victim of more than one allegation abuse type in more than one substantiated case. The table above provides a count of abuse types that were substantiated. The 4,440 victims were included in a total of 8,590 allegations of abuse.

POLICY BOX

The Nebraska Safety Intervention System: A New Approach to Improving Safety for Nebraska's Children

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

The Nebraska Safety Intervention System (NSIS) is a research-based approach to improving safety for children. It focuses on the safety of all children in the home using a structured, in-depth information gathering and decision-making process. The DHHS Division of Children and Family Services (CFS) introduced NSIS in 2007. It was fully implemented across the state by late spring 2008. The National Resource Center for Child Protective Services helped design the system.

Deciding whether a specific incident of child abuse or neglect has occurred is important in assessing the overall safety of the child; however, this is only one part of the assessment process. With NSIS, child welfare

Changes in Types of Substantiated Abuse Between CY 2006 and CY 2007

	Physical Abuse	Emotional Abuse	Sexual Abuse	Emotional Neglect	Physical Neglect	Medical Neglect of a Handicapped Infant	Total
CY 2006	734	440	439	176	5,984	2	7,775
CY 2007	805	196	449	280	6,860	0	8,590
Percent Change	9.67%	55.45%	2.28%	59.09%	14.64%	100.00%	10.48%
Increase/Decrease	Increase	Decrease	Increase	Increase	Increase	Decrease	Increase

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

cal neglect of a handicapped infant. According to representatives of the Division of Children and Family Services, Department of Health and Human Services, these changes cannot be attributed to any programmatic or policy changes within the Department, so the cause of the disproportionate decrease in emotional abuse is unknown at this time.

Additionally, as of June 2008, there were still 1,775 cases labeled "In Process" (see table on page 16). This is 7.2% of all child abuse and neglect (CAN) reports in 2007, 13.3% of all reports accepted for investigation in 2007, and is nearly triple the number of cases still "In Process" at the same point in 2006. The high number of cases still "In Process," once fully processed, may return some balance to the distribution of abuse types in the table above.

Another question that arises when looking at these data is why so many 2007 cases remain "In Process" relative to previous years. One possible explanation is that the transition to the new safety model (see Policy Box below) has created delays in data entry. Another explanation provided by representatives of the Division of Children and Family Services, Department of Health and Human Services is that, in years prior, a notification was sent out to staff that CAN workers also gather information about how the child functions, discipline within the family, general parenting practices, and how the adults function. Workers use all of this to assess whether or not a child is safe regardless of the finding related to the incident. This is used throughout a family's involvement with DHHS at important decision points. These decision points include: the initial assessment; development of the case plan; when circumstances change in the family; when assessing the return of a child to their family home; and in case closure. Another important piece of the new process is increased involvement of the supervisor to provide oversight and direction of the work.

Service Array

It is DHHS' desire to serve children at the right level of care, in the right setting, for the right amount of time, with the right amount of services and supports, and, of course, in the least restrictive manner possible.

As of July 2008, CFS had about 6,800 children in its care and custody. Of those children, about 70% are served in an out-of-home care setting. DHHS is committed to reversing this reliance on out-of-home care by serving more children in home by 2011. DHHS is also committed to reducing the total number of children in the state's care and custody overall. A full range of services is necessary to reach these outcomes.

Moving in this direction, in early March 2008, DHHS released a Request for Bids (RFB) to select qualified contractors to provide the entire range of 11 safety and in-home services to children and families identified by the Department. Five bidders were given contracts and the contracts went into effect July 1, 2008. These contracts will allow for increased services to children in their homes and communities. DHHS envisions a future system of care that addresses all levels of out-of-home care, in-home care, early intervention and prevention services for children and families.

For more information on the Safety and In-Home Service Contracts, see the DHHS website: **http://www.hhs.state.ne.us/Children_Family_Services/CWJS/index.htm**.

Child Abuse and Neglect Reports, 2004-2007

Calendar Year	Total Reports Received	Reports Alleging Abuse or Neglect (CAN)		CAN Reports Assessed		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%

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

reports would be run on a specified date. This notification was not provided before reports were run for 2007. These are issues that will require a closer look in the next few years as the new safety model is fully implemented and we begin to see the resulting data.

Child Abuse Fatalities in 2006

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[2] (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);[3]
- 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);[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 2007 were not available in time for this report. According to data provided by the Nebraska Department of Health and Human Services in 2006, ten Nebraska children died as a result of child abuse and neglect (one death is still under active investigation). This is up from eight children in 2005, nine children in 2004,[5] ten children in 2003, and seven children in 2002.[6] In five of these deaths in 2006, the child's father was the perpetrator, and a step-father was the perpetrator in another. A mother's boyfriend was responsible for two child deaths in 2006, a babysitter for another, and the perpetrator in the final child death in 2006 is yet unproven.

In 1993, the Nebraska State Legislature mandated formation of a Child Death Review Team to review all child deaths. In October 2007, the Nebraska Child Death Review Team released its fifth report, encompassing findings on 302 child deaths occurring during 2004. 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, to begin to identify strategies to prevent these deaths, and to monitor child death trends.

Domestic Violence/Sexual Assault Programs

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

During the fiscal year 2006-2007, the 22 community based programs served 7,936 people, including 2,798 children and youth who received direct services.[7] Over three thousand (3,134) people received shelter, including 2,168 children.[8] A total of 53,346 shelter beds and 139,194 meals were provided.[9] The programs also provided 751,429 hours of support and assistance to victims of domestic and sexual violence of all ages.[10]

Of the people served by community-based programs who provided demographic information, 3,824 children were reported as living in the home.[11] Nearly three hundred (283) were reported as having been physically harmed, 59 were suspected of being victims of child sexual abuse, and 2,094 had been exposed to the perpetrator's use of violence.[12]

Domestic violence impacts all components of a community. It occurs in all segments of society and crosses all socioeconomic classes, education levels, religions and cultures, races and ethnicities. However, access to economic resources and a person's culture (including race and ethnicity, as well as the norms and values of the family of origin) do impact the ability to seek and receive support. For example, a majority of studies have found that over 50% of women receiving welfare have experienced physical abuse by a partner.[13] As another example, a person of color may be afraid to report domestic violence due to concerns about hate crimes and/or a fear that she will be treated differently based on her race. Language barriers may prevent someone from calling an agency due to a lack of interpreters.

Batterers often use these fears and barriers to further their control over their partners. For example, an abuser may hide someone's documentation or threaten to report them to immigration officials. Family in the country of origin may be threatened if she "shames" the family by telling someone about the abuse or leaving the abuser. The abuser may also prohibit the victim from attending classes to learn English. Children may not be allowed to speak with relatives or may be forced into the role of interpreter and told to lie to agencies about what is happening in the home.

The local domestic violence/sexual assault programs in Nebraska have made many efforts to improve the services available to victims of domestic violence, sexual assault and stalking who may be faced with such barriers to safety. Many programs have bilingual advocates, and a statewide hotline was established in 2005 to provide a 24-hour crisis line in Spanish. The Nebraska Domestic Violence Sexual Assault Coalition and the local domestic violence/sexual assault programs have staff that address cultural competency and assist victims of violence with immigration issues. The domestic violence/sexual assault programs also work with other community resources to enhance options available to victims and survivors and to create a coordinated community response to domestic and sexual violence.

1 The National Child Abuse and Neglect Data System (NCANDS), as qtd. 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's Network of Domestic Violence Sexual Assault Programs Annual Statistical Report*, 2006-2007. Compiled by the Nebraska Domestic Violence Sexual Assault Coalition.

8 Ibid.

9 Ibid.

10 Ibid.

11 Ibid.

12 Ibid.

13 Tjaden and Thoennes, 1998, as cited in Eleanor Lyon, "Welfare, Poverty, and Abused Women: New Research and Its Implications," 2000.

Early Childhood Care and Education

Voices for Children believes that all children in Nebraska 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 they will 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 experiences create the foundation upon which future success and productivity of a child will be built. Toxic stress, such as family tensions or a change in caregivers, weakens this foundation and has actually been found to cause the brain to release chemicals that stunt cell growth. Whether young children are receiving care at home, in centers or preschools, or from family child care home providers, 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 from which all of society will benefit. 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

Early childhood brain research concluded that developmentally appropriate experiences contribute to the healthy de-velopment of an infant's brain and make a significant difference in a child's ability to reach his or her full potential. 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 programs are federally funded programs. The programs provide compre-

hensive 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 Head Start and Early Head Start programs do not have 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.[1] In addition, their parents scored significantly higher than control group parents on many aspects of the home environment and parenting behavior, and Early Head Start programs had positive impacts on parents' progress toward self-sufficiency.[2] Evidence shows that Head Start children experience cognitive, social and physical gains in the short term, which have meaningful implications for long-term academic performance.[3]

During the 2006-2007 program year, 17 Head Start and 10 Early Head Start programs provided services for young children and their families in 77 of Nebraska's 93 counties. 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 serving children eight or more hours per day served 432 Nebraska children, indicating that these children with working parents will not need

Levi and Walker

A Closer Look at Head Start and Early Head Start, 2006-2007

Families	Number	Percent
Two Parent Families	2,647	46.26%
Single Parent Families	3,075	53.74%
One or both parents employed	4,228	73.89%
Families receiving emergency/crisis intervention services[4]	1,513	26.44%
Families receiving adult education (GED programs, college selection, etc.)	1,071	18.72%
Families receiving parenting education	3,361	63.46%
Families receiving at least one family service	4,845	84.67%
Children		
Without health insurance	534	8.61%
With private health insurance	716	12.63%
Completed all medical screenings	5,376	86.65%
Up-to-date on all immunizations	5,739	92.50%
Completed oral health examination (Preschool Programs Only)	4,613	82.90%
Pregnant Women		
Without health insurance	11	6.92%
Medically 'High Risk' Pregnancies	40	25.16%
Receiving dental exams or treatment	52	32.70%
Receiving prenatal and postpartum health care	151	94.97%
Classroom and Staff		
Classroom teachers with an ECE or Related Degree	–	84.94%
Home Visitors with an ECE or Related Degree	–	50.00%
Staff who are Current or Former Head Start Parents	–	23.07%
Teacher Turnover Rate	–	26.60%
Average Class Size	15	–
Classroom Staff to Child Ratio	1 to 6	–

Source: Head Start Program Information Report for the 2006-2007 Program Year, Office of Early Childhood, Nebraska Department of Education.

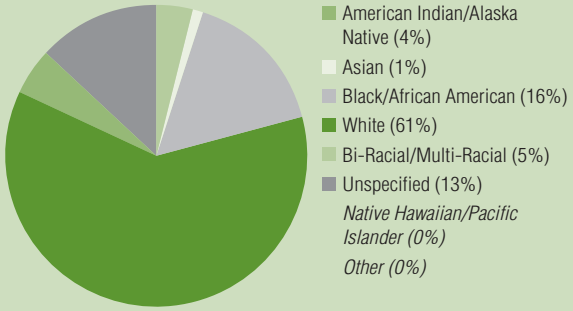
additional child care placements during the day. Head Start grantees serving children at least six hours per day served 1,245 children. An additional 2,978 children were served in part-day programs.

According to the Head Start Program Information Report for the 2006-2007 program year, Head Start/Early Head Start programs in Nebraska served 6,204 children and 159 pregnant women. Thirteen of the women were under 18 years of age. Of the pregnant women served by Early Head Start, 6.92% (11 women) were without health insurance, and 25.16% were considered to have medically 'high risk' pregnancies.

Of the 6,204 children served by Head Start and Early Head Start:

- Approximately 2,666 needed child care for full-days and/or for the entire calendar year because their parents were working or were in job training. For those children who needed full-day or full-year services, they 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 by 1,403 of those served in Head Start/Early Head Start.

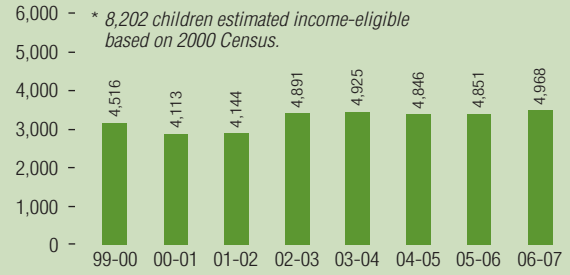
Head Start/Early Head Start Enrollment (Program Year 2006-2007)



Source: Head Start Program Information Report for the 2006-2007 program year, Office of Early Childhood, Nebraska Department of Education.

Note: The race of 800 children enrolled in Head Start/Early Head Start was "unspecified."

Number of Nebraska's 8,202* Eligible Children (3-4 Years Old) Enrolled in Head Start/Early Head Start Programs



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

- There were 832 children served in Head Start/Early Head Start with a determined disability.

State Early Childhood Education Grant Program

In 1992, Early Childhood Programs served young children and their parents in four Nebraska communities. Nebraska's Early Childhood Education Grant Program was 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 2006-2007, 38 school districts or ESUs across the state received grants to provide early childhood education programs. Grantees were required to collaborate with existing local providers, including Head Start. The collaborative groups combined the grant funds with existing resources to operate integrated early childhood programs, which improved access to services for young children in those communities.

A majority of the 1,618 children served in the 2006-2007 school year were from low-income families, as 67% of children served were eligible for free or reduced school lunch. This marks both an increase in children served, up from 1,483 in the 2005-2006 school year, and also an increase in the percentage served that are eligible for free or reduced lunch (up from 63% in the previous year). The grant-funded programs predominately served preschool age children. In fact, 91% of the children served were either three or four years old. For 22% 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 2006-2007, 58% were White, 29% were Hispanic, 8% were Black or African American, 3% were American Indian/Alaskan Native, and 2% were Asian/Pacific Islander.

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 opportunity of low-income families by integrating intensive early childhood education, adult literacy or adult basic education including 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.

During the 2006-2007 grant year, a total of eight Even Start programs were funded across Nebraska. 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 participate together in all components of the Even Start project. Program components include early childhood education/development, parenting and adult education.

Nebraska Even Start programs served 231 families, including 236 adults and 337 children. Of all of the parents served, 61% or 145 parents were English language learners. Of the 123 newly enrolled families, 118 (96%) were living at or below the federal poverty level (see page 30 for federal poverty guidlines).

Early Development Network and Early Childhood Special Education

In Nebraska, school districts are responsible for providing special education and related services to all eligible children in their district, from birth to age 21, who have been verified

Yasmin and Kaylee

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 for the child. Service coordinators with the Early Development Network are available to assist families with children from birth to age three who have disabilities. On December 1, 2007, there were 1,361 children from birth to age three receiving services within the Early Development Network and 5,224 children ages 4 and 5 receiving early childhood special education services in Nebraska.

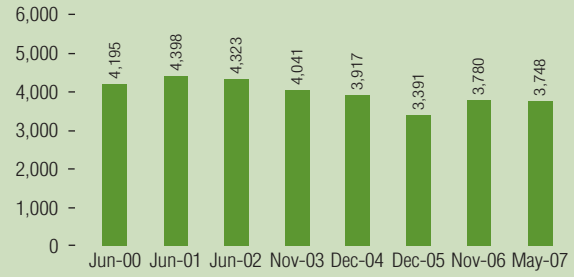
Services for young children with disabilities are required to be provided in natural environments for children birth to age three, and in inclusive environments for children ages 3 to 5. The terms "natural" and "inclusive" environments are defined as settings that would be natural or normal for the child 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 participate fully in the workforce, families need safe, quality child care that supports a full range of children's developmental needs. The U.S. Census Bureau calculated 129,796 children under age 5 in Nebraska in 2007.[5] 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 6 in Nebraska have either one or two working parents.[6] 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 Nebraska Department of Health and Human Services (DHHS). In May 2007, Nebraska had a total of 3,748 child care facilities with a total capacity of 94,988 children. While the number of licensed child care providers is decreasing, the total capacity in licensed child care programs has been continuously rising and 2007 data continues this trend.

In 2007, 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 30), 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 2007, DHHS subsidized the child care of 32,515 unduplicated children, an increase from 31,307 children in 2006. The monthly average of children provided subsidy was 16,534. This is also an increase from 15,894 children served monthly in 2006. With an average annual payment of $1,975 per child, $64,219,704 federal and state dollars were used for child care subsidies in Nebraska. Subsidies are paid directly to the providers. While not all children receive subsidy for 12 months, the

Number of Licensed Child Care Facilities in Nebraska



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

Note: Because of 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 correct this problem from 2008 forward.

average subsidy payment per child paid by the Department of Health and Human Services during state fiscal year 2007 was approximately $324 per month. DHHS rates range 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 dollars per day). For in-home care, where the child care provider comes to the home of the child, DHHS used the federal minimum wage rate – set at $5.85 per hour in 2007 and increased to $6.55 per hour in July 2008.

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

[2] Ibid.

[3] 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.

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

[5] U.S. Census Bureau, 2007 Population Estimates, as published in the "2007 Nebraska Population Report," prepared by David Drozd and Jerry Deichert at the UNO Center for Public Affairs Research.

[6] U.S. Census Bureau, 2006 American Community Survey, Table B23008.

POLICY BOX

T.E.A.C.H. Early Childhood® NEBRASKA

By Linda Zinke, Executive Director, Nebraska Association for the Education of Young Children, Inc. (NeAEYC)

In 1990, Child Care Services Association of Chapel Hill, North Carolina created the Teacher Education And Compensation Helps (T.E.A.C.H.) Early Childhood® Project to address the issues of under education, poor compensation and high turnover within the early childhood workforce. This project has expanded and is now available in over 20 states, including Nebraska. All T.E.A.C.H. Early Childhood® scholarships link continuing education with increased compensation.

Since the beginning of T.E.A.C.H. Early Childhood® NEBRASKA in 2002 through 2007:

- 384 Nebraska teachers, teacher aides, family child care providers and directors have been awarded a T.E.A.C.H. scholarship.
- 227 child care programs have sponsored a T.E.A.C.H. recipient.
- An average of over 13 credits per year have been completed by these students.
- A total of 7,388.5 college credits have been awarded from 2002-2007 at seven community colleges and three universities.
- Compensation increases of 5-8% are average after the completion of one T.E.A.C.H. contract.
- The turnover rate for all T.E.A.C.H. Early Childhood® NEBRASKA students is 13%. In comparison, the turnover rate in the Omaha area ranges from 28.7% – 83.6% (Omaha EQUIP, 2004).
- An estimated 4,400 children have been impacted by a T.E.A.C.H. Early Childhood® NEBRASKA student.

T.E.A.C.H. Early Childhood® NEBRASKA is managed by the Nebraska Association for the Education of Young Children, Inc and is funded through the Department of Health and Human Services System/Nebraska Department of Education and private foundation funds.

Economic Well-Being

Voices for Children believes that all children in Nebraska 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, our communities and our 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 who earns enough income to provide for their basic needs without public assistance. Nebraska Appleseed Center for Law in the Public Interest considers the basic needs budget to consist of food, housing, health care, transportation, child care, clothing and miscellaneous items such as necessary personal and household expenses.[1] If a family has the economic ability to provide these essentials without public assistance, they are considered self-sufficient. 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 a stable income and to 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. All three poverty rates (overall, family and child) have experienced a statistically significant increase since 2000.

Jamie

Poverty in Nebraska

	2000	2007
Child Poverty Rate	10.0%	14.5%
Family/Household Poverty Rate	6.5%	8.2%
Overall Poverty Rate	9.6%	11.2%

Source: U.S. Census Bureau, 2007 American Community Survey, Tables B17006, B17010, and B17001, respectively.

2007 Poverty Rates by Race and Ethnicity*

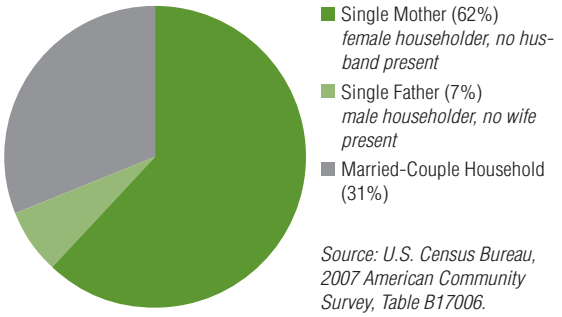
Race	Child Poverty Rate (Under 18)	Overall Poverty Rate
White Alone	11.11%	9.36%
Black or African American Alone	52.49%	34.40%
American Indian and Alaska Native Alone	52.61%	43.35%
Asian Alone	1.23%	6.38%
Some Other Race Alone	28.96%	22.93%
Two or More Races	26.13%	21.73%
Ethnicity		
White Alone, Not Hispanic or Latino	9.88%	8.76%
Hispanic or Latino	28.33%	22.95 %

Source: U.S. Census Bureau, 2007 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.*

Statewide, our child and family poverty rates reveal distinct disparities, particularly among the Black or African American and Native American populations. 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 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 of our children experience the greatest opportunities to succeed.

All Children in Poverty – By Family Type in Nebraska (2007)



Source: U.S. Census Bureau, 2007 American Community Survey, Table B17006.

Single Parent Families

In 2006, 24.5% 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 struggle with the costs of child care, balancing work and home duties and spending quality time with their children. The lack of these essential resources and fewer supports have been linked with parental stress which can lead to a greater occurrence of child abuse.[3] Just over 25% (25.41%) of Nebraska families headed by a single parent lived in poverty, as compared to only 3.69% of married couples in 2007.[4]

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.

In Nebraska, children comprise 74% of total TANF enrollment, according to a snapshot of program recipients from June 2007. There was a monthly average of 19,281 children receiving ADC benefits in state fiscal year (SFY) 2007, a decrease from 21,481 in SFY 2006. ADC was provided to a monthly average of 10,313 Nebraska families in SFY 2007. This is a significant decrease from a monthly average of 11,625 families in SFY 2006. The total amount of monthly payments equaled $44,193,904, an average of $357.10 per family per month in 2007. This is only a 27 cent increase in average payments per family from 2006. Approximately 51% of the cost of ADC benefits was paid for by state general funds, and the remaining 49% was provided by federal TANF funds.

Changes in ADC Enrollment

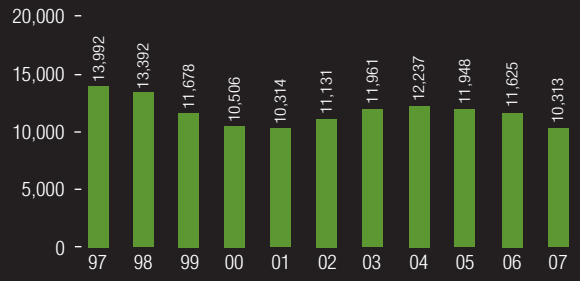
Enrollment Category	Change between 7/03 and 6/06 (SFY 2004-SFY 2006)	Change between 7/06 and 6/07 (SFY 2007)
Families	Decreased by 5.5%	Decreased by 20.28%
Children	Decreased by 2.3%	Decreased by 20.24%
Persons	Decreased by 4.5%	Decreased by 23.11%

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

The maximum ADC payment amounts to approximately 29% of the federal poverty level as prescribed by Nebraska law (see the federal poverty guidelines on page 30). Nebraska ranks 29th in the country for the adequacy of benefit levels relative to federal poverty guidelines.[5] The utilization of ADC decreased from a slight peak in 2004. At its highest utilization, ADC was provided to 17,239 families in 1993. In SFY 2007, we saw a very steady decrease in ADC utilization from July 2006 to June 2007 (see table above). This steady decline seems to display a pattern that has not existed in previous fiscal years. According to representatives of the Department of Health and Human Services, this decrease can be attributed to a more stringent enforcement of Employment First work requirements and thus, an increased use of sanctions for non-compliance.

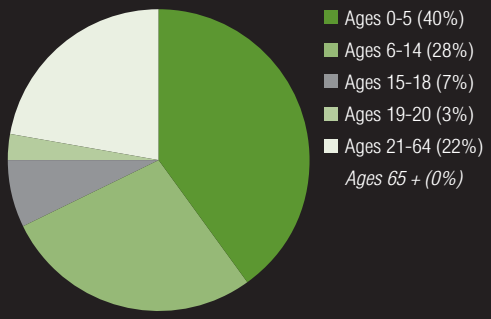
With any decline in TANF enrollment, we would hope to see an increase in employment as well as a decrease in the number of individuals, families, and children living in poverty. Unfortunately, the decline in enrollment occurred as our state was experiencing a simultaneous increase in unemployment throughout the last quarter of fiscal year 2007 and into 2008[6] and an increase in individual, family and child poverty rates since 2000. If TANF is to fulfill its goal of helping families to support themselves without public assistance,

Average Number of Nebraska Families Receiving ADC Monthly



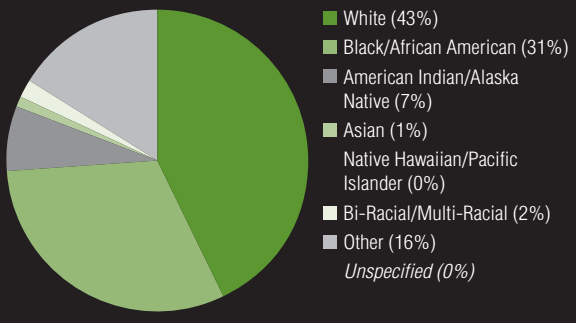
Source: Financial Services, Operations, Nebraska Department of Health and Human Services (DHHS).

ADC Recipients by Age (June 2007 Snapshot)



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

ADC Recipients by Race (June 2007 Snapshot)



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

we must ensure that those leaving the program are able to meet their needs through high-quality employment.

Divorce and Child Support

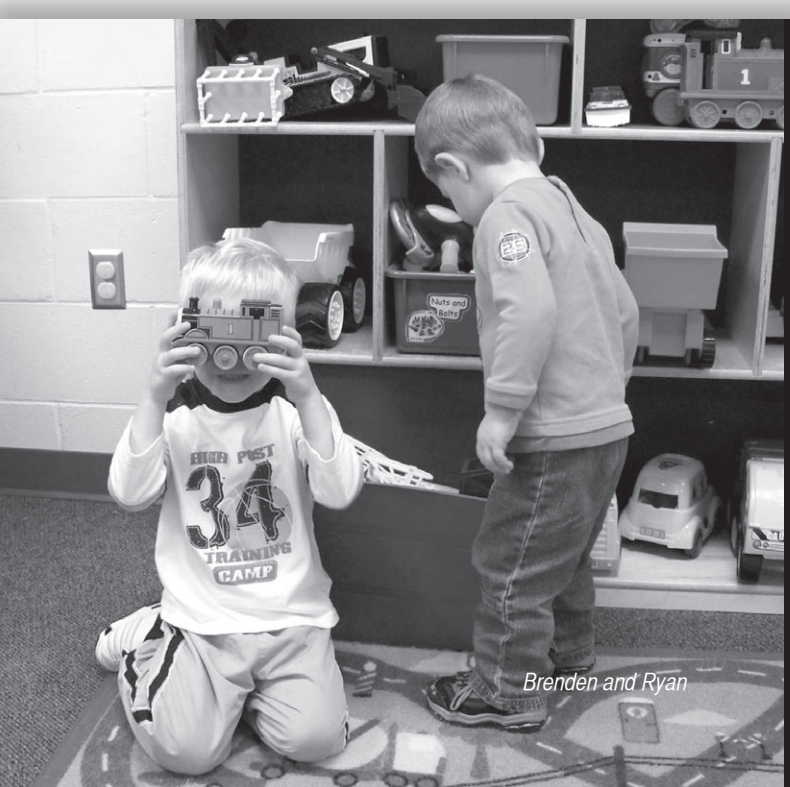
At the time this report went to print, 2007 data on divorce were not available. In 2006, there were 12,053 couples married, and 6,065 marriages in Nebraska ended in divorce. This is an increase in the rate of annual divorces versus marriages from the 2005 totals of 12,262 marriages and 5,827 divorces. The 6,065 divorces in 2006 involved 6,113 children, also an increase from 5,286 children in 2005. Of the 2006 divorces, custody was awarded to mothers 2,073 times, to fathers 354 times and joint custody was awarded 762 times. Child support can be awarded to the custodial parent. Unfortunately, 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. DHHS responded to 106,211 of these cases as of September 2007 and collected $10,891,140 on behalf of children who are dependent on Temporary Assistance to Needy Families (TANF). On behalf of children whose parents were also owed child support but were not receiving TANF, $172,489,389 was collected.

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. Federal tax data for 2007 were not available as of November 2008. In 2006, a total of $203,821,000 was claimed as Earned Income Tax Credit on 112,526 Nebraska tax returns. In addition, 158,908 families claimed the Child Tax Credit, receiving $219,071,000 and 52,284 families claimed the Dependent Care Credit, receiving $24,518,000.

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



Brenden and Ryan

IMPACT BOX

Free and Reduced Meal Eligibility Percentages as Estimates of Low-Income Children by County

Free and reduced meal eligibility in schools is often looked upon as a proxy measure of the number of children living in impoverished and low-income families in a given geographic area. Families must have an income at or below 130% of the federal poverty level (FPL) to receive free meals and at or below 185% FPL to receive reduced price meals. A child is considered to be “low-income” if they are living at or below 200% of the federal poverty level. By this definition, all children determined to be eligible for free and reduced meals

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. Nebraska state EITC was claimed on 113,117 returns (an increase from 104,267 returns in 2006), and $21,411,250 was refunded for 2007. The Child Tax Credit was claimed on 56,427 Nebraska state income tax returns, and the total amount of the CTC received was $12,201,914 in 2007. 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) funds emergency shelters, transitional housing and services for people who are homeless and at risk of becoming homeless. All NHAP-funded agencies are required to participate in a Homeless Management Information System (HMIS). The 2007-2008 NHAP grant cycle was the first grant year that NHAP-funded agencies reported via new systems. There are two HMIS systems: the Nebraska Management Information System (NMIS) and the Nebraska Domestic Violence Sexual Assault Coalition. Year-end data was obtained from both organizations. The data will serve as a baseline count for future comparisons.

For the 2007-08 grant cycle, funded agencies collaborated to assist 20,781 individuals who were homeless and 43,634 individuals who were near homeless. Continuum of Care Regions – Panhandle, North Central, Southwest, Southeast, Northeast and Lincoln – reported a 22.3% increase in the number of people assisted who were homeless and a 40.2% increase in the number of people assisted who were near homeless. No comparisons can be made for Omaha as

would be considered low-income. In this way, free and reduced lunch eligibility can provide a rough estimate of the percent of children in the county who are low-income. Keep in mind that it will be an underestimate because there is still a portion of children who would still be considered low-income that would not qualify for free and reduced meals (those between 185% and 200% FPL).

There were 46 school districts and 17 entire counties that had free and reduced eligibility percent averages at or above 50% of students. Statewide, the free and reduced eligibility rate was 36.42% for the 2006-2007 school year. That means that more than one out of every three students in Nebraska was eligible for free and reduced meals at school. We know that, statewide, child poverty has increased from 13.8% in 2006 to 14.5% in 2007.[i]

Counties at or above 50% Free and Reduced Percentage:

Blaine, 54%	Hitchcock, 53%	Scotts Bluff, 53%
Boyd, 52%	Keya Paha, 61%	Sheridan, 53%
Dawson, 52%	Knox, 54%	Sherman, 52%
Dundy, 50%	Loup, 63%	Thurston, 71%
Garden, 60%	Morrill, 55%	Wheeler, 58%
Greeley, 63%	Pawnee, 51%	

We have added an additional county data indicator to this year's *Kids Count* report that gives the average free and reduced meal percentage from all districts in each county. See the County Data on page 70 to see the free and reduced meal percentage for each county.

[i] *U.S. Census Bureau, 2006 and 2007 American Community Survey, Table B17006.*

Omaha agencies were just beginning to enter data on HMIS during the 2006-2007 grant cycle.

Within the regions, North Central and Northeast reported decreases in the number of people who were homeless (-8.1% and -16.4 %, respectively). The Panhandle (+22.0%), Southwest (+3.5%), Southeast (+45.5%) and Lincoln (+60.9%) all experienced increases in the number of homeless served. Because grantees were transitioning to Homeless Management Information Systems, it was anticipated that the reported number of people assisted would be lower, as the systems allow agencies to unduplicate data. Some of the increases may be attributed to better data collection. However, because counts generally decrease when a region implements an HMIS, the reported increases are of concern.

The number of people at risk of becoming homeless reported by agencies has increased even more dramatically. The Panhandle region is the only continuum reporting a decrease (-12.8%). The regions Panhandle, North Central, Southwest, Southeast, Northeast and Lincoln reported a 25.1% increase in the number of individuals who are at risk of homelessness. Lincoln reported a 143.5% increase in the number of near homeless assisted. The average increase for the Regions: Panhandle, North Central, Southwest, Southeast, Northeast and Lincoln, was 40.2%.

All continuums have reported increased concern for individuals and families because of the difficult economic times. The news media document that concern. The Sunday, July 20, 2008 edition of the Lincoln Journal Star reported bankruptcy filings are up 20.1% for the state for the period January 1 through June 30, 2008. Lincoln's bankruptcy filings are up 16.4%. These numbers were provided by the U.S. Bankruptcy Court, District of Nebraska. Bankruptcies, job loss or underemployment and medical costs are significant reasons individuals and families who are at risk of becoming homeless seek assistance from NHAP-funded agencies. The reported increases need to be analyzed more fully to determine the underlying reasons and causes.

Because this is the first year that NHAP-funded agencies have reported via the new systems, it is difficult to make meaningful comparisons with last year's data. Data on children also is not yet available via the new systems. However, based on historic data, families who are homeless represent over 30% of the homeless population. Families with children who are at-risk of becoming homeless have, historically, represented from 50 to 70% of the population at-risk of homelessness.

2007 Federal Poverty Guidelines

Persons in family or household	Gross Annual Income			
	100% Poverty	130% Poverty*	185% Poverty*	200% Poverty (Low-Income)
2	$13,690	$17,797	$25,327	$27,380
3	$17,170	$22,321	$31,765	$34,340
4	$20,650	$26,845	$38,203	$41,300
5	$24,130	$31,369	$44,641	$48,260
6	$27,610	$35,893	$51,079	$55,220
For each additional person add:	$3,480	$4,524	$6,438	$6,960

Source: Federal Register, Vol. 72, No. 15, January 24, 2007, pp. 3147–3148.

** Approximations based on 100% of the federal poverty level.*

[1] Diana Pearce, Ph.D 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, 2006 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, 2007 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 believes that all children in Nebraska 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 higher income is undeniable. Higher education is often linked to lower divorce rates, lower crime rates 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 thus, 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.

Olivia

High School Graduates

During the 2006-2007 school year, 21,240 Nebraska high school students were awarded diplomas. The 2006-2007 graduation rate was 89.30% (compared to 88.81% in 2005-2006 and 88.04% for the 2004-2005 school year). 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 that will allow the state to calculate the new graduation rate as defined by the National Governors Association. 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.

Graduation Rates 2006-2007 School Year

Students*	Graduation Rate**
White	92.77%
Asian	92.04%
Black	72.76%
Hispanic	70.67%
Indian	61.68%
Female	90.85%
Male	87.82%
Nebraska (All Districts)	89.30%

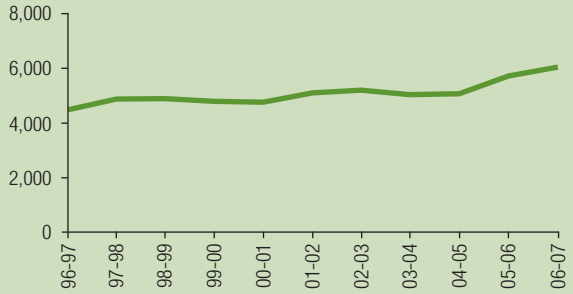
Source: Nebraska Department of Education.

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

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

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 2006-2007 school year, there were 5,956 exempt, or "home school", students in Nebraska. In addition, 1,382 per-

Exempt or "Home School" Students



Source: Nebraska Department of Education.

IMPACT BOX

Dual Language Programming

By Susan Mayberger, Omaha Public Schools

As our world becomes more and more interconnected, the advantages of students being able to speak more than just English increases. In order to help our students excel in the 21st century workplace, the Omaha Public Schools (OPS) instituted the Dual Language, or Two-Way Immersion, program in August of 2000. The Dual Language Program enables students to learn how to speak, read and write in two languages – receiving 50% of their instruction in English and 50% in Spanish. The students in this program are from both English-speaking and Spanish-speaking homes.

At the request of their parents, students may begin the program at the elementary school in Kindergarten. For students that are in middle school or high school, placement into the program is based on recommendation and assessment. South High School offers Dual Language honors courses in math, science, social studies and technology. This challenging curriculum provides academic support to students coming from Spanish-speaking homes, as well as enables English-speaking students to develop fluency in Spanish. At this time, the district has the program in the schools and grades listed in the chart at the right.

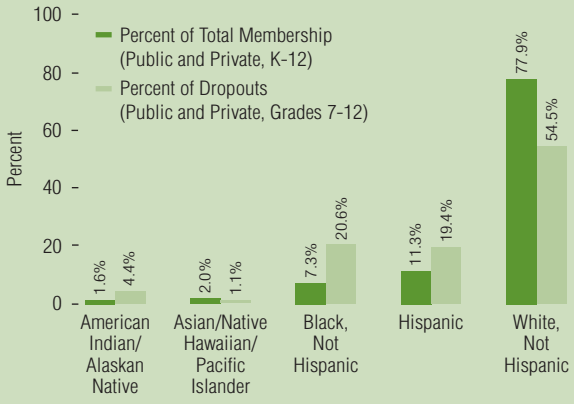
South High School offers a Dual Language option in the following courses: Pre-Algebra, Algebra, Geometry, Algebra 3-4, Honors US

sons ages 16-19 took all or portions of the GED test in 2007. Of these, 915 persons ages 16-19 successfully completed the tests and qualified for a high school diploma.

School Dropouts

During the 2006-2007 school year, 2,709 Nebraska students dropped out of school, 1,541 male and 1,168 female (dropouts are calculated using grades 7-12). This was an increase of 109 dropouts over the previous year. Last year, females comprised 40.41% of the dropouts, but that percentage increased to 43.12% in the 2006-2007 school year. Minority groups have higher dropout rates than White students. In the 2006-2007 school year, White students made up 77.86% of total enrollment (grades K-12, public and private schools) but only comprised 54.49% of the dropouts. While Hispanic students made up 11.32% of Nebraska students in public and private grades K-12, they comprised 19.42% of the dropouts. Just over 7% of students were Black, but this population constituted 20.6% (up from 17.5% in 2005-2006) of the total dropouts. Native American students comprised 4.36% of dropouts, but only 1.6% of the school enrollment.

Percent of Dropouts Compared to Percent of Enrollment by Race/Ethnicity* (2006-2007 School Year)



Source: Nebraska Department of Education.

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

Expelled Students

During the 2006-2007 school year, 959 Nebraska students (unduplicated, grades 7-12), were offered alternative education in response to expulsion from customary education. Data based on expulsions by race and gender are no longer collected by the 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

History, Honors World History, Honors Geography, Honors Economics, Honors American History, Honors Biology and Honors Chemistry. This program requires a special application.

The data on student achievement in Dual Language programming have been very positive. National studies have shown that students in Dual Language programming outperform students learning only in English and that these gains are held even if the student leaves Dual Language programming after six years. The data from the Omaha Public Schools also demonstrates that students are performing at levels comparable or better than students that are learning only in English. One of the biggest challenges to Dual Language programming is finding bilingual staff, but OPS is looking to expand its Dual Language programming to additional grades and schools.

Dual Language Programs

School Year	Gomez-Heritage	Castelar	Spring Lake	Crestridge	Marrs Magnet	Beveridge
07-08	K-4th	K-6th	K-4th	K	5th-8th	Selected classes
08-09	K-4th	K-6th	K-4th	K-1st	5th-8th	7th grade
09-10	K-4th	K-6th	K- 4th	K-2nd	5th-8th	7th-8th
10-11	K- 4th	K-6th	K-4th	K-3rd	5th-8th	7th-8th
11-12	K-4th	K-6th	K-4th	K-4th	5th-8th	7th-8th
12-13	K-4th	K-6th	K-4th	K-5th	5th-8th	7th-8th
13-14	K-4th	K-6th	K-4th	K-6th	5th-8th	7th-8th

Underwood Hills Focus School

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.

Statewide Expulsions

School Year	Number of Expulsions
1997-1998	663
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

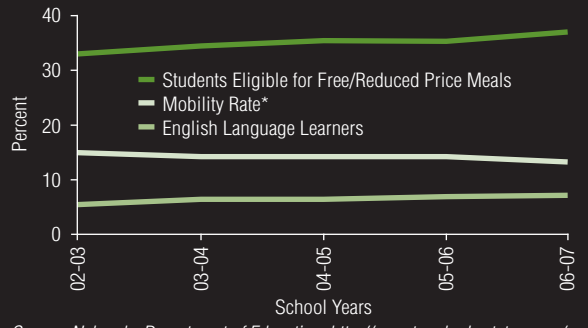
Source: Nebraska Department of Education.

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 December 1, 2007, 47,119 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 6,585 preschool children, birth to age five, with a verified disability receiving special education services. School districts reported 40,534 students ages 6 to 21 with disabilities.

Nebraska Public Schools
Trends in Student Characteristics



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.

Health – Physical and Behavioral

Voices for Children believes that all children in Nebraska 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 children who receive preventive health care throughout their lives make 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 linked to inferior school attendance and performance[1] and

Peter

worse health outcomes for children that will affect their productivity and success as adults. Low-income and minority children experience less access to quality care because of 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, 2007 data were not available in time for this report. In this report, we provide data for both 2005 and 2006 on infant mortality and child death data, as last year's *Kids Count* reported 2004 data. We report 2006 data for births, as we reported 2005 data last year. It is our hope that data for 2007 and 2008 will be available next year.

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.

The goal of prenatal care is to monitor the progress of a pregnancy 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 recommends 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.

Adequacy of Prenatal Care by Race/Ethnicity*

Race or Ethnicity	Mothers Reporting Adequate or Adequate Plus Prenatal Care in 2006
White	73.35%
Black	62.56%
American Indian	44.25%
Asian	65.30%
Other	58.65%
Hispanic	62.21%

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

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

In Nebraska, 3,419 births (13.62%) were recorded to mothers who reported inadequate prenatal care and 3,936 (15.68%) were reported to have intermediate prenatal care in 2006 (out of 25,096 births that had known Kotelchuk Index). This is an increase in the number of mothers reporting inadequate prenatal care by 12.21% but a significant decrease in the number reporting intermediate care by 23.02%. Mothers reporting adequate or adequate plus prenatal care comprised 70.7% of all births in which the quality of prenatal care was reported in 2006.

Uninsured women face greater barriers to prenatal care than insured women, even in the presence of strong

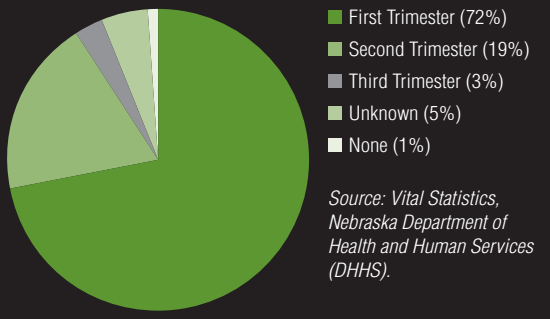
Selected Preconception Risk Factors

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.

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

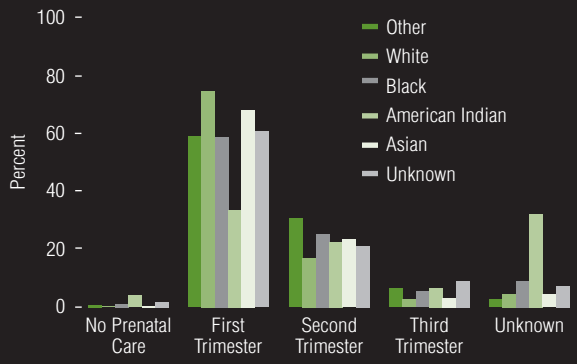
** Teratogen refers to any agent that causes a structural abnormality following fetal exposure during pregnancy.*

Trimester Prenatal Care Began All Births in 2006



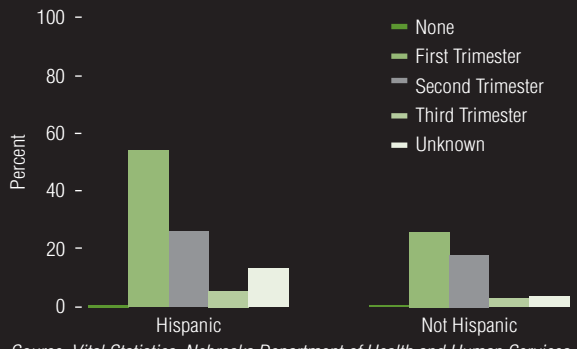
Source: Vital Statistics, Nebraska Department of Health and Human Services (DHHS).

Trimester Prenatal Care Began by Race All Births in 2006



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

Trimester Prenatal Care Began by Ethnicity All Births in 2006



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

Note: There are four births not included in this chart labeled as "Unknown." For both Hispanic and Not Hispanic births, the percent of births in which no prenatal care was provided was less than 1%.

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 pregnancies), and not knowing whether or not they wanted the baby/ambivalence about pregnancy.[6]

Nebraska Births

In 2006, there were a total of 26,723 live births to Nebraska residents.

Infant Mortality

Infant mortality rates are frequently used as an indicator of overall human well-being in a community. Although the United States spends more on health care than any other country, the World Health Report of the World Health Organization issued in 2005 found that the U.S. had the second highest infant mortality rate among 33 industrialized counties, second only to Latvia.[7] Currently, 2007 infant mortality data are not available. In 2005 and 2006, the Nebraska infant mortality rates (deaths per 1,000 births) were 5.62 and 5.54 respectively. In 2005 and 2006, 147 and 148 Nebraska children died prior to their first birthday, respectively.

Infant Mortality Rates* by Race and Ethnicity

	2005	2006
White	5.25	5.63
Black	11.65	11.42
American Indian	20.45	6.24
Asian	14.47	4.85
Hispanic	7.02	6.00
Overall	5.62	5.54**

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.*

*** A significant amount of births in 2006 (2,556 or 9.6%) were labeled race Other or Unknown. This race category only experienced two infant deaths in 2006, an infant mortality rate of .08. We believe that this is driving down the overall infant mortality rate in 2006, lower than all other categories.*

Note: Both American Indian and Asian deaths dropped from 9 in 2005 to 3 in 2006, thus the large change in the infant mortality rate.

Nebraska residents lost 1,695 babies under the age of one from 1996-2005 and 1,640 babies under the age of one from 1997-2006. Birth defects, accounting for 30 infant deaths (20.41%) in 2005 and 45 deaths (30.4%) in 2006, were the number one cause of infant death during these years (tied with SIDS in 2005). Sudden Infant Death Syndrome, or SIDS, accounted for 30 deaths (20.41%) and 18 (12.2%) deaths in 2005 and 2006, respectively. The number of SIDS deaths was up significantly in 2005 from 13.5% of all infant deaths in 2004, but dropped again in 2006. Pre-mature births were the cause of 15 infant deaths (10.20%) in 2005 and 8 (5.41%) in 2006.

Low Birth Weight

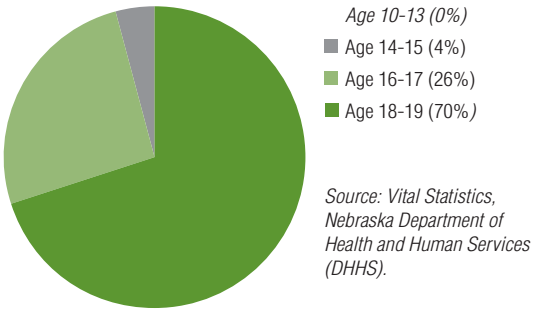
The highest predictor of death and disability in the United States is low birth weight. A newborn weighing below 2,500 grams, or 5.5 pounds, is considered of low birth weight and a newborn weighing less than 1,500 grams, or 3.3 pounds, is considered of a very low birth weight. In 2006 in Nebraska, 1,910 newborns were of low birth weight (7.15% of all births). Of all births, 1.25% (333) were born with a very low birth weight. Both of these figures, low birth weight and very low birth weight births, increased from 2005.

Smoking is an attributable cause of low weight births. Nearly 12% of mothers who gave birth in 2006 admitted to using tobacco during their pregnancy. Pregnant women who smoke cigarettes are nearly twice as likely to have a low birth weight baby as women who do not smoke.[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] While pregnancy certainly occurs at all socioeconomic levels, 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]

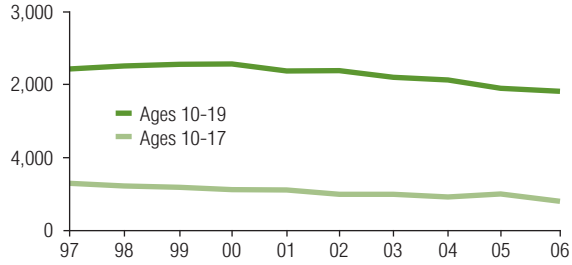
Teen Births by Age, 2006



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

In Nebraska, 2,143 babies were born to girls ages 19 and under in 2006. Births to teens ages 19 and under represented 8.02% of all babies born in 2006, and this number continues to decline from previous years. Across a ten-year span since 1997, 7,639 babies were born to mothers ages 17 and under. The number of births to teens ages 10-17 had seen a steady decline since 1997 and for the first time, increased in 2005. However, births to teens ages 17 and under have returned to the trend of decline in 2006. The percentage of births to teen mothers ages 10-17 in 2006 that were not the mother's first birth was 8.49%. Of the 648 babies born to teen mothers ages 10-17 in 2006, 351 (54.17%) had White

Teen Birth Trends (1997-2006)



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

mothers, 119 (18.36%) were born to Black mothers, 36 (5.56%) had American Indian mothers and 5 (0.77%) were born to Asian mothers. In addition, 135 births (20.83%) were attributed to teen mothers identified as Other and two were Unknown. Teen females ages 10-17 of Hispanic ethnicity gave birth to 219 babies (33.80%).

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 2006, with 8,617 (32.25%) babies born out-of-wedlock. Nebraska children living with single parents were also more likely to live in poverty, with a 37% poverty rate, than children living in married-couple households, with a 6% poverty rate in 2007.[15] The likelihood that a mother will be married upon the birth of the child increases with the age of the mother.

Immunizations

According to the National Immunization Survey for 2007, Nebraska is ranked 5th in the country for high immunization coverage. 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 2007 U.S. national average was 77.4%. According to the National Immunization Survey for 2007, 82.9% 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 increase from 2006.

There were 70 cases of pertussis (whooping cough) reported in Nebraska in 2007, primarily in teens and young adults. This is a slight increase in cases of pertussis from 2006, which had 59 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. Generally, the disease does not have a strong effect on older children or adults, however it can be easily passed to young children who may end up hospitalized. Although there have been no deaths in recent years, pertussis is a potentially deadly disease for young children. The outbreak 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 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.

Child Deaths

Child death data for 2007 were unavailable at the time this report went to print. In 2005, there were 155 child deaths, ages 1-19 in Nebraska. This was a decrease from 169 the previous year. However, in 2006, the number of child deaths ages 1-19 increased again to 174. The leading cause of child death in Nebraska is motor vehicle accidents. In 2005, 54 children ages 1-19 were killed in motor vehicle accidents (34.84% of all child deaths ages 1-19). In 2006, 61 children ages 1-19 lost their lives in motor vehicle accidents (35.06% of all child deaths ages 1-19). Child deaths due to non-motor vehicle accidents accounted for 21 and 27 child deaths in 2005 and 2006, respectively. Eighteen child deaths were attributed to cancer in 2005 and eight in 2006. In the last five

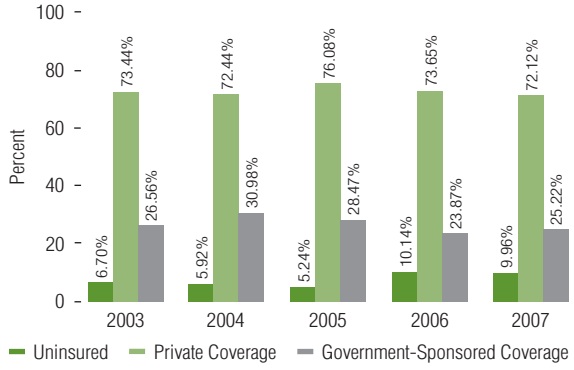
years, Nebraska has seen an increase in child suicides (see graph at right). Substance abuse is often associated with deaths due to suicide and homicide. Suicide was the second leading cause of child death among children ages 1-19 in Nebraska in 2005 and the third leading cause in 2006. Six children ages 1-19 were lost to homicide in 2005 and 15 to homicide in 2006.

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

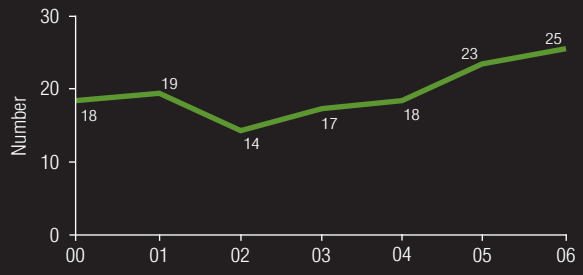
Uninsured children tend to live in employed families that do not have access to insurance. Most often in these cases the employer does not offer insurance, the insurance offered is too expensive or the insurance does not cover all of the necessary medical needs of the family. In 2007, there were 45,000 uninsured children ages 17 and under in Nebraska.[16] According to the U.S. Census Bureau, there were 27,000 uninsured children 18 and under which were considered low-income (living below 200% the federal poverty level or annual income of $41,300 for a family of four) in 2007.[17] In 2006, the number of uninsured low-income children 18 and under was 32,000, while the overall uninsured child total (17

Health Coverage for Nebraska's Children Ages 17 and Under (2003-2007)



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

Child Deaths by Suicide (Ages 1-19)



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

Selected Causes of Child Death Ages 1 to 19 in Nebraska

Causes	Frequency 1996-2005	Frequency 1997-2006
Motor Vehicle Accidents	610	612
Non-Motor Vehicle Accidents	230	232
Suicide	182	185
Homicide	119	123
Cancer	133	125
Birth Defects	60	57
Heart	60	58
Cerebral Palsy	30	31
Asthma	27	22
Pneumonia	13	14
HIV/AIDS	3	2
All Other Causes	268	258
TOTAL	1,735	1,719

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

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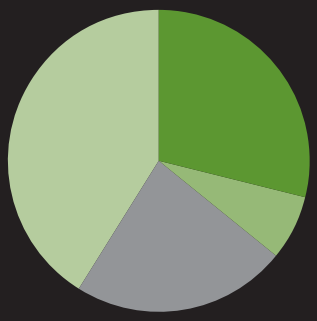
Nebraska Medicaid Expenditures by Category (Fiscal Year 2007)

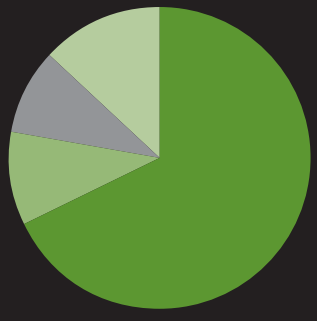


Total: $1,483,783,077

- 29% Children *$414,180,616*
- 7% ADC Adults *$105,182,619*
- 23% Aged *$333,402,607*
- 41% Blind and Disabled *$586,017,234*

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

Nebraska Medicaid Average Monthly Eligible Persons by Category (Fiscal Year 2007)



Total: 198,054

- 68% Children *(133,637)*
- 10% ADC Adults *(20,089)*
- 9% Aged *(18,121)*
- 13% Blind and Disabled *(26,206)*

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

and under) was 45,000. If we continue to see the number of low-income uninsured children (27,000) moving farther away from the total number of uninsured children (45,000), this may be indicating that the problem of uninsured children is creeping higher up the income scale, while public benefit programs are covering a greater number of uninsured low-income children. (These two statistics, the total number of uninsured children and the number of low-income uninsured children, are drawn from the same survey by the U.S. Census Bureau but measure different age ranges. However, while we are not measuring the exact same population, it is the best data available from which to draw conclusions about the uninsured child population in our state.)

Many of these uninsured low-income children are eligible for Kids Connection. Kids Connection provides low-cost health care coverage for children living in families at or below 185% of the federal poverty level (annual income of approximately $38,203 for a family of four in 2007). Kids Connection includes both the State's Children's Health Insur-

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Suicide Prevention in Youth

By David Miers, M.S., LPC
BryanLGH Medical Center Mental Health Services
Co-Chair Nebraska State Suicide Prevention Coalition

Suicide is the second leading cause of death for Nebraska youth (ages 15-19). State Vital Statistics reports that in 2006, 201 Nebraskans died by suicide. Forty-nine (49) of these deaths or 24 percent were young people between the ages of 10 and 24. Although absolute numbers of deaths appear low when compared to those in more populous states, Nebraska suicide rates are higher than the national average. Nebraska's suicide rate for youth ages 15-19 for 1999-2005 was 11.8 per 100,000 population, exceeding the national rate of 7.8 for the same years.

While these facts are disturbing, there is hope. By educating our-

ance Program (SCHIP) and the Nebraska Medical Assistance Program (Medicaid). Kids Connection provided health coverage for 133,637 children, nearly 30% of all Nebraska children ages 18 and under in 2007. Children comprise a little over two-thirds of Medicaid recipients but consume less than one-third of Medicaid expenditures.

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 years of age who has been exposed to lead hazards. In 2006 and 2007, there were 13,962 and 13,242 Nebraska children less than six years-old tested for EBLL, respectively. These are both significant decreases from the 21,158 Nebraska children less than six years-old tested in 2005.

The 34% decrease in children screened between 2005 and 2006 may be attributed to the termination of a federal grant funding screening analysis from the Centers for Disease Control and Prevention (CDC) that ended in 2005. The Nebraska Department of Health & Human Services Division of Public Health (DHHS) Childhood Lead Poisoning Prevention Program (CLPPP) administered targeted screening among children who were at greater risk of lead poisoning through local health departments and Community Action Programs (CAP) from the early 1990s until June 30th, 2005. It is uncertain whether the CDC funding will be available in the future. Clinics and hospitals now decide on their own whether to have a child tested for EBLL or not. There are no general guidelines for this practice, except that Medicaid-eligible children are required to be screened at 1 year and 2 years of age and if not at 1 or 2, at some point between age 3 and 6.

DHHS 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

selves and others, a difference can be made in preventing youth suicide.

The Nebraska State Suicide Prevention Coalition (NSSPC) has been working to help Nebraskans make a difference. The Coalition is a voluntary committee with representation that includes survivors, providers and individuals from across the state. The Coalition has embraced several goals to address suicide rates for youth. Youth-focused goals include:

- Increased public awareness of suicide as a public health problem; and
- Routine availability of depression screening for youth.

The Nebraska Suicide Prevention Coalition endorses the use of two evidence-based practices identified by the Suicide Prevention Resource Center (SPRC), both utilizing a screening process that embraces the partnership of schools, parents and community resources. The Columbia TeenScreen is identified as a screening instrument that is flexible and can be used in school districts of varying size. The Signs of Suicide (SOS) program is also evidence-based and promotes depression awareness and suicide prevention strategies which can be implemented in one or more classroom periods by existing school staff. In addition, the Coalition supports the Yellow Ribbon Suicide Prevention Program® which offers a program to schools and communities that teaches youth how to recognize depression and loneliness and emphasizes that it is “OK to ask for help!” It is critical that each community and school district partners with parents and dedicated groups to ensure continuity and quality of suicide prevention services within the community.

One of the most important steps that schools and families can take is to talk about suicide openly. Evidence clearly states that talking about suicide does not give a young person permission to hurt themselves.

Taking action and implementing programs that promote suicide awareness and screening can be life saving for our youth.

generates reports, identifies children with elevated test results and allows the program to provide appropriate case management.

In 2006, 263 children (1.88% of children tested) had blood lead levels in the range where detrimental effects on health have been clearly demonstrated. In 2007, 231 children (1.74% 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 who are at risk by 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 selected 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 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 Fiscal Year 2007, 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 and an eight-bed treatment group home, both located at the Whitehall campus. The Hastings Regional Center (HRC) operated a Chemical Dependency Program for youth from the Youth Rehabilitation and Treatment Center (YRTC) in Kearney and an adolescent psychiatric residential program. For part of the year, HRC also operated a small adolescent acute psychiatric inpatient program.

A total of 211 youth ages 18 and under received services from a regional center in FY 2007 (duplicated count). In FY 2007, 137 youth received services from the Hastings Regional Center (this number includes those in the unit on the first day of the fiscal year and all additional youth served throughout the year). The Lincoln Regional Center served 74 youth, including 18 youth who received an outpatient psychiatric evaluation.

The Norfolk Regional Center does not have any specialized programs for children or adolescents. No youth under the age of 19 were served at the Norfolk Regional Center in FY 2007.

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 care-giver 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.

The Division of Behavioral Health provided services to children in FY 2007 through the Substance Abuse and Mental Health Block Grants. In Fiscal Year 2007, the Substance Abuse Block Grant Application reports that 4,365 children ages 17 and under received substance abuse services. The Mental Health Block Grant reported that 4,095 children ages 17 and under received mental health services in FY 2007. According to a representative of the Department of Health and Human Services, more detailed data for FY 2007 and reliable data for FY 2008 is unavailable due to a programming error.

Youth Risk Behavior Survey

Developed by the National Centers for Disease Control and Prevention and prepared by 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. This survey is given every two years. The goal of the report is to determine and reduce common youth health risks, increase access and delivery to health services and positively affect the often risky behavioral choices of youth. Unfortunately, in Nebraska, the 2007 YRBS only had a 36% response rate, as compared to 67% in 2005. For this reason, data from the 2007 YRBS are unavailable as a weighted sample of the population. Voices for Children in Nebraska has chosen not to report the unweighted 2007 YRBS data that are available because we cannot draw statewide conclusions from data that are not representative of a sufficient portion of the statewide population. Because 2007 YRBS weighted data are unavailable for the state of Nebraska, school and community leaders are unable to draw conclusions about the health behaviors of Nebraska high school students and how those behaviors may be changing positively or negatively. Several of Nebraska's schools have continually chosen not to participate in the YRBS, thus limiting the ability of the results to act as a representative sample.

There are six categories of health risk behaviors included in the YRBS survey:

Behaviors that result in unintentional and intentional injuries
Tobacco use
Alcohol and other drug use
Sexual behaviors that result in HIV infection, other sexually transmitted diseases and unintended pregnancies
Dietary behaviors
Physical activity

Source: The 2005 Youth Risk Behavioral Survey of Nebraska Adolescents.

Alcohol and Other Drugs

The 2005 YRBS found that alcohol is used heavily by youth in Nebraska, and this finding is 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.

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, in 2007, 31 Nebraska children 17 years of age and younger died in motor vehicle traffic accidents. In 2006, there were 47 deaths, which was almost double the number in 2005 (26 deaths 17 and under). In 2005, we saw the lowest number of child motor vehicle deaths in the last 10 years. Additionally in 2007, 260 children suffered disabling injuries due to accidents; this is also a decrease from 307 in 2006. In the past ten years (1997-2007), 434 Nebraska children have died due to vehicle accidents.

Teen Sexual Behavior

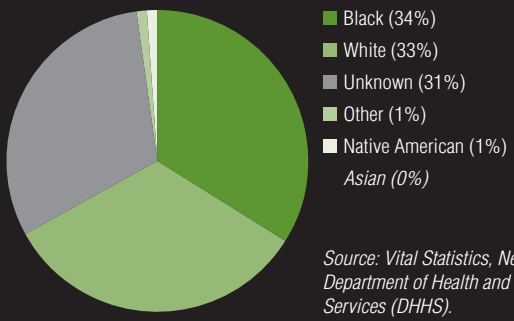
According to the 2005 YRBS, 40.8% of the adolescents surveyed reported that they had experienced sexual intercourse at least one time in their life, a decrease of 2.2% from 2003. Twenty-four percent of the adolescents who reported having had sexual intercourse used alcohol or drugs prior to their last 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 2,331 cases of sexually transmitted diseases reported by children ages 19 and under in Nebraska in 2007. This is a decrease from 2,549 cases in 2006.

According to the Centers for Disease Control and Prevention (CDC), young people, especially youth of minority

2007 Reported STD Cases By Race (19 and Under)



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

races and ethnicities, are at a persistent risk for HIV infection. HIV infection often progresses to AIDS more slowly among infected young people. Nationally, African Americans were disproportionately affected by HIV infection, accounting for 55% of all HIV infections reported among persons ages 13-24.[18] In Nebraska, there are 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.

According to the CDC, adolescents 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 equals 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.

[7] *World Health Organization, The World Health Report (WHO: Geneva: 2005) as quoted in* Save the Children's "State of the World's Mothers 2006."

[8] *U.S. Department of Health and Human Services*, "The Health Consequences of Smoking: A Report of the Surgeon General—2004," Centers for Disease Control and Prevention, Office on Smoking and Health, Atlanta, GA, May 2004.

[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, 2007 American Community Survey, Table B17006.

[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] *Centers for Disease Control and Prevention*, "HIV/AIDS among Youth," CDC HIV/AIDS Fact Sheet, Revised August 2008.

Juvenile Justice

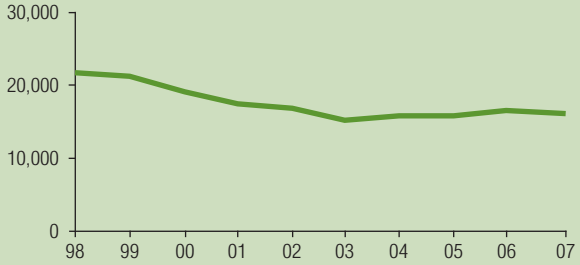
Voices for Children believes that all children in Nebraska have a right to due process and equal protection under the law, access to judicial systems that provide appropriate, fair and lawful determination and rehabilitative social services where needed. Children can find themselves involved in the juvenile 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 2007, 15,649 Nebraska juveniles were arrested. This is a decrease of 487 arrests from 2006 but remains higher than in 2005. Female juvenile offenders comprised 31.32% of all juvenile arrests in 2007, and male offenders made up the remaining 68.68%. 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 2007.

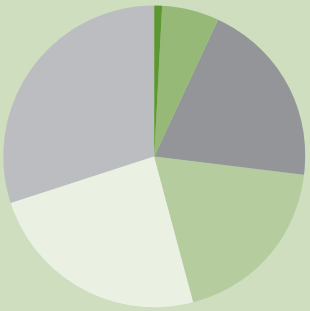
Juvenile Arrests, 17 an Under (1998-2007)



Source: Nebraska Commission on Law Enforcement and Criminal Justice.

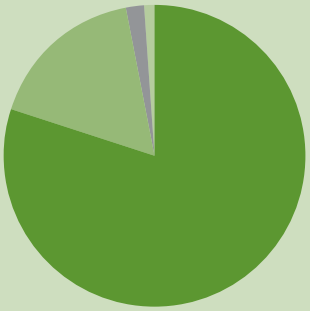
While we can track juvenile arrest by race, unfortunately, we are unable to report juvenile arrests by ethnicity statewide because the Omaha Police Department and the Douglas County Sheriff's Office do not track the ethnicity of juveniles arrested. For this reason, we have no way of knowing whether or not

Juvenile Arrests by Age (2007)



Source: Nebraska Commission on Law Enforcement and Criminal Justice.

All Juvenile Arrests by Race (2007)



Source: Nebraska Commission on Law Enforcement and Criminal Justice.

Hispanic juveniles are overrepresented at juvenile arrest in the largest and most diverse city and county in the state.

Juvenile Detention

Statewide, there were a total of 2,878 juveniles held in detention facilities in 2007. Seventy-five percent (2,162) of those juveniles were male. The Douglas County Youth Center detained over half (55.28% or 1,591) of all the juveniles detained in 2007.

We remain unable to report accurate statistics on Hispanic juveniles in youth detention facilities because the Douglas County Youth Center (DCYC) does not track ethnicity. All 1,591 juveniles detained at the DCYC are classified as "Unknown" according to ethnicity. As the DCYC detains over half of the total juveniles detained statewide, we are unable to draw any statewide conclusions about the rate of detention for Hispanic juveniles. In the other three juvenile facilities represented on page 50, excluding the 1,591 DCYC "Unknowns," Hispanic juveniles represented nearly 20% (252) of the youth held in detention.

There were 183 juveniles held in adult detention facili-

Selected Nebraska Juvenile Arrests by Offense and Gender 2007*

Offense	Males	Females	Total
Violent Offenses	215	35	250
Aggravated Assault	117	28	145
Robbery	72	6	78
Forcible Rape	22	0	22
Murder and Manslaughter	4	1	5
Non-Violent Offenses	10,533	4,866	15,399
Larceny Theft (Except Motor Vehicle)	1,758	1,216	2,974
Liquor Laws	1,472	1,053	2,525
All Other Offenses (Except Traffic)	1,654	701	2,355
Simple Assault	1,380	561	1,941
Drug Abuse Violations	942	236	1,178
Vandalism- Destruction of Property	1,023	150	1,173
Disorderly Conduct – Disturbing the Peace	670	275	945
Runaways	201	231	432
Curfews and Loitering Law Violations	279	137	416
Burglary- Breaking or Entering	263	28	291
Driving Under the Influence	199	90	289
Weapons: Carrying, Possessing, etc.	185	12	197
Sex Offense (Except Forcible Rape and Prostitution)	116	16	132
Stolen Property: Buy, Receive, Possess, Conceal	149	31	180
Offenses Against Family and Children	23	38	61
Arson	52	5	57
Forgery & Counterfeiting	13	11	24
Prostitution and Commercialized Vice	0	1	1

Source: Nebraska Commission on Law Enforcement and Criminal Justice

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

Juveniles Held in Juvenile Detention Facilities By Race in 2007

Agency	American Indian/ Alaskan Native	Asian/Pacific Islander	Black	White	Unknown	Total (Count)
Lancaster County Juvenile Detention Center	3.53%	1.46%	23.02%	70.40%	1.58%	100% (821)
North East Nebraska Juvenile Services (Madison County)	16.41%	0.31%	8.05%	73.68%	1.55%	100% (323)
Western Nebraska Juvenile Services (Scotts Bluff County)	26.57%	0%	2.80%	69.93%	0.70%	100% (143)
Douglas County Youth Center	1.63%	0.31%	52.29%	45.00%	0.75%	100% (1,591)
Statewide Total	5.07%	0.63%	36.52%	56.71%	1.08%	100% (2,878)

Source: Nebraska Commission on Law Enforcement and Criminal Justice. *Note: Row totals may not equal 100 percent exactly due to rounding.*

ties in 2007. 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). Males spent fewer days in adult detention facilities, averaging 14.5 days, while females averaged 19 days. Native American juveniles experienced the longest periods of detention in adult jails and lockups, averaging 41.07 days. Hispanic juveniles were detained in adult jails an average of 38.68 days. White juveniles followed with an average stay of 14.16 days, and Black juveniles averaged 7.53 days detained in adult jails and lockups.

Of all juveniles held in detention, in both juvenile and adult facilities, 41.04% were youth of a minority race, while 58.96% were White youth. Again, because DCYC does not track ethnicity, we are unable to factor Hispanic youth into this calculation and would anticipate that the rate of youth of color in detention would be even higher if we were able to accurately track the ethnicity of all juveniles detained in DCYC.

Probation

In 2007, there were 5,842 juveniles supervised on probation, a slight increase from the 5,671 juveniles in 2006. Of those juve-

POLICY BOX

Nebraska Probation is "Thinking Differently"

By Corey Steel, Office of Probation Administration

Two years ago the Office of Probation Administration began to explore the integration of "new evidence-based practices" into our day-to-day responsibilities, and the Community Safety Impact and Rehabilitation Model was created as a result. This model provides officers and other staff the skill sets to help them identify and target interventions that are proven to:

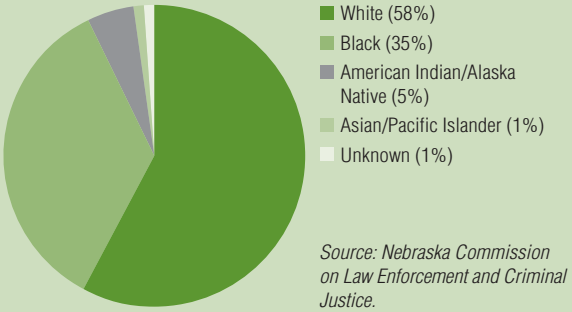
- reduce a juvenile's high-risk behavior,
- prevent the juvenile from penetrating further into the criminal justice system,
- offer the juvenile and the juvenile's family meaningful rehabilitative assistance.

The five separate functions of the Community Safety Impact and Rehabilitation Model include: **Intake**, **Assessment**, **Supervision and Programming**, **Support Services**, **Evaluation and Outcomes**.

Probation has moved to a new coordinated approach with its assessment of juveniles. Our assessment instruments are the driving force for recommendations to the court, family case management and targeted treatment. The assessment instruments target juvenile risk behaviors, which allows the probation officer to accurately target risk and needs and appropriately offer an individualized approach for case management.

The supervision approach of juveniles is an individualistic, family-

Juveniles Held in Detention by Race (2007)



Source: Nebraska Commission on Law Enforcement and Criminal Justice.

niles placed on probation in 2007, 65.73% were White, 15.27% were Black, 2.57% were Native American, 0.74% were Asian, and 15.70% were of a race classified as "Other." Sixteen percent of juveniles placed on probation were Hispanic. During 2007, 2,334 juveniles were successfully released from probation. Of those juveniles successfully released from probation, 70.87% were White, 12.08% were Black, 1.63% were Native American, 0.73% were Asian, and 14.7% were classified as "Other." 13.88% of juveniles released were Hispanic.

The number of juveniles placed on probation for a misdemeanor offense decreased slightly to 2,660 youth, and the number of juveniles placed on probation for a felony offense increased slightly to 284 youth.

Youth Rehabilitation and Treatment Centers (YRTC)

The two Youth Rehabilitation and Treatment Centers in Nebraska 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 2006-2007, 433 males (326 of whom were first time commitments) males were admitted for treatment to Kearney and 127 females (104 of whom were first time commitments) to Geneva for a total of 560 youth committed to YRTC care from July 2006-June 2007. This was a decrease of 28 total YRTC commitments over the previous year.

YRTC Kearney had an average daily population of 153 in fiscal year 2006-2007 (this does not include youth that have been paroled from YRTC Kearney to the Hastings Juvenile Chemical Dependency Program). Males at Kearney remained

focused, targeted approach to reduce high-risk behaviors. The assessment instruments identify high-risk behaviors and the supervision targets appropriate programming and treatment needed to reduce them. Every juvenile will have a family-focused case plan to act as a road map to guide the juveniles and the family. The family-focused case plan will address risk behaviors by providing techniques that include treatment, teaching, coaching and modeling incorporating interventions and setting goals. The use of cognitive behavioral groups has been implemented for juveniles who are at high risk as an enhancement to Probation's supervision programming. Probation officers will use positive reinforcements when working with the youth and family throughout supervision. Engaging ongoing support in the juvenile's community is another key supervision tactic. This involves linking juveniles to pro-social activities and positive peers in the community as a proven way to reduce risk behaviors.

The Office of Probation Administration has raised the bar in expectations for probation officers requiring core skills needed to change a juvenile's behavior. In the past two years, officers have been trained in family-focused case planning, juvenile brain development, and motivational interviewing. Motivational interviewing is a skill that an officer uses to create intrinsic motivation in a juvenile to change their behaviors. These skills are proven ways to reduce the risk of continued negative behaviors.

The goal of Probation is to implement strategies so juveniles do not penetrate the juvenile system any further, to keep them out of the adult system in the future, and to keep communities safe. We continue to look for new research-based and better ways to assess, case plan, supervise, and engage the community in these goals.

an average of 210 days, and 61.35% were 16-17 years of age. Nearly half of all young men committed to Kearney were White (48.63%), 23.69% were African American, 21.70% were Hispanic, 5.24% were Native American and 0.75% were Asian. The major offenses committing males to YRTC Kearney were theft (20.70%), assault (18.45%) and possession of drugs (12.97%). Thirty-five students earned their General Equivalency Diplomas (GED) while at Kearney. The average per diem cost for 2006-07 at Kearney was $176.38 per youth. Additionally, through the Hastings Regional Center, Kearney utilizes a Chemical Dependency Unit for youth. During fiscal year 2007, 94 youth were paroled from YRTC Kearney and served in this program.

Geneva provided services for an average of 75 females per day, a decrease from 88 in 2005-2006. The average female committed to Geneva in 2006-2007 was 16 years old at admission and remained there seven and a half 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 (23.08%), possession of drugs (14.53%), and shoplifting (9.40%). Drug possession and shoplifting replaced theft and criminal mischief in fiscal year 2007 year in the top three offenses. Twelve students received their high school diplomas in fiscal year 2007. The majority of females placed at YRTC Geneva were White/Non-Hispanic (53.54%), 18.90% were Hispanic, 17.32% were Black/Non-Hispanic, and 10.24% were American Indian. The per diem cost of Geneva for 2006-2007 was $222.88.

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 the systems of the brain which govern "impulse control, planning and thinking ahead are still developing well beyond age 18."[3] Research consistently indicates that

IMPACT BOX

DHHS-OJS Solutions to Enhance Services and Programs for OJS Youth

Todd Landry, Director – Division of Children and Family Services

The Division of Children and Family Services, Office of Juvenile Services (OJS), has identified and is implementing a number of "solutions" to enhance programs and services to the 1,600+ youth served by OJS. These solutions include the development and implementation of new programming for community-based programs and the Youth Rehabilitation and Treatment Centers (YRTC) in Kearney and Geneva, NE.

The following services and programs have been completed or partially completed at this time by OJS:

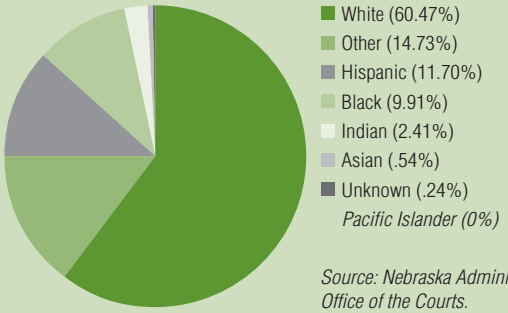
1. Additional cognitive-behavioral and evidence-based programming at YRTCs. *(Partially Completed)*
2. Planning, cost analysis, and a capital construction proposal to renovate the living units at YRTC-Kearney. Proposal was submitted to the Nebraska Building Division, Capital Construction Committee in October 2008 for approval. *(Partially Completed)*
3. In collaboration with DHHS-Division of Behavioral Health, planning is underway for a 24-bed secure-care and a 48-bed chemical dependency treatment facility for male youth paroled or transferred from YRTC-Kearney. Proposal was submitted to the Nebraska Building Division, Capital Construction Committee in 2008 for approval. *(Partially Completed)*
4. Housing aggressive and violent female youth not amenable to treatment in a special living unit at YRTC-Geneva. *(To be completed)*
5. OJS contracted with Heartland Family Services (who also subcontracted with Boys Town) for a 2-year pilot program that opened in April 2008. "Youth Links" serves status offenders and juvenile delinquents. The new facility offers programming that includes: a) OJS

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."[4] 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 Nebraska, there were 5,512 juveniles tried in adult courts in 2007. This is over 35% of all juveniles arrested in 2007.

Once processed through the adult system and committed to adult prisons, research shows that juveniles have fewer treatment opportunities in the adult correctional system than youth held in juvenile facilities.[5] Nationally, youth in adult jails and prisons face high rates of victimization, particularly sexual assault or beatings, and are more likely to commit suicide.[6] In 2007, 52 Nebraska youth ages 18 and under were processed through the adult system and housed in adult prisons. This is a promising decrease from the past two years (86 in 2006 and 72 in 2005). Of these youths, eleven were incarcerated for robbery and ten for assault. Two youths were

Juveniles Tried in Adult Court in 2007



Source: Nebraska Administrative Office of the Courts.

Note: There were 812 cases labeled as "Other" which make up 14.73% of the total number of juvenile cases tried in adult court. There were also 13 cases labeled "Unknown." The courts use "Unknown and "Other" interchangeably.

evaluations; b) transitional living for YRTC youth returning to the Eastern Service Area; and c) crisis intervention. *(Partially Completed)*

6. OJS staff are receiving specialized training through the Center for Children, Families and the Law to meet the unique case management needs of juvenile delinquents. *(Completed)*
7. The ability for OJS to issue apprehension and detention requests for absconders is now established in all service areas as a result of the combined efforts of the Nebraska State Patrol, the FBI and DHHS-OJS. *(Completed)*
8. The Youth Level Service/Case Management Inventory (YLS/CMI) assessment in partnership with State Probation was implemented. It is a validated risk and needs assessment tool for juvenile offenders. In conjunction with the YLS/CMI, a new assessment tool for the YRTCs is in the development stage. The tool crosses Behavioral Severity with the YLS/CMI. *(Partially Completed)*
9. Implementation of a U.S. Department of Justice, Justice and Mental Health Collaboration Program grant for young adults, to include juvenile delinquents. This grant will improve the cross-disciplinary system of care for youth /adults with mental illness who encounter the criminal justice system. *(Partially Completed)*
10. Omaha Independent Living Pilot program- a collaboration between DHHS, Nebraska Children and Families Foundation, Sherwood Foundation and the William and Ruth Scott Family Foundation to offer services to youth age 16 and older. An assessment and a plan for each youth is developed which included life skills related to education, employment, etc. *(Partially Completed)*

DHHS-OJS is committed to the rehabilitation of Nebraska's delinquent youth in order to help them become positive citizens through case management, supervision, community-based services, placement and other programs. Reducing and working to eliminate juvenile delinquency takes a collaborative effort of OJS, Probation, Law Enforcement, Judges, Attorneys, advocates and other community stakeholders.

2007 Juvenile Interaction with the Justice System by Race

	Teen Population[i]	Arrests	Detention	Placed on Probation	YRTC Commitments[ii]	Juveniles Tried in Adult Court[iii]	Juveniles Incarcerated in Adult Prison[iv]
White	80%	80%	58%	66%	50%	60%	19%
Black	5%	17%	35%	15%	22%	10%	38%
Native American	1%	2%	5%	3%	6%	2%	15%
Asian	2%	0%	1%	1%	1%	1%	0%
Other	12%			16%	21%	26%	28%
Unknown		1%	1%			0%	
Total	100%	100%	100%	100%	100%	100%	100%

Numbers are rounded to the nearest whole number

[i] The "Teen Population" comprises youth in Nebraska ages 10 through 19 in 2007. We were unable to obtain current population data for just juveniles ages 10-17. "Other" category includes "Two or More Races, Not Hispanic" and "Hispanic" categories.

Source: Population Estimates Program, U.S. Census Bureau - Age, Sex, and Race/Ethnicity Estimates for Counties, released 8-7-08: Compiled by Center for Public Affairs Research, University of Nebraska Omaha.

[ii] 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 2007.

[iii] Juveniles Tried in Adult Court is broken down by race and ethnicity, so the "Other" percentage encompasses 12% Hispanic and 15% Other. This is a particularly high number of cases for "Other," particularly given the inclusion of both race and ethnicity. There were only 13 cases labeled "Unknown." "Unknown" and "Other" were used interchangeably for data entry by the courts.

[iv] Juveniles in Adult Prison is broken down by race and ethnicity, so the "Other" percentage encompasses 26% Hispanic and 2% Other.

incarcerated for homicide, one male and one female. The only other female youth incarcerated in adult prison was for robbery charges. Twenty-five percent of the youth 18 and under incarcerated in adult prisons in Nebraska were 16 and under. Of all youth 18 and under incarcerated in adult prisons, at least 76.92% are youth of color (classified as Black, Hispanic or Native American). Only 21.15% are White, and 1.92% are classified as "Other."

As of September 2007, there were 24 persons serving life sentences without the possibility of parole that were sentenced as juveniles 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.

[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] "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.

[4] *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.

[5] *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.

[6] 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.

[7] Nebraska Department of Correctional Services in response to a request from the *Nebraska Criminal Justice Review*, "Detail of Nebraska Inmates Serving 1st Degree Life Sentences," September 2007.

Nutrition

Voices for Children believes that all children in Nebraska 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

Food Stamps

The Food Stamp Program 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 food stamp benefits, while administrative costs are shared by the states. Food Stamp benefits, distributed via Electronic Benefit Transfer (EBT) cards, are provided by the United States Department of Agriculture (USDA) to aid families that have incomes at or below 130%

Kormick

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 Food Stamp Program. DHHS received a bonus of $1,023,369 from the U.S. Department of Agriculture (USDA) for demonstrating excellence in administering Food Stamp Program benefits. Nebraska was rewarded for payment accuracy and for a zero negative error rate in fiscal year 2007. A zero negative error rate means that DHHS is correctly distinguishing between those applicants who do and do not qualify for food stamp benefits. This is the fifth consecutive year that Nebraska has received a bonus. The Food Stamp Program 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 (see Policy Box below for more details), 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 the year 2007, 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

POLICY BOX

Strengthening America's Nutritional Safety Net:

The 2008 Farm Bill and Changes to the Food Stamp Program

The Food Stamp Program is the nation's most important food assistance program, helping low-income children and their families, as well as the elderly, disabled and unemployed individuals. The 2008 Farm Bill strengthened the Food Stamp Program in several ways, implementing changes that went into effect on October 1st, 2008. With an additional $7.8 billion added to the program over the 2009-2017 period,[1] the 2008 Farm Bill:

- Ends the erosion of the purchasing power of food stamps by raising the program's standard deduction and minimum benefit and indexing it to inflation.
- Eliminates the cap on the dependent care deduction.
- Excludes tax-preferred retirement accounts and education savings accounts from the program's asset limits.
- Fully eliminates the use of food stamp coupons in favor of the more modern Electronic Benefit Transfer (EBT) cards.
- Renames the program, which will now be called SNAP or the "Supplemental Nutrition Assistance Program."

The standard deduction in food stamp rules allows households to subtract a portion of their income to reflect the cost of non-food essentials such as housing and transportation. Prior to 1996, the standard deduction was indexed to inflation. However, benefit cuts in 1996 removed the indexation. With the standard deduction frozen at 1996 levels, recipients have seen the erosion of food stamp benefits with each passing year. The minimum benefit, having not been adjusted for nearly 30 years, will also be tied to inflation and will adjust annually. These changes are meant to ensure that food stamp benefits keep up with inflation and the rising cost of living from year to year.

The food stamp benefit formula currently allows families to deduct some of their dependent care expenses from their income in acknowledgement that money spent on caring for dependents leaves less to spend on food. The 2008 Farm Bill lifts the cap on dependent care costs, allowing families to deduct the full cost they incur. This provision will reduce the strain on food budgets for those with significant out-of-pocket child care costs or those caring for a dependent adult.

average of 120,629 persons or 51,915 households monthly in 2007. The average payment was $204.70 per household or $88.09 per person totaling $127,521,769 (99.83% of the funding was provided by the federal government). There were 63,752 children, ages 18 and under, who received food stamps in Nebraska in 2007. This is an increase from 61,523 children in 2006.

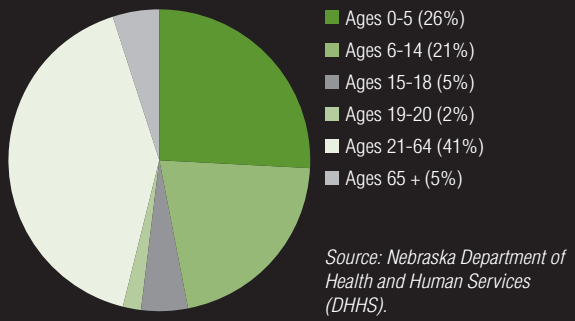
School Lunch

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 receive free lunch and at or below 185% FPL to receive

In recognition of the fact that asset development is important to helping low-income Americans transition out of poverty, the 2008 Farm Bill made changes to the food stamp asset-limit formula. The food stamp asset limits will adjust annually to reflect inflation and will exclude all tax-preferred retirement accounts and education savings accounts from countable assets. The overall asset limits had not been raised since 1986 and have decreased in real terms every year since then. Encouraging asset development in the form of retirement and education savings will allow low-income persons to make investments in their own education or that of their children and also increase their financial stability in the long-term.

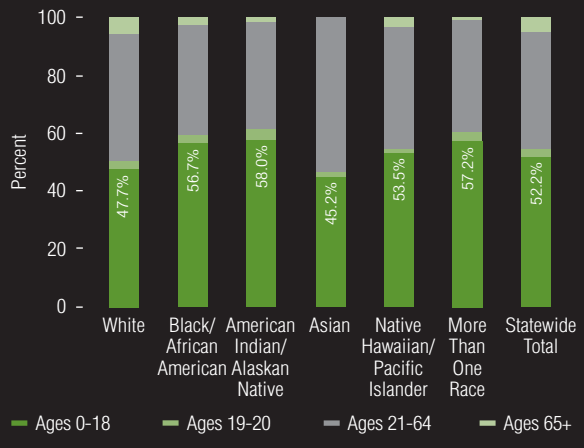
The Center on Budget and Policy Priorities estimates that an additional 49,000 Nebraskans will receive additional benefits in 2012 because of the improvements made in the 2008 Farm Bill.[2] An estimated $27 million in additional benefits will be allocated for Nebraska between FY 2009 and 2017. Food stamp benefits have an economic multiplier effect. When food stamp recipients invest benefits into the purchase of goods, production is stimulated. Beyond helping recipients put food on the table, the USDA estimates that every $5 of food stamps generates $9.20 in local economic activity, through increased production, labor and spending as it circulates through the economy.[3]

Nebraska Food Stamp Participants by Age (June 2007)



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

Food Stamp Recipients by Race and Age



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

reduced price meals (see Economic Well-Being section, page 30, for federal poverty levels). Through this program, the USDA subsidizes all lunches served in schools. During the 2006-2007 school year, 416 districts participated with 1,279 sites. There were 128,060 children found to be income eligible for free and reduced meals in October 2007. This is an increase from October 2005, in which 115,475 children were found to be income eligible for free and reduced price lunches. (See County Data section for 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 2006-2007 school year, 1,031 schools in 255 districts participated in the school breakfast program.

A total of $39,461,699.63 was reimbursed for all free/reduced breakfast and lunches in fiscal year 2007 in Nebraska.

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. An average of 8,506 meals were served daily to Nebraska children and their families through the SFSP in 2007. This is a 15% increase from 7,378 in 2006. In 2007, 25 of the 93 Nebraska counties offered the SFSP. Sites were added in Box Butte, Dodge and Knox counties for summer 2007.

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 fiscal year 2007 (July 1, 2006 to June 30, 2007), a total of 82,533 Nebraska households were served with Pantry Baskets through the Commodity Distribution Program, an average of 6,880 households per month. In this same time period, a monthly average of 52,854 persons were served in soup kitchens through this program, totaling 634,240 persons served.

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 fiscal year 2007, a monthly average of 950 women, infants and children were served by CSFP totaling 11,400 food packages. Seniors, age 60 or older, who are at or below 130% of poverty, may also participate in the program. Seniors received 138,840 food packages averaging 11,570 per month. The CSFP serves all 93 counties through 8 local non-profit agencies and 20 warehouses across the state. The monthly average number of women, infants and children served by the CSFP decreased by 16.5% in fiscal year 2007, and the monthly average number of seniors served decreased by 2%. Each year, the USDA determines the number of people who can be served, or the caseload, and allocates funds appropriately. In 2006, the CSFP did not meet their caseload, and thus, the allocated caseload for 2007 was significantly smaller.

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 supplemental foods such as milk, juice, cheese, eggs 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.

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 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 fiscal year 2007, Nebraska WIC served a monthly average of 41,482 participants (10,157 women, 10,477 infants and 20,848 children) per month through 109 clinics. Participation in the WIC program has continued to steadily increase. While 2007 Nebraska birth data were not available at the time this report was published, 55% (14,987) of the 26,723 babies born in 2006 were enrolled in the WIC program. The 2007 average cost for food benefits and nutrition services for a pregnant woman participating in the Nebraska WIC Program was approximately $684 per year (fiscal year).

[1] Congressional Budget Office as qtd. 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.

NE WIC Participation by Category for Federal Fiscal Year 2007*

Breastfeeding Women	4,341
Postpartum Women	2,713
Pregnant Women	3,103
Infants	10,477
Children	20,848
Total	41,482

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

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

WIC Participants

Year	Average Monthly Program Participants
1998	31,081
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

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

Out-of-Home Care and Adoption

Voices for Children believes that all children in Nebraska 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.

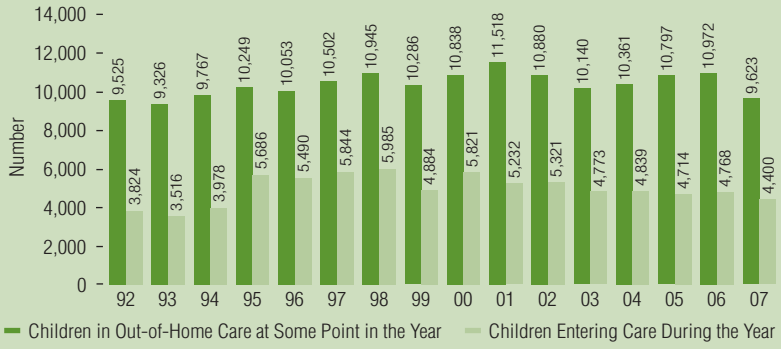
How Many Children Are in Out-of-Home Care?

In 2007, a total of 9,623 Nebraska children were in out-of-home care at some point. This was a decrease of 1,349 children, or 12.3%, from 2006. On January 1, 2006, there were 5,186 children in out-of-home care. This is also a decrease from 2006, down 16.4% (or 1,018 children). During the year, 4,400 entered care (decrease from 2006) while 4,796 children exited (an increase from 2006).

A total of 5,110 cases were closed in 2007, but 314 of those children left foster care more than once during the year, totaling 4,796 children exiting in the year. A total of 5,043 children were in care on December 31, 2007 – 143 less children in care than the previous year. Of the 4,400 children who entered care in 2007, 2,710 (61.59%) were placed in out-of-home care for the first time and 1,690 for the second time or more. Of the 5,043 children in care on December 31, 2007, 4,907 were DHHS wards.

Minority children make up 22.4% of Nebraska's child population (ages 19 and under).[1] However, children of a minority race or ethnicity represent at least 40.73% of children in out-of-home care (calculated by subtracting "White, Not Hispanic" and "Unidentified Race/Ethnicity" from the total and dividing by the total).

Children in Out-of-Home Care



Source: State Foster Care Review Board.

Angela and Jamie

Out-of-Home Care Children by Race and Ethnicity (December 31, 2007)

Race/Ethnicity	Number	Percent
American Indian, Not Hispanic	339	6.7%
Asian, Not Hispanic	27	0.5%
Black, Not Hispanic	929	18.4%
White, Not Hispanic	2,957	58.6%
Other, Not Hispanic	182	3.6%
Hispanic	482	9.6%
Multi-Racial	95	1.9%
Unidentified Race/Ethnicity	32	0.6%
Total*	5,043	100%

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

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 of decisions 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 350 trained citizen volunteers serve on local FCRBs to engage in this important review process. Com-

POLICY BOX

The Safe Haven Law in Nebraska

Voices for Children in Nebraska has had a tenuous relationship with the concept of "safe haven" laws and certainly with the Safe Haven law as codified in Nebraska during the 2008 legislative session. Our initial opposition to the concept of "Safe Haven" was based on research drawn from the Evan B. Donaldson Adoption Institute in 2003, which concluded, "There is no evidence demonstrating that these laws solve the problem at which they are aimed."[4] The research went on to suggest that these new laws might lead to unintended consequences, such as:

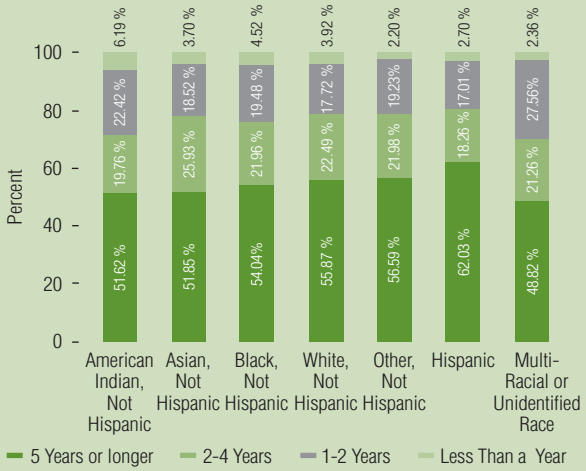
- Encouraging women to conceal pregnancies, then abandon infants who otherwise would have been placed in adoptions through established legal procedures or would have been raised by biological parents or relatives;
- Creating the opportunity for feuding family members to abandon babies without the birth mother's consent;
- Inducing abandonment by women who otherwise would not have done so because it seems "easier" than receiving parental counseling or making an adoption plan;
- Depriving biological fathers of their legal right to care for their sons or daughters, even if they have the desire and personal resources to do so;
- Ensuring that the children who are abandoned can never learn their genealogical or medical histories, even when the consequences for their health are dire;
- Precluding the possibility of personal contact and/or the exchange of medical information between birth parents and children in the future; and
- Sending a strong signal, especially to young people, that they do not have to assume responsibility for their actions and that deserting one's children is acceptable.

Voices for Children has and will continue to make the following recommendations to be discussed when considering any changes to Nebraska's Safe Haven law:

pleted 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.

In 2003, a change was made in the method for collecting data documenting the reasons for entering care. Previously, each category was broken into subcategories. Currently, no sub-category data is collected. Due to the changes, it is difficult to compare the reasons for entering out-of-home care to previous years.

Consecutive Time* in Foster Care by Race/Ethnicity (Children in Foster Care on December 31,2007)



Source: Foster Care Review Board.

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

- Ensure that only people with explicit permission and legal rights are leaving a child;
- Clarify provisions to specify process and time frame for terminating parental rights;
- Clarify immunity from civil prosecution;
- Provide a process for securing information from biological parents and provide them with counseling and support services;
- Create public service messages about child abuse prevention, parenting options, and alternatives to child abandonment;
- Create mechanisms for notifying birth fathers about abandonments and provide opportunities for them to assert their legal rights;
- Allow birth parents to regain custody within a specified time period and, if they do not, quickly terminate parental rights so that adoption can be expedited;
- Fund pregnancy prevention and permanency planning services; and
- Developing a tracking system for "Safe Haven" cases.

Nebraska's Safe Haven law, in providing an avenue for child abandonment at any age, has shed light on a critical absence of services, specifically physical and behavioral health services, for children of all ages and their families. Ultimately, Voices for Children in Nebraska believes that the concept of "safe haven" should be focused on infants. While saving the lives of children is a critically important objective, our support for changing the age parameters in Nebraska's Safe Haven law will be predicated upon whether or not steps are taken to increase access and awareness of these support services for older children and families before age limits are changed under Nebraska's Safe Haven law. To change the age provisions of Nebraska's Safe Haven law without increasing access to basic family supports and prevention services would only serve to jeopardize the safety of older children. Voices for Children in Nebraska will continue to advocate for implementation and funding of a full and effective array of services for children and their parents to support them even in the most difficult times and prevent a child's entry into the limbo of foster care. The Safe Haven law, as created, only opens another door into the foster care system. Our money would be better spent and would support better outcomes for child well-being if invested in prevention and service provision.

Summary of Reasons Children Entered Foster Care for Children Reviewed During 2007

Reasons for Entering Foster Care Identified Upon Removal[i]

			By Number of Removals			
Category	All children reviewed- reasons for entering care upon removal (Frequency)		Reasons for reviewed children who were in foster care for the first time		Reasons for reviewed children who had been in foster care at least once previously	
Neglect[ii]	2,417	63.5%	1,561	62.4%	856	65.6%
Parental Drug Abuse	1,465	38.5%	1,043	41.7%	422	32.7%
Parental Meth Abuse	400	10.5%	309	12.4%	91	7.0%
Parental Alcohol Abuse	607	16.0%	382	15.3%	225	17.3%
Housing Substandard/Unsafe	953	25.0%	585	23.4%	368	28.2%
Physical Abuse	875	23.0%	529	21.1%	346	26.5%
Parental Incarceration	428	11.6%	275	11.0%	153	11.7%
Abandonment	339	8.9%	202	8.1%	137	10.5%
Sexual Abuse[iii]	326	8.6%	208	8.3%	118	9.1%
Parental Illness/Disability	345	9.1%	214	8.6%	131	10.1%
Death of Parent(s)	93	2.4%	44	1.8%	49	3.8%
Relinquishment	33	0.9%	7	0.3%	26	2.0%
Child's Behaviors	739	19.4%	324	13.0%	415	31.8%
Child's Mental Health	137	3.6%	52	2.1%	85	6.5%
Child's Disabilities	101	2.7%	60	2.4%	41	3.1%
Child's Drug Abuse	89	2.3%	35	1.4%	54	4.1%
Child's Alcohol Abuse	51	1.3%	25	1.0%	26	2.0%
Child's Illness	55	1.6%	33	1.3%	22	1.7%
Child's Suicide Attempt	16	0.4%	7	.3%	9	.7%
Total Children Reviewed	3,806		2,502		1,304	

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

Source: State Foster Care Review Board.

Neglect is the most frequently recorded cause for removal of children from their parent(s)' or guardian(s)' home. 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 substandard or unsafe housing.

Comparing data between 2006 and 2007, we saw major increases in the reasons for removal in children who had previously been in foster care in the areas of neglect (up from 44.2% in 2006 to 65.64% of removals in 2007), parental drug abuse (up from 20.3% in 2006 to 32.36% of removals in 2007), parental alcohol abuse (up from 10.6% in 2006 to 17.25% of removals in 2007), substandard or unsafe housing (up from 19.5% in 2006 to 28.22% of removals in 2007), and physical abuse (up from 19.4% in 2006 to 26.53% of removals in 2007). These reasons for removal must be monitored closely to ensure that a pattern is not developing in which children are being returned to unsafe situations of neglect, parental drug or alcohol abuse, unsafe/substandard housing, or physical abuse, only to then to be subsequently removed because prior issues have not been dealt with effectively.

Out-Of-Home Care Placements

There are a variety of placement possibilities for children in out-of-home care. Of the 5,043 children in care on December 31, 2007, there were 2,148 (42.59%) in foster homes, 1,057 (20.96%) placed with relatives, 815 (16.16%) in group homes or residential treatment centers, 470 (9.32%) in jail/youth development centers, 2 in private adoptive homes not yet finalized and 258 in emergency shelters. The remaining children were involved in: Job Corps/schools; centers for the disabled; psychiatric, medical, or drug/alcohol treatment facilities; or child caring agencies. Lastly, 121 were runaways/whereabouts unknown and 59 were living independently as they were near adulthood.

Of those children who left foster care during 2007, the majority of them were returned to their parents (3,473 or

67.96%) and 446 children (8.73%) left foster care because they were adopted. Nearly 400 children reached the age of majority and became independent (397 or 7.77%) and exactly the same number of children, 397, left corrections (presumably returned to their parents). Three children died while in foster care in 2007.

Licensed and Approved Foster Homes

In December 2007, there were 2,338 licensed foster homes, a decrease of 258 homes from December 2006. 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 2007, there were 1,845 approved foster homes, a decrease of 1,062 approved foster homes from 2006. There were large increases in licensed and approved foster homes between December 2005 and December 2006 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 reversed this year, losing 258 licensed homes and 1,062 approved homes between December 2006 and December 2007. As the total number of youth in foster care has decreased, it follows appropriately that there would be a corresponding decrease in the number of licensed and approved homes. Some of the additional losses in licensed homes may have resulted because the licensed homes adopted 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 placed in an approved home.

Lack of Foster Care Homes

According to DHHS, a total of 4,183 approved or licensed homes were available in Nebraska in December 2007. This is a decrease of 1,508 possible placements from December 2006, following an increase of 1,523 approved and licensed homes between December 2005 and December 2006. The number of children in need of foster homes has continued to rise for a number of years, thus creating an ongoing need for foster placements. Foster care providers are 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 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. See page 77 of this report for definitions.

In 2006, 55.1% of children in foster care on December 31, 2006 had experienced four or more placements. In 2007, that statistic has decreased to just a little over half of the youth in foster care on December 31, 2007 experiencing four or more placements (51.68%). Generally, Black and American Indian youth experienced the most placements,

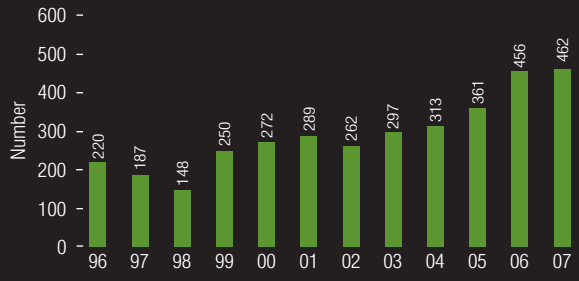
Alicia and Ashley

Number of Placements by Race and Ethnicity
(Percent of children in foster care on 12/31/07)

Race/Ethnicity	1 to 3 Placements	4 or More Placements
American Indian, Not Hispanic	44.84%	55.16%
Asian, Not Hispanic	59.26%	40.74%
Black, Not Hispanic	40.15%	59.85%
White, Not Hispanic	49.5%	50.15%
Other, Not Hispanic	50.55%	49.45%
Hispanic	51.24%	48.76%
Multi-Racial	60.0%	40.00%
Unidentified Race/Ethnicity	81.25%	18.75%
Statewide Total	48.32%	51.68%

Source: State Foster Care Review Board

State Ward Adoptions in Nebraska (1996-2007)



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

Note: Due to updated data, these numbers are different than those reported in years prior to the 2007 report.

compared to all other youth in foster care on December 31, 2007. Approximately 25% (24.48%) of American Indian youth in care on that date had experienced 10 or more placements, and just over 20% of Black youth (21.3%) had experienced 10 or more placements. Sixteen percent of White youth (16.33%) and nearly 15% of Hispanics (14.94%) had 10 or more placements.

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, has developed a book of information on adoption and adoption subsidies for adoptive parents.

In calendar year 2007, there were 462 adoptions of state wards finalized in Nebraska. This is a small increase from 2006, following a 79% increase in state ward adoptions from 2005. Contributing factors to the rise in adoptions were the "Through the 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.

[1] U.S. Census Bureau, 2007 Population Estimates Program – Age, Sex, and Race/Ethnicity Estimates for Counties, released 8-7-08: 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] Evan B. Donaldson Adoption Institute, "Unintended Consequences: 'Safe Haven' Laws are Causing Problems, Not Solving Them."

2008 County Data Notes

1. TOTAL COUNTY POPULATION IN 2007

   Source: U.S. Census Bureau, 2007 Population Estimates Program – Age, Sex, and Race/Ethnicity Estimates for Counties, released 8-7-08: Compiled by Center for Public Affairs Research, University of Nebraska Omaha.

2. CHILDREN 19 AND UNDER IN 2007

   Source: U.S. Census Bureau, 2007 Population Estimates Program – Age, Sex, and Race/Ethnicity Estimates for Counties, released 8-7-08: Compiled by Center for Public Affairs Research, University of Nebraska Omaha.

3. CHILDREN UNDER 5 IN 2007

   Source: U.S. Census Bureau, 2007 Population Estimates Program – Age, Sex, and Race/Ethnicity Estimates for Counties, released 8-7-08: Compiled by Center for Public Affairs Research, University of Nebraska Omaha.

4. MINORITY CHILDREN 19 AND UNDER IN 2007

   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, 2007 Population Estimates Program – Age, Sex, and Race/Ethnicity Estimates for Counties, released 8-7-08: Compiled by Center for Public Affairs Research, University of Nebraska Omaha.

5. PERCENT OF RELATED CHILDREN AGES 17 AND UNDER LIVING IN POVERTY

   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

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

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

   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

    Data has been corrected since 2007 Kids Count report.

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

11. AVERAGE MONTHLY NUMBER OF FAMILIES ON ADC IN SFY 2007

    There was a monthly average of 12 families on ADC in 2007 that were out-of-state.

    Source: Financial and Program Services, DHHS.

12. AVERAGE MONTHLY NUMBER OF CHILDREN ELIGIBLE FOR MEDICAID AND SCHIP SERVICES IN 2007

    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. There were 1,128 average monthly out-of-state eligibles in 2007.

    Source: Financial and Program Services, DHHS.

13. NUMBER OF CHILDREN AGES 18 AND UNDER RECEIVING FOOD STAMP BENEFITS IN JUNE 2007

    There were 119 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 2007

    Source: DHHS.

15. AVERAGE NUMBER OF FREE/REDUCED LUNCHES SERVED DAILY IN OCTOBER 2007

    Calculated as the total number of free and reduced lunches served in October 2007 divided by the average number of days that meals were served.

    Source: Nebraska Department of Education.

2008 County Data Notes continued

16. PERCENTAGE OF STUDENTS ELIGIBLE FOR FREE AND REDUCED PRICE MEALS

For counties with multiple school districts, district percentages were averaged to create a county average. 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 2007

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 2006

2007 data were not available.

Source: Vital Statistics, DHHS.

19. TEEN BIRTH RATE AGES 10-19 IN 2006

Number of teen births, ages 19 and under, per 1,000 total births (rounded to nearest whole number).

Source: Vital Statistics, DHHS.

20. NUMBER OF BIRTHS TO TEENS AGES 10 TO 17 YEARS OLD FROM 1997 to 2006

2007 data were not available.

Source: Vital Statistics, DHHS.

21. NUMBER OF OUT-OF-WEDLOCK BIRTHS FROM 1997 TO 2006

2007 data were not available.

Source: Vital Statistics, DHHS.

22. NUMBER OF INFANT DEATHS FROM 1997 to 2006

2007 data were not available. We reported 1995-2004 data in our 2007 Kids Count. Data for 1996-2005 data are available on our website through our CLIKS database.

Source: Vital Statistics, DHHS.

23. CHILD DEATHS (AGES 1 TO 19) FROM 1997 to 2006

2007 data were not available. We reported 1995-2004 data in our 2007 Kids Count. Data for 1996-2005 data are available on our website through our CLIKS database.

Source: Vital Statistics, DHHS.

24. NUMBER OF INFANTS BORN AT LOW BIRTH WEIGHTS IN 2006

2007 data were not available.

Source: Vital Statistics, DHHS.

25. HIGH SCHOOL GRADUATES 2006-2007 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 2006-2007 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 DECEMBER 1, 2007

Source: Nebraska Department of Education.

28. COST PER PUPIL FOR THE 2006-2007 SCHOOL YEAR BY AVERAGE DAILY MEMBERSHIP

Source: Nebraska Department of Education.

29. HEAD START and EARLY HEAD START ENROLLMENT FOR NOVEMBER 2007

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, 2007.

Statewide total includes 111 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 1998-2007

There were 38 STD geographically unidentified or "missing" cases.

Source: DHHS.

32. JUVENILE ARRESTS 2007

Note: County data marked in bold and italics indicates that some agencies within the county were delinquent in reporting 2007 juvenile arrest data. Therefore, this data may not reflect a true total of juvenile arrests in 2007.

One juvenile arrest, included in the state total, occurred on state property, but was not allocated to any county.

Source: Nebraska Commission on Law Enforcement and Criminal Justice.

33. PERCENT OF CHILDREN AGES 17 AND UNDER THAT WERE UNINSURED IN 2005

Note: The SAHIE Nebraska uninsured totals for ages 17 and under are significantly lower than the most recently released U.S. Census Bureau's 2008 Current Population Survey which found 45,000 uninsured children in Nebraska in 2007 of the same age group. The 2005 SAHIE estimates do not capture the large increase of uninsured children in Nebraska that has occurred since 2005. These estimates are most likely an underestimate of the number of uninsured children in each county.

Source: U.S. Census Bureau, Small Area Health Insurance Estimates Program (SAHIE), 2005 Experimental Counties and States Estimates by Demographic and Income Characteristics, Released October 2008.

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 include the most current population estimates available, provided by the U.S. Census Bureau, 2007 Population Estimates Program – Age, Sex, and Race/Ethnicity Estimates for Counties, released 8-7-08: 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 was previously provided counted children 17 and under.
- County Data Indicator #10 has been corrected. The data source remains the same, U.S. Census 2000, however many of the county calculations had to be corrected.
- County Data Indicator #33 – These data were obtained from the U.S. Census Bureau's Small Area Health Estimates Program (SAHIE) in 2005. We believe these data underestimate the growing number of uninsured children in Nebraska. Statewide data from the U.S. Census Bureau's (2008 CPS) for 2007 places the state total of uninsured children ages 17 and under at 45,000 or 9.9%. However, we chose to report the SAHIE data because it is the only source, that we are aware of, which provides county-level data on uninsured children.

2008 County Data

	1. Total Population (2007)	2. Children 19 & Under (2007)	3. Children Under 5 (2007)	4. Minority Children 19 & Under (2007)	5. % Children 17 & Under in Poverty (2000)	6. % Children Under 5 in Poverty (2000)	7. % Minority Children 17 & Under in Poverty (2000)	8. % Children 17 & Under in Poverty Single Parent Household (2000)	9. % Children 17 & Under in Poverty/ Married-Couple Family (2000)	10. % Mothers in Labor Force with Children Under 6 (2000)	11. Families on ADC (2007)	12. Medicaid and SCHIP Eligible Children (2007)	13. Food Stamp Participation Children 18 & Under (June 2007)	14. WIC Participation (Sept. 2007)	15. Free/Reduced School Lunch (Oct. 2007)	16. % Students Eligible for Free/ Reduced Meals (Oct. 2007)	17. Summer Food Program (2007)
Adams	32,990	9,023	2,171	1,409	10	12	17	68	32	73	192	2,480	1,000	725	1,675	32	217
Antelope	6,757	1,657	339	66	17	19	39	41	59	87	15	558	187	116	514	46	
Arthur	356	94	28	6	15	20	50	38	62	100	0	31	3	1	0	0	
Banner	734	159	23	23	19	8	69	31	69	59	1	58	17	13	57	48	
Blaine	448	98	25	3	22	32	0	3	97	70	2	51	6	16	113	54	
Boone	5,527	1,428	270	44	12	15	18	28	72	81	7	257	115	134	326	42	
Box Butte	11,001	2,960	705	684	14	18	37	68	32	73	70	1,005	545	322	569	41	48
Boyd	2,119	453	74	8	20	16	0	21	79	76	3	157	33	53	150	52	
Brown	3,207	697	153	18	15	22	46	45	55	83	3	240	67	69	149	34	
Buffalo	44,976	12,884	3,201	1,514	11	14	24	71	29	79	212	3,351	1,554	1,009	2,083	30	444
Burt	7,059	1,703	369	131	12	9	13	56	44	80	24	436	191	137	331	35	
Butler	8,377	2,177	431	110	10	14	33	29	71	77	16	419	171	135	618	40	
Cass	25,577	7,095	1,631	430	7	12	5	68	32	76	60	1,350	517	353	986	25	
Cedar	8,530	2,323	491	54	11	8	0	23	77	85	5	376	80	134	485	32	
Chase	3,698	819	203	107	11	16	15	41	59	69	10	245	100	96	238	40	
Cherry	5,718	1,420	336	153	13	17	22	44	56	72	22	572	174	147	288	47	
Cheyenne	9,972	2,610	664	300	12	15	31	57	43	74	25	621	266	163	459	35	197
Clay	6,330	1,563	323	187	13	16	26	40	60	75	21	420	179	119	280	36	115
Colfax	9,974	3,139	957	1,647	14	16	21	26	74	73	44	857	259	590	1,128	35	
Cuming	9,365	2,467	624	411	10	14	24	34	66	74	8	458	132	182	951	41	
Custer	10,849	2,823	636	124	16	20	26	36	64	79	22	905	247	299	599	43	
Dakota	20,312	6,748	1,821	3,486	15	17	23	67	33	70	109	2,207	958	1,120	1,726	33	192
Dawes	8,818	2,420	476	359	14	31	32	47	53	77	46	737	367	186	343	47	91
Dawson	24,744	7,927	2,181	3,733	14	16	21	48	52	72	121	2,651	1,035	1,163	2,350	52	476
Deuel	1,893	384	91	19	12	13	29	42	58	94	5	97	53	55	129	49	
Dixon	6,243	1,616	383	244	12	17	12	46	54	85	9	351	123	107	251	36	
Dodge	36,004	9,496	2,489	1,468	10	14	22	53	47	73	177	2,794	1,377	1,134	5,313	36	184
Douglas	497,416	146,918	41,284	49,706	13	14	31	77	23	72	5,270	44,538	24,303	12,783	54,084	26	1,838
Dundy	2,031	426	81	51	16	16	31	24	76	91	3	164	34	37	180	50	
Fillmore	6,051	1,529	324	132	8	11	21	56	44	72	13	457	145	121	327	25	
Franklin	3,158	688	139	15	17	15	43	41	59	77	8	201	71	66	115	45	
Frontier	2,663	650	110	14	10	10	10	30	70	74	5	159	66	45	196	38	
Furnas	4,732	1,071	225	54	15	17	44	45	55	69	13	377	134	109	551	45	
Gage	23,219	5,611	1,364	308	10	13	26	53	47	84	71	1,466	745	541	892	28	
Garden	1,834	331	69	19	22	22	52	26	74	92	3	149	45	22	140	60	34
Garfield	1,722	386	70	16	12	11	0	8	92	85	5	154	47	53	95	37	
Gosper	1,971	436	97	16	11	6	0	22	78	89	5	104	44	35	72	41	
Grant	613	133	22	1	17	21	0	50	50	33	1	41	10	16	50	41	
Greeley	2,326	603	129	31	22	23	0	46	54	73	6	188	46	81	301	63	
Hall	55,642	16,400	4,629	5,589	16	20	29	59	41	71	393	6,047	2,760	2,363	5,088	36	899
Hamilton	9,298	2,521	527	105	10	10	37	51	49	80	13	512	195	172	402	26	
Harlan	3,392	749	147	25	14	20	4	17	83	77	12	232	97	44	118	43	

County Indicator	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.
Hayes	980	217	34	16	26	26	46	3	97	54	1	43	6	10	45	42	
Hitchcock	2,844	641	153	43	23	26	37	33	67	64	6	257	102	81	109	53	
Holt	10,312	2,570	555	102	15	13	22	14	86	80	24	793	254	311	649	48	101
Hooker	736	151	39	2	5	6	0	30	70	71	1	46	18	11	74	44	
Howard	6,612	1,720	431	80	14	13	24	35	65	79	17	455	151	152	411	45	
Jefferson	7,516	1,672	378	80	10	15	8	51	49	72	26	467	257	167	539	38	63
Johnson	4,476	981	252	245	11	11	11	40	60	79	15	286	100	98	251	34	72
Kearney	6,602	1,677	381	111	10	10	2	56	44	78	13	397	132	94	264	29	
Keith	8,024	1,881	428	158	13	20	25	40	60	69	19	574	255	174	360	29	
Keya Paha	850	205	43	19	34	46	0	12	88	48	2	65	12	8	49	61	
Kimball	3,602	843	171	78	12	13	22	29	71	82	18	334	114	85	168	35	
Knox	8,665	2,175	488	402	20	23	36	27	73	72	40	800	316	109	660	54	50
Lancaster	275,665	75,684	20,318	13,813	10	12	24	67	33	77	1,207	17,585	8,921	5,832	9,467	17	761
Lincoln	35,500	9,663	2,504	1,233	12	16	21	64	36	74	176	2,792	1,533	956	2,819	29	318
Logan	745	187	54	7	13	18	11	32	68	100	4	47	8	15	65	36	
Loup	644	146	24	9	23	23	9	5	95	56	1	35	4	12	55	63	
Madison	502	120	23	5	13	17	32	55	45	76	175	2,987	1,436	1,088	2,205	40	118
McPherson	34,134	9,743	2,563	2,078	22	11	100	19	81	70	1	29	13	11	0	0	
Merrick	7,690	1,979	425	114	10	10	25	61	39	76	16	495	157	180	365	33	
Morrill	5,047	1,293	307	294	20	24	36	27	73	69	22	517	244	113	464	55	66
Nance	3,572	882	188	31	17	24	23	30	70	76	5	251	75	65	264	34	
Nemaha	7,039	1,669	383	114	13	20	0	35	65	70	29	461	265	131	308	31	
Nuckolls	4,533	1,014	271	49	17	17	39	33	67	83	15	283	95	83	415	38	
Otoe	15,647	4,057	971	399	9	14	28	53	47	81	53	878	391	279	773	26	
Pawnee	2,686	564	100	22	14	14	0	37	63	75	6	165	71	40	226	51	
Perkins	2,928	690	156	52	20	25	17	24	76	63	7	162	47	46	104	36	
Phelps	9,175	2,362	538	178	12	12	34	43	57	75	33	609	247	185	408	31	
Pierce	7,284	1,985	434	64	14	18	28	30	70	84	10	366	126	125	405	31	
Platte	31,849	9,161	2,259	1,736	9	11	20	43	57	75	98	1,950	823	764	1,835	36	
Polk	5,208	1,268	308	73	7	11	48	42	58	77	10	257	130	55	382	35	
Red Willow	10,748	2,763	649	228	11	14	17	65	35	85	24	809	310	296	1,153	46	
Richardson	8,351	1,952	429	200	11	15	29	60	40	75	22	639	332	155	595	47	24
Rock	1,515	293	71	6	36	36	63	22	78	65	2	121	29	31	142	44	
Saline	13,873	3,909	931	1,140	9	7	21	51	49	71	28	920	270	478	823	27	
Sarpy	146,756	46,208	12,545	8,096	5	6	8	60	40	74	416	5,540	2,502	1,991	3,649	15	1,110
Saunders	20,184	5,456	1,257	272	7	10	8	46	54	75	40	985	386	292	831	28	
Scotts Bluff	36,370	9,924	2,583	3,259	22	26	42	58	42	73	275	4,066	2,070	1,189	2,144	53	566
Seward	16,554	4,570	978	266	6	8	9	43	57	78	20	594	229	188	521	20	
Sheridan	5,450	1,346	323	375	20	27	42	48	51	72	30	597	249	163	371	53	92
Sherman	3,013	691	157	23	19	33	0	27	73	59	6	215	56	79	244	52	
Sioux	1,351	288	55	20	24	12	0	26	74	58	2	68	12	5	0	3	
Stanton	6,395	1,807	399	149	7	5	25	68	32	82	9	326	128	57	161	39	
Thayer	5,163	1,177	235	59	15	16	51	55	45	77	12	319	90	91	320	37	
Thomas	600	121	31	3	21	10	0	14	86	76	1	43	15	25	33	45	
Thurston	7,208	2,760	725	2,034	33	34	41	61	39	69	268	1,679	1,104	47	955	71	432
Valley	4,263	980	217	57	16	17	58	47	53	74	10	328	111	88	202	38	
Washington	19,959	5,276	1,139	346	8	12	13	46	54	79	33	759	336	211	733	16	
Wayne	9,317	2,518	484	230	11	16	40	48	52	80	27	401	170	120	454	33	
Webster	3,609	782	136	28	14	12	27	30	70	65	9	219	83	40	175	42	
Wheeler	809	209	37	4	28	32	100	19	81	56	0	71	9	9	52	58	
York	14,370	3,777	924	434	10	13	56	41	59	79	17	953	341	305	651	33	
State Total	1,774,571	498,642	129,796	111,656	12	14	27	60	40	74	10,313	133,637	63,752	42,206	125,712	36	8,506

2008 County Data

	18. Total Births (2006)	19. Teen Birth Rate Ages 10-19 (2006)	20. Number of Teen Births Ages 10-17 (1997-2006)	21. Number of Out-of-Wedlock Births (1997-2006)	22. Infant Deaths (1997-2006)	23. Child Deaths Ages 1-19 (1997-2006)	24. Low Birth Weight (2006)	25. Graduates (2006-2007)	26. Dropouts (2006-2007)	27. Special Education (Dec. 1, 2007)	28. Cost Per Pupil (2006-2007)	29. Head Start (Nov. 2007)	30. Foster Care (Dec. 31, 2007)	31. STDs 19 & Under (1998-2007)	32. Juvenile Arrests (2007)	33. % Uninsured Children Age 17 & Under (2005)
Adams	444	104	139	1,242	31	29	31	346	29	918	$9,400.92	162	98	278	277	7
Antelope	76	79	14	148	4	6	4	125	2	201	$11,451.67	15	8	16	***5***	14
Arthur	6	0	0	5	0	0	0	****	0	15	$18,428.32	0	0	0	0	23
Banner	7	429	0	7	1	1	0	****	****	16	$13,159.42	0	0	0	***1***	23
Blaine	6	0	0	1	0	0	0	13	0	22	$15,172.63	0	0	1	***0***	16
Boone	46	65	14	127	4	8	2	97	3	143	$10,946.32	17	2	12	***2***	15
Box Butte	150	113	46	470	5	11	11	133	3	401	$9,589.23	0	8	45	180	8
Boyd	13	77	3	22	2	5	0	50	0	85	$13,483.24	0	4	2	10	14
Brown	31	32	10	65	1	6	3	48	****	70	$10,909.21	26	2	17	0	17
Buffalo	709	59	120	1,532	35	41	43	566	76	1,113	$8,429.33	116	87	358	553	7
Burt	81	86	23	204	1	8	4	94	5	254	$9,711.26	17	8	19	***21***	12
Butler	98	61	16	202	2	10	7	112	2	220	$9,915.06	0	28	12	34	10
Cass	301	70	80	760	22	26	15	234	10	687	$9,097.74	140	48	127	49	8
Cedar	108	46	11	158	6	18	5	171	3	220	$11,252.66	17	1	7	4	16
Chase	43	116	13	103	2	7	2	69	4	92	$11,482.55	10	7	3	14	17
Cherry	67	104	20	203	3	8	6	71	7	104	$12,380.19	0	11	2	31	7
Cheyenne	121	74	40	349	11	12	9	119	7	285	$9,523.59	40	13	18	81	7
Clay	82	85	16	176	2	12	4	46	3	156	$10,591.88	36	11	13	***1***	15
Colfax	173	145	97	682	17	19	6	172	17	247	$9,048.57	75	24	25	116	15
Cuming	110	82	35	278	6	7	10	164	4	262	$9,388.54	38	18	16	10	15
Custer	131	69	33	257	9	7	6	152	1	297	$10,948.68	27	19	21	60	10
Dakota	374	94	156	1,479	22	19	29	210	39	621	$8,610.63	140	51	188	249	9
Dawes	95	63	22	271	3	3	6	172	35	172	$10,062.40	0	10	136	18	7
Dawson	418	127	196	1,500	34	56	26	306	44	886	$8,748.13	61	47	120	346	10
Deuel	21	95	7	44	0	5	1	36	5	59	$13,820.10	15	5	2	4	13
Dixon	83	48	25	201	3	7	6	98	5	172	$8,837.20	4	12	14	30	16
Dodge	494	67	130	1,434	34	41	39	409	108	1,192	$8,371.13	125	74	257	290	7
Douglas	8,548	86	2,769	25,751	578	440	704	5,674	1,244	13,239	$8,671.92	1,088	1,811	12,682	4,429	5
Dundy	14	71	4	40	0	4	1	****	0	86	$12,516.50	10	4	1	***0***	20
Fillmore	61	66	19	129	5	13	7	99	1	256	$11,064.73	18	20	82	***0***	11
Franklin	33	61	5	59	0	2	2	34	0	48	$10,461.04	32	1	1	4	12
Frontier	28	107	8	51	1	7	3	52	1	92	$11,505.25	10	4	8	6	16
Furnas	43	47	15	90	3	8	0	86	2	205	$11,279.57	20	9	11	17	12
Gage	277	87	73	696	16	32	17	226	20	639	$8,965.64	74	41	83	241	5
Garden	16	125	3	34	1	4	2	33	****	36	$14,629.21	7	6	6	0	13
Garfield	16	0	3	26	1	2	1	22	0	49	$11,114.42	17	3	1	***0***	12
Gosper	26	38	8	50	4	2	0	****	****	74	$10,952.75	10	3	3	2	19
Grant	7	0	0	5	1	4	0	16	0	19	$18,290.83	0	0	3	***0***	17
Greeley	26	77	9	54	3	3	1	56	0	96	$12,429.58	16	11	3	***8***	18
Hall	969	101	409	3,387	74	61	59	684	126	1,461	$7,886.21	185	185	436	478	7
Hamilton	103	29	22	180	5	7	14	119	1	291	$9,145.98	18	15	22	2	8
Harlan	40	50	5	68	2	3	1	27	0	71	$9,103.85	10	10	4	8	15

County Indicator	18.	19.	20.	21.	22.	23.	24.	25.	26.	27.	28.	29.	30.	31.	32.	33.
Hayes	9	111	3	11	0	2	0	18	0	16	$16,040.10	0	3	2	***2***	24
Hitchcock	27	74	6	66	3	2	2	*****	0	48	$13,736.08	10	3	1	1	13
Holt	124	48	30	251	10	13	8	183	5	285	$11,466.81	46	11	19	39	10
Hooker	4	0	1	10	0	0	0	15	0	23	$12,980.03	0	1	0	0	14
Howard	72	14	17	179	2	4	1	104	6	180	$9,401.75	20	7	19	9	12
Jefferson	76	92	27	196	5	8	8	137	7	363	$10,721.67	31	10	22	70	8
Johnson	66	91	14	125	2	8	2	68	2	118	$10,403.06	0	11	23	***0***	15
Kearney	76	53	16	147	6	8	5	114	7	304	$9,832.35	17	4	14	56	11
Keith	91	121	40	268	7	8	10	108	3	163	$9,807.59	17	20	24	82	11
Keya Paha	15	67	3	12	0	0	2	13	0	5	$15,613.29	0	0	0	5	17
Kimball	48	83	12	128	2	3	5	37	8	80	$12,444.55	20	13	16	***2***	13
Knox	102	88	32	307	7	20	7	136	2	266	$10,854.50	52	4	18	4	10
Lancaster	4,095	68	987	9,870	236	166	283	2,614	504	6,430	$8,481.64	600	1,057	3,528	3,224	5
Lincoln	512	96	136	1,452	30	39	41	388	15	1,130	$8,644.80	70	201	184	368	7
Logan	15	0	2	15	1	2	1	16	0	42	$12,824.46	0	0	1	***0***	21
Loup	3	0	1	5	0	1	0	*****	0	25	$12,456.64	0	0	0	***0***	20
Madison	536	123	194	1,813	39	35	32	473	29	982	$9,653.78	112	87	274	521	10
McPherson	8	0	1	9	0	1	0	12	0	13	$17,476.82	0	0	1	***0***	22
Merrick	77	52	12	201	5	11	8	97	5	151	$9,063.13	16	15	17	1	11
Morrill	50	100	22	161	7	10	5	75	3	119	$9,425.40	20	11	30	55	12
Nance	39	51	15	103	4	8	3	73	3	119	$9,112.54	16	6	8	2	14
Nemaha	87	80	19	186	3	10	10	80	4	189	$9,047.62	32	5	28	53	8
Nuckolls	50	160	16	103	4	5	2	*****	*****	273	$12,008.76	35	3	17	***0***	13
Otoe	189	138	61	524	17	20	20	202	17	498	$8,419.93	55	8	60	***71***	9
Pawnee	25	0	5	46	1	3	3	43	3	95	$11,208.45	17	3	4	0	13
Perkins	40	50	4	50	1	2	2	38	*****	76	$11,950.23	10	3	2	2	21
Phelps	117	43	27	253	2	8	2	103	6	334	$9,160.09	17	24	16	47	8
Pierce	81	49	15	168	5	8	2	130	4	235	$9,475.92	4	4	15	***11***	14
Platte	499	90	151	1,237	31	40	17	452	28	779	$8,356.37	189	54	135	352	10
Polk	64	31	7	103	2	8	5	107	3	180	$10,318.07	0	11	13	18	13
Red Willow	121	99	40	364	5	8	4	151	5	380	$8,068.98	18	27	58	138	8
Richardson	84	83	32	279	6	13	5	137	3	290	$10,669.02	52	8	38	49	7
Rock	16	0	4	14	1	1	3	20	0	26	$15,182.19	0	1	1	2	18
Saline	221	86	56	528	8	12	14	189	20	424	$8,707.04	52	21	73	86	13
Sarpy	2,520	50	358	4,012	110	88	188	1,706	61	3,129	$8,296.85	185	210	980	1,514	6
Saunders	246	41	38	435	14	23	17	291	7	427	$8,955.47	44	27	51	83	8
Scotts Bluff	552	127	295	2,050	36	47	30	383	50	742	$9,812.33	334	194	372	581	6
Seward	202	40	26	313	7	15	17	219	12	363	$8,831.42	18	29	37	108	9
Sheridan	68	88	27	240	4	7	1	75	3	134	$12,554.64	0	9	25	***38***	9
Sherman	27	37	7	73	3	4	1	37	0	90	$10,533.41	18	6	6	0	15
Sioux	10	100	1	12	0	0	0	*****	0	12	$19,588.64	0	0	1	7	17
Stanton	90	100	21	158	0	7	4	*****	0	84	$10,045.04	17	1	10	68	13
Thayer	63	63	9	85	2	10	8	73	2	160	$12,682.24	17	8	10	21	14
Thomas	9	0	2	7	1	3	2	*****	0	19	$15,166.82	0	0	2	***2***	20
Thurston	174	213	132	1,096	15	15	7	80	30	354	$13,208.13	208	13	304	1	5
Valley	56	18	10	90	4	7	1	53	1	98	$11,091.94	17	10	8	***18***	13
Washington	234	38	36	435	16	18	14	244	3	503	$8,300.19	18	17	86	131	10
Wayne	111	72	13	247	9	10	3	122	7	239	$9,076.69	18	4	51	22	9
Webster	30	33	9	82	3	5	3	56	0	123	$9,578.30	37	10	5	12	12
Wheeler	6	0	0	13	2	1	0	21	0	18	$13,469.59	0	0	0	0	21
York	191	89	29	451	8	8	15	196	19	418	$10,224.42	51	39	31	191	8
State Total	26,723	80	7,639	71,523	1,640	1,719	1,910	21,240	2,709	47,126	$9,023.44	5,106	5,043	21,733	15,649	7

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 polulation. 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 judgment 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."

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.

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, STD's, 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.

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., pre-placement visits with a subsequent foster care provider or pre-adoptive 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.